School based intervention programs and shared care collaborative models targeting the prevention of or early intervention in child and adolescent mental health problems: a rapid review

Summary

Aims of the report

This report has two aims. The first is to examine **programs designed to prevent mental disorders** in schools. Most prevention programs are designed to be delivered in classrooms to all students. However, these programs can also be delivered to a selected group of students, or specifically to individuals who may have symptoms of mental health problems but who have not yet reached criteria for disorder. The second aim is to review **collaborative care or shared care programs, which link education and health sectors** and provide assistance to those with a mental health condition. Twenty to thirty percent of young people will experience a mental health condition during the period when they are at school. The aim of shared care or collaborative care programs is to get assistance from mental health professionals for those identified within the school environment.

Prevention Programs

Our findings suggest that there are effective prevention programs that can be introduced into schools to prevent the onset of mental disorders. Below we summarise when mental health disorders emerge, programs that have evidence to support their effectiveness and the age at which prevention should be introduced. These programs can be offered to prevent externalising disorders (such as Attention Deficit Hyperactivity Disorder, Conduct Disorder and Oppositional Defiant Disorder), substance abuse, depression, anxiety, social phobia and eating disorders. This information is displayed in Figure 1 below.

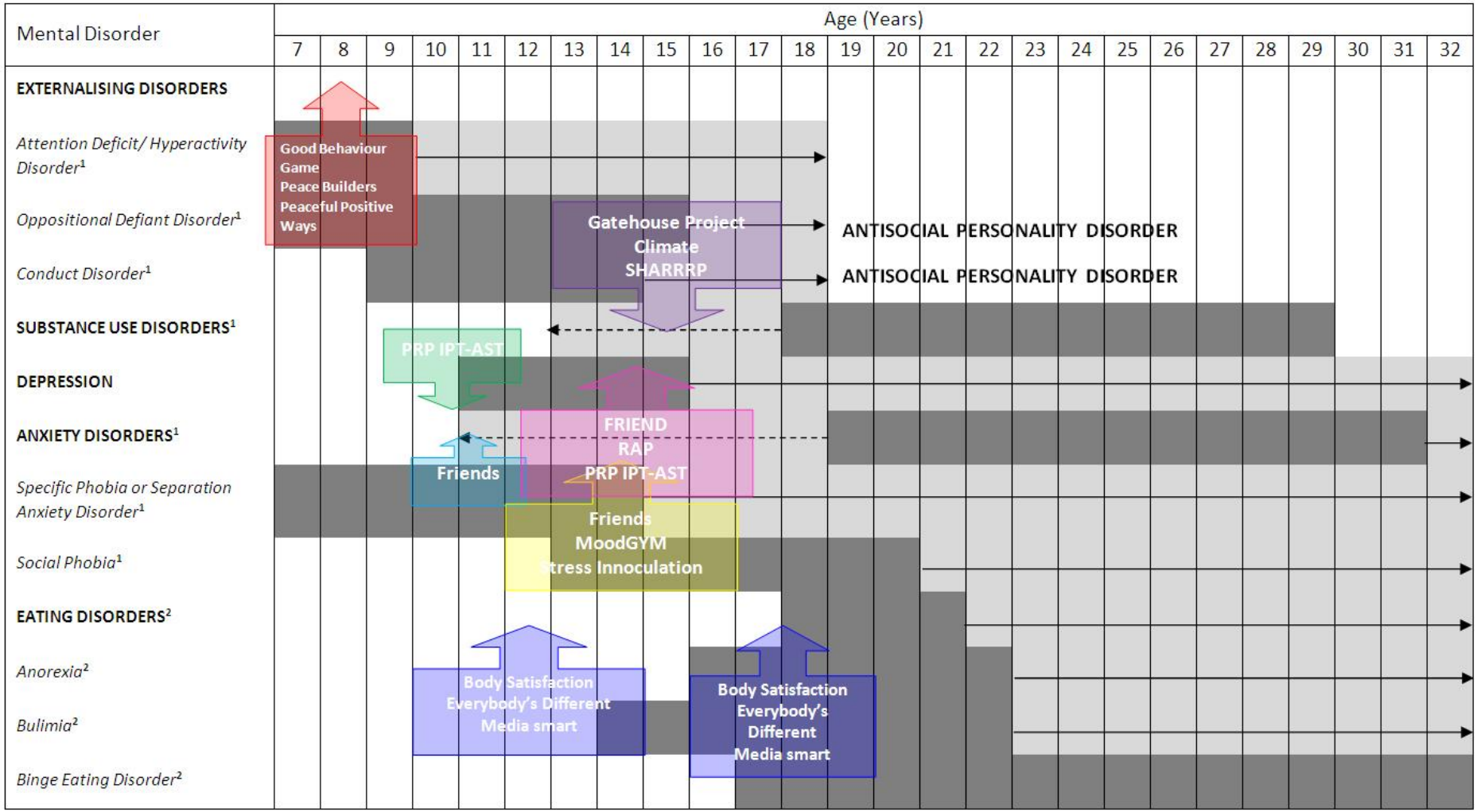
Table 1 below provides a summary of recommended programs, and the age at which they have been found to be effective. Key references to these programs can be found in the body of the report.

Table 1: Effective prevention programs and age for intervention

PROGRAM	AGE/GRADE EFFECTIVE
Anxiety	
FRIENDS	9-16 years. Optimal time (9-12 years).
Stress Inoculation Training	15-17 years
MoodGYM	13-17 years
Depression	
FRIENDS	9-16 years. Optimal time (9-12 years).
Resourceful Adolescent Program	13-14 years

PROGRAM	AGE/GRADE EFFECTIVE
Penn Resiliency Program	11-14 years
Interpersonal Psychotherapy-Adolescent Skills Training	11-16 years
Substance Abuse	
Climate Schools	13 years
GateHouse Project	13 years
SHAHRP	13 years
Externalising Behaviour	
Good Behaviour Game	Grade 1
PeaceBuilders	Grades K-5
Responding in Peaceful and Positive Ways	Grade 6
Eating Disorders	
US Planet Health	Females, 10-14 years
Everybody's Different	11-14 years
Media Smart	Grade 8

Figure 1: Recommended programs and optimal point of delivery



Data from Hudson, Hiripi, Pope, & Kessler, 2007; Kessler, Berglund, Delmer, Jin, et al., 2005; Kovacs, Obroksy, Gatonis, & Richards, 1997; Lewinsohn, Clarke, Seely, Rhode, 1994¹ Median Range² Interquartile Range

Shared Care Collaborative Models

The following programs were found which included a component aimed at assisting young people in need of clinical services. The following programs were auspiced by **education** institutions. The first four are Australian programs, while the last is based in the United Kingdom:

KidsMatter designed for Primary School (including an Early Intervention Component)
MindMatters designed for High School (including *MindMatters Plus and MindMatters Plus GP)*
beyondblue Secondary Schools and Tertiary Programs
The GateHouse Project
Social and Emotional Aspects of Learning including Wave 2 and Wave 3 interventions (*SEAL*)

The following programs were auspiced by **health organisations** or agencies and explicitly discussed school linkages:

NSW School-Link initiative
headspace Australia National Youth Mental Health Foundation
headstrong and Jigsaw Ireland (The National Centre for Youth Mental Health)
Youth One Stop Shop in New Zealan;
Child and Adolescent Mental Health Services, UK

At this stage, the findings have been very limited on the success of these programs in reducing mental ill health in those at risk of a disorder. *The GateHouse Project* was successful in reducing substance abuse, but the effect it had on those with a mental health disorder is not well documented. With respect to the effectiveness of the programs in forging linkages with external agencies, the most relevant data for Australia come from the *KidsMatter* program. *KidsMatter* has been reported to lead to improved referral links for children with high risk. *MindMatters Plus* and *MindMatters Plus GP* have not been associated with new linkages to external health agencies, as these were found to already exist.

With respect to the health led programs, at this stage, there is insufficient evidence to evaluate the effectiveness of collaborative care models, and, in particular, there is no evidence to determine whether they improve the mental health of those who need early intervention. Except for the *NSW School-Link initiative*, most of the new programs, such as *headspace*, are recent developments. In Australia, the provision of mental health services to schools seems to be largely ad hoc. The only exception may be the *NSW School-Link initiative*, although other state based models may exist, of which we are unaware.

Conclusions and recommendations

1. Single element effective prevention programs should be adopted and delivered to all students within the curriculum. This is a relatively easy option and, based on evidence, will lower incidence rates of mental illness in schools.
2. A range of procedures should be adopted in schools that will bring "at risk" students systematically to the attention of mental health staff.

3. A range of mechanisms should be considered in schools through which students, their parents and teachers can gain access to professional and other help from mental health services such as general practice, headspace centres, specialist mental health centres, local youth workers, psychologists or psychiatrists.

Based on the evidence, there is a clear need to forge linkages between schools and health services. Currently, there seems to be three models for creating these relationships: Ad hoc arrangements where schools make connections to services in their local areas; structural arrangements where health services are funded to coordinate mental health services to provide support to schools (e.g. *NSW School-Link initiative*) or commissioning arrangements where schools are funded to commission mental health services for their school (SEAL Program, UK). Given the complexities in linking health and education portfolios, and in implementing programs in the complex environments of health and education, appropriate funding needs to be provided with clear outcomes and reporting lines articulated when new models are established.

New methods might need to be considered, such as virtual counselling, Internet programs and online clinics as mechanisms to allow high school students to reach services. Given the shortage of counsellors, *headspace* centres and private practitioners in both city and rural areas, there is a need to think clearly about new models for individual health care of students in our schools.

Christensen, H., Calear, A., Tait, R., Gosling, J., Griffiths, K., Murray, K. School based intervention programs and shared care collaborative models targeting the prevention of or early intervention in child and adolescent mental health problems: An *Evidence Check* rapid review brokered by the Sax Institute for the NSW Ministry of Health, 2011.
(http://www.saxinstitute.org.au/contentUploadedByEWeb/Files/Adolescent%20Mental%20Health%20Report.pdf)