

A Framework for Professional Practice: Behind the Scenes of the Educational Program and Book

Donna White, David Dossetor, and Lesley Whatson

Introduction

Children and adolescents with intellectual disability are at greater risk of developing mental health issues than their typically developing peers (Einfeld & Tonge, 1996; Emerson, 2003). This is due to the cumulative effects of developmental, biological, psychological, social and cultural difficulties (Hatton & Emerson, 2004; Hulbert-Williams & Hastings, 2008; Wallander, Dekker, & Koot, 2006). Mental health services available to this population within New South Wales are limited (Steitz, 2008) and services often don't meet the complexities of the associated needs of young people with intellectual disability and emotional/behavioural disturbances (Jess et al, 2008; Scior & Grierson, 2004). Professionals often have inadequate training in developmental disabilities and dual diagnosis (Costello et al., 2007; Phillips, Morrison, & Davies, 2004; Whitehurst, 2008) resulting in lack of expertise and confidence in working with this population (Mohr, Phillips, Curran, & Rymill, 2002; Tsiantis et al., 2004). There is also poor interagency collaboration across services that weaken the effectiveness of service delivery (Worrall-Davies, Kiernan, Ander-ton, & Cottrell, 2004).

This article briefly describes a partnership between the Department of Psychological Medicine at The Children's Hospital at Westmead and the Statewide Behaviour Intervention Service, Ageing Disability and Home Care (ADHC, Department of Human Services NSW) to develop, implement and evaluate an educational program for professionals working in child mental health and intellectual disability. This involved a multi-phased project that began in September 2007 and will finish in June 2010. The project has developed a framework of core clinical interventions; developed, implemented and evaluated a 2-day training seminar program; and edited a book of clinical papers.

The educational program provides a holistic framework that considers the 'biological, developmental, family, educational, social, and cultural contexts of children and adolescents with intellectual disability' and provides an evidence based perspective about the 'specific interventions that can effect change and improve the quality of life' of young people with intellectual disability, and their families (White, in press). The training events, based on the framework, were aimed at building staff capacity in order to promote the social, behavioural and emotional well-being and mental health of young people with intellectual disability (White, in press).

Project Phases

The Training Curriculum Project progressed through a number of phases so that key goals could be achieved. These phases are listed below (see White, in press for a detailed description of phases 1-4).

Phase 1

This involved the *development of a framework of core clinical interventions* that included a literature review, analyses of clinical and training data, expert opinion, review of existing resources and curricula, and a clinical forum. The framework consisted of four clinical domains that focused on: understanding and integrating scientific approaches; the impact of disability and family well-being; individual emotional and behavioural well-being; and integration of service systems (White, Dossetor, & Whatson, 2008).

Phase 2

A *training needs analysis (TNA)* was conducted that necessitated surveying clinicians to establish a consensus view of the core content requirements of the proposed framework. The TNA also identified the topics within the framework that were the highest priority for inclusion in the training events.

Phase 3

This entailed the development of a *two-day seminar program* for professionals that focused on the developmental, emotional and behavioural needs of young people with intellectual disability. It also included the collation of papers, on topics across the four clinical domains of the framework, from clinical experts into an *edited book* to supplement the information in the training events.

Phase 4

This phase was concerned with the *implementation and evaluation of the educational program* through three training events in 2009. Pilot training events were implemented in two regional centres in New South Wales and evaluated extensively. Feedback from these pilot events resulted in modifications to the training event content that was then implemented in metropolitan NSW. The results from the evaluations revealed positive outcomes for participants with increased knowledge, confidence and positive attitudes to multidisciplinary and interagency collaboration, and application of learning to work practices.

Phase 5

The last phase of the project has involved investigation of *sustainability* options to allow for the educational program to be available for future professional development once the project is completed at the end of June 2010. A further training event is to be held on 7-8 June 2010 as part of the sustainability plan.

Conclusion

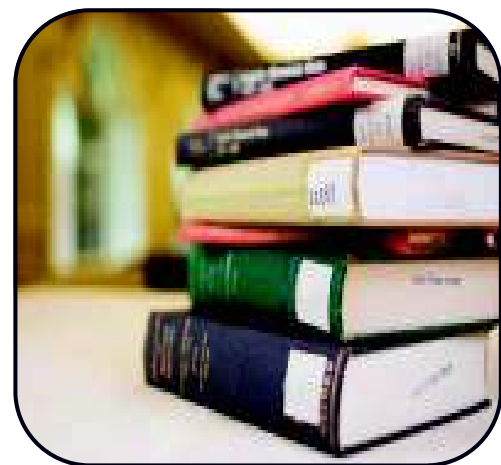
Since 2007, the Training Curriculum Project has achieved all its key goals including training of 300 professionals in 2009 and an edited book that is believed to be the first in its genre. The develop-

ment of the framework and training events has provided a network of professionals with expertise that has become the basis of enhanced partnerships across agencies. The focus is now on moving towards prevention and early intervention, staff competencies across agencies, and clarifying pathways to care. The project has also provided a learning environment that has fostered interagency collaboration in new and existing projects and clinical work e.g., the Developmental Psychiatry Clinic, Triple P Stepping Stones training.

In addition, presentations at conferences in South Africa, Sydney and Tasmania have enabled peer review of the project and framework at international and national levels. Abstracts have recently been accepted to present the project outcomes at conferences in Brisbane and Rome at the end of 2010. By sharing the research with professionals in child mental health and intellectual disability, and providing ideas on the practical application of core interventions, it is hoped that this will help meet the developmental, behavioural and emotional needs of young people with intellectual disability. ●

References

- Costello, H., Holt, G., Cain, N., Bradley, E., Torr, J., Davis, R., et al. (2007). Professional training for those working with people with intellectual disabilities and mental health problems. In N. Bouras & G. Holt (Eds.), *Psychiatric and behavioural disorders in intellectual and developmental disabilities* (2nd ed.) (pp. 400-411). UK: Cambridge University Press.
- Einfeld, S. L., & Tonge, B. J. (1996a). Population prevalence of psychopathology in children and adolescents with intellectual disability: I rationale and methods. *Journal of Intellectual Disability Research, 40*(2), 91-98.
- Emerson, E. (2003). Prevalence of psychiatric disorders in children and adolescents with and without intellectual disability. *Journal of Intellectual Disability Research, 47*(1), 51-58.



Hatton, C., & Emerson, E. (2004). The relationship between life events and psychopathology amongst children with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 17, 109-117.

Hulbert-Williams, L., & Hastings, R. P. (2008). Life events as a risk factor for psychological problems in individuals with intellectual disabilities: A critical review. *Journal of Intellectual Disability Research*, 52 (11), 883-895.

Jess, G., Torr, J., Cooper, S. A., Lennox, N., Edwards, N., Galea, J., et al. (2008). Specialist versus generic models of psychiatry training and service provision for people with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 21, 183-193.

Mohr, C., Phillips, A., Curran, J., & Rymill, A. (2002). Interagency training in dual disability. *Australasian Psychiatry*, 10(4), 356-364.

Phillips, A., Morrison, J., & Davies, R. W. (2004). General practitioners' educational needs in intellectual disability health. *Journal of Intellectual Disability Research*, 48(2), 142-149.

Scior, K., & Grierson, K. (2004). Service provision for young people with intellectual disabilities and additional mental health needs: Service-providers' perspectives. *Journal of Applied Research in Intellectual Disabilities*, 17, 173-179.

Steitz, M. (2008). *Access to Services*. Unpublished manuscript, The Improved Service Access and Parenting for Families with Children and Adolescents with Intellectual Disability in NSW Project, Mental Health and Drug and Alcohol Office (MHDAO) of NSW and Hunter New England Area Health Service.

Tsiantis, J., Diareme, S., Dimitrakaki, C., Kolaitis, G., Flios, A., Christogiorgos, S., et al. (2004). Care staff awareness training in mental health needs of adults with learning disabilities. *Journal of Learning Disabilities*, 8(3), 221-234.

Wallander, J. L., Dekker, M. C., & Koot, H. M. (2006). Risk factors for psychopathology in children with intellectual disability: A prospective longitudinal population-based study. *Journal of Intellectual Disability Research*, 50(4), 259-268.

White, D. (in press). Development of the 'framework for professional practice'. In D. Dossetor, D. White, & L. Watson (Eds.), *Mental health of children and adolescents with intellectual disability: A framework for professional practice*. Melbourne, Australia: IP Communications.

White, D., Dossetor, D., & Watson, L. (August, 2008). *A training curriculum of clinical interventions in child mental health and intellectual disability*. Poster presentation at the 13th IASSID World Congress, Cape Town, South Africa. [Abstract: *Journal of Intellectual Disability Research*, 52(8-9), 739].

Whitehurst, T. (2008). Impact of mental health training for frontline staff working with children with severe intellectual disabilities. *Journal of Policy and Practice in Intellectual Disabilities*, 5(1), 6-11.

Worrall-Davies, A., Kiernan, K., Anderton, N., & Cottrell, D. (2004). Working with young people with complex needs: Practitioners views. *Child and Adolescent Mental Health*, 9(4), 180-186.

Shared Care Family Support Program

MORE THAN JUST RESPITE – A HOLISTIC AND THERAPEUTIC APPROACH TO WORKING WITH MULTI-STRESSED FAMILIES

The Shared Care Family Support (SCFS) Pilot program is a new and innovative program, set up in 2007 by Interaction Disability Services, to provide clinical and case management support to families of children aged 7 to 15 with an intellectual disability and challenging behaviours/high needs. SCFS aims to prevent the incidence of breakdown in families with children with intellectual disability and challenging behaviours by providing support primarily across the family home and a facility environment, which acts as a controlled environment in which a dedicated and trained staff team implement a behaviour management/skill building program for each individual child.

The centre based care allows thorough assessment of each child and their challenging behaviour and provides an opportunity to trial effective behaviour management strategies. Access to the centre based facility is offered in a predictable yet flexible format, being a combination of mid week and weekend stays or solely midweek or weekends only, also with an option to opt out of access to the facility and commence in home support sooner.

SCFS also offers brokerage funding that can be used by each family to access specialist support, services, or equipment as needed and in accordance with family goals.

The philosophy behind this program is to work alongside the whole family to provide sustainable and tailored intervention whilst collaborating effectively with all other agencies/professionals working with that family. Having a facility that the families can access voluntarily and in a regular and predictable manner gives the family the chance to 'recharge',

which helps with more meaningfully engaging with clinical programs within the home environment. It further gives the family an opportunity to better plan and structure their life, which can often be missing when having a child with a disability. The program also offers home based support, whereby a worker will work alongside, demonstrating and coaching families in preventing and managing their child's behaviour at home, based on the strategies found to be effective in the facility environment.

Working with multi-stressed and multi-needs families also requires working creatively, collaboratively, and in a staged approach. The SCFS program works with each family's goals, and considers how the clinical strategies can be made to 'fit' for each family such as to make it sustainable.

Families that have accessed this program have reported increased confidence when managing their child's behaviour and that they can 'see' the strategies work as a result of in-home support. Families have reported increased hope and have been more successful in adopting the strategies once seeing them work and with active support beside them.

This program has also demonstrated decreased parental psychopathology, improved understanding of reasons for behaviours resulting in better behaviour management, increased skills in clients, amongst other benefits as a result of the combined services provided. Below are collected measures outlining generalised decreases in parental psychopathology over the course of time in the program. ●

Natalie Robbins (SCFS Program Manager) & Jessica Radovan (SCFS Clinician / Psychologist), Interaction Disability Services
www.interactiondisability.com/

