CHW School-Link:

Jodie Caruana, School-Link Coordinator
jodie.caruana@health.nsw.gov.au
www.schoollink.edu.au

Department of Psychological Medicine
Children’s Hospital at Westmead (CHW)
Sydney Children’s Hospital Network
Acknowledgements & Resources:

- Dr David Dossetor, Director Mental Health, CHW
- Dr Phil Ray, Senior Psychologist, CHW
- Hebah Saleh, School-Link, CHW
- Dr Stewart Einfeld, Faculty of Health Sciences, Brain and Mind Research Institute
- Dossetor D, Donna White, Leslie Whatson (Eds).

Abbreviations

- ADHC: Ageing, Disability and Home Care
- CAMHS: Child and Adolescent Mental Health Service
- CB: Challenging Behaviour
- C&A: Children and Adolescents
- DEC: New South Wales Department of Education and Communities
- DGO: District Guidance Officers from DEC
- DD: Developmental Disability
- ID: Intellectual Disability
- IDD: Intellectual and Developmental Disabilities
- MH+ID: Mental Health and Intellectual Disability
- PD: Psychiatric Disorder
- PPEI: Prevention, Promotion and Early Intervention
- SSP: School for Specific Purposes
Outline

• School-Link
• Prevention, Promotion & Early Intervention
• Stepping Stones Triple P
• Resources
OVERVIEW OF SCHOOL-LINK
Background to School-Link

- NSW School-Link Program began in 1999.
- 2009 CHW granted funding to focus on children and adolescents with an intellectual disability.

\[ \text{DEC} + \text{the children's hospital} + \text{ADHC} = \text{CHW School-Link for ID/DD} \]
Background to School-Link

CHW School-Link focuses on three main areas for children and young people with an intellectual/developmental disability:

• Mental Health Prevention, Promotion and Early Intervention Programs
• Mental Health Training and Education and Awareness Raising
• Assisting in identifying Mental Health Pathways to Care
ID support classes in schools

- 107 SSPs in NSW
- 60 Government SSPs catering for ID

<table>
<thead>
<tr>
<th>School Type</th>
<th>IM</th>
<th>IO/IS</th>
<th>IS</th>
<th>MC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>support classes in special schools</td>
<td>-</td>
<td>428</td>
<td>27</td>
<td>62</td>
<td>517</td>
</tr>
<tr>
<td>support classes in regular schools</td>
<td>351</td>
<td>449</td>
<td>10</td>
<td>383</td>
<td>1193</td>
</tr>
<tr>
<td>distance education support unit classes</td>
<td>3</td>
<td>8</td>
<td>-</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>354</td>
<td>885</td>
<td>37</td>
<td>445</td>
<td>1721</td>
</tr>
</tbody>
</table>

Adapted from DEC, 2013

Key
- IM  Mild ID
- IO  Moderate ID
- IS  Severe ID
- MC Multi-categorical (moderate/high support needs)

Table 1: Distribution of ID support classes in NSW Government Schools by School Type and level of Intellectual Disability 2013
MENTAL HEALTH PREVENTION PROMOTION & EARLY INTERVENTION
Risk Factors and Protective Factors potentially influencing the development of mental health problems and mental disorders in individuals (particularly children)
Individual Factors

RISK FACTORS
- prenatal brain damage
- prematurity
- birth injury/ complications / low weight
- physical/ intellectual disability
- poor health in infancy
- insecure attachment in infant/child
- low intelligence
- difficult temperament
- chronic illness
- poor social skills
- low self –esteem
- alienation
- impulsivity

PROTECTIVE FACTORS
- easy temperament
- adequate nutrition
- attachment to family
- above average intelligence
- problem-solving skills
- social competence/ skills
- good coping style
- optimism
- moral beliefs
- values
Family/ Social Factors

**RISK FACTORS**

- having a teenage mother or single parent
- absence of father in childhood
- large family size
- antisocial role models
- family violence/disharmony, marital discord
- poor supervision & monitoring of child
- low parental involvement
- neglect in childhood
- long term parental unemployment
- criminality in parent
- parental subs misuse and/or mental disorder
- harsh or inconsistent discipline style
- social isolation
- experiencing rejection
- lack of warmth and affection

**PROTECTIVE FACTORS**

- **supportive caring parents**
- family harmony
- secure and stable family
- small family size
- more than two years between siblings
- responsibility within the family
- **supportive relationship with other adult**
- strong family norms and morality
School Context

RISK FACTORS
· bullying
· peer rejection
· poor attachment to school
· inadequate behaviour management
· deviant peer group
· school failure

PROTECTIVE FACTORS
· sense of belonging
· positive school climate
· pro social peer group
· required responsibility and helpfulness
· opportunities for some success and recognition of achievement
· school norms against violence

(Commonwealth Department of Health and Aged Care 2000)
Life Events & Situations

RISK FACTORS
- abuse
- school transitions
- divorce/family breakup
- death of family member
- physical illness/impairment
- unemployment/homelessness
- incarceration
- poverty/economic insecurity
- job insecurity
- unsatisfactory work relationships
- workplace accident/injury
- living in nursing home/hostel
- caring for someone with a disability
- war or natural disasters

PROTECTIVE FACTORS
- involvement with significant other person (partner/mentor)
- availability of opportunities at critical turning points or major life transitions
- economic security
- good physical health

(Commonwealth Department of Health and Aged Care 2000)
Community & Cultural Factors

RISK FACTORS
- socioeconomic disadvantage
- social or cultural discrimination
- isolation
- neighbourhood violence and crime
- population density and housing conditions
- lack of support services including transportation, shopping, recreational facilities

PROTECTIVE FACTORS
- sense of connectedness
- attachment to and networks within the community
- participation in community group
- strong cultural identity and ethnic pride
- access to support services
- community/cultural norms against violence

(Commonwealth Department of Health and Aged Care 2000)
Mental Ill Health Prevention

• Prevention interventions work by focussing on reducing risk factors and enhancing protective factors associated with mental ill-health.

Hunter Institute for Mental Health (2011)
Mental Health PPEI Programs

- Lack of empirical studies on PPEI programs with ID.
- **Mental Health Promotion** programs report applicability to ‘special needs’ but not specified for ID let alone mild, mod or severe disability level.
- **Early intervention/treatment approaches** only when problems are recognised but problems in identifying problems.
- Only a small amount occurring in SSPs
- No programs targeting adolescents with ID/DD.
<table>
<thead>
<tr>
<th>Program</th>
<th>Age</th>
<th>Aim</th>
<th>Target</th>
<th>Children</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stepping Stones Triple P</td>
<td>3-12</td>
<td>Positive parenting</td>
<td>parents</td>
<td>disabilities &amp; disruptive behaviour</td>
<td>Roberts et al 2006</td>
</tr>
<tr>
<td>Signposts</td>
<td>3-16</td>
<td>Problem solving</td>
<td>parents</td>
<td>Develop. delay or an intellectual disability</td>
<td>Parenting Research Centre (PRC) &amp; RMIT 2008</td>
</tr>
<tr>
<td>Stop Think Do</td>
<td>4-15</td>
<td>Problem solving</td>
<td>Children</td>
<td>anxiety, ADHD, Aspergers</td>
<td>Petersen 2002</td>
</tr>
<tr>
<td>The Alert Program</td>
<td>8-12</td>
<td>Arousal regulation</td>
<td>children</td>
<td>sensory processing &amp;/or learning impairment</td>
<td>Williams &amp; Shellenberger, 1996</td>
</tr>
<tr>
<td>Social Decision Making</td>
<td>6-13</td>
<td>Emotions and problem solving</td>
<td>children</td>
<td>Learning disabilities</td>
<td>Elias &amp; Bruene Butler, 2005</td>
</tr>
<tr>
<td>The Paths Curriculum</td>
<td>4-9</td>
<td></td>
<td>Children</td>
<td>Learning disabilities</td>
<td>Greenberg &amp; Kusche 1998</td>
</tr>
<tr>
<td>Emotion Based Social Skills Training</td>
<td>8-14</td>
<td></td>
<td>Parents Teachers children</td>
<td>With ASD and mild ID</td>
<td>Ratcliffe, Grahame, &amp; Wong, 2010</td>
</tr>
</tbody>
</table>
Prevention Framework in Schools

1. A positive school community
   - Sense of belonging and inclusion by a welcoming and friendly environment.
   - Collaborative sense of involvement of students, staff, parents, community.
   - Examples, PBL or PBIS

2. Social & emotional learning for students/
   Student Resilience
   - Emotion Based Social Skills Training
   - Stop Think Do
   - The Paths Curriculum
   - Social Decision Making
   - The Alert Program
   - The Secret Agent Society

3. Parenting support & education
   - Specialised training programs
     - Stepping Stones Triple P
     - Emotion Based Social Skills Training
   - Other sessions that collaborate with disability or health services on communication or behaviour

4. Early intervention for students experiencing mental health difficulties
   - Behavioural approaches
   - Augmented and Alternative Communication
   - Cool Kids Child Anxiety Program ASD Adaption
Stepping Stones Triple P

- Adapted from Triple P system (Sanders, 2012; Prinz et al, 2009)
- A multi-level parenting and family support strategy for families of children with disabilities (Mazzucchelli & Sanders, 2011*)
How is SSTP delivered?

- Media campaigns
- Website
- Seminars
- Group Programs
- One-on-one
Need for Parental Support

- Children with disabilities have 3 - 4 times the rates of behavioural and emotional problems (Einfeld & Tonge, 1996)
- Parents and caregivers of children with disabilities experience greater parental stress
- Parental stress is related to the level of behavioural problems their child experiences
- There is a low level of participation in evidence based programs
Hypothesis

Implementation of GSSTP in schools will:

- Improve the behaviour of children at home and school.
- Have a positive impact on mental health, behaviour management skills and confidence of parents.
Design

- Group delivery within a school environment, by co-facilitators (School + ADHC)
- Pre, Post and 3 Month Follow Up testing by parents and class teachers.
- No control group (unfortunately).
- Our sample was not randomised, an opportunity sample.
Participants

• For Phase 2: Parents or caregivers of a child attending a special education school that caters for intellectual disability.

• For Phase 3: Parents or caregivers of a child attending a special education school, regular public school, private school, catholic school and/or unit that caters for autism.

• Recruitment of parents by the school.
Measures

1. Family Background- Family Background Questionnaire (Adapted from Zubrick et al, 1995).


4. Parenting Confidence- Parenting Tasks Checklist (Sanders and Woolley, 2005).

5. Parental Adjustment- Depression, Anxiety and Stress Scale (Lovibond and Lovibond, 1995)
Phase 2 & Phase 3

**Phase 2 (2012)** focussed on children with ID
- 56 sets of parents of children with ID.
- 37 of the those children also had a dual diagnosis ASD
- Groups were in 10 special education schools and 1 regular school with support class.

**Phase 3 (2013)** focussed on children with ASD
- 95 Sets of Parents with children with ASD
- Groups were in 12 Schools with various settings e.g. SSP’s, Private Schools, Units etc.
Results
Phase 2: 2012 ID

Developmental Behaviour Checklist - Parent

- Disruptive/Antisocial: 18% decrease*
- Self Absorbed: 6% decrease
- Communication Disturbance: 1% decrease
- Anxiety: 10% decrease
- Social Relating: 11% decrease
- Total: 10% decrease*

All scores stayed above Clinical cutoff

*=<.05  **=<0.01 (significance levels)
Phase 2: 2012 ID

Developmental Behaviour Checklist - Teacher

- Disruptive/Antisocial: 29% decrease**#
- Self Absorbed: 26% decrease**#
- Communication Disturbance: 16% decrease*
- Anxiety: 24% decrease**
- Social Relating: 32% decrease***#
- Total: 25% decrease***#

* = <.05      ** = <0.01 (significance levels)
# = Change to below Clinical cutoff
Phase 3: 2013 ASD

Developmental Behaviour Checklist – Parent

- Disruptive/Antisocial: 23% decrease**
- Self Absorbed: 20% decrease**
- Communication Disturbance: 13% decrease**
- Anxiety: 15% decrease**
- Social Relating: 16% decrease**#
- Total: 15% decrease**

All scores except # stayed above Clinical cutoff
3 Month Follow Up: All maintained or dropped further.
E.g. Total DBC Score 82% -> 66% -> 60% (cutoff 58%)

# = Change to below Clinical cutoff
**=<0.01 (significance levels)
Phase 3: 2013 ASD

Developmental Behaviour Checklist – Teacher

- Disruptive/Antisocial: 9% decrease
- Self Absorbed: 7% decrease
- Communication Disturbance: 3% decrease
- Anxiety: 16% decrease
- Social Relating: 6% decrease
- Total: 8% decrease

- All scores below Clinical cutoff
  * = <.05 ** = <0.01 (significance levels)
### Phase 3: 2013

**DBC Average Totals**

<table>
<thead>
<tr>
<th></th>
<th>Parent Total 2012 ID</th>
<th>Teacher Total 2012 ID</th>
<th>Parent Total 2013 ASD</th>
<th>Teacher Total 2013 ASD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre</strong></td>
<td>63.91</td>
<td>51.46</td>
<td>63.98</td>
<td>37.39</td>
</tr>
<tr>
<td><strong>Post</strong></td>
<td>58.11</td>
<td>40.38</td>
<td>51.43</td>
<td>34.32</td>
</tr>
<tr>
<td><strong>3 Month Follow Up</strong></td>
<td></td>
<td></td>
<td>47.48</td>
<td>33.82</td>
</tr>
</tbody>
</table>
## Phase 2 & 3
### 2012 vs 2013

<table>
<thead>
<tr>
<th>Parenting Scale</th>
<th>2012 ID</th>
<th>2013 ASD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laxness</td>
<td>19% Decrease**</td>
<td>16% Decrease**</td>
</tr>
<tr>
<td>Overreactivity</td>
<td>18% Decrease**</td>
<td>14% Decrease**</td>
</tr>
<tr>
<td>Verbosity</td>
<td>22% Decrease**</td>
<td>13% Decrease**</td>
</tr>
</tbody>
</table>

**=<0.01 (significance levels)
## Phase 2 & 3
**2012 vs 2013**

### Parenting Tasks Checklist

<table>
<thead>
<tr>
<th></th>
<th>2012 ID</th>
<th>2013 ASD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting Efficacy</td>
<td>10% Increase**</td>
<td>13% Increase**</td>
</tr>
<tr>
<td>Behaviour</td>
<td>16% Increase**</td>
<td>20% Increase**</td>
</tr>
</tbody>
</table>

**==<0.01 (significance levels)**
Phase 2 & 3
2012 vs 2013

<table>
<thead>
<tr>
<th>DASS-21</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>55% Decrease**</td>
<td>57% Decrease**</td>
</tr>
<tr>
<td></td>
<td>(Mild -&gt; Normal)</td>
<td>(Extremely Severe -&gt; Moderate)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>52% Decrease**</td>
<td>50% Decrease**</td>
</tr>
<tr>
<td></td>
<td>(Normal -&gt; Normal)</td>
<td>(Severe -&gt; Mild)</td>
</tr>
<tr>
<td>Stress</td>
<td>43% Decrease**</td>
<td>60% Decrease**</td>
</tr>
<tr>
<td></td>
<td>(Normal -&gt; Normal)</td>
<td>(Severe -&gt; Mild)</td>
</tr>
</tbody>
</table>

Program halves presentation regardless of intensity

**=<0.01 (significance levels)
GSTTP Conclusions

• School-based delivery of GSSTP is an effective early intervention for children with ID and ASD.
• Parent stress, anxiety, depression levels decreased whilst confidence in parenting increased.
• Benefits continue after the program is complete.
• Collaboration beneficial.
• Additional by products of the groups included increased peer support and improved parent/school relations.
Parents and staff from Beverley Park School.
The Stepping Stones Triple P Project

A public health approach to supporting parents and caregivers of children with disabilities

Professor Stewart Einfeld
THE CHALLENGE

Increase the number of parents and caregivers of children with a disability who complete evidence-based parenting programs & professionals to deliver them.

To enhance parenting competence and confidence at a population level.

To reduce the prevalence of child social, emotional and behavioural problems at a population level.
The Stepping Stones Triple P system of intervention
Efficacy of Stepping Stones Triple P

META-ANALYSIS: STEPPING STONES TRIPLE P

So it has efficacy, but is it effective?

The Triple P Stepping Stones (SSTP) Project

- National Health & Medical Research Council (NHMRC) funded Program Grant

- Aims:
  - To decrease the prevalence of emotional and behavioural problems in children with a disability in the community
  - Determine the public health benefit & cost-effectiveness of the SSTP program at a population level
  - Delivered as a community wide strategy across three states: Queensland, Victoria, and New South Wales
Stage 1
- “My Say” population level survey of parents, caregivers and professionals

Stage 2
- NSW roll-out of Stepping Stones Triple P parenting program

Stage 3
- Population level survey of parents and caregivers, and professionals to assess changes in levels of emotional and behavioural problems
STAGE 1: MY SAY SURVEY

- Parents and caregivers of children with a disability aged 2-10 years

- Professionals who work with children with disabilities and their families (e.g., teachers, psychologists, occupational therapists, speech therapists, disability support workers, case management workers).
**MY SAY WEBSITE**

www.mysay.org.au
STAGE 2: TRAINING OF PROFESSIONALS

- Free Stepping Stones training will be offered to professionals who work with children with a developmental disability.
- Professionals can indicate their interest in receiving Stepping Stones training when they complete the “My Say” survey.
- Professionals will be chosen based on their capacity to deliver the program to families.
STAGE 2: SUPPORT FOR FAMILIES

- NSW roll-out of the Stepping Stones program free of charge to all eligible parents and caregivers of children with disabilities aged 2-12 years.

- This includes a sub-set of parents and caregivers of children aged 2-10 years with an intellectual disability or developmental delay. These parents and children will be followed up more intensely.
The SSTP strategies

<table>
<thead>
<tr>
<th>PROMOTING A POSITIVE RELATIONSHIP</th>
<th>ENCOURAGING DESIRABLE BEHAVIOUR</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Spending quality time with your child</td>
<td></td>
</tr>
<tr>
<td>• Communicating with children</td>
<td></td>
</tr>
<tr>
<td>• Showing affection</td>
<td></td>
</tr>
<tr>
<td>• Descriptive praise</td>
<td></td>
</tr>
<tr>
<td>• Positive attention</td>
<td></td>
</tr>
<tr>
<td>• Providing other rewards</td>
<td></td>
</tr>
<tr>
<td>• Engaging activities</td>
<td></td>
</tr>
<tr>
<td>• Setting up activity schedules</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TEACHING NEW SKILLS AND BEHAVIOURS</th>
<th>MANAGING MISBEHAVIOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Setting a good example</td>
<td></td>
</tr>
<tr>
<td>• Using physical guidance</td>
<td></td>
</tr>
<tr>
<td>• Incidental teaching</td>
<td></td>
</tr>
<tr>
<td>• Ask-Say-Do</td>
<td></td>
</tr>
<tr>
<td>• Teaching backwards</td>
<td></td>
</tr>
<tr>
<td>• Behaviour charts</td>
<td></td>
</tr>
<tr>
<td>• Using diversion to another activity</td>
<td></td>
</tr>
<tr>
<td>• Ground rules</td>
<td></td>
</tr>
<tr>
<td>• Directed discussion</td>
<td></td>
</tr>
<tr>
<td>• Planned ignoring</td>
<td></td>
</tr>
<tr>
<td>• Clear, calm instructions</td>
<td></td>
</tr>
<tr>
<td>• Teaching children to communicate</td>
<td></td>
</tr>
<tr>
<td>• Logical consequences</td>
<td></td>
</tr>
<tr>
<td>• Blocking</td>
<td></td>
</tr>
<tr>
<td>• Brief Interruptions</td>
<td></td>
</tr>
<tr>
<td>• Using quite time</td>
<td></td>
</tr>
<tr>
<td>• Using time-out for serious misbehaviour</td>
<td></td>
</tr>
</tbody>
</table>
SSTP resources

Workbooks

Primary care booklets
As part of the project we will create resources for 7 disability syndromes groups and their specific behaviour phenotypes:

- Autism Spectrum Disorder
- Down Syndrome
- Fragile X
- Fetal Alcohol Spectrum Disorders
- Williams Syndrome
- Prader Willi Syndrome
- Velo-Cardio-Facial Syndrome/ 22q Deletion Syndrome
SSTP tip sheets for parents

The modules include three resource sheets for each syndrome

› Parent tip sheets about:
  • The nature of the syndrome
  • Behavioural phenotype
  • Behaviour management strategies specific to their child’s syndrome

---

Fragile X Syndrome

Being a parent of a child with Fragile X is a challenging job, but it can also be very rewarding. The aim of good parenting is to help your child to reach their full potential. Most adults begin their parenting careers unprepared for what lies ahead, and learn parenting skills through trial and error. Parents of children with Fragile X often experience frustration and disappointment as the parenting skills they have learnt are not effective with their child. Many parents have high expectations of themselves — how they should feel and cope with being a parent. Unrealistic expectations can lead to feelings of disappointment or inadequacy. This tip sheet gives some suggestions to help you manage the challenges that come with being a parent of a child with Fragile X.

WHAT IS FRAGILE X?

Fragile X is the most common inherited cause of developmental difficulties in males. It causes varying degrees of learning difficulties and symptoms may be comparable with children who have autism spectrum disorder. The main areas of difficulty are:

- Intellectual impairment
- Speech and language development
- Motor skills development

The better because early treatment can help children reach their full potential.

HOW DOES FRAGILE X AFFECT CHILDREN?

If your child has Fragile X syndrome, you may notice some particular behaviours or an overall delay in their cognitive development. This might include:

- Social withdrawal
- Poor concentration
- Self-harm

OTHER PROBLEMS ASSOCIATED WITH FRAGILE X

It is also common for children with Fragile X to have an intellectual disability, levels of intellectual functioning tend to be lower in males and more variable in degree in females.

---

Mental health concerns most commonly reported in this population include conduct or oppositional disorder, attention deficit hyperactivity disorder, autism, obsessive compulsive disorder and emotional disorders such as depression.

OUTCOME

The developmental gap between children with DS and typically developing children tends to increase with age. Hyperactivity and temper outbursts tend to decline by adolescence while social withdrawn can increase with age, particularly with the onset of adolescence. Overall behavior difficulties tend to become easier as children get older.

FAMILIES ARE IMPORTANT

Mental Health Services

- Counselling
- Support groups
- Education programs

---

Develop strategies to prevent early avoidance behaviours

Children with DS have a tendency to avoid tasks they find difficult. Assistance may be obvious such as refusal or running away, or it may be subtle, such as avoiding the person making demands or encouraging them to do the task. Assistance behaviors can have negative effects, particularly later in life. It is therefore important to identify these behaviors at a young age and ensure all caregivers are aware of what they are and how best to discourage them.

Developing healthy choice-making

Providing opportunity for children to

---
Practitioner tip sheets provide information about:

• Behavioural and cognitive characteristics of the syndrome
• Key points to remember when working with families with a child with the syndrome
• Key links to further information
An example of a strategy for children with Prader Willi syndrome

| Setting up activity schedules | Activity schedules may reduce outbursts, anxiety and repetitive questioning in children with PWS. A visual activity schedule can be used to help children understand what is happening throughout the day including what and when they will be eating. Schedules are also great for helping children prepare for changes in routines and when transitioning between activities. |

An example of a strategy for children with Fetal Alcohol Spectrum Disorder

| Using behaviour charts | Using a behaviour chart with a visual reminder of the reward can be used to teach children with FASD the consequences of appropriate behaviour |
EXPECTED BENEFITS

- Increase our understanding of the experiences of families of a child with a disability.
- Provide professionals with access to evidence-based parenting interventions and to increase professional skills in delivering such interventions.
- Improved parenting confidence, refined parenting skills, decreased family stress and a reduction in the children’s challenging behaviours.
- Increase population level awareness of the mental health concerns that can affect young people with developmental disabilities.
- Focus on the sustainability of evidence-based parenting programs.
Is it cost-effective? Stepping Stones Triple P: Economic evaluation of a public health intervention

Is the cost of implementing SSTP outweighed by a reduction in cost of care of the child?

Cost of the program

Cost of a child with ID/DD

Informal care costs

Parental access to workforce

Direct cost of care

Cost of the Program
Email: fhs.steppingstones@sydney.edu.au

Phone: (02) 9114 4060

www.mysay.org.au

https://www.facebook.com/SteppingStonesTriplePProject
SCHOOL-LINK RESOURCES
Developmental Disabilities, Challenging Behaviour and Mental Health Conference

Wednesday, July 3, 2013 at 1:30 PM

Save the Date - Friday 7 November 2014

Developmental Disabilities, Challenging Behaviour and Mental Health: Research to Practice and Policy

The latest developments in disability and mental health research and practice will be presented by leading international and Australian researchers.

Speakers include:
- Prof. James Heron, Johns Hopkins University USA
- Prof. Karen Morse, Harvard University USA
- Prof. Michael Rutter, Institute of Psychiatry, London UK
- Prof. Paul Hewson, Institute of Psychiatry, London UK, University of Sydney
- Prof. Eric Emerson, University of Sydney, Lancaster University UK
- Prof. Sirena Lusardi, University of New South Wales
- Prof. David Cooper, University of Sydney
- Prof. Julian Tatt, University of New South Wales

Schools Conference

MISID

Mental Health and Intellectual Disability Schools Conference 5th August
Journal of Mental Health for Children and Adolescents with Intellectual and Developmental Disabilities: An Educational Resource

Volume Five, Issue One, 2014, ISSN 1837-8803, SHIPD IAY 110496
The Medicine Cabinet

- **Clonidine (1.2M)**
  This article by Judith Longworth in the CHW School-Link Newsletter Volume 4 issue 3/4 explains clonidine.

- **Fluoxetine (187K)**
  This article by Judith Longworth in the CHW School-Link Newsletter Volume 2 issue 2 explains the use of fluoxetine.

- **Mood Stabilisers Part 1 (266K)**
  This article by Judith Longworth in the CHW School-Link Newsletter Volume 3 issue 3/4 explains mood stabilisers used with children and adolescents with an intellectual disability. In part 1 medications discussed include lithium and carbamazepine.

- **Mood Stabilisers Part 2 (233K)**
  This article by Judith Longworth in the CHW School-Link Newsletter Volume 4 issue 1 explains mood stabilisers used with children and adolescents with an intellectual disability. In part 2 medications discussed include lamotrigine, topiramate, levetiracetam, gabapentin and other anticonvulsants.

- **Obesity and Medications (271K)**
  This article by Judith Longworth in the CHW School-Link Newsletter Volume 3 issue 1 explains how medications can cause weight gain. Medications discussed include antipsychotics, mood stabilisers, and antidepressants.
E-List

Sign up to our e-list to receive our quarterly journal and from time to time relevant emails about professional development opportunities.

www.schoollink.chw.edu.au
Book


http://www.ipcommunications.com.au
City 2 Surf 2015

Running as superheros to raise money for kids with Autism at Children’s Hospital at Westmead.

Your school is invited to join us in 2015!

Like & share our Facebook page:
www.facebook.com/AutismWestmead