

GRANT WHEATLEY
CHURCHILL FELLOWSHIP REPORT, DECEMBER 2006

**THE WINSTON CHURCHILL
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CHURCHILL FELLOWSHIP 2005

Investigation into the classification systems for students with
psychiatric disabilities and relevant service models existing between
education and health.

Prepared By:

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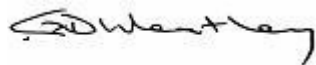
Investigation of the classification systems for students with psychiatric disabilities and relevant service models existing between education and health.

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Dated 25/1/07

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1. ACKNOWLEDGEMENTS

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- Last but certainly not least, my family; my wife Dianne who accompanied me on this trip and as always gave me the love and support I needed to achieve my goals; my sister in law who helped us so much in 2006; and my father, mother and sister who are always there for me.

2. EXECUTIVE SUMMARY

Fellowship Objective

To investigate the classification systems for students with psychiatric disabilities and relevant service models existing between the education and health.

Fellowship Highlights

All of it.

Conclusions, Dissemination and Implementation

Western Australia has a good sub-structure for the support of students with psychiatric disability. Processes for high level collaboration between Education and Health, the expansion of the existing continuum of services and policy development are recommended in this report. A draft of this report has been consulted on by colleagues within Western Australia, across Australia and in the countries I visited. After I have briefed the Department of Education and Training (DET), I will present my report to a variety of audiences such as, the National Directors of Student Services Forum, the Association of Independent Schools of Western Australia, the Mental Health Network (DoH) and the Hospital Organisation of Pedagogues of Europe (HOPE) association. Implementation of some of my recommendations is already occurring, others are a matter of policy direction and yet others will require successful budget bids and major support from the system to come to fruition. Regardless of the extent of implementation, the fellowship was a great experience for me on both a personal and professional level and has elevated my thinking in this area of dramatic need. My only hope is that my work may contribute to a healthier life of even one child.

3. PROGRAM

DATE OF VISIT		PLACE	INSTITUTION/ORGANISATION TO BE VISITED (main Contact for all visits)
From	To		
13 Aug	27 Aug	Glasgow, Scotland	The Hospital and Home Tuition Service linda.brown@yorkhill.scot.nhs.uk)
		York, England	National Foundation for Educational Research m.atkinson@nfer.ac.uk
		Penrith, England	National CAMHS Support Service cynthiafletcher@camhs.org.uk
28 Aug	10 Sep	London, England	<ul style="list-style-type: none"> • Collingham Gardens Program • Chelsea Childrens Hospital School • Bromptom Hospital Program Janettesteel@cchs.org.uk • Bethlem and Maudsley Hospital School John Ivens head@maudsley-bethlemhospital.southwark.sch.uk • Wandsworth Hospital and Home Tuition Service Carla Chandler chandler.hhts.wandsworth@lgfl.net
11 Sep	30 Sep	Stockholm, Sweden	<ul style="list-style-type: none"> • Skolan BUP Sodersjukhuset School Carinedlund@sofiadistans.nu • BUP Samverkansklassteam Allan.Scharf@sl.se
		Uppsala, Sweden	<ul style="list-style-type: none"> • University Children's Hospital School • Arbetssalt Resource School • Office of the Rektor of Specialpedagogika Upsalla Gerd.falk.schalk@lul.se
		Orebro, Sweden	<ul style="list-style-type: none"> • Child Psychiatry Program • Child Health Clinic School Nils.ericksson@orebro.se

		Linköping, Sweden	<ul style="list-style-type: none"> • Daggkapan Centre and Child and Adolescent Mental Health Clinic School • Office of the Director of Special Education, Linköping Klas.Brunnander@lio.se
15 Oct	22 Oct	Montreal, Canada	Beyond Borders Conference Palais des Congres de Montreal
23 Oct	30 Oct	Toronto, Canada	<ul style="list-style-type: none"> • Halton Regional Child and Adolescent Psychiatric Inpatient Unit • Office of the Section 23 Principal, Halton District School Board. • Syl Apps, Kinark • Transition Secondary School Program Transitions for Youth • EEI OH program Woodview Children's centre. capis@allstream.net
31 Oct	5 Nov	London, England	Hospital Organisation of Pedagogues (HOPE) Conference Institute of Child Research

4. INTRODUCTION

There may have been considerable attempts to diagnose and treat a range of mental health or behavioural problems in the primary school years, but of course less than 10% of young people with problems actually get to use the already stretched mental or other health or educational services¹.

It is common for large numbers of agencies and interventions to be involved in community based mental health services, (Moretti et al,1997), emphasise that, “when services are not integrated with a common goal, a common paradigm for understanding the social problem, a common language of how to work together, families and children fall prey to fragmented services and interagency debates about mandates and responsibilities” (p646). This quote sets the context and goal for this fellowship.

4.1 BACKGROUND

The findings and recommendations of *Pathways to the Future: A Report of the Review of Educational Services for Students with Disabilities in Government Schools* (Department of Education and Training of Western Australia, 2004), reflected the need for improved services for students with a psychiatric, cognitive or neurological disability in Western Australia (WA). Having been part of a team who researched and wrote *Pathways to the Future*, I was fortunate to be able to undertake a further review project in 2004 for the Inclusive Education Standards Directorate of the WA Department of Education and Training (DET) with the brief of reporting on the following areas:

- The necessary criteria and processes in the identification of psychiatric disabilities in public school settings;
- The gaps in current DET service delivery in school settings and the interface between DET and the Department of Health (DoH); and
- Service models and processes that have been found to be effective with school aged children and adolescents and would be suitable within the WA context.

¹ Professor Fiona Stanley AC (2003) NATIONAL PRESS CLUB ADDRESS; THE REAL BRAIN DRAIN – WHY PUTTING CHILDREN FIRST IS SO IMPORTANT FOR AUSTRALIA. Australian of the year address.

The findings from this six month review were published by the DET as, *Students with a Psychiatric Disability in West Australian Public Schools* (2005). A summary of that review, with the assumed benefit of two years hindsight, is presented below in order to provide a context to this report.

In order to consider the educational implications that a particular disabling condition might have for a student it is necessary to reach some sort of consensus with regard to how the condition is defined and to reach a common understanding of its features. With regard to reaching a common understanding of a description of psychiatric disability in children and adolescents, two issues are prominent. Firstly, there is a plethora of terminology relating to the symptoms and definition of psychiatric disabilities. Secondly, there is a risk of high personal costs associated with a label of psychiatric disability (e.g. loss of reputation).

Without Australian federal legislation that specifies the terminology and accompanying descriptions of psychiatric disability, the various states and territories have developed independent descriptions. This has led to a range of terms and criteria being used across Australia and between agencies. Bor and Dakin (2006), argue that, "significant reform is required (*in Australia*) to rectify discrimination towards the large numbers of children disadvantaged due to the failure of some education systems in recognising mental disorders as disabilities".

Since 2005, DET has formally acknowledged mental health problems with significant educational implications as the disability category *Severe Mental Disorder*². Implementing this recommendation has been effective in promoting improved communication and collaboration between DET and DoH in WA. In part this has been due to the intentional adoption of the terminology articulated in DoH's *Infancy to Young Adulthood: Mental Health Policy for Western Australia* (2002).

² http://www.schoolsplus.det.wa.edu.au/splus/Publications/eligibility_criteria

An adequate safety net of services needs to exist for students with Severe Mental Disorders as well as focus on prevention and early identification for students with Mental Health Problems. In WA public schools provide a range of services and programs for all students inclusive of those students with Severe Mental Disorders.

In WA, students with Severe Mental Disorders can be engaged in a variety of settings with a range of support services made available to them. Some of the support available includes:

- District Student Services Teams

These teams assist schools to enhance the learning outcomes of all students. Teams consist of school psychologists, attendance officers, social workers, Aboriginal Liaison Officers and Curriculum Officers. As part of Student Service teams the DET employs approximately 180 school psychologists (registered psychologists with an educational qualification). School psychologists work at individual, group and system levels, with staff, students and parents in the area of learning, behaviour and social / emotional wellbeing.

- Additional Classroom Support

Since the report *Students with a Psychiatric Disability in West Australian Public Schools* (2005) the DET has included the disability category Severe Mental Disorder into its process for allocating additional classroom resources, *SchoolsPlus*. The process requires determination at the school site of an extended impairment, in key descriptor areas or a current impairment with severe symptoms and evidence of a diagnosis of a designated mental disorder by a Child psychiatrist or pending diagnosis by a Student Services Area Manager.

- Schools of Isolated and Distance Education (SIDE)

The Referral Program at SIDE enrolls approximately 250 “special needs” students throughout WA each year. It is estimated by SIDE staff that approximately 30% of these students have significant psychiatric/psychological problems or disabilities.

- Socio-Psychological Educational Resource (SPER)

SPER Centres assist schools to manage students with psychological, social and/or emotional difficulties manifesting in behavioural concerns in the school setting. One SPER Centre is located in each of the four DET district service areas.

- Hospital School Services

The Hospital School Services operates a number of programs jointly with DoH.

- Families at Work (FAW) is a state-wide tertiary residential program at Bentley Hospital for primary aged students.
- The Education Pathway program of Family Pathways is for primary aged students and adopts a multi-modal approach.
- The Princess Margaret Hospital (PMH), Ward 4H is an 8 bed acute residential unit for students (K-12) with psychiatric difficulties who require short stay assessment and/or treatment.
- Bentley Transition Unit is based on a recovery model for both inpatients and outpatient students of secondary school age.
- The Andrew Relph Centre is a day program based upon a systems view of understanding and intervention for students (K-12) transitioning from primary to secondary school.
- The Eating Disorders Unit is an intensive treatment program at PMH for inpatients and outpatients.
- The PMH Consultation Liaison team caters for a range of students with acute and chronic health conditions.

- CAMHS and the Education Liaison Team (CELT) provide support to schools through district education offices working from most metropolitan Child and Adolescent Mental Health Services.

5. MAIN BODY

5.1 Research Model

I decided to adopt a research model to help synthesise the amount of information a fellow must process and help with that important task of developing recommendations. This fellowship was undertaken using a qualitative data analysis methodology known as *Grounded Theory* (Glaser & Strauss, 1967). Its name underscores the nature of the method, generation of theory from data. The result of *Grounded Theory* is not so much a reporting of facts but rather hypotheses about the relationship between concepts from collected data. Validity in its traditional sense is consequently not an issue in *Grounded Theory* as its results should be judged by fit, relevance, workability, and modifiability (Glaser, 1998).

The process I followed involved setting a research question:

What would be the exemplary service models and processes that Western Australia could adopt between the education and health sectors to best support children with psychiatric disabilities?

I conducted a literature study before the fellowship trip to provide a good foundation of knowledge for my experience. On my visits to programs I asked open ended questions (see Appendix I) and kept “open coded notes” (Strauss & Corbin, 1990) on each of my visits in a journal and posted overviews to a website (see Appendix II). The concepts identified in these notes were then analysed to identify emerging themes. These themes and corresponding recommendations are presented as the conclusions of this study.

5.2 Findings

It can be said that the applicability of international models is restricted by the degree to which the society and the particular system of study resemble one's own.

However, I sought to review the policy and procedures in a range of countries. The United Kingdom (UK), Sweden and Canada were chosen for this fellowship as it was considered that:

- The UK has very similar mental health and education systems and policies to Australia thus allowing for ease of comparison.
- Sweden has a different social and political structure to Australia and so could offer examples of programs unfamiliar in our culture.
- Canada is well known for its focus of prevention and early intervention models and for the use of outsourcing as a response to the high need in this area.

The United Kingdom

The *United Kingdom Education Act* (1996) lays out how local education authorities must identify and provide for children's special educational needs, and includes those with impairments of "memory or ability to concentrate, learn or understand". In 1998 the British Government issued guidance on the assessment of children with special educational needs which suggested that they could have a range of problems³ including being excessively withdrawn, having difficulties in forming relationships or being aggressive or severely disruptive.

There is a continuum of support that schools can draw upon in the UK, both internally and externally, in order to meet the mental health needs of children and young people.

All schools must have a Special Educational Needs Co-ordinator (SENCO) whose role is to co-ordinate the provision of support for children with special educational needs. Learning Support Assistants, Peer Supports, Home-School Link Workers, Pastoral Staff, Learning Mentors/Mentors, Specialist Educational Support, Education Social Workers, Behavioural Support Staff and Educational Psychologists all support schools.

³ (2) For the purposes of these Regulations a pupil has "special requirements" if he has any needs arising from physical, medical, sensory, learning, emotional or behavioural difficulties which require provision in terms of any of the facilities referred to in regulation 3 or regulation 9 which is additional to or different from that generally required by children of his age in schools other than special schools.
http://www.opsi.gov.uk/si/si1996/Uksi_19960360_en_1.htm

- *Emotional Behavioural Difficulties Centres and Pupil Resource Units:*
Children experiencing problems (predominately externalising problems) in schools have tended to be defined as having emotional and behavioural difficulties (EBD). There are now over 900 centres and units for such students across England.
- *Health Professionals Working in Schools:*
School Nurses exist in most schools and some Local Education Areas have also employed primary mental health workers.
- *Health Professionals Operating outside Schools:*
General practitioners, community paediatricians, specialist mental health professionals, clinical psychologists, psychiatrists, educational psychologists, community psychiatric nurses support schools. Many of these specialist mental health professionals are located within Child and Adolescent Mental Health Services (CAMHS).

If a mainstream teacher has a concern about the mental health of a student they will refer to the SENCO and an Individualised Education Plan (IEP) will be developed for the duration of one term. If after one term the major targets in the IEP have not been achieved then it becomes the Head Teacher's responsibility to engage other educational support. A mental health nurse from CAMHS would most probably be brought into the educational planning and for potential referral to or consultation with CAMHS. Then "statementing", a documented planning process with legal ramifications, could result. Statementing mandates action over a 26-week period.

The Green Paper *Every Child Matters* (2003) emphasised the need to find ways of working which integrate education, health and social services around the needs of the child. The Green Paper proposed that Children's Trusts should be established by 2006 to prevent children falling between the cracks. The concept of the trusts recognises the complexity of society and the need for multi agencies to address every aspect of a child's life.

In 2005–06 Child and Adolescent Mental Health Services (CAMHS) funding to councils was increased substantially to support the development of prevention and early intervention services.

In 2006 the Local Government Association initiated research through the National Foundation for Educational Research to examine the funding models and mechanisms in place within CAMHS. While the report has not been published one of the overall aims of the research was to assess the current priority areas within CAMHS, including the balance between preventative and acute services.

Initial work indicated that while CAMHS wanted to move towards preventative services, the education sector very much-wanted CAMHS to develop more collaborative acute services.

Sweden

It is estimated that 5 and 20 percent of school students have mental health problems in Sweden, (Sroufe & Rutter, 1984). Mental health problems in Sweden are described as issues in self-esteem, the capacity to socialise with other children and adolescents, freedom from parents and adaptation to school. Behavioural problems or mental disorders are seen as more severe and are defined as internal problems such as nervousness, shyness, depression and physical problems, and/or external problems such as lack of self-control, aggressive stance and asocial behaviours (Cederblad, 1996)

The current situation in Sweden is a movement away from hospital inpatient stays for children and adolescents with mental disorders. Research is quoted such as that by, Ostman (1991) that examined 142 patients cared for by child and adolescent psychiatry, who were followed up to the age of 37 years. Results were that 49% were re-treated by adult psychiatry between the ages of 20-25 years, and 20% of the 49% required hospitalisation. Twenty-one percent had received sentences for criminal offences. It is argued that new approaches are necessary to de-institutionalise care so that re-hospitalisation and jail sentences can be lessened.

Education and Mental Health services have a long history of collaboration either in joint mental health programs in schools or through Hospital Schools in Sweden. The trend is to locally manage resource centres for students with special needs that are supported by specialist psychologists employed by education or provided by mental health services. Hospital School teachers are

increasingly being required to become consultants to schools or be involved in intensive family assessment programs.

Canada

The Canadian Human Rights Act (*Canadian Human Rights Act: An Act to extend the laws in Canada that proscribe discrimination, 1976-77*) includes as a disability “any previous or existing mental or physical disability...” and the application of the Act with regard to education is the mandate of the 12 Provinces of Canada. The Canadian *Charter of Rights and Freedoms* provides support to individuals who wish to maintain their child in the “least restrictive environment” and this issue has formed the basis of litigation in a number of mental health cases.

Canada reports high prevalence rates for mental health problems in children and adolescents. These reach 18.1% in Ontario and 19.9% in Quebec (Breton, Plante, & St-Georges, 2005). However, according to others (Moretti et al., 1997), mental health services for children and adolescents in Canada have been starved of resources. They also state that there has been a direct influence of political agendas on program selection and funding, “...during the past decade, public outcry regarding youth crime has prompted politicians to implement programs that ensure public safety and restitution that are often designed to appease public demands rather than to implement new programs based on research” (p647). In Ontario students with mental disorders are supported through Section 23 of the *Education Act*, which, allows for the free provision of educational staff to any agency or company that provides services for children up to the age of 21.

6. CONCLUSIONS

Need

The Australian Institute of Health and Welfare Bulletin (*Australian Institute of Health and Welfare 2006: Australia's Health, 2006.*) reported that there were 47,500 (1.2%) students (0-14 years) with a main condition of a psychiatric disability across Australia and that 77% of these students experienced difficulties at school. Percentages would be higher if co-morbidity of disorders were considered and for particular groups of students, such as those in rural and remote locations, some Aboriginal students and survivors of trauma.

The *Western Australian Child Health Survey* (Zubric et al., 1997) reported that 17% of children have mental health problems and this group were five times more likely to have below-age academic competence.

Levav et al (2004) in a European survey of mental health services in 36 countries (70.5% of all European countries) reported that:

- The degree of coverage and quality of services for the young were generally worse in comparison with adults.
- 17% of countries reported that there were sufficient numbers of school-based services.

Common language

None of the countries I visited had unified language between agencies to refer to students with psychiatric disabilities. The ranges of challenging behaviours that schools confront are complex and include students with recognised disabilities as well as students who are not labelled. Schools with their supports generally achieve very well with the students in their care but when case management issues escalate the combined efforts of multiple agencies is necessary. When such case management involves students with a disability label, such as intellectual or psychiatric, then services and roles are more easily identified.

Willoughby (Willoughby1999) indicates that multi- agency ownership of mental health problems requires broad approaches to the definition of children's mental health problems and consequently of approaches to resolving these problems. To move away from a reliance on diagnosis without interagency involvement presents a variety of risks for an education system. Thomas and Glenny (2000) state that in the UK the term emotional and behavioural difficulties (EBD) has included troublesome children into a quasi-clinical category that has reached legal status.

Integrated Services

Collaborative practices are now well documented as increasing effectiveness and efficiency in response to service needs (Ahmad & Miller, 2000).

Thus, the answer to meet the ever increasing needs for children with mental health problems can only lie in collaboration as so many of the experiences of this fellowship indicated. Relevant Australian and WA DoH policies promoting the collaborative practice of mental health services include:

- The *National Practice Standard 8.3 - Integration with Other Sectors* states that; The Mental Health Service develops and maintains links with other sectors at local, state and national levels to ensure specialised coordinated care and promote community integration for people with mental disorders and/or mental health problems.
- *Mental Health Strategy 2004 - 2007*, Key Objective 4, is to enhance service coverage and accessibility and provide a whole of service/government approach to ensure that young people with a mental health problem are given the best opportunities for early intervention.

To summarise from the principles articulated in *Students with a Psychiatric Disability in West Australian Public Schools*, (2005) education must collaborate to be successful with students with psychiatric disability, as it neither has the mandate or resources to provide sole treatment. The USA has a far stronger federal legislation (*Individuals with Disabilities Education Act*, 1997) than Australia regarding students with disabilities. It mandates free and appropriate education and mental health services in the least restrictive environment for students with Severe Emotional Disturbance (SED) (Sedlak & Sedlak). However, despite such a mandate, Rones and Hoagwood, (2000) found

schools in the US functioned as the defacto mental health system with less than 45% of students with SED receiving services other than through the school. So great is the problem that the US Department of Education in May 2006 called for submissions for 20 Grants of between \$150,000 and \$350,000 to “ increase student access to high quality mental health care by developing innovative approaches that link school systems with the local mental health system”.

6.1 RECOMMENDATIONS

Need

The Inclusive Education movement has been very successfully managed in Western Australia. Catering for severe mental disorders in our schools brings pressure to bear on many factors such as staffing, finances and professional training. Innovative models of collaboration rather than the traditional special education or behavioural models are required for this group of students.

Recommendation 1

The following principles should underlie the DET role in supporting students with severe mental disorder and the intent of the principles integrated into all relevant policies and procedures:

- *The public education system has a significant and expanding role to play in the identification of severe mental disorder in children and adolescents.*
- *The public education system is not mandated for, nor does it have the appropriate resources, to provide sole treatment for severe mental disorder in children, adolescents or parents.*
- *The public education system has a legislative and ethical obligation to provide access to the curriculum for school-aged children and adolescents that is appropriate to their current level of mental health.*

Common language

A unified language between agencies to refer to students with psychiatric disability is essential for the level of collaboration required for meeting the complex needs of these students.

The downfall to developing such language often starts with the debate on who should be included or excluded from support.

Recommendation 2

That a forum inclusive of interagency and private provider representation be held to develop a process for the identification of students with severe mental disorders who require additional classroom support

Integrated Services

CAMHS organises services in based on a tiered, strategic model (Table 1). This model is adopted as the structure to make the following recommendations.

Tier 1

Services at this level are provided by practitioners who are not mental health specialists working in universal services; this includes GPs, health visitors, school nurses, teachers, social workers, youth justice workers, voluntary agencies. Practitioners will be able to offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development, and refer to more specialist services.

Tier 2

Practitioners at this level tend to be CAMHS specialists working in community and primary care settings in a uni-disciplinary way (although many will also work as part of Tier 3 services). For example, this can include primary mental health workers, psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services. Practitioners offer consultation to families and other practitioners, outreach to identify severe or complex needs which require more specialist interventions, assessment (which may lead to treatment at a different tier), and training to practitioners at Tier 1.

Tier 3

This is usually a multi-disciplinary team or service working in a community mental health clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders. Team members are likely to include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists.

Tier 4

These are essential tertiary level services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units. These can include secure forensic adolescent units, eating disorders units, specialist neuro-psychiatric teams, and other specialist teams (for children who have been sexually abused, for example), usually serving more than one district or region.

Table 1. CAMHS four-tier strategic framework⁴.

Tier 1

Recommendation 3

Establish a specialist mental health position within DET to support the understanding in DET personnel of severe mental disorder.

This role should be on going and allow for secondment from CAMHS on an annual basis with one role for the officer being to provide formal and informal training to Central Office, District Offices and school staff.

Tier 2

Recommendation 4

Seek interagency seeding funding for innovative practice linking the CAMHS and Education sectors.

⁴ <http://www.everychildmatters.gov.uk/health/camhs/>

Mel Ainscow and Anne Francis, (Ainscow & Francis, 2005) reviewed the outcomes of the seeding funding to establish Behaviour and Education Support Teams and recommended the following criteria principles for future projects:

- Enhancement or improvement of collaborative efforts between school-based and mental health services to diagnose and treat students.
- Enhancement of the availability of crisis intervention and appropriateness of referrals.
- Provision of training for school personnel and mental health professionals.
- Provision of assistance and consultation to school and mental health systems and families.
- Provision of linguistically appropriate and culturally competent services.
- Evaluation of the effectiveness of the program in increasing student access to quality mental health services.

I would also add that:

- Mental health screening and assessment are implemented only with appropriate follow-up services in place.

Applying these criteria would allow for the selection of innovative practice joining the two agencies. For example at a small cost school psychologists could have a short-term non-clinical placement within CAMHS to learn about referral and treatment processes. The development of a Common Assessment Framework⁵ as is operating in England would also be a very worthwhile trial.

Tier 3

A program at this tier should have two main purposes, to maintain the young person in their enrolled school and to assist in the prevention of admission to Tier 4 provision. The present waitlist for students into joint DET and DOH programs is hard to ascertain as the programs are either acute-care wards capped by the number of beds available, or have a capacity driven by program philosophy.

In the 2004 report, I wrote that the following principles should underlie the DET involvement in any current or future programs:

- only in partnership with DoH;
- DoH providing clinical supervision;
- a focus on family involvement in the program;
- DOH providing referral gateway but in consultation with DET;
- clear transition pathways from programs including professional development for the integrating schools; and
- case management employed to ensure service coordination and therapeutic direction.

Two years on and based on experiences from the Fellowship the following principles should also apply:

- a focus on family involvement in the program;
- programs open to both sexes;
- low student to teacher ratios;
- set quality assurance processes;
- Care Plans utilised;
- agreed therapeutic framework for intervention;
- signed off service protocols;
- DoH providing clinical supervision, and
- care provided in the least restrictive, most normative environment as is clinically appropriate with clear transition pathways from programs.

DET as a system is under increased pressure as experienced in NSW and the UK to re-establish withdrawal units for students with extremely challenging behaviour. Where previously I would have been outspoken in my opposition to such units when placed off DoH sites and without DoH's role as the primary referral gateway I have seen that some viable models do exist if they are still done in collaboration with DoH and other agencies. The following recommendations should be implemented in order and all efforts made to increase the number of joint day programs on CAMHS sites before Recommendation 8 is trialled and evaluated.

⁵ <http://www.everychildmatters.gov.uk/deliveryservices/caf/>

Recommendation 5

That the specialist mental health position in DET acts to develop and implement a risk management process for schools when dealing with students presenting high risk and suspected of having a severe mental disorder.

Recommendation 2 to establish a needs based approach to the identification of students with severe mental disorders could alleviate pressure for diagnosis. It will require a common language to identify educational supports that can complement treatment. Any language has its variations and to deal with borderline cases DET must carefully assess its risk and recommend appropriate responses where agencies can not reach consensus.

Recommendation 6

That a set of protocols between DET and other WA agencies involved with students with severe mental disorders is established.

The Disability Services Commission and DET established a Memorandum of Understanding (MoU) regarding students with disabilities in 2004. It clearly articulates communication strategies and collaborative protocols between the two agencies. This MoU needs to be expanded for students with severe mental disorders and other agreements struck with CAMHS, the Department for Community Development and Juvenile Justice. Ideally these MoUs would be reviewed annually with the goal to establishing ongoing committee structures at all levels to support such agreements. As discussed in *Pathways to the Future: A Report of the Review of Educational Services for Students with Disabilities in Government Schools* (2004) a website could also be established to promote the content of the MoUs at all levels of the system.

Recommendation 7

That a school support team for severe mental disorder is established.

Such a team would need to be carefully mapped into the system and their role defined against existing services such as SPER, the Autism Intervention Team and the DoH and JJ, Multi Systemic Teams. It should have rural and remote support as its first priority and a focus on early intervention and training.

The Hospital Education and Home Tuition Service in Glasgow started an Outpatient Liaison Teacher (OLT) role in 1999. There are now six teachers in place across the 9 CAMHS in Glasgow. The OLT and WA CELT projects have very similar operational models and both have been evaluated positively MacKay, 2000⁶ and Jenkins, 2005⁷. With five years of successful collaboration in the OLT project, the next step taken was another joint initiative with CAMHS to trial a Direct Access Liaison Team, inclusive of four teachers. Referrals to the joint team can come from General Practitioners and schools as well as other CAMHS. Services include assessment, intervention and training.

Tier 4

The need for collaboration between services, particularly at Tier 4 level is essential. The problem is programs tend to be established under the umbrella of one service with a mandate to collaborate with other services. The responsibility to establish the collaboration is then often left to practitioners within the services and can be difficult to achieve. The aim of education's involvement in such services should be to facilitate the return of the young people to mainstream education when they are ready and to make reintegration as seamless as possible. Follow up support through Tier 3 services should be a key feature. Few inpatient programs I visited on my fellowship had embraced the level of outreach support to schools that the teachers at HSS have professionally pioneered. Many Hospital School teachers I met on the fellowship felt threatened by such new and expansive roles and the Hospital Pedagogues of Europe (HOPE) association marveled at the level of outreach support HSS manages to achieve.

⁶ Internal Hospital Education and Home Tuition Service report

⁷ Internal Hospital School services report.

Recommendation 8

That a trial be conducted with DoH involvement of a school-based centre for students with complex cases that could fit the category of severe mental disorder.

In Stockholm I met at length with a Child Guidance Consultation Team that has been in existence for 26 years and is currently supporting 22 special day programs integrated into mainstream schools. About 100 students aged from 7 to 17 years, are supported through this system each year. The team of 8 consultants and co-coordinators are employed by the mental health system and support the special day programs through a detailed organisational model and set of formal agreements. Such special classes or resource centres were replicated across Sweden but with mental health input coming most often from consultants employed by the education system. Risk management is of major concern with such centres being on a mainstream school site. Also a constant tension existed regarding the availability and level of support provided to the programs by the consultants. However, research (only available in the Swedish language) indicated that the program had been highly successful over time although transition from the programs was a major issue.

Recommendation 9

That HSS teachers in general and specifically in this context those in Tier 3 and 4 programs be recognised for their willingness to embrace outreach roles and be consulted in any implementation of the recommendations in this report.

Recommendation 10

A policy and research role is assigned to the specialist mental health position within DET to conduct ongoing research into existing and proposed services for severe mental disorders.

This recommendation is essential to determine the future direction of DET involvement in collaborative mental health services.

Agreement to complete the teacher version of the Strengthens and Difficulties Questionnaire should be established in DET to form the basis of an evaluation process whether it is the provision of an educational assistant or attendance at a joint DoH and DET program.

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8. APPENDIX I

Open-ended focus questions

- What common language regarding mental health problems exists across health and education sectors in your country/region/program?
- How are behaviour problems distinguished from mental health problems in your country/region/program?
- What examples of CAMHS and Education sectors working together exist in your country/region?
- What principles are adopted in the provision of Education Day Programs in your country/region?
- What examples of mental health outpatient programs exist in your country/region?

8.1 APPENDIX II

See weblog of the Churchill Trip at www.grantschurchill.blogspot.com