Mental Health

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From the editors

Nicole Watts Pappas and Marleen Westerveld

Nicole Watts Pappas (left) and Marleen Westerveld

WHEN *ACQ* COMMITTEE MEMBER ANDREA MURRAY PROPOSED the idea of a mental health special issue of *ACQ* we initially wondered whether this topic would be of interest to the broad range of speech pathologists that make up our readership. However, as many of the articles in this edition demonstrate, the role of the speech pathologist in mental health is something we all need to be aware of. For example, Dean Sutherland and colleagues discuss the important links between behaviour problems and language impairment in children and adolescents, whereas Julie Ball and Ferhana Khan discuss the speech pathologists' role in the care of children who have experienced trauma. Other articles describe working with children with selective mutism, speech pathologists' involvement in intervention for children with behavioural difficulties, and the importance of fostering mother–infant attachment. In an interesting article, Sandra Drabrant and her colleagues describe the role of the art therapist in working with clients with mental health concerns. Our regular columns are here too, including a poignant Webwords in which Caroline Bowen recalls her own experiences of the impact of the mental health of a client's family on speech pathology practice, and the research updates column which reports on current research being conducted into the mental health of adults who stutter.

Andrea and her colleagues in mental health have done a wonderful job in helping to bring this issue together, demonstrating the expertise of speech pathologists working in a variety of roles in mental health across the country. Many thanks to all of them and we hope this edition of ACQ highlights ways in which you may further the role of speech pathology in mental health. As always we welcome feedback from our readers about the journal. Please feel free to email us at nwattspappas@hotmail.com or m.westerveld@gmail.com.

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Cori Williams

Cori Williams

I SAT DOWN TO START WRITING THIS COLUMN – LATE again, and, feeling uninspired, procrastinated by deciding to complete a (necessary) task for my day job. Some 90 minutes (not five, which is all it should have taken) later I have achieved that task, but at some expense to my mental health. Perhaps I should have written the column first – procrastination seldom reaps rewards!

Mental health is certainly an issue of which we should all be aware. In particular, we need to be aware of the role that language and communication play in mental health. The links between behaviour disorders and communication impairment are clearly established, and addressed in a number of papers in this issue. The personal experiences of clinicians working in this area promise to be fascinating. Is awareness enough though? As we strive to increase the influence of the profession, perhaps we need to include mental health as one of the areas in which we advocate for the needs of our clients. It is fitting that the Association is embarking on a review of the position paper *Speech pathology in child and adolescent mental health*. Once completed, this will provide members with information which may be used in advocacy.

We also need to be aware of our own mental health. This necessity was raised at the forum on the Association Code of Ethics, held at the 2009 National Conference in Adelaide. As professionals working in a caring profession,

striving to deliver excellent, ethical, evidence based services to our clients, to advocate for the rights of people with communication and swallowing disorders, and to meet the demands of employers, it may be that our own mental health and wellbeing are challenged from time to time. It is easy to take on more and more, often at some cost to ourselves. Is it ethical to focus on our aspirations for working with others, and to neglect our own wellbeing? Will neglecting our own well-being ultimately impact on the delivery of excellent services to our clients? The organisation Managing Work Life Balance International (http://www.worklifebalance.com.au/) sees work–life balance as a "bottom-line business issue" which, when achieved, has potential benefits in terms of employee satisfaction, retention and productivity. Perhaps it is also a bottom-line professional issue which impacts on satisfaction, retention and productivity in our professional lives. The issues of responsibility to ourselves will be considered in the review of the Code of Ethics – but we may all need to consider them from a personal viewpoint.

Work–life balance is dynamic, not static. We may find that getting the balance right can help us to achieve at higher levels. Finding the balance is the challenge. Hilary Clinton said, "Our lives are a mixture of different roles. Most of us are doing the best we can to find whatever the right balance is … For me, that balance is family, work, and service". What is the right balance for you?

Introduction

Andrea Murray
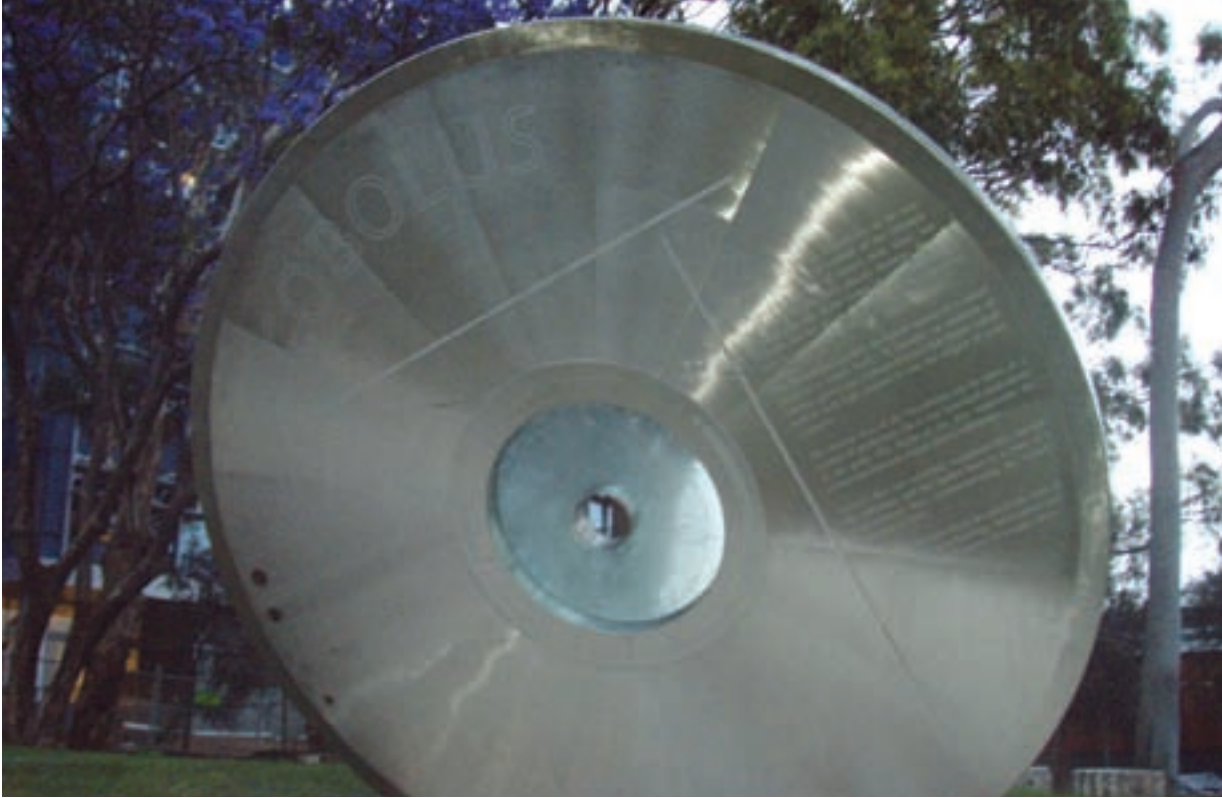
Andrea Murray

The Discobolus, or discus thrower, was known in ancient Greece as a symbol of the Olympic Games and signifies the Greek values of a "sound mind in a sound body". The discobolus became an emblem of balance, power, and rhythmical grace that the Greek culture held in high esteem. At the Olympic stadium in Sydney there is a large discus built for the Olympic Games held in 2000. The inscription states that its circular shape is a symbol of perfection or excellence. The flight of the discus represents a connection between distant places and times and its resemblance to the modern day CD is described as a fitting symbol of the advances in knowledge and technology in modern times. I liked it when I saw it, because as a clinician working in a mental health service, a "sound mind in a sound body" is the goal that is aspired to for clients. In mental health services we also recognise the impact of one's past on the present, aspire to excellence through innovative practice and actively seek to acquire, expand and disseminate knowledge about mental health via modern day technology and research.

Mental health affects *all* ages and is present or absent across the lifespan, from the newborn infant to the elderly. It can be compromised at any age. Often what is described as "mental health" is actually mental *ill* health. The World Health Organisation states that "Mental Health is a state of well being in which the individual realises his or her own abilities, can cope with normal stressors of life, can work productively, and is able to make a contribution to his or her community" (http://www.who.int/mediacentre/factsheets/fs220/en/). Mental ill health encompasses both mental illness as well as mental health problems. Difficulties can range from mild to severe and may interfere to a minimal or high degree on a person's day to day functioning.

The focus of this issue, Mental Health, is relevant to everybody as all speech pathologists deal with matters of mental health. Therapeutic services may be preventative in nature and reduce the risk of mental ill health, or they may be remedial, thus building skills, improving social and emotional functioning and enhancing resilience.

The issue was initiated as a joint project of the National Peer Supervision Group, comprising senior speech pathologists working in child and youth mental health services in Queensland, Victoria and South Australia. The mental health discus has, however, travelled metaphorically around Australia and beyond, with articles also submitted from NSW, Western Australia and New Zealand. The issue is diverse and thought-provoking and, in keeping with mental health practice principles, it is also reflective, with clinicians, students and a consumer sharing their stories. We hope that the issue will inform, challenge and inspire you.

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Communication impairments and behaviour problems in children and adolescents

A review of the literature

Dean Sutherland, Brigid McNeill, and Gail Gillon

Dean Sutherland

Young children experiencing communication impairments may also display behaviour problems that persist into adolescence and adulthood, contributing to a range of negative long term outcomes such as low academic achievement and anti-social behaviour. Additionally, children and adolescents identified with behaviour problems often present with undiagnosed communication impairments. This paper provides a narrative review of research that has investigated the relationship between communication impairments and behaviour problems in children and adolescents over the past 30 years and examines the potential role of speech pathologists working in this area of practice.

Children with communication impairments are at increased risk of experiencing social, emotional, and behaviour disorders (e.g., Gallagher, 1999; McCabe, 2005). Similarly, children with emotional and behaviour disorders often present with coexisting communication impairments (Camarata, Hughes, & Ruhl, 1988; Ruhl, Hughes, & Camarata, 1992). Comorbidity estimates of communication disorders and behaviour disorders range from 12% to 71% (e.g., Benner, Nelson, & Epstein, 2002; Pinborough-Zimmerman, Satterfield, Miller, Hossain, & McMahon, 2007) with methodological differences across studies contributing to the variation in reported rates.

The prevalence of communication impairments and frequent co-occurrence with behaviour problems suggest that speech pathologists have a role to play in assessing and supporting children and adolescents diagnosed with language and/or behaviour problems. This is particularly important considering the risk of poor long-term social and employment outcomes for adolescents and adults who experience significant childhood speech-language difficulties (e.g., Clegg, Hollis, Mawhood, & Rutter, 2005; Snow & Powell, 2008). We conclude this paper with suggested strategies to support speech pathologists in working with children and adolescents presenting with complex communication and behavioural needs.

Communication impairments and behaviour problems

Preschool children

The association between communication impairment and problems with behaviour and social skills is evident from a young age (McCabe, 2005; Qi & Kaiser, 2004). Qi and Kaiser investigated the behaviour and social skills of 3- and 4-year-old children (n = 60) from low socioeconomic backgrounds who were attending a head start program. The behaviour characteristics of 32 children with receptive and/or expressive language delays were compared with 28 children with typical language development. A combination of classroom observations and teacher reports were used to determine that children with language delay demonstrated significantly higher levels of behaviour problems (e.g., hitting other children and disrupting class). McCabe (2005) examined behaviour and social skills of 170 preschool children with and without speech and/or language impairments using teacher and parent ratings. McCabe found children with language impairment were rated as less social and exhibited more errant behaviour (e.g., physical aggression) compared to children with speech impairment only or to children without communication impairment. In contrast, McCabe and Meller (2004) found no difference in problem behaviours reported by teachers and parents for 4–5-year-old children with and without speech-language impairment. However, in comparison to children with typical language development, children with speech-language impairment were rated lower on a measure of self-control by parents and lower on assertiveness by teachers. These studies contribute to a growing evidence base supporting the early emergence of a relationship between communication impairments and behaviour problems. Early language and behaviour difficulties are in turn likely to hinder children's readiness for school entry (Justice, Bowles, Pence Turnbull, & Skibbe, 2009) which also increases the risk of poor academic outcomes (Duncan et al., 2007).

School-aged children and adolescents

School-aged children with specific language impairment (SLI) often experience social and behaviour problems in classroom contexts (Conti-Ramsden & Botting, 2004). For example, school-aged children may experience difficulty following multi-step classroom instructions which a teacher may interpret as non-compliant behaviour (Redmond & Rice, 1998). Conti-Ramsden and Botting (2004) used a range of behavioural questionnaires and checklists (e.g., Strengths

and Difficulties Questionnaire; Goodman, 1997) during a longitudinal study of behaviour and social skills among 242 children with SLI. At age 7, this group was overrepresented in the areas of conduct difficulties (e.g., bullying other children) and hyperactivity. However, by age 11, this overrepresentation was not evident. Rather, at age 11 these children presented with social difficulties such as withdrawn social style and were the recipients of higher levels of bullying compared to children without SLI.

School-aged children with written language impairments can also demonstrate a range of behavioural and psychiatric problems (Carroll, Maughan, Goodman, & Meltzer, 2005; Willcutt & Pennington, 2000). High levels of Attention Deficit Hyperactivity Disorder (ADHD), depression, aggression, and conduct and anxiety disorders were reported among a cohort of twins aged 8 to 18 years experiencing reading disability (Willcutt & Pennington, 2000). Male participants were more likely to display aggressive behaviour, and female participants demonstrated higher levels of depression and anxiety. Somatic complaints and depression correlated strongly with reading disability after controlling for ADHD and additional behaviour disorders (Willcutt & Pennington, 2000). Carroll et al. (2005) reported a similar pattern of findings among a large national sample of British children aged 9–15 years (n = 289) with reading disorder. The presence of ADHD mediated the link between reading disability and disruptive behaviour, and conduct disorder; however, reading disability was directly linked with anxiety. Given that children with histories of SLI are at risk of reading problems (e.g., Catts & Hogan, 2003), it could be that studies investigating school-aged children with written language impairments have among them children with histories of spoken language impairment. This would suggest the importance of investigating both spoken and written language skills in school-aged children suspected of or diagnosed with behavioural problems.

Adolescents with behaviour or psychiatric problems often present with undiagnosed communication impairments. Sanger, Hux, and Belau (1997) investigated the oral language skills of female juvenile delinquents (aged 14;1 to 17;11) who had no history of language impairments. Comparison was made with an age-matched control group with no history of special education needs. The juvenile delinquent group demonstrated difficulty in the domains of syntax, semantics, and morphology. Similarly, Camarata, Hughes, and Ruhl (1988) examined the language skills of 38 children aged 8 to 13 years with mild to moderate behaviour disorders enrolled in special education programs within regular schools. Students were identified with a behaviour disorder based on the authors' criteria which included non-compliant behaviour and attention problems. They reported 37 out of 38 subjects performing at least one standard deviation below the mean on one or more subtests of a broad-spectrum standardised language test. Furthermore, 27 subjects scored 2 standard deviations or greater below the mean on at least one subtest.

Older adolescents and adults

The psychosocial effects of childhood language impairment often persist into adolescence and beyond (Arkkila, Räsänen, Roine, Sinoten, & Vilkman, 2008; Brinton, Fujiki, & Robinson, 2005; Clegg et al., 2005). Brinton et al. (2005) presented a longitudinal case study of a child (Cody) identified with SLI at age 4 through to age 19. Across his development, Cody experienced persistently high levels of anxiety and poor quality social relationships which the authors linked to his significant and ongoing language difficulties. Larger comparison studies also present evidence

of poor psychosocial outcome. Beitchman et al. (2001) reported adolescents with communication impairments being at increased risk of psychiatric problems. In a prospective longitudinal design, the researchers tracked the psychiatric profile of children from age 5 to 19 according to three categories: 1) speech disorder only (n = 38); 2) language impairment with and without speech impairment (n = 77); or 3) typical development (n = 129). At age 19, adolescents with childhood language impairments at age 5 were more likely to experience anxiety disorders, particularly social phobia, compared to children with speech disorder only, and children experiencing typical development. Brownlie et al. (2004) investigated behaviour disorders within the same group of children. They used parental reports to identify higher levels of delinquent behaviour (e.g., lying, cheating, stealing) among 19-year-old males with a language impairment compared to males and females with speech impairments or typically developing language. Clegg et al. (2005) compared the psychosocial outcomes of 17 adults with a history of severe developmental language disorder with their siblings and a group matched on intelligence. The adults with a language difficulty experienced higher levels of social difficulties and emotional disturbance. Four adults with language difficulty also reported clinically relevant mental health disorders (e.g., anxiety related disorders). In a Finnish study using a health-related quality of life questionnaire, researchers reported higher levels of *distress* and lower levels of cognitive functioning among 33 adults who experienced childhood SLI compared to an age-and-gender matched control group (Arkkila et al., 2008). All these studies highlight a link between childhood communication impairments and behaviour problems later in life.

Communication impairments and juvenile offenders

The influence of poor language skills on adolescents' behaviour and social experiences is also evident by the language and literacy difficulties experienced by adolescents in the juvenile justice system (Bryan, 2004; Putninš, 1999; Snow & Powell, 2008). A study by Putninš reported young offenders (aged 13–18 years) in secure care facilities in South Australia as demonstrating poor literacy and numeracy skills compared to age-matched controls. However, uncontrolled group differences such as socioeconomic background, gender, and cultural background may have contributed to the group differences. Similarly, linguistic profiles for 30 young offenders (aged 18–21 years) in a Scottish institution highlighted that 73% of young offenders performed below the normative range on an expressive syntactic task (Bryan, 2004). Half of the participants also performed poorly on picture description and naming tasks. In a recent Australian study, Snow and Powell (2008) compared the language and social skills of 50 juvenile offenders (mean age 15;8) with a control group matched on age, IQ, gender, and socioeconomic background. The performance of juvenile offenders was significantly poorer than the control group on both social skills and language assessments, and 26 of these offenders (52%) were noted as having language impairment. These findings provide further support for the link between language, literacy and social communication skills and low academic achievement (including learning and attention difficulties) and anti-social behaviour for many young offenders.

In summary, a considerable body of evidence has developed over the past 30 years to identify a relationship

between child and adolescent behaviour problems, and underlying deficits in language comprehension and/or expression. This evidence has highlighted that children who experience communication impairments are at increased risk of behaviour problems and that some young people with behaviour problems are likely to present with unidentified communication impairments. The following section outlines the role of speech pathologists in this area of practice.

The role of speech pathology in managing clients

Historically, children with behaviour problems and adolescents generally have received minimal input from speech pathologists (Larson & McKinley, 2003). For example, Ruhl et al. (1992) identified 30 school-aged students (8 females and 22 males aged 9;4 – 16;2) from a Pennsylvania school district with mild/moderate social skill disorders and IQs within the typical range. Although all participants performed at least one standard deviation below the mean on both receptive and expressive language measures, the researchers reported that no speech pathology services had been provided for these students. Similarly, Camarata et al.'s (1988) study summarised above identified only 2 out of 38 school-aged children with behaviour disorders as receiving services from speech pathologists. This was despite 97% of the participants demonstrating significant difficulties on one or more subtests of a standardised language test. More recently, Snow and Powell (2008) noted a subgroup of young offenders (n = 16) with language impairment experiencing early intervention such as reading recovery; however, no speech pathology input was reported.

Considering the evidence of the relationship between communication impairments and behaviour problems, speech pathologists have a role to play in identifying and supporting children with behaviour problems (Snow & Powell, 2004). However, speech pathologists are generally not qualified to diagnose behaviour or social problems. Therefore speech pathologists should work together with developmental and educational psychologists and behaviour specialists, parents, families, and children during the evaluation and intervention process.

Speech pathologists also have significant capacity to increase professional understanding of social and behaviour disorders by providing insight and advice on children's linguistic strengths and weaknesses (Ruhl et al., 1992). Input from speech pathologists will contribute to the development of appropriate communication, social, academic, and psychological profiles, which can then be used to determine functional intervention goals across domains and environments (Hummel & Prizant, 1993). Speech pathologists will also be able to provide insight into the appropriateness of assessment tools. For example, many psychological assessment tools require competent language skills in order to formulate appropriate responses to questions. Therefore children and adolescents with underlying language impairments are at risk of poor performance on these assessments. When called upon to evaluate a child or adolescent with behaviour problems a number of assessment considerations are recommended (see Brinton & Fujiki, 1993; Larson & McKinley, 2003):

- What is the status of this child's higher level language skills (e.g., ability to draw inferences)?
- What is the impact of this child's language abilities on their social interactions and relationships with peers and adults?

- What is the role of emotions, motivation, and self-esteem in this child's daily life?
- How does this child think and learn best?

Each of these considerations is designed to provide information in order to develop intervention goals that aim to equip children and adolescents with the skills and confidence to participate effectively in classroom contexts. These include goals that target meta-linguistic development and discourse skills that are commonly used during academic problem-solving activities and social interactions. Investigating this area of development is particularly important considering the lack of information on these higher level language skills provided by traditional norm-referenced assessments (e.g., *Clinical Evaluation of Language Fundamentals* (4th ed.): CELF-4; Semel, Wiig, & Secord, 2003). Developing intervention goals based on a profile of children's higher level language skills may reduce the risk of negative outcomes reported in the literature for children and adolescents experiencing communication impairments and behaviour problems. These negative outcomes include social withdrawal, academic failure, anti-social, and criminal behaviour. Specifically, these intervention goals should aim to (Prizant, Audet, Burke, & Hummel, 1990):

- enhance basic and higher level language skills and communicative competence;
- promote positive social relationships with peers, family, and adults; and
- develop cognitive and academic skills.

There is also a clear need for research into the role of speech pathology in improving behaviour, social, and academic outcomes for children and adolescents with communication impairments. This research must determine effective ways to:

- identify children with communication impairments who are at risk of behaviour problems;
- identify children and adolescents with behaviour problems and unidentified communication impairments; and
- provide support for developing communication, social and academic skills and reducing behaviour problems.

Summary

This review has summarised a large body of evidence for the relationship between communication impairments and behaviour problems in children and adolescents. This relationship is not surprising considering the critical role of speech and language skills during social interactions and academic experiences. The potential for positive long-term outcomes for children with behaviour and communication difficulties may be increased if speech pathologists work closely with the child, their family, professionals and researchers, towards intervention goals based on accurate communication and behaviour evaluations. However, further research is needed to identify specifically how speech pathologists can best contribute to this area of practice.

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Art therapy in mental health practice

Application in a multidisciplinary day program for young people with severe mental health problems

Sandra Drabant, Maggie Wilson, and Robert King

THIS ARTICLE HAS BEEN PEER-REVIEWED

Sandra Drabant (top), Maggie Wilson (centre), and Robert King

This paper examines the role of art therapists in a multidisciplinary team providing services in a day program for children and adolescents with severe mental health problems. Two dimensions of the art therapy role are examined. The first is the use of art therapy in a multidisciplinary group intervention. The second is the use of art therapy in the case management role that integrates services for individual clients. The specific contribution and value of art therapy with this client group and in this treatment setting is discussed.

While writings from psychiatrists about the artwork of their clients date back over 100 years, the field of art therapy has formally developed only since the 1940s. Over a period of nearly 70 years, art therapy has developed from an adjunct to psychoanalytic therapies to a form of intervention that can be used in partnership with a wide range of therapies, and a stand-alone intervention (Borowsky-Junge & Pateracki-Asawa, 1994). It can be used in both individual and group work (Liebmann 2004; Malchiodi 2007; Waller 1993). It has also found application with problems and in settings outside the field of mental health. These include but are not limited to children and adolescents in schools, physically ill and dying children, bereaved children, people with developmental delays, and immigrants (Wadeson, 2000).

Art therapists were initially resistant to evaluation using standard scientific procedures but have more recently recognised the importance both of better understanding the processes by which engagement in art activity promotes recovery and of establishing an evidence based for effectiveness (Bar-Sela, Atid, Danos, Gabay, & Epelbaum, 2007; Eitel, Szkura, Pokorny, & von Wietersheim; Rao et al., 2009).While there remains a paucity of high-quality studies (Ruddy & Milnes, 2005), there is encouraging evidence that participation in art therapy enhances well-being as measured by standardised instruments (Oster et al, 2006; Svensk et al., 2009).

Art therapy has been recognised as having particular value in work with clients who have difficulty expressing themselves verbally, such as refugees, children, and individuals with specific disabilities (Rousseau & Heusch 2000; Shearer 1997; Waller, 2006). In a child and youth mental health setting, art making can contribute to engagement, assessment, intervention, and treatment as part of the recovery plan. Symbolic or visual language is often central to the way children and teens express themselves and they are often more at ease with this medium than with answering questions. Contemporary child and youth mental health services typically employ a multidisciplinary team and a case management model of service delivery. There are opportunities for the art therapist to contribute both as a case manager and as part of a therapy team. In this paper, we describe and discuss the role of art therapy in the treatment of children and adolescents with severe mental health problems, having reference both to specialist therapeutic roles of art therapists and to the role of the art therapist as a case manager.

The Mater CYMHS Day Program

Mater's CYMHS Day Program serves young people aged 6 to 18 living with a mental illness and their families. The day program treatment provides an intensive therapeutic milieu throughout the day for young people who have a range of diagnoses. The target group is young people who need more intensive treatment than can be provided in a community service but who do not require full inpatient care. The young people involved in treatment attend on a daily basis for one or more school terms and participate in individual, group, and family therapies as well as in a school program. Each client is allocated a case manager who may be any member of the team, including the art therapist. The case manager builds a strong therapeutic relationship with the young person and also has the responsibility of coordinating treatment. Although each young person involved in the program has a designated case manager, typically she or he will work closely with several members of the multidisciplinary team.

The art therapist in multidisciplinary psychotherapy: the Compass group

"Compass" is a group developed by the art therapist and psychologist for the adolescent cohort at the Mater CYMHS Day Program. This group was designed to combine mindfulness techniques (King, 2006; Monti et al., 2006) and art therapy to address the needs of the young people attending the program at the time. The overall purpose of the group was to provide a safe space for the young people to identify and express their feelings, both visually and verbally, and to develop a better understanding of the connection

between their minds and bodies. This included promoting heightened self-awareness and reflection, practising relaxation techniques, developing better communication skills, sharing experiences and insights, relating to others, and discovering coping strategies.

The psychologist utilised mindfulness meditation techniques to help the adolescents find new techniques to be calm and gain insight into their own behaviours. The art created in the group enabled an external expression of these young peoples' internal experiences.

This group comprised 8 one-hour sessions conducted over a period of eight weeks with six adolescent participants with varying mental health diagnoses, such as somatoform pain disorder, anxiety with school refusal, depressive symptoms, and eating disorder. Each session included mindful breathing and a "visual check-in" whereby each member selected an image that caught their attention and verbally shared with the group something about the image they chose. Both the consistency and practice of these weekly interventions were designed to give the group of young people a sense of security, inner calmness, and connection with one other. In addition, each group included specific activities that may run over more than one session. Two of these specific activities are described in more detail.

Water colours

In this activity, the meta-message was "explore your potential", using this flexible, yet sometimes unpredictable medium. Initially the group worked on a collective artwork. Although a brief demonstration of the medium was given by the art therapist as well as a reminder to be respectful of each others' work, no specific form was required. The exercise was simply about each participant learning about what he or she could do with the paint while interacting with others. Specifically, participants needed to actively communicate with each other if they wanted to add to someone else's art and were not to obliterate anyone else's work by painting over it.

Following the collective activity, the psychologist conducted a mindful breathing exercise (with eyes closed). At the end of the exercise, participants opened their eyes and were asked to identify an emotion or feeling they had become aware of or were experiencing at the time. Using colour, lines, and marks they were asked to depict that particular feeling "emotion cards" were placed around the room for the group members to refer to, if they required a further visual and vocabulary prompt. The group members easily engaged in the art making and were subsequently invited to guess what feeling each group members' image was depicting, as well as to guess a possible reason for their interpretation of their peers' image. The original artist then had an opportunity to clarify (if needed) what their image represented and share their image's meaning with the rest of the group. This sharing encouraged a more natural, conversational group process and engagement through the artwork that contributed to group cohesion.

Body tracing

The initial session of the body tracing intervention included the visual check-in and mindful breathing. The main focus was on relaxation with both group discussion about participant experience of relaxation and a progressive muscular relaxation exercise. The body tracing, in which each participant had another member trace the outline of their body while they were either standing up against a large piece of paper taped on the wall or laying down on a large piece of paper on the floor (Luzzatto, Sereno, & Capps, 2003) began in the second session. If the group members did not feel comfortable enough to have someone trace around their body, they also had the option to use a pre-traced life-sized outline of a body.

After the tracings were complete the psychologist conducted a mindfulness exercise in which the focus was on developing awareness of tensions within the body. Once a participant identified a bodily tension, he or she was asked to think of a colour to connect with that feeling. At this point, the art therapist directed the group members to represent these tensions, using the colours that represented them by making marks with a paintbrush and acrylic paint on the body tracing, specifically in the areas of tension in their "bodies". Discussion about this followed and further painting about similar emotions, such as anxiety, fear, loneliness, stress, etc. also depicted with colour and marks. Once more, "emotion cards" were used to give a visual (words) tied to these emotions.

In the third session, participants put their body tracings up on the wall. Some group members had been working on these tracings horizontally and the act of placing them vertically provided a very different perspective for viewing their work. Participants stood in front of their art and quietly observed, mindfully absorbing what they had created. A group discussion followed in which the art therapist asked the group members to identify colours that evoked feelings of being calm and relaxed recalling previous group reflections from the progressive relaxation. The group members were then asked to apply these colours, as much or as little as they wanted, on the parts of the tracing. The final processing of this intervention occurred with group discussion about the entire process over the previous three sessions.

Art therapy in case management

In the day program, each member of the team has case management (Rapp & Goscha, 2004) responsibilities for one or more clients. During the intake process, each new client is assigned to a case manager who develops a therapeutic relationship with the client and provides the linkage between the client and his or her family and the wider multidisciplinary team. This section will examine two ways in which the art therapist as case manager uses art work to assist in the development and maintenance of a successful relationship with the client.

The case as visual metaphor in the development of a collaborative relationship

One of the challenges in the development of an effective case management relationship is helping the young client to understand what the relationship involves. Case management is an abstract and organisationally oriented concept that may have little meaning to children and adolescents. The young person knows he or she has a "case manager" but what is this?

To assist with the process of engagement and alliance building at the beginning of a case management relationship, the art therapist has developed some visual tools to assist the young person to engage in a dialogue about case management. These tools consisted of simple line drawings (Figure 1) depicting a suitcase.
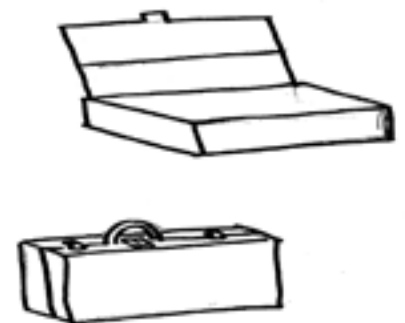
Figure 1. The "cases"

The drawn "case" then functions as a visual metaphor for the child, making an abstract concept more concrete, and providing the child with a way of both visually and verbally representing him or herself. As the therapeutic engagement develops, the art therapist as case manager invites the child into an ongoing dialogue about the "case" using questions such as "What have you been doing with the case this week?"; "What do you want to get out of (put into) the case this week?"; "How can I help you with the case this week?"

The "case" has a transitional role. It is the container of the child's problems, fears and worries as well as hopes and expectations. However, it is not the whole child. The child achieves a certain distance from the case and can join with the case manager in working out how to deal with problems that are either in the case or associated with the case. The case manager is there to manage the case but not the child.

Artwork and play in assessment and the therapeutic work of case management

The case manager is usually the primary individual therapist (Kanter, 1989) and draws on the therapeutic framework and repertoire of therapeutic techniques in which she or he has been trained. When the case manager is an art therapist, it follows that much of the individual work with the child will utilise art therapy, as the following case illustration shows.

A 10-year-old boy with long history of severe emotional and physical abuse and deprivation with impulse control, attention deficit, and attachment problems was referred to the service following multiple suspensions from primary school. At the time of the referral he was incapable of participating in normal classroom activities and was spending just an hour or two each day in special one-to-one learning activities. Even these sessions often ended in eruptions and physically aggressive outbursts.

In the initial interview, he exhibited extreme anxiety, pacing around the room unable to sit down at the table the art therapist, as case manager, had prepared with art materials on it. The case manager asked him "if you had three wishes what would they be?" and suggested he use the big white-board with a photocopying function to draw on – hoping that the use of gross motor skills would dissipate his nervous energy. He produced a car (Figure 2) including himself with

Figure 2. The car

Figure 3. Teddy plus

arms at the steering wheel but with no legs or foot-controls for breaking or acceleration. He said he would like to own a V8 with mag wheels. He then drew his second wish which was a teddy with arms and legs and said he wanted more

toys (Figure 3). Finally he drew a cannon, which he wanted so he could "shoot everyone away".

In his drawings he revealed his needs both for intimacy (the teddy) and his need for control in the face of fears of obliteration (the car and the cannon). This assessment led to the development of an art and play activity which gave him opportunity both for control and for connection with his therapist. The activity, which extended over much of the term, revolved around a remote-controlled Meccano car. He wanted the car and was prepared to earn the kit by cooking and serving lunch for the staff team (with the assistance of the case manager). The kit consisted of 413 pieces that he and the case manager assembled together over eight weeks. He was more keen on driving than building the car so a compromise was made by which he could drive the partly built car for a while after each session of building. In the building process, he took the role of mechanic, directing the process, while the case manager assisted by sorting the components and assisting with some of the fine motor tasks that were too difficult for him.

In addition to building the car, the client and art therapist worked together to make traffic signals (red, amber and green) which were used in driving sessions to establish external controls for the car. The car with wheels and a partially finished body became an external representation of the young person as a work in progress - who was able to stop, start, and move around, subject to a set of non-arbitrary external controls.

Discussion

The art therapist brings a framework that affirms the value of art making as a means for both expression of complex phenomena such as emotions and communication through metaphor. While art therapy can be an intervention in its own right, it particularly lends itself to application in a multidisciplinary setting. Art making provides another dimension to the verbal, behavioural, and medical interventions that are characteristic of treatment of children and adolescents with severe mental health problems.

The first example of the application of art therapy in a specialist CYMHS service shows how art therapy can be successfully integrated with a psychological intervention to provide a rich group experience. Mindfulness is widely used in contemporary evidence based psychological interventions because it promotes self-awareness in a manner that is non-threatening and typically anxiety reducing. The addition of art therapy extends mindfulness into domains of expression and communication. Art therapy promotes enhanced awareness of emotions and providing a medium for communication with peers about these emotions. In the creation of this collaborative group activity, the art therapist and the psychologist enhanced their practice frameworks and created a coherent experience for participants that was both enjoyable and an opportunity for learning and development.

The second example shows how the art therapist can bring specific skills and techniques to the work of case management. A core task in case management is the development of a collaborative trusting relationship. This enables the case manager to identify client needs, develop a multidisciplinary treatment plan, and monitor the effectiveness of the plan. Children with complex mental health problems often struggle in purely verbal environments. With such children, art and play provide a medium for

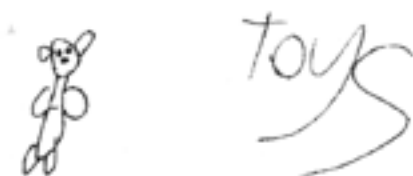communication that is more manageable for the child. In this case simple artwork produced by the case manager assisted the child to understand the purposes of the role of and relationship with the case manager and art was integrated with play to facilitate assessment and provide both a means of communication and a process that assisted the child to regulate his affects and impulses.

The clinical experience reported here is consistent with previous accounts of art therapy as a clinical intervention. Rousal (1996) described how art therapy can be integrated with psychoanalytic, normalisation, behavioural, and cognitive approaches in treatment of children. According to Milia (2000) the use of creative activity provides an arena for the discharge and mastery of aggressive impulses and develops self-esteem, and symbolic capacities. Similarly, Wilson (1996) previously reported that the use of imagery in case management develops a relationship in a non-threatening way, helps the young person choose self-affirming behaviour, adapts to meet the unique needs of the young person, and brings the inner life of the client to awareness, improving mastery and self-sufficiency.

While reports such as these suggest that art therapy can play a key role and sometimes a central role in the treatment of mental health problems, it remains a priority to establish an empirical evidence base for the effectiveness of such interventions. Clinical reports provide a "proof of concept" but art therapy lags behind many other clinical interventions for mental health problems in the development of status as an empirically supported treatment. There are several reasons for this. One is that art therapists often come from creative backgrounds and have limited understanding of either the culture or methods of scientific research. A second reason is that art therapy is not always a stand-alone treatment. Rather it forms part of a complex intervention, and separation of art therapy effects and other treatment effects presents methodological challenges. A third reason is that the absence of a well-developed art therapy literature in the mental health field may in itself mean that investigation of art therapy effects is regarded as a lower priority by research funding agencies. None of these problems are insuperable, as is shown by a recent randomised controlled trial demonstrating the effectiveness of art therapy in enhancing quality of life for women with breast cancer (Svensk et al., 2009). However, we think that there may be an important role for qualitative studies and uncontrolled repeated measures studies as steps on the way to the development of an evidence base.

We also think it important to appreciate that art therapy does have a distinctive research tradition that operates outside the scientific research tradition. This includes employing visual research drawn from art historical methods and art-based case studies designed to capture the layers of process that are involved in an art therapy intervention (Gilroy, 2006). Such research might use interviews, photographs or other visual records of work and process to document changes, both in the images created and in the experience of the person creating the image.

Conclusion

Art therapy has an established and valued place in the multidisciplinary work of the Mater CYMHS Day Program. The outcomes of such work are team outcomes rather than outcomes associated with a specific intervention; however,

both the specific contributions of each specialist discipline and the integration of these contributions through the case management relationship provide the basis for this model. The integral role of art therapy in the day program, alongside more traditional health professions such as medicine, nursing, social work, and psychology, is a testament to the value added by the visual arts to the treatment of severe mental illness in young people.

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Selective mutism or selective deafness?

Debbie Plastow

Contemporary approaches to the management of children with selective mutism generally recommend various forms of behavioural intervention. Such approaches focus predominantly on the child's symptom of not speaking. Nonetheless, the child does not exist in isolation. It is proposed in this paper that the child's inability to speak in certain situations may be co-extensive with the difficulty of being heard by others. This may include the child's family, teachers and even mental health professionals. An alternative treatment approach using psychoanalytic principles will be described in which the child's symptom is considered in relation to the history of the family. The objective of this paper is to elaborate these notions through reference to a clinical case study.

The expertise of the speech pathologist in the assessment and treatment of children with selective mutism is becoming increasingly recognised in the psychiatric literature (Paul, 2007). *The Diagnostic & Statistical Manual of Mental Disorders* (4th ed.) [DSM-IV] criteria for diagnosis of selective mutism exclude a communication disorder (American Psychiatric Association, 2000), yet these children have an increased incidence of speech and language problems (Gidden, Ross, Sechler, & Becker, 1997). The speech pathologist therefore has a significant role in assisting with differential diagnosis, as well as in providing treatment in collaboration with mental health professionals (Gidden et al., 1997; Paul, 2007). In the field of speech pathology, most current approaches to the treatment of children with selective mutism advocate behavioural strategies, with specific goals outlined in graded stages with rewards for speaking (Gidden et al., 1997; Johnson & Wintgens, 2001). In such approaches, although the parents may be involved in aspects of the treatment, the focus is generally on the child's symptom, that of not speaking. This paper will describe an alternative approach to the treatment of selective mutism, one which considers the child's symptom in relation to the context of the family.

Various treatments for selective mutism have been reported in the literature, including family systems, psychodynamic, pharmacological, and behavioural approaches (Stone,

Kratochwill, Sladezcek, & Serlin, 2002). However, according to Paul (2007, p. 427), "the most convincing literature pertains to behavioural modification approaches". Stone et al. (2002) conducted a meta-analysis of the four most common approaches used in the treatment of selective mutism. It was concluded that behavioural approaches appeared to be effective in treating selective mutism, however further findings were limited due to insufficient quantifiable data in most of the studies. The authors recommended that future researchers adopt standardised measures and use a manualised treatment for consistency of approach.

In their meta-analysis, Stone et al. (2002) noted that there was a paucity of information on family pathology in the children receiving behavioural interventions, suggesting that such frameworks do not give great significance to the family situation. Verhaeghe (2007) questioned the validity of such evidence-based methodologies in assessing the efficacy of most psycho-therapeutic treatments, and stated: "Instead of concluding that [evidence-based] methodology is too limited to [determine the effectiveness of psychotherapeutic treatments], the message is that those therapies that cannot be tested … are simply not scientific nor effective" (p. 5). Verhaeghe argued that the insistence on manualised or standardised approaches does not take into account the individual client or their social situation, including the place of the family.

In this paper I would like to put forward that in a treatment that focuses predominantly on the behaviour of the child, the therapist unwittingly becomes aligned with the parents' and teachers' demand for the child to speak. In such approaches there may be the potential to bypass what lies behind the child's silence, and the place of the parents in this. In other words, such treatments may overlook the particularity of the child and the family context. Family pathology is one aspect, but perhaps more important is the child's symptom in relation to the family.

What place, then, is there for the child to speak in his or her voice? In *The Child, his "Illness" and the Others* (1987), Maud Mannoni, French child psychoanalyst, wrote: "We find ourselves grappling with the history of a family … The child who is brought to us does not come alone, for he occupies a definite place in the fantasy of both parents" (p. 60). The history referred to concerns the spoken account that each of the parents gives of themselves and their child. Through this, the manner in which the child is caught up in the parents' own wishes, aspirations, and ideals, becomes articulated. Consequently, the work undertaken with the parents can allow them to hear where they place the child in their own accounts. In this paper, a description will be given of my

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work with the parents of a child with selective mutism, using these principles.

Case vignette

A child was brought to the child and adolescent mental health service by her parents. Chloe[1] was six years old and had been diagnosed with selective mutism. Not only did she refuse to speak to anyone outside the family home, she also refused to go to the toilet, requiring medication for her chronic constipation. Her mother stated, "She holds everything in". The parents gave her rewards for going to the toilet and for participating in gymnastics. At school, Chloe did not speak to anyone, including her teacher and the other children. She was unwilling to participate in school or classroom activities, despite the best efforts of her teachers.

Chloe had been seen by a number of professionals, on the instigation of her teachers, since she was four years old. The first was a speech pathologist, but treatment was discontinued by the family after Chloe drew an evocative picture in a session. When Chloe drew a picture of her family in which her father was veiled behind a curtain, this evidently disturbed the parents enough to have them withdraw her from treatment. Upon Chloe starting school, the family enlisted the help of a private psychologist, who met with them and provided strategies to the teaching staff to encourage Chloe to speak. This graded behavioural program, involving rewards for talking in various situations, met with no success. Chloe remained silent at school, and never smiled or joined in.

When I became involved in working with Chloe via a speech pathology referral from the case manager, I was told that the assessment was complete. The formulation and management plans were written, recommending individual sessions for the child and behavioural strategies for the school. When I asked for details of the family history I was told that, in view of the child's diagnosis of selective mutism, the family context had little significance. After some discussion, the case manager and I agreed to conduct further interviews with the parents to obtain a more comprehensive family assessment.

In our initial family assessment session, Chloe's father, Nino, was the more verbal of the couple, holding the floor with jokes and talk of his own anxiety-related problems. He admitted he was not sure of the point of coming to our service, although he said that he wanted "information" and "strategies to help". But he was hoping to see someone recommended by another parent in a support group, another clinician who worked in the same service. According to him, this clinician was an expert in the field of selective mutism. The father wrongly pronounced the clinician's surname as "Cannear". In other words, what I perceived him to say was that he wanted someone who *can hear*. To take him literally, the person who can hear is someone other than himself.

While her parents were being interviewed by my colleague in the room, Chloe played with her younger brother, Lachlan, who was four years old and very verbal. He chose to draw and she copied him, the two siblings sitting and drawing side by side. Lachlan chatted away but Chloe was silent, apart from a few whispered protests directed at her brother. She finished her drawing, which was busy and loud. I commented on this to Chloe and asked her some questions about it. She responded in a quiet voice, telling me that the drawing was of her brother and their dog, Mitsy. At the end of the interview, as the family was leaving, Nino made an off-hand comment about his daughter. He explained that, as was always the case in situations such as this, "She didn't speak".

1. All names used in this paper are pseudonyms.

Dominique, Chloe's mother, spoke of her family of origin. She seemed guarded, and sat with her handbag clutched tightly to her chest. She said that her mother suffered from severe anxiety and mood swings. As a child, Dominique felt she had to be careful what she said to her mother, as she never knew how she might react. Dominique said she was an introvert as a child and had worries. She identified Chloe as being like her: "a scaredy cat" in social situations. "We got the genes", she said. "We were doomed to be in this family".

Nino said his was "a bitter, twisted, derailed sort of family". In his account, he and his two siblings were all nail-biters who grew up with an alcoholic father prone to violent outbursts. Nino said he had to look after himself from an early age. He kept his problems and feelings to himself. He described his brother, sister, and extended family as mad. They held grudges and didn't talk to each other for years at a time. Nino was reluctant to speak of his experiences as a child as, he said, they were "things you don't wanna see". Nino reported that when he was annoyed, he would "shut down" for days, not speaking to Dominique or the children. He said he did this "to punish myself and punish the others". The children had learned not to approach their father when in this "shut down" state.

Chloe's parents stated that their daughter's muteness caused them distress, because they were each reminded of their own difficulties that emerged from their own childhoods. Chloe was identified by each of her parents as being like them. Despite Dominique saying, "I don't want her to be like me", what she did, in effect, was to perpetuate this identification. When she said, "We were doomed to be in this family", she was beginning to hear that something of her own history had manifested in her daughter.

We note that in Nino's account of his own childhood there were things that he did not want to see, just like in his account of Chloe in which there were things he didn't want to hear. In the father's words, Chloe is mute, but it is the father who cannot hear. Chloe's drawing was colourful and loud; she whispered quietly and clearly had something to say. But why speak if no one can hear? I would put forward that Chloe's "selective mutism" is congruent with her father's selective deafness. Perhaps Chloe's "mutism" is a symptom of something problematic already played out in Chloe, and this precludes the possibility of her speaking in her own voice.

As there were significant difficulties raised by the child's parents in relation to their own histories, and because other treatments with Chloe in the past had failed, work with the parents was attempted first. They agreed to come to see me together for fortnightly sessions. As I began to work with the parents, Dominique began to speak more freely, and on one occasion even put her handbag on the floor beside her. Nino put on less of a show, became quieter, and appeared more relaxed. When asked about this change, he replied, "It's nice to hear Dominique talking". Dominique stated that they did not discuss Chloe at home as Nino "doesn't want to hear things about his daughter". They agreed that he avoided parent–teacher interviews and school drop-offs and pick-ups for this reason. The sessions provided an opportunity for the parents to speak about Chloe. "It forces him to listen", explained Dominique.

After some weeks had elapsed, it was reported that Chloe took part in the school's Christmas concert, dancing and singing on stage. A few months later, Chloe spoke in front of the class for show and tell, with the assistance of a PowerPoint presentation arranged by her mother and the teacher. Perhaps even more importantly, she was beginning to speak with other children in the playground.

Nino admitted having had no part in planning the PowerPoint presentation for Chloe. He said, "I should have been deaf". He said it was hard to hear about Chloe as it made him worry. He said it "kills" him to see or to hear about his daughter's difficulties as she reminded him of himself and his own troubles. He stated that as a child he had nobody to comfort him or pay attention to him. Following some reflection on this point, he added that he had no one to listen to him. This was how Nino had proposed himself in the past, but also how he spoke of himself in the present.

Nino took himself off to see his general practitioner where he was referred to a psychologist and prescribed antidepressants. He explained that coming to the parent sessions prompted him to seek help for himself. Dominique reported that he had not been "shutting down" since our discussion about this in the session some months ago. According to the parents, Nino was also "shutting up" in the sessions, which allowed him the possibility of listening.

I attended a school meeting with my teaching colleague. The class teacher, principal and Chloe's mother were present. The principal reported that Chloe began to talk after the school removed the demand on her to speak. Chloe's teacher was thrilled to announce that Chloe, who had always appeared "frozen" and unhappy at school, was now animated and smiling and keen to participate. She put up her hand in class to volunteer for tasks and spoke audibly with her teacher or in a small group of children. Chloe was reliant on her best friend Christine, but had recently used this to her advantage, performing in a class play in front of the whole school, reciting her two lines with Christine by her side.

I presented an account of Chloe and her family in a team meeting. I spoke of the parents' demand for "strategies", and of Chloe, who cannot be heard. I then focused on the parent sessions and some of the changes reported to have taken place with Chloe. At the end of the presentation, one colleague suggested that the parents' demands should be met. They should be given information. Another colleague asked, "What are the outcome measures and individual service plan?" My colleagues cannot hear what I am saying, just as the parents cannot hear Chloe's attempts to speak.

My colleagues insisted on providing more strategies, more behavioural measures, as if they had not heard her wanting to speak. Their response was akin to the parents' demand for strategies, despite the fact that when these were given previously, the treatment failed. The team identified with the parents. What I am proposing is not able to be heard by the team, reiterating some of the deafness surrounding Chloe, who cannot be heard beyond the level of the demands of the parents.

Conclusion

In our work with a child with selective mutism, we are constantly dealing with the demands of others: demands for information, for strategies, for anything that will make the child speak. The challenge for the therapist, however, is not to align him or herself with the parents and others' demand for the child to talk, but to consider what lies behind the child's silence. It is only by thinking beyond the diagnosis of selective mutism that we can consider what is particular about the child, including his or her family situation.

Mannoni (1987) proposed that the child's symptom is central to the problems experienced by the parents in their own past histories. She wrote:

> Society confers a special status on the child by expecting him, all unknowing, to fulfil the future of the adult. It is the child's task to make good the parents'

> failures, to make their lost dreams come true. The complaints of parents about their offspring thus refer us first of all to their own problems. (Mannoni, 1987, p. 3)

Chloe's parents each speak of their own backgrounds in terms of something that they experience as missing or failing in some way. By unknowingly placing their child in the position of fulfilling their ideals, the child is spoken for. In allowing the parents to recount their own stories, we begin to hear where the child is placed in relation to their histories, and the way the child is caught up in these. When, finally, the demand of others to speak is removed, and there is someone to listen, Chloe begins to speak. Chloe speaks on her own terms, rather than in response to a demand.

If a child is mute, there are others who insist that the child speaks. This silence can be heard as a refusal of the other's demand for the child to speak in such a way that their speech is reduced to a mere echo. By refusing to speak on demand, the child attempts to take up a position different to that which is placed upon her unwittingly by these others, including the parents.

In dealing with a child who is presented by his or her parents as not speaking, the diagnosis of selective mutism is only one part of the story. The child's mutism may be a response to the selective deafness of those around her. It is through the process of speaking and being heard that we allow the parents to let go of their own childhoods in order to provide an opportunity for the child to speak for herself, without being spoken for. This creates the possibility for the child to emerge and to speak in her own name.

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Communication and childhood complex trauma

An evaluation of speech pathology consultation liaison and assessment services to a complex trauma treatment team

Julie Ball and Ferhana Khan

Julie Ball (top), and Ferhana Khan

Communication difficulties in children are not always obvious and present a potential barrier to the child's care and recovery from complex trauma. Many aspects of complex trauma intervention rely on the young person understanding, reasoning and incorporating ideas; and telling the mental health clinician about knowledge, events and thoughts. This paper reports the perceptions of nine mental health workers before and after collaboration with speech pathologists and investigates the potential role of the speech pathologist within the complex trauma treatment team.

Children who have experienced abuse and neglect are at risk of demonstrating developmental difficulties and are more likely to utilise medical, mental health, correctional and social services (van der Kolk, 2005). Children who have experienced abuse and neglect and who have subsequently been placed in foster care are at greater risk of suffering from feelings of anxiety, abandonment, rejection and fear (Grigsby, 1994), are more likely to use mental health services (Bilaver, Jaudes, Koepke, & George, 1999; Coombs-Orme, Chernoff, & Kager, 1991; James, Landsverk, Slymen, & Leslie, 2004), and are at increased risk of demonstrating developmental delays (Leslie et al., 2005). The literature dealing with maltreated children reveals clear evidence of communication impairment within the population of children that have been abused or neglected (Law & Conway, 1992). For example, Lynch and Roberts (1982) found that language difficulties were more common in children who had been exposed to abuse and neglect as compared to other developmental delays.

There is a reciprocal relationship between child maltreatment and communication difficulties. Children with communication difficulties and mild learning difficulties have been found to be at greater risk of neglect, emotional, and physical abuse. For example, in one recent British study, children with communication difficulties were found to be three times more likely to be registered with child protection services (Spencer et al., 2005). Conversely, children who have been maltreated are at greater risk of developing poor language abilities (Allen & Oliver, 1982). It is hypothesised that mothers who neglect their young child create a linguistically disadvantaged environment and communicate in a style that is less stimulating and less sensitive than typical mothers (Crittenden, 1989).

Young people from a background of maltreatment are often out of touch with their feelings; they lack understanding and the insight of cause-effect and their own impact on the social problem (van der Kolk, 2005). These children also have reduced self-talk to regulate their emotions as their poor high-level language impacts on their range of emotional vocabulary necessary for self-talk and self-regulation. Poor social information processing skills together with the child's higher aroused state results in poor interpretation of ambiguous faces in social contexts. Further, they have difficulty understanding and relating their life story through narrative. Due to a history of inadequate pro social modelling and failed social interactions, the child may adopt strategies that appear maladaptive to others including: tactlessness, interrupting inappropriately, and an inability to empathise with other points of view. It seems likely, the child has adopted these patterns of interaction to accommodate their frustration and lack of understanding.

There is an increasing awareness of the need for speech pathology involvement with children who have experienced abuse and neglect because of their poorer outcomes across the lifespan, including the risk of dropping out of school, poorer education and vocational outcomes, increased involvement in the justice system and increased need for adult psychiatry services (Clegg, Hollis, Mawhood & Rutter, 2005). Identification of persons with speech and language impairment is a specialist field and the child's communication difficulty may not be immediately obvious to health professionals who have not had specialist training (Enderby & Philipp, 1986). Speech pathologists who work in child and youth mental health assist mental health clinicians to have an understanding of their client's communication abilities and difficulties, thus ensuring suitable diagnosis and intervention (Speech Pathology Australia, 2009).

The current study

The complex trauma treatment team is multidisciplinary and connected to an interagency panel of senior practitioners from child safety, education, disability services and mental health. The model of service delivery incorporates attachment, neurobiology, developmental, and systemic frameworks of intervention. The clinical team consists of a psychiatrist, clinical psychologists, social workers, occupational therapists, and an indigenous health worker. Due to the intensity of the service each clinician has only a small case load. Although previously the team did not

include a speech pathologist, because of the strong evidence in the literature of communication impairment in children with a history of abuse and neglect, management determined that the two speech pathologists working within community mental health would extend their service and collaborate with the complex trauma treatment team in the following areas:

- attending case conference;
- assisting with the identification and subsequent management of children with communication difficulties;
- providing input into treatment planning, and enhancing the teams' capacity to plan and deliver more appropriate intervention;
- helping mental health clinicians interpret speech pathology assessments in terms of the child's bio-psycho-social functioning;
- performing communication assessments and feedback utilising a bio-psycho-social model;
- providing education about communication and mental health;
- psycho-education to key stakeholders about communication; and
- facilitating referrals to relevant services.

The aims of this study were to ascertain if the mental health clinicians within the team perceived an increase in their ability to identify and adapt their communication style and treatment plan for children with communication difficulties subsequent to collaboration with speech pathologists.

Method

Participants

Participants were 9 mental health clinicians working as case managers for the complex trauma treatment team. The group included 6 clinical psychologists, 2 social workers and 1 occupational therapist. All clinicians were asked to complete pre-questionnaires when they commenced employment with this team.

Questionnaires

Pre and post questionnaires were developed by the speech pathologists and research officer of the complex trauma team. These consisted of:

- pre-evaluation questionnaires prior to collaboration with speech pathology. This questionnaire consisted of 5 questions, asking the participant to rate their level of confidence in working with children with communication impairment on a five point scale.
- post-evaluation questionnaires administered after 6 months of clinician collaboration with speech pathology.

Table 1. Results of the pre and post questionnaires (n = 9)		
Question	**Pre-questionnaire**	**Post questionnaire**
Please state how confident you feel when identifying communication impairment in children?	25% confident 50% uncertain 25% reasonably uncertain	71% confident 29% uncertain
How confident are you when managing a child with communication impairment?	50% uncertain 25% reasonably uncertain 25% very uncertain	86% confident 14% reasonably uncertain
How confident are you in adapting your therapy to meet the needs of a child or adolescent with communication impairment?	25% confident 50% uncertain 25% reasonably uncertain	72% confident 14% uncertain 14% reasonably uncertain
Do you feel confident adjusting your style of communication to accommodate for those children with a communication difficulty?	50% confident 50% uncertain	71% confident 29% uncertain
Do you believe you have a thorough understanding of the co-morbid nature of communication and mental health problems?	25% thorough 75% uncertain	29% very thorough 14% thorough 57% uncertain
The role of the SLP (assessment and consultation) is adequate to service the needs of the children:	Post only	12.5% strongly agree 50% agree 12.5% uncertain 12.5% disagree 12.5% strongly disagree
I believe the time SLPs are able to devote to the team is adequate to service the clients with a SL deficit:	Post only	25% strongly agree 25% agree 37.5% disagree 12.5% strongly disagree
It is easy to identify if the children referred are receiving other SLP interventions:	Post only	50% agree 12.5% uncertain 37.5% disagree
I think some children would have better outcomes if they received direct interventions from the speech and language pathologists.	Post only	50% strongly agree 50% agree
I think the time between identification and assessment of the child is acceptable:	Post only	12.5% strongly agree 62.5% agree 12.5% uncertain 12.5% disagree

This questionnaire consisted of the same 5 questions, as well as an additional 5 questions, which asked the participant to rate their knowledge, skills and attitude towards speech pathology on a five point scale. The post questionnaire also included 2 open ended questions asking for suggestions for service improvement and specific examples of how the clinicians' practice had changed.

Results

Table 1 provides an overview of the pre- and post-questionnaire results.

The comments the clinicians provided in response to the two open-ended questions contained in the post questionnaire are displayed in Box 1.

Box 1. Participant feedback following speech pathology collaboration

Question 1: Could anything be changed to improve the way in which services are provided?
Increased SLP time?

SLP position (i.e., a full time speech pathology position within the complex trauma treatment team)

Need assistance communicating SLP needs of child.

It would be a great improvement if a speech language therapy service could be provided rather than just assessment.

Would benefit from having SLP provide therapy as well as assessment/consultation as they have a strong background in mental health.

I think it would be helpful for clients to receive intervention from CYMHS speech pathologist in addition to assessment and consultation. It would assist in the provision of a more holistic service to the client group.

I think that the SLP team provide a flexible service to (team). Direct intervention would be ideal although this is not logistically possibly. I like the idea of a mandatory screening tool for all clients

Question 2: Please state any specific areas in which your practice has changed since collaborating with the speech and language therapists.

More aware of the child's SLP needs.

More sensitive to speech & language disorders, think about it more & identify problems with more skill.

I have greater understanding of different levels of speech and language problems but could do with a greater education regarding modifying practise/style of communication & make suggestions (to carers) for intervention in daily lives for kids.

[...] it was the first time that I had sat down with the SLP team and found out about the service that they offer. It has made me more aware of the service and how to work collaboratively with them.

It has been helpful to have the insider knowledge of the speech therapists particularly in the assessment process. As I have become more informed and aware of what to look for in relation to speech and language problems.

I understand more about SLP role for example they can specialise in speech impairments, literacy and emotion/social use of speech. I assess for speech difficulties in my practise more and take it into account into my interventions.

Discussion

Mental health clinicians within this multidisciplinary team who completed the pre questionnaires indicated a lack of confidence in their ability to work with children who have communication difficulties. This is significant as the literature indicates that communication disorders are the most common developmental outcome of child abuse and neglect (Lynch & Roberts, 1982). Prior to collaboration with speech pathology, the majority of the mental health clinicians found it challenging to identify children who were having communication difficulties. They also indicated a lack of confidence in their ability to adapt therapy and adjust their style of interaction to meet the communication needs of these children. In addition, 75% of the clinicians had difficulty understanding the co-morbid nature between communication difficulties and mental health problems.

After the clinicians had worked with the speech pathologists for over six months there was a shift towards the clinicians feeling more confident in their ability to identify, adapt and adjust intervention to meet their clients' needs. Speech pathology appeared to have the greatest impact on the clinicians' confidence in their ability to manage children with communication difficulties (see table 1). There was only a slight shift towards the clinicians feeling they had a more thorough understanding of the reciprocal relationship between communication and mental health. This indicates that further education needs to be provided to these clinicians about the bio-psycho-social impact of communication difficulties.

While half of the clinicians agreed and the other half disagreed that the time speech pathologists were able to devote to the team was adequate, there was 100% consensus by the mental health clinicians that some children would have better outcomes if they received direct intervention from the speech pathologists. It is suggested, therefore, that the multidisciplinary complex trauma treatment team should include a speech pathologist allowing for provision of the full range of vital services including consultation liaison, assessment, intervention, and education.

There are some obvious limitations to the study. First, the results from the questionnaire may have been influenced by a lack of anonymity. The study was also limited by the small number of participants due to the number of staff in the complex trauma treatment team. The study did not control for some of the mental health clinicians previously working with speech pathologists. Furthermore, this study only evaluated the perceptions of the clinicians' knowledge and confidence, not their actual ability.

How can speech pathology contribute?

Ongoing complex trauma negatively modifies the developing brain. However, therapeutic experiences can change the brain and result in positive outcomes. The benefit of intervention depends on the nature, timing, pattern, and duration of therapy (Perry, 2006). Kinniburg et al. (2005) advocated for health practitioners to adopt a flexible model of intervention embedded in a developmental and social context. Cook, Spinazzola, Ford and Lanktree (2005) suggested treatment of complex trauma should address six central goals:

1. safety
2. self-regulation
3. self-reflective information processing
4. traumatic experiences integration

5. relational engagement
6. positive affect enhancement

These six goals are incorporated into the attachment, self-regulation, and competency (ARC) intervention framework. ARC intervention involves systemic, milieu-based interventions with an emphasis on understanding and intervening with the child in context. It incorporates individual, familial and systemic changes (Kinniburg et al., 2005). The mental health workers in the complex trauma treatment team utilise a bio-psycho-social model of intervention incorporating the treatment goals within the ARC model. Speech pathology was able to contribute and work within this framework of intervention at each level, as outlined below.

Attachment phase of intervention

Establishment of safety is essential during the attachment phase of intervention. Safety for the child incorporates both their surroundings and feeling safe within themselves (Kinniburg et al., 2005). When providing intervention to a child with communication impairment it is vital that the mental health therapist understands the communication needs of the child. Speech pathologists can assist by providing education about the child's language level to the clinicians so that the child is able to fully understand and participate in mental health interventions. Visual resources outlining daily routines, timetables, and calendars of events can assist with the establishment of safety and predictability. Provision of psycho-education to the carers about the communication abilities of the child and the impact on social-emotional functioning can support enhancement of empathy the carer feels for the child and assist to foster the attachment relationship.

During the attachment phase, accommodations for communication difficulties may also include establishing a common language of behaviour management to assist with consistent limit setting that is predictable across environments. The speech pathologist can provide the carer with insight into the child's behaviour and interaction style by discussing implications of language results. For example, the child's perceived disobedience may be due to an inability to understand the instruction. Psycho-education to the carers and key stakeholders about the strategies the child may be using to mask or copy with their communication difficulties is often helpful in getting others to understand the reasons behind the child's behaviour.

Self-regulation phase of intervention

The regulation phase incorporates working towards being able to adjust arousal and return to equilibrium (Kinniburg et al., 2005). Children with a history of maltreatment have reduced self-talk to regulate their emotions and their poor high-level language impacts on their range of emotional vocabulary necessary for self-talk and self-regulation. Emotional literacy involves establishing the underlying language processes to support emotional vocabulary development. This supports the child to be able to name and more deeply understand the expression and behaviour linked to a full range of emotions, not just the stereotypical feelings which are happy, sad and angry but also feelings related to anxiety, grief and loss. Enhancement of emotional language incorporates the use of visual plans to identify, describe, name, and connect behaviour with emotion. Connecting affect to behaviour can also be done through use of therapeutic social stories, drawings and role plays. Speech

pathology narrative work may assist with the integration of client's traumatic experiences and with self-reflective information processing. Psycho-education given to the carer and key stakeholders about modelling emotional language and how to explicitly label the strategies used to regulate emotions can assist with generalisation.

Competency phase of intervention

When the young person has reached the competency phase, they are in the space to participate in more developmentally and academically focused speech pathology therapy. Speech pathology can work to enhance pro-social interactions through development of social information processing skills. There needs to be focus on pragmatics, social skills and problem-solving as these children have had a history of poor pro-social interactions modelled to them. Psycho-education to carers about the importance of modelling new skills will assist with generalisation to other contexts.

Therapeutic progress with this population can be slow because the child can continually move across the continuum of attachment, regulation, and competence phases. Many factors have an impact on how effective intervention can be including the number of placement changes and the age of the child. As we know early intervention is best; however, intervention can also occur with adolescents working with their environment and their strengths.

Conclusion

This study showed that the speech pathology service was valued by the mental health clinicians. They acknowledged and understood the importance of communication and the implications of communication impairment in the recovery process of the client. However, not all clinicians found it easy to modify their practice and communication style; or understood the co-morbid nature of communication and mental health problems, indicating the need for ongoing speech pathology consultative liaison and psycho-education. All clinicians agreed that clients identified as having communication impairments should receive the service of speech pathology intervention within the complex trauma treatment team, thereby enhancing communication skills and positive psycho-social functioning.

Acknowledgment

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Differentiating between childhood communication disorders

Implications for language and psychosocial outcomes

Andrew Whitehouse

Specific language impairment and autism are considered distinct developmental disorders. However, while "textbook" cases of these conditions can be differentiated with little difficulty, there is a substantial proportion of children who display "intermediate" characteristics. One such example is the group of children who exhibit pragmatic language difficulties in the absence of other autism-like behaviours, so called pragmatic language impairment. There is contention as to whether the difficulties of these children are best considered a mild form of autism, or whether they represent a diagnostic category in their own right (so-called pragmatic language impairment). This paper highlights current thinking in the diagnostic differentiation of these disorders, using evidence from a longitudinal study investigating the language, psychosocial, and mental health outcomes in adulthood of children with each condition. The findings reinforce the validity of the pragmatic language impairment diagnosis, and suggest that adult psychosocial outcomes can be predicted from their childhood language profile. Mental ill-health was one outcome that was relatively common among the adults with a history of a communication disorder, suggesting that a good working knowledge of psychiatric conditions is beneficial for speech pathology practice.

Communication disorders are, by their very nature, heterogeneous; it is rare to find two individuals with identical difficulties. Part of the issue here is that communication is a broad category, encompassing both structural (e.g., phonology, morphology, and semantics) and pragmatic aspects of language (i.e., how language is used in context). One of the goals of research in this area has been to provide "order", by identifying diagnostic categories into which children can be grouped. Differential diagnosis has benefits for both research (e.g., helping to elucidate the underlying aetiology of each condition) and clinical practice (identifying interventions that may be more effective with different groups of individuals).

Differential diagnosis

The current diagnostic approach is to differentiate "specific language impairments" (SLI) from "non-specific language impairments". The former category includes those children whose difficulties are restricted to the language domain, whereas the latter category includes difficulties that are associated with a broader condition, such as autism. "Textbook" cases of SLI and autism are relatively easy to identify and differentiate. The broad communicative difficulties of individuals with autism (affecting both structural and pragmatic aspects of communication) contrast with SLI, in which there is a relatively specific deficit in the development of linguistic skills. However, research over the past decade has raised concerns over the validity of this diagnostic divide. For example, many children have behavioural characteristics that could be considered "intermediate" between SLI and autism. Autism, in particular, is widely recognised as a broad spectrum of disorders, ranging from autism at the severe end of the continuum, to pervasive developmental disorder – not otherwise specified (PDD-NOS; behaviours characteristic of autism, but not at a quantitative and/or qualitative severity to reach full criteria for autism) and Asperger syndrome (behaviours characteristic of autism, without any clinically significant delay in language or cognitive development) at the less severe end. The spectrum-nature of this condition has led to the now widely used term *autism spectrum conditions* (ASC), which refers to individuals with either a diagnosis of autism or PDD-NOS. It is also not uncommon to observe a child with pragmatic difficulties, but without the repetitive behaviours and marked social deficits that are required to meet criteria for an ASC. Such children have led to the additional diagnostic category of pragmatic language impairment (PLI). Originally referred to as semantic-pragmatic disorder, there has been a transition to the alternative label of PLI, particularly in the United Kingdom, due to findings that semantic and pragmatic deficits do not always occur in combination (Bishop, 1998). Although the current paper will adopt ASC and PLI to refer to the syndromes described above, it is important to note that the terms are not currently recognised in international diagnostic guidelines.

The jury is still out on the ecological validity of the PLI diagnostic category. Perhaps the most comprehensive

Andrew Whitehouse

Table 1. Number of adults (with SLI, PLI, or ASC) with mental health problems			
	SLI (n = 18)	PLI (n = 7)	ASC (n = 11)
Major depressive disorder	2	–	–
Major depressive disorder and anxiety disorder	3 (Obsessive compulsive disorder, social phobia, agoraphobia)	–	3 (all three, generalised anxiety disorder)
Anxiety disorder	–	1 (generalised anxiety disorder)	1 (obsessive compulsive disorder)

study of PLI to date came from Bishop and Norbury (2002), who examined the clinical symptomatology of a cohort of children clinically diagnosed with either SLI, PLI or ASC. A number of interesting findings emerged. First, many children with a diagnosis of SLI were found to exhibit considerable pragmatic symptoms. Second, a minority of children with PLI or SLI showed autism-like characteristics, such as poor eye-contact and poor social awareness, but at sub-threshold levels (i.e., not reaching diagnostic criteria for ASC). Third, there were changes in symptomatology over time, so that some children meeting criteria for ASC at one age did no longer do so at a later age (and vice versa). Together these findings reinforced the notion that there was no sharp dividing line between SLI and PLI on one hand, and PLI and ASC on the other.

Longer term outcomes

Another way to determine whether PLI represents a valid diagnostic entity is by examining the longer-term outcomes of children with this diagnosis. If PLI is best viewed as a mild form of ASC, then we would expect the outcome of these individuals to more closely resemble those with ASC, rather than SLI. Recently, my colleagues and I at the University of Oxford investigated this question through a longitudinal study of children who took part in research during the 1980s and early 1990s. All children had received a clinical diagnosis of developmental language disorder and had been categorised at initial assessment as showing a profile consistent with either PLI or SLI. Despite exclusion of participants having a diagnosis of autism in childhood in the initial study, a small proportion of participants retrospectively met full criteria for autism. We have interpreted this finding as reflecting the broadening of autism diagnostic criteria from DSM-III (American Psychiatric Association, 1980) through to the most recent guidelines of DSM-IV-TR (American Psychiatric Association, 2000). These participants (n = 11) were pooled to form a separate ASC group, providing a useful comparison group for the SLI (n = 18) and PLI groups (n = 7). The participants were aged between 16 and 30 years of age. A detailed account of these findings have been reported elsewhere (Bishop, Whitehouse, Watt, & Line, 2008; Whitehouse, Line, Watt, & Bishop, 2009; Whitehouse, Watt, Line & Bishop, 2009).

Language outcomes

The first finding to emerge was that language and literacy profiles tended to persist into adulthood: at follow-up, the PLI group presented with predominantly pragmatic language deficits, the SLI group with considerable structural language and literacy impairments (as well as moderate difficulties with pragmatic language), and the ASC group with a combination of both structural and pragmatic language difficulties (Whitehouse, Line, et al., 2009). The psychosocial characteristics of the three groups of adults also demonstrated some separation in outcome. The adults with a diagnosis of SLI were not high-academic achievers, but

most had gained some form of vocational qualification. Many participants with SLI had difficulty finding stable employment, and those who were employed, were in professions that did not require high language and literacy skills (e.g., carpet fitter, cleaner, painter). A significant minority of participants in the SLI group had difficulty establishing friendships, and around one-half of the group had never had a romantic relationship of three months or more. The PLI group appeared more academically able than the SLI group and the majority of participants were employed in "skilled" professions (e.g., nurse, website designer, computer software designer). However, the PLI participants had substantially more difficulty in establishing and sustaining friendships and romantic relationships. The ASC group had significant difficulties with independence when assessed in adulthood, and many adults were living in supported accommodation. Most participants were working toward a vocational qualification, but few had ever obtained stable employment. No ASC participant reported having a close friendship or having experienced a romantic relationship.

Psychosocial outcomes

The psychosocial outcomes were in line with what we would predict from each group's communicative profile. For example, there would be an expectation that individuals with structural language problems (i.e., those with SLI) would have particular difficulties with university education and associated employment. Similarly, it is reasonable to predict that individuals with pragmatic language problems (i.e., those with PLI or ASC) would have some difficulty in establishing and maintaining social relationships. However, it is important to note that there was a degree of variability in the language profiles of each group; some individuals with SLI demonstrated considerable pragmatic difficulties, while a minority of individuals with PLI had structural language deficits.

Mental health outcomes

One of the most striking findings of the study was the high incidence of mental health problems observed among adults with a history of developmental language problems. At follow-up, participants were asked whether they had ever been referred to a psychiatrist and, if so, what was the purpose and outcome of this referral. As seen in Table 1, mental health problems were reported in all three groups. Five of the 18 participants with an SLI diagnosis had received psychiatric treatment for an affective disturbance. Two of the three SLI participants with major depression and comorbid anxiety disorder had spent a period of time in a psychiatric hospital (one for two weeks and the other for two months). The third participant with this comorbidity had a history of violence towards his parents, and had repeatedly attempted suicide (the first attempt at age 10 years). Four ASC participants had been diagnosed with an anxiety disorder and two of these adults had spent periods as a resident at a psychiatric hospital. One PLI participant had received a diagnosis of generalised anxiety disorder, and had

also experienced a period of psychosis in which he saw religious figures in his bedroom.

Clinical implications

The findings of this longitudinal investigation highlight a number of clinical implications. First, childhood language profiles (i.e., SLI vs PLI vs ASC) were found to predict language and psychosocial outcomes in adulthood. The broad differences in the outcome of the groups suggest that PLI may represent a meaningful diagnostic category. Importantly, however, it was communicative profile (i.e., structural language difficulties only vs pragmatic language difficulties only vs structural and pragmatic difficulties), and not diagnosis that was the best indicator of later outcome. Childhood language difficulties are likely to persist to adulthood, and have wide-ranging implications on other aspects of development. The association between early abilities and adult outcome highlights the importance of a wide-ranging assessment in childhood. Pragmatic difficulties have traditionally been difficult to assess, and we have made a concerted attempt to develop a range of assessments that reliably measure these abilities in children (*Children's Communication Checklist* – 2; Bishop, 2003) and adults (*Communication Checklist – Adult*; Whitehouse & Bishop, 2009). Obtaining an understanding of communicative ability across the entire language profile will afford greater insight into the possible outcomes of different children, and assist in the identification of areas likely to be in need of current or future intervention.

Second, the findings demonstrate that mental health problems are of serious concern among those with developmental language disorders. It not yet clear whether the increased rate of psychiatric problems among those with communication problems reflects a genetic predisposition for disorder (Whitehouse, Spector & Cherkas, in press) or the result of accumulated experience. For example, in a recent study we found that affective disorders among adolescents with ASC were more common for those who expressed a desire to develop friendships (Whitehouse, Durkin, Jaquet & Ziatas, 2009). A mismatch between the desire of adolescents with ASC to develop friendships and their reduced ability to do so may lead to a clinical level of low mood. While this is a question to be answered by future research, the findings of the longitudinal study were clear: mental health problems are common among adolescents and adults with a history of communication disorder. It is thus important for speech pathologists to have a good working knowledge of psychiatric conditions, and be vigilant to disorder onset in their clients.

Summary

In sum, there is considerable variability in symptomatology among children diagnosed with a communication disorder. Obtaining an appreciation of an individual's strengths and difficulties across the full communicative profile will not only enable a better understanding of potential avenues for intervention in childhood, but also provide important insights into possible adult outcomes. Severe mental health problems are common among adults with a history of developmental language disorder, and therefore an understanding of these conditions should form an important part of a speech pathologist's intervention arsenal.

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Clinical insights

The Autism Diagnostic Observation Schedule-Generic (ADOS-G): A clinical referral pathway for young people suspected of pervasive developmental disorders at a mental health clinic

Nickolina Aloizos

Nickolina Aloizos

Speech and language disorders often overlap with social, emotional and behavioural disorders in childhood. For young people who present to a mental health clinic with these conditions it is not always clear whether a diagnosis of a communication disorder, a pervasive type of developmental disorder and/ or a mental health disorder should be given. The issue of correct diagnosis is critical, as precision in the classification and subtypes carries implication for outcome and response to treatment (Mahoney et al., 1998). This paper outlines a systematic approach to critically appraising the evidence and participating in the decision-making and assessment and intervention process for speech pathologists working in mental health services.

Mental health services for young people

Child and Youth Mental Health Services (CYMHS) are a component of Queensland Health's Mental Health Program. It targets service delivery to children and young people aged 0–18 years, whose emotional, social or behavioural disorders are severe and complex, or at risk of becoming so, and whose needs cannot be met by other services. All clients entering CYMHS are given a diagnosis following bio-psychosocial assessment. The diagnostic classification system used is the *International Classification of Diseases, Tenth Revision* (ICD-10: World Health Organization, 1992).

Within the mental health team, the speech pathologist has primary responsibility for the diagnosis and remediation of communication impairment. Research literature is consistent in finding that communication disorders are a pervasive feature of mental health conditions (Cantwell & Baker, 1991; Gualtieri, Koriath, & Bourgondien, 1983). The speech pathologists' area of expertise in mental health is specialist knowledge of the reciprocal relationship between communication, bio-psychosocial development, psychopathology and the impact of adverse psychosocial contexts. Specialist speech pathology practice requires a capacity to effectively evaluate communication competence, to analyse the impact of communication vulnerability in the context of psychosocial adversity and then to select management responses relevant to the communication needs of the client.

Pervasive developmental disorders

Pervasive developmental disorders (PDD) are a group of disorders characterised by qualitative abnormalities in reciprocal social interactions and in patterns of communication, and by a restricted, stereotyped, repetitive repertoire of interests and activities in all situations (ICD-10: World Health Organization, 1992). Although PDD is the overarching ICD-10 category, some services (e.g., Queensland Department of Education) have adopted autism spectrum disorder (ASD) for those conditions that are referred to in the literature as either PDD or autistic spectrum disorders (ASD). These include autistic disorder, Asperger's disorder, childhood disintegrative disorder, Rett's syndrome, and PDD not otherwise specified. ASD is a specific diagnosis with a variety of communication characteristics and social interactions central to the recognition of the condition (see Whitehouse, this issue, for further information on the differential diagnosis of ASD). Although speech pathologists do not diagnose PDD (or ASD), they are often the first professionals to come into contact with a young child with ASD (Wetherby, Prizant, & Hutchinson, 1998), and can assist with the diagnosis and can provide communication and behaviour interventions. The co-occurrence of several disorders in the same individual is not uncommon in the mental health field (Giddan & Milling, 1999). However, the importance of distinguishing ASD from a mental health disorder becomes crucial because of the detrimental effects on parents and young people through inappropriate diagnoses and treatment recommendations and delays in inappropriate intervention (Sikora, Harley, McCoy, Gerrard-Morris, & Dill, 2008).

PDD and mental health disorders

There has been a significant increase in the number of cases diagnosed with PDD and this has been associated with corresponding decreases in the use of other diagnostic categories (Shattuck, 2006, p. 1028). However, typical features of PDD can also be present in other mental health disorders (i.e., communication, socialisation and repetitive/ restricted behaviours) (Goin-Kochel, Mackintosh, & Meyers, 2006). Diagnostic procedures for PDD may also be complicated by the confounding factors of behaviour, childhood schizophrenia, psychosis, anxiety, mood, and attention disorders (Giddan & Milling, 1999; Sikora et al., 2008). At CYMHS services in Queensland, an established referral pathway exists to assist clinicians in making a

differential diagnosis of clients presenting with possible communication disorders, PDD and/or mental health disorders. This pathway uses the Autism Diagnostic Observation Schedule-Generic (ADOS-G) as a clinical diagnostic utility because of its sensitivity and specificity in this client group (Sikora et al., 2008).

Autism Diagnostic Observation Schedule-Generic (ADOS-G)

The ADOS-G is a semi-structured, standardised assessment of communication, social interaction, play and imaginative use of materials. It is used as a diagnostic tool alongside clinical and contextual information to identify if an individual warrants a diagnosis of autism or ASD. The ADOS-G is a test that shows excellent inter-rater reliability, test-retest reliability, internal consistency, and generally good agreement across domains with the highest agreement being for communication/social interaction and lowest agreement being for repetitive behaviours/stereotyped interests (Lord, Rutter, DiLavore, & Risi, 2003). However, the use of the ADOS-G is clearly related to the skill of the examiner and requires specific training and practice (Lord et al., 2000). The standardised activities in the ADOS-G allow for the observation of behaviours that have been identified as important to the diagnosis of autism and ASD at different developmental levels and chronological ages. It assesses what the participant "doesn't do" which is as important as what he or she "does do" in the specific domains of communication, social interaction and social reciprocity, play, creativity and imagination, and stereotyped behaviours and restrictive interests.

The examiner focuses on the quality of the interactions and the capacity of the child to use communication and knowledge about relationships to complete the tasks. Four modules are available, with one of those administered based on level of expressive language and chronological age. Each item is scored on a scale from 0 (no abnormal behaviour) to 3 (markedly abnormal behaviour). The derived scores on each of these main areas are compared to specified cut-off scores. If a child scores higher than the cut-off score for example, this indicates that the child has scored within the range that a high proportion of participants with autism and similar levels of expressive language have scored.

ADOS-G does not provide a diagnosis on its own and involves the assessment of the interaction between the child and examiner across a range of social conditions or tasks. It can help inform clinical judgment and should never be the sole piece of evidence for an ASD diagnosis. The "thresholds" for a diagnosis are derived simply from "optimising statistics" (aiming to identify true positives) and not from clinical judgment. Consequently, it makes good clinical sense that, as clinicians are faced with a large body of literature concerned with language, communication, and behaviour in the area of PDD, they use an ADOS-G in conjunction with other tests, observation schedules and interviews when making a differential clinical diagnosis.

Referral pathway for ADOS-G

Figure 1 shows the standard clinical process for assessment of PDD within CYMHS. Each community and hospital CYMHS clinic maintains an ADOS-G subteam consisting of speech pathologists, psychologists, and/or social workers. Each member initially receives specialist training which is maintained at intermittent stages to ensure the reliability and viability of the test results obtained.

Figure 1. District referral pathway

Intake team
May or may not identify PDD.

Initial case presentation
May or may not identify PDD.
Determine range of assessments and timing.

Clinical case conference
Review of checklists, observations, collateral from school and social settings, formal and informal test results. Refer to the ADOS team if indicated.

ADOS-G team
Assist with the differential diagnosis.

Process:
1. Young people with symptoms or previous diagnosis of PDD who meet the CYMHS intake criteria may be identified or flagged for possible ADOS referral at intake. They will undergo the standard initial clinical assessment and case presentation.
2. Clinical case conference is the forum for discussion regarding the range of possible assessments and diagnostic processes.
   - Where the young person clearly *does* have PDD and treatment planning and intervention is unambiguous, an ADOS-G assessment would not be indicated.
   - Where the young person *does not* have a diagnosis of PDD, but has features which might suggest this, further assessment or information gathering may be recommended. The range and timing of this will be determined at a case conference. These range across a number of domains and formats and include:
     i. checklists,
     ii. observation,
     iii. gathering collateral information, i.e. in-depth developmental interviews, school and other relevant sources,
     iv. formal assessments such as cognitive or language.
   - This information is reviewed in the presence of the consultant child psychiatrist and team leader, and if the information suggests a possible diagnosis of PDD, then referral to ADOS-G using the ADOS referral form is made.[1]
3. An appointment at CYMHS is then made for the client. The test takes one hour to complete and all scoring is completed immediately by two to three trained staff. Differential diagnosis is made by the team at case review. Feedback is then given to the family with a written report for the file and family. Additional reports may be provided as necessary.

Case vignette

Sam (a hypothetical client) attends high school. He had significant history of anxiety and sporadic attendance at school due to school refusal for past two years. He also had a diagnosis of language impairment and non-verbal learning disorder. CYMHS treatment goals focused on reducing anxiety and improving psychological functioning (especially in

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1. Please contact the author for a copy of the referral form.

relation to social activities), on returning to school, and on alleviating the familial stress in relation to his anxiety. Sam was referred for an ADOS assessment for clarification of whether his social difficulties and anxiety were exacerbated by an underlying co-morbid PDD condition.

Sam's ADOS-G score suggested a diagnosis of autism. Despite this, a diagnosis of autism did not appear to be appropriate to explain his presenting concerns. First, for a diagnosis of autism to be warranted, the young person must show developmental difficulties by the age of 3 years old. As his development was reported to be normal until the age of approximately 10 years, he did not meet this criterion. Second, impairments in the quality of social relationships must always have been present. Again, he was reported not to have shown difficulties in his social development until 10 years of age. Additionally, during the assessment of the ADOS-G, his social interactions improved in quality over time suggesting that his social skills deficits may be attributed to his marked anxiety. Third, autism is also characterised by restricted, stereotyped and/or repetitive interests. He showed no evidence of exhibiting such behaviours or interests, showed no evidence of rigidity of behaviour, and did not perseverate on any object or topic during the assessment. Finally, his significant language impairment was likely to have impacted on the ADOS-G score by artificially inflating the result. Therefore, it was concluded that his difficulties could be better explained by his high levels of anxiety, his diagnosed language impairment and non-verbal learning disorder, and his poor social skills that were likely to have been exacerbated due to his long period of school refusal.

Sam's profile gives clear evidence of the complexity of the difficulties inherent in assessing young people who present to a mental health service with mental health and developmental disorders. The ADOS-G was an essential diagnostic tool for clear diagnostic clarification and had a direct impact on treatment provided. For Sam, ADOS-G gave a false positive diagnosis and he therefore did not get a PDD diagnosis. However, the mental health diagnosis for his anxiety and school refusal were addressed by the family and education staff, and appropriate supports and interventions were implemented at home and at his high school. Both his language and learning difficulties were targeted in the intervention program.

This case example supports the view that ADOS-G can be regarded as a useful clinical tool to assist with the differential diagnosis. As Sikora et al. (2008) pointed out, several clinical issues should alert clinicians to avoid making hasty and clinically unsupported diagnoses. These include 1) the risk of a false positive diagnosis of PDD, 2) a relative risk of incorrectly classifying mood disorders, and 3) a relatively lower risk of misclassifying disruptive behaviour disorders. The need for multiple sources of information during the diagnostic process, accurate differentiation of mental health disorders from PDD, as well as the identification of co-morbid mental health disorders and PDD warrant careful consideration.

The referral pathway recommended provides a guideline for clinicians to follow so that the complex and subtle clinical issues can be identified and addressed.

Conclusion

The referral pathway currently used in CYMHS has been established to ensure that information from multiple sources and the ADOS-G may be used to help inform clinical judgment for making a differential diagnosis for this client group. Importantly, ADOS-G should not be used as the sole piece of evidence for an ASD diagnosis and hasty and clinically unfathomed decisions should be avoided. Precision in the classification and subtypes carries implications for outcome and response to treatment.

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Webwords 35

Wednesday's child

Caroline Bowen

Beautiful Val was uncontainable when she brought 4-year-old Timothy to his Wednesday speech appointment several weeks ago. Interrupting constantly with peals of appreciative laughter – in response to her own witticisms and asides – she disrupted the session to the point that persisting was futile.

"Oh God, I'm terrible, terrible, terribly terrible" she chortled unrepentantly, flicking her perfectly coiffed hair with impeccable, fluttering French Tips. "I promise to be good next time. Best behaviour." Even in this loud, agitated, witty state there was something brittle about her. A needy, vulnerable fragility.

She switched topic unexpectedly, exploding into song to the tune of "I'm getting married in the morning", "I'll make a motza minta money, when I buy those fresh food people shares; pull out the stopper, let's have a whopper! But get me to the Broker on time!" The melody changed to a familiar supermarket refrain. "Oh! Woolworths the fresh food people, get me to the Broker on time." She stopped. "Would Woolies be one ell or two? Two would be a jumper, wouldn't it? Warm woollies from Woolies. My English dad always talked about his woollies. Winter woollies. Tepidus vestio; valde tepidus ornatus – he was a Classics scholar, you know! Latin, Greek, Hebrew, not Yiddish. Anyway, with those shares I'll be a rich wo-MAN." New tune. It took me back to 1976, *Fiddler on the Roof*, and my unforgettable first encounter, as a speech-language pathologist, with a family in which the mother had a **mental illness**[1]. I remembered her name, and the child's, and the father's. Alison and Lindsay, and Ben aged 3. And there was a baby.

"If I were a rich man, Ya ha deedle deedle, bubba bubba deedle deedle dum. All day long I'd biddy biddy bum. If I were a wealthy man. I wouldn't have to work hard. Ya ha deedle deedle, bubba bubba deedle deedle dum. If I were a biddy biddy rich, Yidle-diddle-didle-didle man."

Timothy looked at me imploringly with a face that said, "Make her stop!"

"Do you know what the midwife said to my dad when I was born? She told him I was strong and healthy, and he said, 'then she shall be called Valerie'."

"Is that what Valerie means?"

"Well, yes, in Latin, but obviously, OBVIOUSLY, it's a joke, a nonsense ..." shrieked Val. "A paradox, a contradiction, an absurd and illogical inconsistency, a cruel and ironic joke ... a mad misnomer ... oh God, you know ... with my mental health *issues* ... you know, *iss – youse* ... are youse having *iss – youse*?"

She continued talking and singing incessantly, ideas and neologisms flying, as worried, over-responsible little Timothy propelled her out the door. I wondered about his mental health, **now**[2] and in the **future**[3].

A state of well-being

Mental health is defined in the section of the **WHO website**[4] devoted to such matters as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Elsewhere on the web, in dictionaries and encyclopaedias it is described as a state of emotional and psychological well-being in which an individual is able to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life.

Full of woe

The following week saw a different Val, medicated to the hilt. Still beautiful, with that indefinable frailty, the French Tips had been gnawed to nothing, the hairdo was awry and she drooped into the room – a picture of defeat. Timothy, hair lank and knotted, clothes grubby and breath sour, followed her closely: casting sad, apprehensive eyes around the room, slumping into a chair, bearing his unpredictable world on his shoulders. Wednesday's mother; Wednesday's child. "Mine Nan bring me d-nuther day. Mine Nanny Sylvia. Mummy go hos-pul get better again. Mummy come back." He hugged himself-for reassurance. "Yes," she said expressionlessly to herself, self-absorbed, without looking at him or at me. "I'll be back."

Toggling between windows

Timothy and his grandmother arrived bright and early the following week, both bandbox fresh, enjoying each other's company. Sylvia and I were probably both thinking that this was the fifth time we had met and that each time was because Val was having treatment. The first time had been when Timothy presented initially as a non-verbal 2-year-old. Sylvia explained that Val would be bringing him to therapy in due course, but not for a while because she had **postpartum depression**[5] and wasn't up to it. Surprisingly, in rapid succession over just eighteen months, Val's psychiatric diagnosis had been changed to **chronic depression**[6] and then, soon after her husband left and filed for divorce, **bipolar disorder**[7]. She was in and out of hospital repeatedly, and, as she put it, "Toggling between windows". When I asked what she meant she responded that life, frankly, for her was either at a distance, through a window on the world clouded by mood stabilising medications and deep malaise, or up close and extreme. The view from this second, exciting window was intensified by manic mood swings and (usually) a refusal to medicate.

Maternal depression

The incidence of depression in all women is reported to be between 10% and 12%. This figure skyrockets to at least 25% for low-income women. Exposure to maternal depressive symptoms, whether during the prenatal period, postpartum period, or chronically, has been found to increase children's risk for later cognitive and language difficulties (Sohr-Preston & Scaramella, 2006). Indeed, depression is a significant problem among both mothers and fathers of young children. Intriguingly it has a more marked impact on the father's reading to his child than on the mother's and, subsequently, the child's language development (Paulson, Keefe & Leiferman, 2009).

Classically, depressed mothers are seen as "under-stimulating", being less involved than well mothers, or inconsistently nurturing with their children (Field, 1992). They have been found to: initiate parent–child interactions less frequently than non-depressed mothers and not get as much pleasure from them; talk less to their infants; have reduced awareness of and responsiveness to their infants' cues; rarely, if ever, use child directed speech ("parentese"); be slow to respond to their children's overtures for verbal or physical interaction; make overly critical comments and criticise more frequently; show difficulty in fostering their children's speech and language development; experience trouble asserting authority and setting limits that would help the child learn to regulate his or her behaviour; and find it hard to provide appropriate stimulation.

By contrast, some depressed mothers interact excessively, over-stimulating their infants and causing them to turn away. Whether under- or over stimulating, these mothers are not responding optimally to their infants' cues or providing a suitable level of feedback to help their children learn to adjust their behaviour. Additionally, there is evidence to show that the children of depressed mothers mirror their mothers' negative moods and are overly sensitive to them (Goodman & Gotlib, 2002). Some mothers envelop their children in an inappropriate closeness and over-identification with their own moods. Children who are preoccupied with and invested in the reactions of their mothers, fathers or other caregivers may not learn to seek out comfort or accept consolation or reassurance when they need it. As a result, their own activity and ability to express emotion may not develop adequately.

Another story

Of course it is impossible to predict how the story of Val and Timothy will unfold, but hopefully it will not be as tragic as the 1976 story of Alison, Lindsay, Ben and the baby. When Alison brought Ben for a speech assessment, the 3-week-old baby, there in a corner in a carry cot, had not been named. I was concerned when Alison told me dully that she had not had the energy to talk to Lindsay properly about a name for "it", and the perfunctory, disinterested way she dealt with the tiny infant's survival needs. She told me she would be all right when the baby blues had passed, as they had done months after Ben's birth. But this was more than the blues; it was more like postpartum depression. She was off her food, wasn't sleeping, was irritable with intense angry outbursts, and overwhelmingly tired. As the weeks passed she told me that she was not bonding with "it" (Jessica) and that she was having troubling fantasies about harming herself and the baby. At the time I shared rooms with a psychiatrist, and a meeting with him for Alison and Lindsay was quickly organised. Once on medication she seemed better, but still something was **not quite right**[8]. Towards the end of Ben's therapy block Lindsay rang to cancel his last three appointments, explaining that they had had "a family calamity". I left the door open, not daring to guess what the calamity was. When Ben resumed his intervention there was no Alison and no baby. She had smothered the infant and taken an overdose.

Good advice: just simply ask

Debriefing was hard. The psychiatrist said I had done the best one could do by facilitating the referral, and I told him I knew he had done all he humanly could. It was unsatisfactory and sad. His advice to me at the time has been integrated into practice over several decades. "*Ask*," he said. "When you take a history, ask each mum, or dad, or other primary caregiver who accompanies new clients, as a matter of routine, about his or her state of mind. Don't try to look for tell-tale signs or red flags in a history. Just simply *ask*."

This good advice is to be had everywhere in the Internet era on a wide range of websites. It can be found in the US Preventive Services Task Force (2009) recommendations for the routine screening of adults for depression, where health professionals are advised to ask two basic questions that may lead to appropriate referrals:
1. "Over the past two weeks, have you felt down, depressed or hopeless?" and
2. "Over the past two weeks, have you felt little interest or pleasure in doing things?"

If an adult client answers "yes" to either or both questions they should be referred, according to the task force, to an appropriately qualified professional in the mental health field to be guided through an in-depth questionnaire to rule depression in or out.

The panel did not make a comparable recommendation for (or against) routine screening of children (7 to 11 years) and adolescents (12 to 18 years) for depression, citing a **lack of evidence**[9] about the reliability and efficacy of such tests in youngsters.

Speech-language pathologists working with young children should know that a loss of interest in play is a red flag that a child of 3 to 6 years of age is depressed, and that two other major warning signs are sadness and irritability (Luby et al., 2003).

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3. http://au.reachout.com/
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5. http://www.mayoclinic.com/health/postpartum-depression/DS00546
6. http://au.reachout.com/find/articles/depression-types-causes-and-symptoms?gclid=CJD6vInx5ZsCFZMwpAodpHK36g
7. http://www.nimh.nih.gov/health/publications/bipolar-disorder/complete-index.shtml
8. http://www.sane.org/information/factsheets/something_is_not_quite_right.html
9. http://www.ahrq.gov/clinic/uspstf09/depression/chdeprrs.htm

Webwords 35 is at http://speech-language-therapy.com/webwords35.htm with live links to featured and additional resources. Clients' names in this column are pseudonyms.

Exploring the need for the speech pathologist in forensic and mental health settings

Laura Caire

This article provides a brief overview of findings in the literature concerning comorbidity of communication impairment and social, emotional, and psychiatric difficulties including those associated with juvenile offending. The need for and role of speech pathologists in mental health and forensic settings is discussed.

Language is an essential tool for communication (Speech Pathology Association of Australia, 2001). It is through language that humans learn to express emotions and thoughts, develop self-image and influence the behaviour and attitude of others. It is not surprising, therefore, that the comorbidity of communication disorders and mental health problems has been estimated as ranging from 50% to 80% (Baltaxe & Simmons, 1988; Benner, Nelson, & Epstein, 2002; Cantwell & Baker, 1991; Cohen, Barwisk, Horodezky, Vallance, & Im, 1998; Cohen, Davine, Horodezky, Lipsett, & Isaacson, 1993; Eichmann, 2008; Giddan, Milling, & Campbell, 1996; Gualtieri, Koriath, Bourgondien, & Saleeby, 1983; Kotsopoulos & Boodoosingh, 1987; Zadeh, Im-Bolter, Cohen, 2007). Many of these language impairments are unsuspected. Among children who have a language impairment, the most common types of psychopathology are externalising ones, e.g., ADHD, CD, ODD (Zadeh et al., 2007). Many juvenile offenders also present with language impairment. For example, in a study conducted by Snow and Powell (2008), more than 50% of a community sample of male youth offenders had unidentified language impairment which could not be accounted for by low IQ. The participants presented with particular difficulties in narrative (storytelling) skills and figurative/abstract language.

It is ironic that although so many juvenile offenders present with language impairment, the justice system expects them to perform many tasks that require higher level metalinguistics, executive functioning and language skills, without appropriate communicational support. The tasks include:

- understanding rules, linking actions to and predicting consequences;
- learning from their "mistakes" and responding to punishment;
- comprehending commonly used signs such as "no trespassing" and words like "penalty, caution" and "flammable";
- understanding questions posed by police and solicitors;
- understanding the court process;
- dealing with complex information and understanding lengthy explanations (such as those regarding diagnoses, medication and treatment options);
- understanding ulterior motives, such as recognising when they are being scapegoated or set up by peers, being taken advantage of, or knowing when another person is joking or serious;
- practising appropriate social behaviour including empathy and using language in a way that takes account of a social hierarchy (e.g., peer vs. teaching assistant vs. principal);
- appropriately problem-solving and resolving conflict through offering of verbal solutions (vs. aggressive/ physical/impulsive ones) and negotiating outcomes;
- taking responsibility for their actions (when they may not even understand what they did wrong);
- proposing ways to make amends;
- telling a clear narrative of events using adequate detail and sequencing;
- making positive peer and community connections;
- giving reasons for their behaviour and actions;
- organising themselves, planning ahead and formulating goals;
- making sound judgments and thinking through decisions; and
- regulating affect, behaviour, and emotional arousal and controlling their responses and participating in talking-based therapies.

(Cohen et al., 1998; Conti-Ramsden & Durkin, 2008; Gilmour, Hill, Place, & Skuse, 2004; Hart, Fujiki, Brinton, & Hart, 2004; Sanger, Moore-Brown, Magnuson, & Svoboda, 2001; Snow & Powell, 2008; Fujiki, Spackman, Brinton, & Hall, 2004; Speech Pathology Association of Australia, 2001; Zadeh et al., 2007).

It could be argued that because of these adolescents' inability to request assistance or participate in communicative discourse with mental health and legal professionals they could easily be taken advantage of or not treated fairly as a result. In the Charter of Human Rights and Responsibilities document "Protection of freedoms and rights for everyone in Victoria"(2009), Victoria's Attorney-General, The Hon. Rob Hulls MP, writes "At the heart of Victoria's Charter of Human Rights and Responsibilities is respect: the belief that everyone is entitled, as we say, to 'a fair go'" (p. 2). On their website under "The Victorian Charter of Human Rights and Responsibilities explained" the

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Victorian Equal Opportunity & Human Rights Commission (2009) states:

Human rights are the foundation for freedom, justice, peace and respect, and are an essential part of any democratic and inclusive society that respects the rule of law, human dignity and equality … Human rights are about recognising and respecting the dignity of other people,

which includes the right to a fair trial. Unfortunately, many mental health and legal professionals are unaware that their client has a communication disorder and/or do not have access to speech pathology support to ensure their client can fully participate in trial proceedings.

In Section 25 ('Rights in criminal proceedings') Part (2), the Charter of Human Rights and Responsibilities Act 2006 states:

A person with a criminal offence is entitled without discrimination to the following minimum guarantees:

a) to be informed promptly and in detail of the nature and reason for the charge in a language or, if necessary, a type of communication that he or she speaks or understands; and

b) to have adequate time and facilities to prepare his or her defence and to communicate with a lawyer or adviser chosen by him or her; and

c) …to have the free assistance of assistants and specialised communication tools and technology if he or she has communication or speech difficulties that require such assistance.

Providing this support to the clients who need it will not occur if the professionals working with them are not aware of their difficulties and need for support. Therefore, it seems fair to suggest that the human rights of many juvenile offenders and mental health clients are being violated unintentionally. This is a good reason for professionals in the mental health and forensic areas to consider speech pathology input for their clients. However, concerned professionals need professional development and education in this area. Due to their specialisation in understanding communication impairment, its consequences and appropriate intervention, speech pathologists are in a prime position to take on the role of educating professionals in the areas of forensic and mental health and advocating for the clients within these settings.

Speech pathologists can take on many roles in mental health and forensic settings. These include:

- routinely screening for language impairments in clients presenting with behavioural, emotional, and psychiatric problems (Fujiki et al., 2004; Snow, 2008);
- providing consultation to professional teams regarding a child's communication skills and developmental level, to help inform appropriate diagnoses and management (e.g., visual prompts, social stories, simple language) (Gallagher, 1999; Russo, 2004; Toppelberg & Shapiro, 2000; Westerlund, Bergkvist, Lagerberg, & Sundelin, 2002; Zadeh et al., 2007);
- providing opportunities for and facilitating social connections for children and families (Australian Research Alliance for Children & Youth, 2008);
- enhancing resilience of children and families, and their ability to problem-solve and cope (Australian Research Alliance for Children & Youth, 2008);
- facilitating treatment that targets social skills training (e.g., social skills groups), language of feelings, and self-talk (Giddan & Milling, 1999; Gilmour et al., 2004);

- engaging in public health advocacy regarding the importance of oral language competence (Snow, 2009; Snow & Powell, 2004);
- providing speech-language therapy to improve behaviour and socialisation (Gilmour et al., 2004; Girolametto, Steig Pearce, & Weitzman, 1996; Robertson & Weismer, 1999);
- participating in and providing support for restorative justice programs enhancing parental knowledge about child and youth development;
- enhancing nurturing, attachment, and early bonding between children and caregivers (Australian Research Alliance for Children & Youth, 2008); and
- developing, facilitating, and participating in promotion, early intervention and prevention programs concentrating on the communication problems, particularly in neglected and maltreated children (Snow, 2009; Sylvestre, Payette, & Tribble, 2002).

Some ideas for acting locally include:

- input at clinical reviews (case discussions) and participation in working parties and focus groups;
- development of resources in your workplace (e.g., visual plans);
- provision of professional development to colleagues and community settings, e.g., Children's Court clinic, correctional facilities, Department of Justice, Disability Forensic Assessment & Treatment Service, Regional Mental Health Services, Victoria Police, Victorian Institute of Forensic Mental Health, and Youth Justice;
- undertaking research and postgraduate study;
- participating in policy writing and development;
- presenting at relevant conferences, e.g., Forensic Psychology, Australian & NZ Association of Psychiatry, Psychology & Law, and Forensic Disabilities; and
- lobbying to local members of parliament for increased funding to this area.

Hopefully, in time, awareness will be increased, more research done, and policies changed so that we may, one day, see the communication-impaired juvenile offender in a police interview room or legal proceeding not only with their lawyer but also with their speech pathologist, sitting by to provide them with the prompts and cues required to maximise communicative effectiveness and the client's subsequent fair participation in the legal system's processes.

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Clinical insights

Kool Kids Positive Parents: A school-based early intervention and prevention program for children with challenging behaviour and emerging conduct disorder

Suzanne Lim

Suzanne Lim

In this paper, the Kool Kids, Positive Parents (KKPP) program, which provides school-based consultation and programs for young children with behavioural problems, is described. The rationale, background and development, levels of intervention and outcomes are outlined.

Rationale

Childhood behavioural problems such as defiance, tantrums and arguing with adults are fairly common especially when children are hungry, tired, upset or stressed. Sometimes these behaviours can be a temporary reaction to stress, such as a family crisis or an important transition, such as going from kindergarten to school. However, when these problems are chronic and impact on the child's social, emotional or academic development, these children may be at risk of developing more persistent or serious behavioural problems, such as oppositional defiant disorder (ODD), or conduct disorder (CD) (American Academy of Child and Adolescent Psychiatry [AACAP], 2009; for definitions of these disorders visit http://www.mentalhealth.com/p20-grp.html).

Research has shown that approximately 67% of children diagnosed with ODD who receive treatment are symptom free after three years, yet approximately one-third go on to develop CD. Adolescents with CD have significantly higher rates of comorbid psychiatric conditions, such as anxiety and depressive disorders and are more likely to engage in concurrent substance abuse. Thus, the long-term outcomes for children with persistent behavioural difficulties can be poor, and even less optimistic if there is an early onset of symptoms, or if those symptoms are severe such as persistent aggression towards others (AACAP, 2007).

It is therefore not surprising that a key approach to working with children with behavioural problems is prevention and early intervention. Schools are an ideal place to deliver programs to groups of children, to their parents and to provide support to school staff. The Incredible Years program, for example, provides parents of young children with conduct problems support and education, while the children receive group training in social skills, emotional regulation and conflict resolution skills (Webster-Stratton & Reid, 2003).

Background and development

KKPP, based at Eastern Health Child and Adolescent Mental Health Service (CAMHS), Melbourne, started in May 2004 as one of two 3-year pilot projects. It was initially funded by the Victorian Department of Human Services, Mental Health Branch (DHS MHB) and aimed to provide early intervention and prevention of conduct disorder.[1] There was great excitement when this pilot project was announced, as it was one of the first of its kind in mental health to provide a school-based early intervention approach. The project brief described a multi-level, multi-pronged approach to be implemented at schools together with school staff, thus providing a vehicle for collaboration between the health and education sectors. While the project brief provided the overall guidance and framework, it was up to the KKPP team leader and multidisciplinary staff to develop and implement the project. The first KKPP groups for children and parents targeting problematic behaviour were implemented in six pilot schools in second semester of 2004. During 2005, further components such as teacher training and classroom programs were developed while running the program in more schools. At the end of that year, KKPP was the recipient of the Victorian Healthcare Award for Innovations in Models of Care. By mid-2006, when the combined CAST and KKPP project evaluation had been completed (Brann, Corboy, Costin, McDonald, Hayes, & Turner, 2007), the Vic DHS MHB awarded recurrent funding to both projects.

Levels of Intervention

There are three main components: 1) *universal prevention*: school-based professional development and building of social emotional skills for all children, 2) *targeted early intervention*: parent groups and child groups aimed to support children already showing signs of challenging behavior, and 3) *indicated early intervention:* for those children who require additional or a more individualised focused approach (see table 1).

Universal prevention

The KKPP's aims at the universal prevention level are to build awareness and knowledge in schools and communities about severe behavioural disorders, such as ODD and CD, and about the importance of early identification and intervention. At a broader level this includes links with community agencies, and presentation at conferences as well as linking in with the media. At the primary school level this includes professional development to all the school staff about behaviour disorders, associated behavioural and developmental problems and management strategies.

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1. The other project, *Cool at School Together* (CAST) is based in the Grampians (in rural western Victoria).

Table 1. Levels of KKPP intervention

Universal prevention	Community level	Community presentations, conferences, links with community agencies and media
	School level	Whole school professional development Teacher consultations Presentations to parent and school community around social/emotional wellbeing
	Classroom level	Provision of a classroom program around social and emotional skills development Teacher consultation Focus on grades prep to 3
Targeted early intervention	Group level	Tools for early identification of children at risk Kool Kids group program for children with identified problematic behaviour Group program for parents of identified children Both groups jointly run by KKPP staff and school staff Focus on grades prep to 3
Indicated early intervention	Individual level	Individualised focussed intervention for specific children with additional concerns Behavioural assessment and development of a positive behaviour support plan May involve additional meetings with parents and/or teachers Focus on grades prep to 3

Further professional development about child social-emotional development is provided mid-way through the year and following this, the KKPP classroom program is implemented for all children in grades prep to 3. KKPP clinicians support teachers to implement this program by working side by side in the classroom for some sessions, which include discussion, games, music, role-plays and activities with the optional use of puppets, worksheets and follow up activities.

Targeted early intervention

A key component of the KKPP program is the focus on early intervention for children who already show behavioural difficulties. Careful selection of participants involves discussion with teachers and use of a screening tool, the Strengths and Difficulties Questionnaire (SDQ; Goodman, 2001). The SDQ is short, simple and easy to use, has good psychometric properties, comes in youth, teacher and parent versions, and is publicly available on-line at no cost. Once completed, the SDQ yields a total difficulties score as well as scores on five subscales: 1) emotional problems, 2) conduct problems, 3) attention and over-activity, 4) peer relationship problems and 5) prosocial skills. Children "at risk" are those scoring high on conduct problems. The KKPP clinician then contacts the parents of "at risk" children to arrange an interview, engage the parent, gather a history, discuss the program and expectations and to set goals. The parent needs to give consent for their child to take part in the children's Kool Kids group, and make a commitment to attend the KKPP parent group. For many parents, the idea

that problems in social skills and emotional regulation in their child might at least partly underlie their problematic behaviour is a new concept and the majority of parents are keen for their child to learn these skills, especially if this means that their child might be diverted from going down the "naughty child" path. Finally, parents are given a number of questionnaires to complete. A further understanding of the child is gained from conducting child observations and teacher interviews, and an individual interview with each selected child helps to establish rapport with them.

Areas targeted in the Kool Kids group include understanding, expressing and managing emotions (especially anger), thinking about other people's feelings, friendship and problem solving skills, as well as social communication skills. A combination of games, activities, role-play, stories, books, puppets, discussion, and music is used. The Kool Kids program uses social learning theory, behavioural methods and basic cognitive behavioural strategies in a structured 12 x 60 minute program (see table 2). Each group is jointly facilitated by a KKPP clinician and a school staff member, e.g., a school welfare coordinator, chaplain, assistant principal or teacher.

Table 2. Kool Kids group

Session	Topic/area
1	Getting to know you
2	Speaking and listening skills
3	Feelings in self
4	Feelings in others and perspective taking
5	Recognising anger
6	Kev's calming down steps
7	Managing angry feelings
8	Problem busters
9	Joining in and turn taking
10	Being friendly
11	Cool compliments
12	Review and celebration

The KKPP parent group is based on Parent Management Training (PMT); this being one of the most empirically supported interventions for school-aged children with behaviour problems (AACAP, 2007). The main areas addressed in the KKPP parent group program are in strengthening the parent–child relationship, planned use of behaviour management strategies, attunement and communication with children. Use of a group program also provides an opportunity for parents to feel less alone and more supported by others. The KKPP parent group runs for 8 x 120 minute sessions (see table 3). The parent group programs are again jointly facilitated by a KKPP clinician and a school support staff member, such as the school psychologist, guidance officer, social worker, assistant principal or chaplain. All of the school co-facilitators for the parent groups and the children's group attend a full day's training for each group program and receive manuals, materials and on-the-job training and support.

Indicated early intervention

Consultation with teachers around problematic behaviour in specific children is available to all teachers of children from prep to grade 6. For children who have particularly problematic

Table 3. KKPP parent group	
Session	Topic/area
1	Understanding child behaviour Quality time
2	Giving effective commands, behaviour management (use of praise and ignoring)
3	Active listening – tuning into your child
4	Incentive planning – how do we promote more positive behaviour?
5	Managing misbehaviour
6	Helping children to manage their emotions
7	Helping children develop social skills
8	Building positive school/home relationships

behaviour, an individualised focus might include further parent or teacher interviews, pupil support group meeting to discuss specific issues, referrals for additional assessments or the setting up of a positive behaviour plan. Representatives from all schools are invited to training in functional behavioural assessments and development of a positive behaviour plan for children with particularly challenging behaviour.

KKPP has time-limited involvement with each school. All parents who are involved with the targeted component receive written and verbal feedback with recommendations. To aid sustainability, schools are provided with the training and materials to implement the programs for a second time without KKPP clinical staff (who are available on a consultant basis).

Outcomes

Both qualitative and quantitative evaluation of KKPP was completed on data collected from the 32 schools concerning 220 children and their parents who were involved at the targeted level of intervention, from mid 2004 to the end of 2006. The children were mainly boys from grades 1 and 2, who had high levels of conduct problems compared to their peers, with teachers rating more than 70% of these children as being in the clinical range.

Analysis of parent and teacher SDQ data found significant decreases in children's problems following the group interventions, with improvements on all scales, i.e., children's overall difficulties, emotional problems, conduct problems, hyperactivity, peer problems and prosocial behaviours. The percentage of children who were in the clinical range on the SDQ fell from 75% to 53% according to teachers. Analysis of the Social Skills Rating Scale Gresham & Elliott, 1990) found statically significant improvements in social skills and academic competence as well as significant reductions in problem behaviour according to both teacher and parent reports (Brann et al, 2007). Results also indicated that parents had a greater sense of competency and satisfaction following the program and had become less verbose, lax and over-reactive (Brann et al., 2007). Long-term follow up showed that these improvements in parents and children were sustained up to 6 to 18 months post program delivery (Partridge, 2009).

Analysis of feedback questionnaires from education staff, parents, children and co-facilitators indicated that satisfaction with the programs was high and the strategies introduced were valued. The group activities were popular with the small Kool Kids group as well as the whole class and the use of puppets made an enormous difference in engaging the children. "Sam" – a large boy puppet – rapidly became the KKPP mascot!

Future directions

Four new early intervention and prevention programs have now been established, at the Austin, Royal Children's Hospital, Bendigo and North Eastern CAMHS. Collectively, these programs are now known by the acronym CASEA (CAMHS and Schools Early Action), the name reflecting collaboration between the Mental Health and Education services. Although all CASEA programs have the same model and over-riding philosophy, they have evolved as separate programs, with slightly different emphases, staffing and execution of the program.

KKPP is a program constantly developing program and is committed to evaluating its outcomes. Future directions include further research and university partnerships, more links with community agencies, and extending the work to the preschool population. The work to date has been exciting and stimulating with positive outcomes overall, showing that a collaborative and early intervention approach to behavioural problems does make a difference for teachers, parents and the children themselves by getting them on a more positive life trajectory.

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To tube or not to tube: Who can ethically answer that question?

Helen Smith and Noel Muller

In this edition of Ethical Conversations, we consider ethical issues related to informed consent and the placement of feeding tubes. Informed consent is the right of individuals to make decisions about their treatment based on all relevant information of the risks and benefits of that treatment (Mitchell, Kerridge, & Lovatt, 1996). It is predicated on the principle of client autonomy. Autonomy is about respecting the rights of people to self-determination in relation to decisions which affect them (Speech Pathology Australia, 2000). Autonomy is the principle that underpins issues such as consent, refusal of treatment, and confidentiality (Smith, 2007).

In certain circumstances a person's right to give consent may be removed. This can occur as a result of impaired capacity to make decisions or in the case of severe mental health issues when a person's choice could result in harm to themselves or others (Trobec, Herbst, & Žvanut, 2009). In these circumstances another person or statutory body may become the designated substitute decision-maker.

Three cases are provided to illustrate a number of issues speech pathologists may want to consider when contemplating substituted informed consent for the placement of feeding tubes (either short-term such as nasogastric tubes [NGTs] or long-term such as percutaneous endoscopic gastrostomy tubes [PEG tubes]).

Case scenarios

Case 1

John is in his early 30s and has a long history of schizophrenia. John's schizophrenia is being managed by medication and is currently stable. He is single and lives with his very caring father. On this most recent admission to hospital, John presents with swallowing problems as a result of treatment for cerebral lymphoma. He is unable to communicate coherently nor is he able to eat, drink, or swallow his medications safely. He pulls out all NGTs and intravenous therapy. The medical team propose surgically placing a PEG feeding tube into John's stomach to provide nutrition, hydration, and medications while he continues his treatment for lymphoma. There is a good prognosis for his lymphoma treatment.

Case 2

Anna is in her late 60s and has suffered a stroke. On the day after her stroke she has severe language impairment (dysphasia) and is unable to speak or answer simple yes/no questions. She has profound dysphagia and her poor swallowing prevents her from taking any food, fluid, or medication by mouth. Anna has no family but has a legally prepared Advanced Care Directive[1] that states she does not want artificial (tube) feeding. Medical management favours placement of a temporary NGT so Anna can be given urgent cardiac medication which can only be given via a tube or by mouth. If she does not receive this medication she is at risk of a heart attack or further strokes.

Case 3

Max is an 88-year-old resident in a nursing home. He has advanced dementia. He presents to hospital with a severe pneumonia as a result of profound dysphagia which is due to his end-stage dementia. He has no advanced care directives and no family. His financial affairs are managed by the public guardian. Medical management favours placement of a PEG so that Max can be discharged back to his nursing home as soon as possible.

Discussion

Who can give informed consent?

Each of these cases raises different issues for the team with regard to who can provide informed consent. When considering substituted consent, speech pathologists need to be aware of not only ethical considerations that arise in individual cases but also relevant laws and legislation. These may include:

- *Emergency decisions* If there was an urgent (life and death) emergency need for medications for John, Anna or Max, then two doctors could consent to the placement of a NGT (or PEG, including administration of anaesthetic). Placement of a NGT for delivery of medication could most easily be argued by medical teams in Anna's situation.

- *Mental health act* An important consideration for John is whether he is covered by a mental health act.[2] Each Australian state and territory has a different mental health act. In some states, treatment decisions may be made for John by the State Director of Mental Health Services (a psychiatrist). Establishing whether John is covered under a mental health act is simply done by contacting his treating mental health team. If he was covered by a mental health Act his affairs may have been handed over to an adult guardian. The adult guardian would then be the substitute decision-maker for John's general health and well being. If John was not covered by a mental health act then his father would be considered his next of kin and would be the substitute decision-maker.

- *Consent to treatment and palliative care acts* Unfortunately, in Anna and Max's cases there are no clearly designated decision-makers to assist in determining appropriate treatment options. The challenge in Anna's case is the advanced care directive simply stating she does not want tube for feeding. Is this the same as refusing a tube for medication? Would Anna perceive a tube for medication as an extraordinary measure and refuse it if able?

- It is reasonable and ethical to respect Anna's right to have control over the end of her life. From state to state, however, there are different views about advanced care directives and their legality and validity.[3] In Anna's case, if we are to consider the principle of autonomy, it would suggest her clearly expressed wish should be respected and form part of the treating team's deliberations. The absence of

Helen Smith (top) and Noel Muller

family or a medical power of attorney to reinforce Anna's advanced directive means the treating team have to consider even more strongly what Anna would want.

Role of guardianship boards

In Max's case he has a right to treatment that will be effective despite his age and cognitive capacity. This may involve the treating team providing best practice medical management for his pneumonia and referring to a speech pathologist for advice on swallowing management. However, a doctor is not obligated to provide futile treatment, and in Max's case best practice evidence might suggest insertion of a PEG to be futile (Meier, Ahronheim, Morris, Baskin-Lyons & Morrison, 2001), even placing him at greater risk of aspiration (Hoffer, 2006). If the team wishes to consider consent for a PEG as a non-urgent surgical treatment, a substitute decision-maker would be required.[4]

Further ethical considerations for the speech pathologist

Justice

In all three cases it is important for speech pathologists to consider the principle of justice, that is, fairness and equity of access to services for John, Anne and Max. This may involve ensuring John is not discriminated against due to his longstanding mental health issues. For Anna it may be advocating against treatment she would not want. It might be ensuring Max receives reasonable treatment for a reversible medical condition but does not receive futile treatment.

Beneficence/non-maleficence

The principle of beneficence/non-maleficence or "to do good" is also relevant in the cases of John and Max. John has a potentially reversible dysphagia and communication impairment, but needs nutrition, hydration and access to medications while he is receiving treatment for lymphoma. In John's case a PEG, which he may find less irritating than a NGT, may be better tolerated. Similarly, by assessing Max's swallowing we may be able to show beneficence by being able to provide him with oral intake he is able to tolerate comfortably. By highlighting the complications and risks of PEGs in individuals such as Max with end stage dementia, we may also prevent doing harm through the potentially unnecessary placement of a feeding tube.

Duties to clients

When considering our duties to clients we may contribute to discussions with substitute decision-makers by providing information that meaningfully informs the decision-making process. Such information may include for example, the risks and benefits of NGT or PEG tubes, or the meaning of "comfort" oral intake, that is oral intake which may be aspirated but is still provided for patient centered symptom management and family care in individuals receiving palliative care (Waldrop and Kirkendall, 2009). It may be information provided in conjunction with other members of a treating team such as gastroenterologists, dieticians and physicians.

Conclusion

In this column we have highlighted the many and varied deliberations a treating team may undertake when determining the placement of feeding tubes to provide non-oral nutrition, hydration and medication. As has been discussed, many ethical and legal issues need to be considered by the treating team when contemplating substituted informed consent. Speech pathologists have a vital role to play in these deliberations and are well placed to positively influence the decisions that are made and the actions undertaken. Our clients will clearly benefit from our ability to discuss these issues in an open and informed manner with other team members and the relevant decision-makers.

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1. www.agpn.com.au/site/index.cfm?display=4207
2. http://www.mhca.org.au/documents/Definitionsofmentalhealth.pdf
3. For more information on a state-by-state basis see the following: Consent to Medical Treatment and Palliative Care Act 1995, SA; Health Act 1911, WA; Natural Death Act 1988, NT; Medical Treatment Act 1988 ,Vic; Medical Treatment – Health Directions Act 2006, ACT; Health Services Act 1960, Tas; Consent to Medical Treatment – Patient Information 2004, NSW.
4. The appropriate "substitute decision-maker" will vary from state to state – it may be a member of the Guardianship Board or other authority.

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Clinical insights

A good start to attachment: The Story Telling and Rhyme Time (START) group

Lisa Dyer

The START group aims to develop the protective life skills of good communication. Through story, song, and rhyme "at risk" families cement the parent-child relationship and promote healthy social emotional development. By increasing caregivers' awareness of infant development the START group, supporting the development of caregiver-infant interaction, fosters attachment, communication skills, and global development.

The Story Telling and Rhyme Time (START) group evolved in the corridors of the Cranbourne Integrated Care Centre in the City of Casey, 45 kms south east of Melbourne's CBD. With 146 new residents moving into the area each week, Casey is one of the country's fastest growing municipalities (as of 2006 census, www.casey.vic. gov.au/demographics). Understandably, the workload of maternal and child health nurses has grown exponentially in recent times and through their partnerships with Child and Adolescent Mental Health Service (CAMHS) and Community Health (CH), a growing number of "at risk" mother–infant dyads – that is, dyads presenting with attachment disorder, post natal or general depression, lower socioeconomic status, babies of low birth weight or perinatal complication, and/or infants/toddlers who have been abused (Baker & Cantwell, 1987) – have been referred to post natal depression self-help groups or Parent and Infant Relationship Support(PAIRS) groups. It was observed by CH that a proportion of these infants presented for speech pathology services at 2 or 3 years of age. The question was raised "Had we missed the boat?" The World Health Organization's *Report on the Social Determinants of Health* emphasises the role of early intervention to reduce the risk of disadvantage (Wilkinson & Marmot, 2003). With this in mind, the idea of a group that would support the mother–infant relationship while enhancing the carers' language enrichment skills at a very early age was born!

The START group, a multi-faceted program, draws on a range of existing programs including *The Parent–Child Mother Goose Programme*® (2003; http://www.nald.ca/mothergooseprogram/), *Keys to Caregiving*® (NCAST-AVENUW; http://www.ncast.org/), and *Parent Child Interaction Teaching Scales* (NCAST, 1995; http://www.ncast.org/), and taps into the literature supporting the crucial link between early attachment and development. Speech pathology has long been aware of the critical period for language development – birth to four years of age. It is well established that the first two to three years of life are considered vital for developing emotional control and set the foundations for competence and coping skills, elemental to learning and health throughout life (McCain & Mustard, 1999).

Attachment describes the affective bond between an infant and a primary caregiver (Bowlby, 1988). Through healthy attachments the infant learns to respond in socially acceptable and flexible ways, demonstrating a range of appropriate spontaneous reactions and emotions. By 6 to 12 months of age infants have usually learnt to elicit a desired response from their caregiver (Cooper, Hoffman, Marvin, & Powell, 2001). The relationship between early attachment, emotional regulation, language development, and cognitive development has become increasingly clear (Van IJzendoorn, 1995). Van IJzendoorn's meta-analysis revealed that (i) the quality of parent infant attachment is strongly associated with language development and (ii) insecure attachment is more often associated with lower cognitive functioning and language competence. Insecure emotional attachment and poor stimulation are thought to lead to: restricted school readiness, low educational attainment, problem behaviour, and increased risk of social marginalisation in adulthood (Wilkinson & Marmot, 2003).

Early attachment is dependent on many factors including the primary caregiver's mental health. Field (1995) found that 3-month-old infants who detected depression in their mothers demonstrated developmental delays at the age of 1. Interestingly, "treating mothers' depression, even successfully, is not in itself sufficient to change the mother–child relationship, or the mother's negative view of the child" (Forman, O'Hara, Stuart, Gorman, Larsen, & Coy, 2007, p. 507). In contrast, interventions designed specifically to improve a mother's sensitivity to her infant's communication have been successful, particularly with low-risk samples (e.g., van den Boom, 1995). Focusing on just one aspect of parenting behaviour is likely to have less effect upon the overall parent–child relationship (Egeland, Weinfield, Bosquet, & Cheng, 1999), suggesting that partnerships between services such as CAMHS and CHS with a holistic approach are more likely to effect change.

The START group, a weekly program over two months, is facilitated by two speech pathologists, one each from CAMHS and CH. Up to eight caregivers and their infants attend. Pre and post interviews provide outcome measures based upon the results of the Communication and Symbolic Behavior Scales™ (CSBS) Infant Toddler Checklist (Wetherby & Prizant, 2001), which screens early language and symbolic

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communication skills, and the *Parent Child Interaction Teaching Scales*, a tool used widely in the United States of America and the United Kingdom. As per the Teaching Scales criteria, videoing of a structured teaching task enables the clinician to assess dyad reciprocity, caregiver sensitivity to infant cues and the caregiver's capacity to provide an environment that is conducive to the development of social, emotional and cognitive skills. The interaction also enables assessment of the clarity of the infant's cues.

Each week caregivers and infants join the clinicians for an hour and a half of floor time to enjoy a variety of songs and rhymes. Repetition ensures that mothers and infants become highly familiar with their favourite songs or rhymes and learn adaptive use of the material to meet their individual needs (e.g., to increase alertness, to settle, or to alleviate distress). The benefits of routine are demonstrated using key songs to signal program changes. Broad smiles are elicited when the mums become cognizant that the song "I'm a little teapot" means they can sit back, sip a cuppa, chat and be waited upon for 20 minutes. The song "This is the way we pack away" is soon understood by even the youngest of infants to signal the end of bubble-and-ball time and returning to their mothers' arms. A brief "mothers only" time is always a challenge to the facilitator left to manage up to six infants and sometimes toddlers (bubbles are truly a blessing!) while the second speech pathologist leads a discussion with the mothers.

First Words Project Home Activities (http://www.firstwords. fsu.edu/) introduce early communication development. The NCAST *Baby Cues: A Child's First Language* (http://www. ncast.org/) flash cards explore the concepts of engagement and disengagement cues (Givens, 1978). Most parents, adept in identifying potent engagement cues (moving arms towards caregiver/ babbling) or equally potent disengagement cues (back arching/withdrawal from quiet alert to active sleep state), learn to use songs to facilitate transitions from one state to another – from active alert where the baby is fussing to quiet alert where the baby's eyes are focused (http://www.ncast. org/). Recognising more subtle engagement cues (brow raising/facial brightening) or subtle disengagement cues (diffuse body movements/tongue showing), and identifying clusters of cues can be a new experience for some.

Preliminary outcome measures (sample size of 6) have shown encouraging results. Caregivers improved in their ability to interpret their child's communication and foster a sensitive reciprocal interactional style that promotes cognitive and emotional development interaction. Caregivers accessed support for their own mental health concerns and infants were streamed, where required, into community programs and ongoing developmental programs at an early age. Feedback from the mothers has been heartening. Responses included "I realised that talking to my child is the best thing I can do for her" and "I can read her body language better".

Early results thus indicate that the START group provides caregivers with increased knowledge of early communication development and the importance of sensitive interaction. Gwynne, Blick and Duffy (2009) conducted a pilot program in Sydney, utilising a relationship-based model of care, which highlighted the benefits of integrated centre-based interventions. Similarly, the START group is an additional building block in the development of at risk mother–infant interaction that fosters attachment, communication skills and global development.

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My journey into relationship-based practice

Kristy Collins

Sandra[1] and her son, Jonah (2), arrive late to their first speech pathology appointment at the Child and Adolescent Mental Health Service (CAMHS). Jonah is unsettled and Sandra looks exhausted and somewhat agitated. I usher them into a clinic room, where a range of toys are laid out on the floor. Sandra launches into a vivid description of her son's explosive tantrums, her concerns that he only says a couple of words and her fears that he will turn out like his abusive father. As she speaks, Jonah moves aimlessly around the room. I ask Sandra what she is hoping to gain from attending CAMHS. She says she wants Jonah to say more words and that she would like the psychologist, who is also seeing the family, to address his anger management problems.

Where should I begin with this family? As a young graduate, I felt compelled to rush into gathering data about a child's developmental milestones, risk factors for communication difficulties and current functioning. I found this information useful but soon realised that I was asking about areas that trigger strong emotions. A child with difficulties tugs at the very core of parents and many of the families I was seeing were experiencing grief, loss, anger, frustration, and even gut-wrenching guilt. This was scary stuff! Clearly, I needed to acknowledge and validate these emotions but I felt totally out of my depth in providing what I then viewed to be counselling. Too often, I found myself trying to put a "bandaid" on a parent's negative affect by being the "bright and bubbly" clinician and by prematurely offering problem-solving strategies.

Now, after a decade of experience and reflection, I understand that all clinical encounters occur in the context of relationships. This means that when a parent presents as overwhelmed or anxious my first goal should be to create a safe environment in which their feelings can be acknowledged and supported (Geller & Foley, 2009; Weatherston, 2000). Information gathering is complemented with the building of therapeutic relationships, which constitutes a shift from simply establishing rapport for the sake of encouraging participation in therapy. The time it takes to establish a therapeutic relationship can be lengthy with some families, particularly when the barriers parents face in forming relationships with their children also act as barriers to forming therapeutic relationships with the clinician (Geller & Foley, 2009).

With this in mind, I spend the first part of the session with Sandra and Jonah sitting with the strong emotions

1. Names and details have been changed.

in the room. I empathise with Sandra's difficulties, explore the history of her relationship with Jonah and highlight her good intentions for his development. At the same time, I watch how Jonah interacts with his mother, his environment and with me. I am interested in where he positions himself in the room, his use of other people, verbalisations, eye contact and emotional regulation. Observing the relationship between a child and caregiver is crucial because the quality of the infant–caregiver relationship may impact on emotional and developmental difficulties in children (Mares, Newman, Warren, & Cornish, 2005). I notice that Jonah moves quickly from one toy to the next, with only the occasional glance at his mother. Although I am concerned about this behaviour, I resist the temptation to initiate interactions with him or to scaffold his play. While I have always invested much energy into building connections with children, I have learnt that it is critical to first attune to the emotional needs of the parent, particularly when there are difficulties in the parent–child relationship. Fully concentrating on connecting with Jonah at this stage may only result in Sandra feeling inadequate, undermined and unheard (Chambers Amos, Allison, & Roeger, 2006).

When Sandra has expressed her feelings and concerns fully, I encourage her to engage with Jonah in play. This allows me to observe Jonah's communication and play skills as well as providing insight into how well Sandra can follow his lead and read his emotional cues. This is important as it reflects how sensitive and attuned she is to him, both of which are pivotal in the formation of a secure attachment relationship (Cohen et al., 1999; Mares et al., 2005). I move away from traditional ideas of (1) assessment, (2) recommendations, and (3) therapy and instead use a more dynamic therapeutic approach where all three may be occurring simultaneously. At this moment, Jonah is pulling pieces out of a puzzle. Sandra sits down next to him on the floor and asks him to name the animals in the puzzle. Jonah responds by looking at her, offering her the piece he was holding and making the noise of a dog. Sandra does not take the piece or extend on his utterance. Instead, she tells him to put the piece in the puzzle. Jonah tries but quickly gives up without asking for help. He throws the pieces across the room. Sandra flinches. I wonder aloud about what might have triggered the outburst. She tells me that Jonah is "feeling naughty" and if they were at home, he would "trash the whole house". I work to contain the situation by speaking on behalf of Jonah, and by mirroring the emotional tone and internal states of both mother and

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child (Geller & Foley, 2009). To rush to offer advice or to demonstrate positive play methods, although superficially satisfying, is often ineffective and can add additional stress to an already tense parent–child relationship. Furthermore, language stimulation techniques that might be suggested to develop early language skills are applied during play. I would suggest that if the parent–child relationship is poorly developed, enjoyable interactions between parent and child may not be occurring. Therefore, to recommend a parent target language goals during their time together is likely to cause frustrations and feelings of inadequacy, risking further damage to the relationship. Initial therapeutic goals might instead focus on achieving positive interactions with their child, for example, following their child's lead during play. In order to develop language through positive play, positive play must first be achieved.

As it turns out, this approach works for Sandra and Jonah. Over the course of several weeks, we videotape and jointly review a number of informal play sessions. Videotaping is an excellent method for supporting parents to reflect on how their child communicates, and on their role in parent–child interactions (Marvin, Cooper, Hoffman & Powell, 2002; McDonough, 2005). Sandra notices that Jonah often uses gesture to initiate interactions. She also reflects that she is often quiet because she is not sure if he wants her around. I highlight moments when Sandra successfully attunes to Jonah's affective states. As she feels more empowered and comfortable, Sandra spends more time in the session focusing on what she can do to achieve positive interactions with Jonah. Sometimes I offer specific suggestions about following his lead during play. At other times, I put the video-camera down to demonstrate positive play methods and occasionally even a language stimulation technique. All the time, I am gathering more data about Jonah's speech and language skills, as well as developing Sandra's ability to support his development in these areas. Of course, it is not all smooth-sailing. At times, progress seems painfully slow. I feel pressured to move the clinical work forward. Holding Sandra's strong emotions is emotionally exhausting but she needs to be helped to co-regulate Jonah. Fortunately, regular reflective supervision and the opportunity to co-work with the family's psychologist provide much needed emotional support and clinical guidance.

I know we have made significant progress when Sandra proudly tells me that she is "getting down on the floor" every day with Jonah at home, and when she begins to ask for copies of the videotaped footage to give to Jonah when he is older. She is learning that she matters to Jonah, and that she can support him to grow and develop. As her confidence grows, so does mine. Relationship-based practice works!

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A national snapshot of clinical placements in Australia

Heads of Speech Pathology Programs and Speech Pathology Australia

Clinical education placements are a core part of every university speech pathology course in Australia. Clinical education placements allow students to develop both generic and speech pathology specific clinical competencies in real environments with real people. Among other things they also allow students to determine whether they have chosen the "right" career path, to identify areas of clinical work they enjoy or don't enjoy, and to understand the roles speech pathologists take in different workplaces. University programs strive to provide their students with a variety of high quality clinical learning opportunities throughout their degrees.

Clinical education is also the interface between universities and the speech pathology profession. Feedback flows to and from members of the profession and university staff on a range of issues that include the changing nature of the workplace, theoretical advances, new service delivery models, changes to educational approaches and aspirations for the future of the profession. This ongoing dialogue keeps those who chose to participate in clinical education updated with what is happening in universities and the workplace. The dialogue also ultimately benefits students, graduates and employers because graduates are well prepared to enter contemporary workplaces.

Despite the recognised core role of clinical education in the preparation of speech pathologists for the workplace, it is under threat from all sides. Universities are commonly required to justify the expense incurred in sourcing and supporting external clinical placements. Speech pathologists in the field often receive little workplace support for accepting students on placement and as workloads and pressures rise, it becomes increasingly more difficult to accommodate students within an already busy day, week, or month. Partly in response to this, speech pathology university programs have increasingly moved clinical education experiences into on-campus clinics and university financially supported external clinics. This in turn results in more questioning by university leaders about the cost of clinical education in speech pathology. University administrators look across university programs and compare the cost of speech pathology programs with the external internships of engineers who are paid by industry to complete their placements in their company, and exercise and sports science students who find and negotiate their own professional practice experiences.

In this environment of increasing threat from all sides, Heads of Speech Pathology Programs and the then national president of Speech Pathology Australia, Trish Bradd decided that it was timely to take a baseline measure of clinical education experiences across Australia. The baseline will serve as an ongoing measure regarding the percentages of clinical education provided by universities versus external organisations and the proportions of adult, child and mixed placements as well as rural and regional placements. The remainder of this article presents a snapshot of the clinical placements that occurred in Australia in 2005.

The context

Before presenting data about clinical placements in each state it is important to contextualise this information. Table 1 presents the number of Speech Pathology Australia members in each state in 2005 so as to provide a guide to the relative proportions of speech pathologists in each state. The table also presents the approximate numbers of students enrolled in speech pathology degrees (undergraduate and postgraduate) in 2005.

A snapshot of clinical placements in 2005

University clinical coordinators and administrators were asked to supply information regarding the number of weeks of clinical education placements undertaken by their student cohort in 2005. All types of placements including one day or half day per week placements were converted to a total number of weeks involved in the placement. Universities also provided information about where the placements occurred and the type of caseloads that students worked with. This information is summarised for each state in Table 2.

Michelle Lincoln

Table 1. Approximate numbers of Speech Pathology Australia members and speech pathology students by state, 2005				
State	Speech Pathology Australia members	Number of university programs	Approximate number of students	Approximate number of final year students
NSW/ACT	1,124	5 (3UG, 2PG)	620	150
Vic	952	2 (1UG, 1PG)	360	95
Qld	693	3 (2UG, 1PG)	300	75
Tas.	71	0	0	0
SA	198	1 (1UG)	130	33
WA	446	2 (1UG, 1PG)	200	55
NT	27	0	0	
Total	3,511	13 (8UG, 5PG)	1,610	408

Table 2. Placement weeks and portion of placement weeks that occurred in various contexts by state, 2005	NSW/ACT	Vic.	Qld	Tas.	SA	WA	NT	Overseas
No. of placement weeks	2,718	1,742	1,106	23	625	906	40	178
% in Australia	38	24	15	0.3	9	13	0.5	2.5
% of all placement weeks in on-campus clinics or univ.-staffed external clinics	32	23	33	–	26	39	–	–
% of placement weeks in non-univ.-based adult clinics	31	35	27	6	24	33	30	12
% of placement weeks in non-univ.-based paediatric clinics	34	28	30	63	20	20	50	12
% of placement weeks with mixed caseloads	5	21	23	31	28	25	20	67
% of regional/rural placement weeks	20	23	26	31	21	21	40	0

Discussion

A total of 7,338 weeks of clinical placement were completed within Australia in 2005. The number of weeks completed in each state, as expected, is proportional to the number of university programs and speech pathology students in each state. Similarly the number of placement weeks are also in proportion to the number of Speech Pathology Australia members in each state in that those states with more placements weeks generally had more Speech Pathology Australia members. According to Table 2 approximately 30% (range 23% to 39%) of all clinical placement weeks nationally occurred in university clinics or university-staffed external clinics. Approximately 30% (range 24% to 35%) of placement weeks in states with university programs occurred in non-university-based adult placements and approximately 25% of placement weeks occurred in non-university-based child placements. This most likely reflects that university-based placements are more likely to be child than adult placements, hence the need for external child placements is reduced. Fewer mixed (adult and child) placements occurred in NSW compared to other states. Impressively, 22% of placement weeks in those states with university programs occurred in regional or rural contexts.

We recognise that across Australia some speech pathologists provide many weeks of clinical placement each year and some do not provide any. However, if we remove the 30% of clinical placement weeks that occur in university-funded clinics and are provided by a small number of speech pathologists, the remaining weeks of placements equate with 1.5 weeks per year per Speech Pathology Australia member in Australia.

Another interesting way of looking at these data is to compare the number of final year students to the attrition rate of speech pathologists from the profession. Recent work by McLaughlin, Lincoln, Adamson, Pallant, and Cooper (in press) found that 13% of Speech Pathology Australia members intend to leave the profession in the next 12 months. We can assume that this is an underestimation of the true rate of attrition given that attrition is likely to be higher in members of the profession who are not Speech Pathology Australia members. Of the 3,511 members in 2005 we can expect that 456 members might leave the profession. At the same time there were approximately 408 final year speech pathology students nationally. This finding is somewhat alarming as it appears that there will be no real gain in terms of the size of profession. Given overall population increases and an increasingly aged population in Australia, the need for more speech pathologists in the future has been firmly established. This adds another dimension to the pressures on the profession and universities from those discussed above.

Since these data were collected new speech pathology courses have been established at James Cook University in Townsville and Edith Cowan University in Perth. Student numbers have either remained the same or increased in most university programs nationally. In addition the growth of Masters Entry Level programs in speech pathology means that graduates enter the workforce in approximately half the time but still require similar clinical placements to undergraduates in order to meet Speech Pathology Australia's Competency Based Occupational Standards (2001). Consequently, it is likely that the need for clinical placements has escalated in the intervening years.

Speech Pathology Australia and universities used the data contained in the paper along with other sources of information to actively advise and feedback to the Council of Australian Governments (COAG) and the National Health Workforce Taskforce (NHWT) regarding potential needs and new models for funding and organising clinical placements. The Australian federal government in response to submissions from across the health sector chose to attempt to tackle shortages in the health workforce by establishing a National Health Workforce Agency which is proposing to administer and maintain a national database of clinical placements. The database is intended to capture the "capacity" for clinical placements within professional groups as well as the "need". This new initiative will allow ongoing tracking of capacity versus needs for clinical placements in the health professions.

Speech Pathology Australia and universities have a productive partnership that encompasses accreditation, professional development activities, evidence based practice, research, competency assessment of students on clinical placements (COMPASS™) and mutual support. Both parties have a vested interest in ensuring that Australia has a competent speech pathology workforce and that students have access to consistent high-quality clinical education experiences. Baseline measures such as the one presented in this article will allow us to track the impact of any changes on funding or organisation of placements. Finally, a word of caution, this snapshot should be interpreted carefully, given that most of the data are approximates and percentages.

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Adolescent mental health versus child development

A new graduate's perspective of working within these settings

Shannon Walsh

My name is Shannon Walsh and I graduated from the University of Queensland in December 2008 with a Bachelor's degree in speech pathology. I entered the workforce working one day per week at Barrett Adolescent Centre and four days per week at Therapy and Support Service for Children on a six-month contract, which ended in June 2009. This article is a brief account of my experiences working within these settings.

Barrett Adolescent Centre (BAC)

Barrett Adolescent Centre(BAC) is situated in the grounds of The Park Centre for Mental Health in Wacol, Queensland and provides inpatient care and schooling to adolescents with complex and severe psychiatric disturbances. The multidisciplinary team includes psychiatrists, psychologists, social workers, speech pathologists, occupational therapists, dieticians, leisure therapists, teachers, teacher-aides and nursing staff.

The role of the speech pathologist within BAC involves recognising the reciprocal nature of communication abilities and mental health, and integrating this knowledge in the assessment, diagnosis, treatment and maintenance of mental well-being. During my time at BAC I worked with two clients, targeting the areas of pragmatics, receptive language and study skills. We also participated in a community access visit, which aimed to increase the students' confidence and interaction with the public, and I found that this had a carryover effect on their participation in therapy sessions.

Working in mental health emphasised to me more than anything the need for a holistic approach to intervention. The adolescent clients needed high levels of support to develop and maintain mental well-being, and this was a philosophy that I tried to incorporate into their management plans. My time at BAC allowed me to develop clinical skills in an area in which I had no practical experience, and my work there was tremendously rewarding.

Therapy and Support Service for Children

Therapy and Support Service for Children (TASSC) is a division of Child and Family Health Service (CAFHS), located in the Community Health Plaza of Ipswich, Queensland, which provides physiotherapy, occupational therapy and speech pathology services to children with developmental delays and disorders. The speech pathologist's role is to assess and provide intervention for children from birth to five years of age with delays or disorders in the areas of articulation, phonology, fluency, voice, motor speech, language and early feeding.

TASSC has exposed to me a different range of clinical skills, and I now have increased confidence in my ability to manage a reasonably large caseload. The most prominent concept I have learned from TASSC is that no two clients are the same, and that therapy planning should consider the techniques to which the child responds well. I have also found that early success in therapy creates a feeling of confidence for the child, which, in my opinion, has been a strong indicator for positive outcomes.

After graduating from university, I felt reasonably confident in my clinical skills in early speech and language, however working at TASSC provided countless opportunities for learning. The multidisciplinary team works together in a way I had not previously experienced, and I believe this greatly benefits the clients. My time at TASSC was thoroughly enjoyable and I feel fortunate to have had the experience.

Conclusion

As a new graduate speech pathologist entering the workforce I was unsure of the direction my career would take, and as I write this article, I remain unsure. The difference between then and now, however, is that I have had many experiences that will assist me in making career decisions in the future. In addition, the clinicians I have worked with have been role models for their high levels of knowledge and dedication to the profession. I feel a strong sense of pride in the speech pathology profession, and helping people achieve their goals has become more than a job – it is a need that drives my determination to deliver quality speech pathology services. My experiences thus far as a new graduate speech pathologist have been the first steps in what I hope will be a long and rewarding career. I look forward to continuing the journey.

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The clinical education experience in Child and Mental Health Service

Melissa Saliba and Carly Littlewood

Melissa Saliba (top) and Carly Littlewood

Reflections from a clinical educator

WHEN I'D DECIDED TO OFFER A STUDENT PLACEMENT at Adolescent Services Enfield Campus (ASEC), I was excited about the learning opportunities and about being a support for an upcoming professional. I had some of the (probably usual) anxieties about how I would perform in this role; manage my workload; and the possible challenges that lay ahead. Additionally, questions arose, such as: "What kind of experience can our service offer a speech pathology student?"

Child and mental health service (CAMHS) speech pathologists rarely work on speech pathology issues in isolation because we work with complex clients in the context of their mental and emotional wellbeing. At ASEC our clients are generally aged between 12 and 16 and present with a variety of issues, including a history of "failure" socially and academically; school refusal/non-attendance; learning/language issues and exposure to domestic violence. Subsequently, the young people often present with low self-esteem and can present as angry or withdrawn. The clinical placement for the speech pathology student was split between the Port Adelaide Community CAMHS team and ASEC.

Rather than worry about what specific speech pathology work ASEC could offer the student, I began to see that this placement could offer some broader experiences. It could provide opportunities for the student to learn how communication and literacy problems link in with mental and emotional well-being, attachments with caregivers, and connections with broader systems such as schools, and other agencies. I also realised that a student placement in CAMHS offers a great opportunity to increase one's self awareness of work–life balance and emotional well-being.

There were many opportunities to be creative in order to provide suitable learning experiences for the student, such as preparing and running social skills groups, using visual supports, working closely in a multidisciplinary team, working on projects, and managing difficult behaviours. I found that it was important to be organised and open in communication across both clinical educators and the student – what one side of the split placement couldn't offer, the other one could make up for.

In the end, I think the student had a unique opportunity to work with toddlers to adolescents in a holistic way, strengthen her generic skills, and learn to work in partnerships with clients and systems. Lucky for us, this speech pathology student was a very capable and competent person – we wish her all the best for the future!

Reflections from the student

There is a lot of stigma attached to the label of mental illness, such as hallucinations or confinement in observation cells. For me, when I found out I was placed at CAMHS, my first reaction was "How can a speech pathologist help people with mental illness?" My misconception of mental illness was dispelled the first week into my placement. What I had been considering mental illness was only seen in a very small proportion of the clients presenting at CAMHS. The majority of young people at CAMHS did not have psychotic disorders; rather they had complex emotional and behavioural issues. Most young people had a history of physical, emotional or sexual abuse combined with a family history of mental illness. The presentation of the young people's mental health issues ranged from behaviour and anger management difficulties, to anxiety, depression, developmental delays, and social withdrawal.

Frequently, these young people lacked the language skills to verbally express their emotions and therefore resorted to disruptive behaviour or social withdrawal. The role of the speech pathologist is important in teaching the communication skills to allow these young people to express themselves. Speech pathologists also have a role to advise those working with the young people of the best approach to use when communicating with them.

My placement was spread across two distinctly different CAMHS sites, the Port Adelaide community service and the Adolescent Services Enfield Campus (ASEC). During my days at the Port Adelaide CAMHS, there was an element of the traditional speech pathology service, in that I saw clients and their significant others individually once a week for assessment and/or intervention. However, that was as far as the "traditional" element went, as the client's behavioural and emotional issues directed the assessment, goal planning and therapy approach in most cases. For example, I found creative ways to assess the language skills of a client with selective mutism and developed tactics to contain a 3-year-old who was notorious for running away in a therapy room.

On the alternate days, ASEC landed me into a world of contrasts. Each minute was completely different to the next. For example, one day the morning group session was running smoothly and then … the duress alarm rang throughout the whole building, sending all available staff to the location of the shouts. There was confusion and outbursts of abusive language. The glass door was smashed. The young person was very upset and torn between going back to the house where he doesn't even have a bed and staying at the refuge of ASEC where he struggled to control his emotions and behaviours.

Amid the management of behaviour, emotional arousal and critical incidences, I was given many opportunities to develop my speech pathology skills. I learned how to break down the language barriers to communicate with the young people in highly emotional situations. I led social skills groups, administered language and social skills assessments, and implemented voice therapy with a client with schizophrenia.

Within the space of 40 days, I was astonished at the array of clients I managed, programs I took part in, and projects I successfully completed and presented. It was a rollercoaster of emotions for not only the clients but also myself. I am, however, extremely grateful to both my supervisors who provided me with a wealth of knowledge, ongoing support and guidance, and the opportunities to extend myself in such a fascinating area of speech pathology.

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A consumer speaks

Barriers of glass: "Tammy's" story

Future Families is an Infant Mental Health service located in the Children's Health Services District, Royal Children's Hospital Child and Youth Mental Health Service, Brisbane, Australia. Clinical assessments and interventions are provided to infants and their families, where there is concern that the mental health of the infant may be compromised in the context of a disturbed or disordered parent-infant relationship. This is an excerpt from one mum's story. Names and identifying details have been changed.

It is very hard to sit and write this story of mine; avoidance is not so easy when you're staring at your life in black and white! Parts of which I am certainly not proud of, parts that don't even sound like me, instead they could be some delinquent uneducated mother high on drugs thinking the most hideous vile things about her baby. This doesn't sound like me and of course it isn't me anymore, but it's been a long hard road to recovery. I don't take drugs, I am successful and educated, have what I would consider a high sense of morals – in fact the Vatican would think I was a bit over the top! I married for the second time 5 years ago and have a very good relationship with my husband, and our blended family works better than most. My kids go to private schools and I live in a nice area. Oh, did I mention I have bipolar disorder? Life is very interesting when my "famous friends" come to visit – not that they have for a while. Maybe now that I am just Tammy, house wife extraordinaire, they find my life style a little dull, but then I *actually go to sleep* now!! I don't paint fences at midnight by torch or decide to rebuild the bathroom at three in the morning. Not that there is anything wrong with those things, its just not good when "Madonna" is holding the paint bucket and the paint is actually an "invisible force field to keep out the paparazzi!!"

I was diagnosed with manic depression when I was 16 after a lengthy stay at a local hospital. I married at 18 and completed an apprenticeship, all the while having episodes of euphoria, and then downs like you wouldn't believe – curling up in a foetal position in a dark cupboard for hours or sometimes days on end, feeling like my heart had been ripped out and replaced with sorrow and emptiness so black I didn't think I would ever be able to crawl out!! At other times I could work 90 hours a week and spring back for more – when everybody was dead to the world, I was up and running.

When I became pregnant I guess in the back of my mind I knew things wouldn't be ok. I had just gotten used to the idea of being pregnant, when I miscarried and my son was gone. My next pregnancy was fraught with anxiety. When I had my baby, everything went wrong. I started crying with the baby blues after three days and didn't stop for three months. I didn't go out – I spent my entire life cleaning a house which was spotless, putting up signs around the house about washing hands and not going to shopping centres. I didn't drive because we would surely crash, and I didn't want people over anymore lest they discover my terrible secret. I ended up as an outpatient at a private hospital and did an intensive course of CBT (cognitive behaviour therapy). I had a good psychiatrist and tried numerous medications but never gave them more than a week to work, so of course they didn't.

When my son was six months old I discovered I was pregnant with my daughter. I was elated but my husband wasn't and my marriage started going sour. I didn't get PND (post natal depression) after she was born. She was a great baby and life was bliss. Three months later I had to go back to work because we were winding down our business. The kids were up one after the other through the

Bipolar Disorder

Approximately 20% of adults are affected by some form of mental health disorder every year, with bipolar disorder affecting up to 2% of Australians (SANE, 2000). Bipolar disorder is commonly known as manic-depression and is a mental illness that causes unusual and intense shifts in mood, energy, and activity levels which can affect the individual's ability to carry out their day-to-day tasks. The intense emotional states that people with bipolar disorder experience that occur in distinct periods are called "mood episodes". An overly joyful or overexcited state is called a manic episode, and an extremely sad or hopeless state is called a depressive episode.

Sometimes, during a severe episode of mania or depression, psychotic symptoms such as hallucinations or delusions are experienced. These psychotic symptoms usually reflect the person's extreme mood. For example, psychotic symptoms for a person having a manic episode may include believing he or she is famous or has special powers. A person having a depressive episode may believe he or she is penniless, or has committed a crime.

Bipolar disorder often develops in a person's late teens or early adult years with at least half of all cases starting before age 25. It can be difficult to diagnose with the early symptoms appearing to be separate problems rather than characteristics of a larger problem. Whilst bipolar disorder is a long-term illness that must be carefully managed throughout a person's life, it can be treated, and people with this illness can lead full and productive lives.

Further information on mental illness, including bipolar disorder, can be accessed on the following websites:
National Institute of Mental Health:
http://www.nimh.nih.gov/health/publications/bipolar-disorder
SANE Australia
http://www.sane.org

night and eventually I cracked. I became suicidal and sought help. It was surreal. I was seeing ghosts, hearing voices and generally becoming unravelled. I sought alternative therapies such as Chinese medicine and acupuncture. The suicidal thoughts did not stop over the next years and neither did the highs and lows – sometimes hitting me so hard, fast and furious that the depression would hit me at 3 o'clock in the morning or while driving the car and I'd start to sob and couldn't stop.

I've never ever let myself experience pure happiness just in case it came back to hit me in the face or in case I lost what I'd been given, but I did enjoy the lead up to my second marriage. We decided to have another child and both being older parents didn't want to wait too long. I knew what to expect and had explained to my new husband my bi-polar disorder, but I don't think he really understood until he saw it in full swing. Falling pregnant was easy for me, but 10 years really makes a difference. At the 20 week scan we were informed that there were complications. We went for weekly scans, and I needed to monitor my sugar levels 6 times a day. I was already irrational and blowing everything out of proportion so didn't accept this; I only knew that this child was trouble. The barrier of glass was up, the baby boy would be born but if I distanced myself enough I wouldn't be hurt!!! I know that this sounds ridiculous but who understands fully the function of the human brain. Don't think that I didn't want my son – I was just scared to death and this was the coping strategy I have used all my life.

In spite of this, I was eager to meet this little fellow. The birth was beautiful and he was the most beautiful child. When I arrived home everything was initially okay. However, when friends came to visit I could not face them as I was crying so much I couldn't talk, let alone socialise. I couldn't sleep and was up every 30 mins checking on Jonathan, then feeding him for 25 minutes each side, changing nappies then checking again to see if he was breathing . My obsessive compulsive disorder had started and I wandered the house tucking in chairs and straightening anything that was crooked, over and over. Besides that I wasn't nice to live with. I was yelling unnecessarily. I had also started hallucinating – terrible thoughts of harming Jonathan. The visiting midwife knew I was unwell and the next day I had a phone call from the PND unit asking me to come in – I did and stayed for 6 months, coming home every now and again.

My older kids were terrified. Their rock had seemingly flown the coup and they were left with their stepfather. It was a scary time for them. I was white knuckled when I went to the PND unit and was always walking and saying no to medication – using the excuse that I was breastfeeding and my baby wouldn't take the bottle. I was so suspicious and paranoid that I accused the kitchen staff of poisoning the baby food as I thought they had some sort of vendetta against me. When I arrived home, at first I was okay. I was seeing my psychiatrist regularly and taking my medication. When you start to feel good, however, often people think they are well enough to stop their medications, not just people with mental illness, this happens with all sorts of illnesses!

I now also had another agenda, I wanted a playmate for Jonathan. I knew as soon as I conceived. I was petrified but saw my psychiatrist through the entire pregnancy and made sure my diet and exercise were good. Jonathan then became a handful – looking back he had become a toddler. I had so much going on and he began having these night terrors, which became day terrors and which could happen anywhere and any time.

The new baby Cameron was born. He was a cuddly easy going little bub. I'd seen my doctor but was holding off on medication as I wanted to breastfeed. When I started hallucinating again, I rang him and we started medication straight away. After the meds had kicked in, I still had some sort of resentment against Jonathan – why, I do not know, but I didn't feel he was my child. He was difficult and moody and would scream like he was being murdered. I don't think the social worker believed me until she saw a full-blown episode in action. Eventually a case worker suggested the Future Families program and referred my case to this wonderful organisation.

At first progress was very slow. My son was their client, and sometimes I thought I was wasting their time and going nowhere. Getting to know the different staff was hard because of my trust issues, but each one of them let me take my time and I never once felt discriminated against or like a second-class citizen! These people have a perfectly synchronised course that is so subtle that I didn't even realize we were benefiting from it until that mind blowing moment when I actually realized and understood what was going on not just with my son and I but the whole family and I could fix it! I could break this cycle of mistrust and fear.

We went on to what is called the "TwoCan"[1] program to work with a speech therapist who very patiently explained what would happen and how speech therapy would be linked with what we had done so far. Jonathan didn't talk until he was three and his frustration became very apparent. Andrea is a total legend and my son adores her though he wouldn't admit it. She would patiently play with him, gaining his trust and mine, working out where he was at and explaining to me how labelling feelings and emotions are a direct link to behaviour and when I had to take Cameron as well, she took it all in her stride. Andrea taught me how to communicate with Jonathan and understand him, thus making life so much more bearable. After TwoCan we followed on with the PAIRS[2] program where we would learn positive techniques to help with separation issues. This was done with a small group. It included singing and learning to play with our children and then a much-needed break from our children where we could freely chat with other mums with similar issues with their children. We then moved on to the Moving Forward[3] program and that's where I am at the moment.

Have you ever opened your eyes in the morning and embraced the day like it was your last, and felt a sense of peace that seeps into your skin and through to your bones. I love my children; I love all of my children. I enjoy their company even Jonathon, the little gorgeous one. I understand him now, I love it when he talks to me, I marvel at his curiosity, and I do delight in him, as I do all my children. I love them unconditionally and that's what I get back. I have no fear anymore and that big glass wall has broken. It didn't even cut anyone coming down. Life's never going to be easy but I no longer live in fear of the great black dog. I enjoy what I have for now and also my children. With a great deal of help from Andrea, she and her team have saved my life.

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1   *TwoCan*, a Parent-Infant Interaction and Communication Program, developed and written by Andrea Murray, an Infant Mental Health Speech Pathologist with Future Families.
2   *PAIRS* (Parent and Infant Relationship Support) groups were developed by Dr Jan Smith from the Southern Health District in Victoria. Dr Smith's original program was adapted for use in the *Future Families Clinical Program* with her permission.
3   *Moving Forward* are skill-based groups for parents, developed and written by Andrea Murray, an Infant Mental Health Speech Pathologist with Future Families.

Our top 10 resources

Infant, child, and adolescent mental health services

Andrea Murray

SPEECH PATHOLOGISTS WORKING IN CHILD AND adolescent mental health services in Australia work with children 0–18 years and their primary caregivers. Clients of these services may have social, emotional and/or behavioural difficulties, or in the case of babies and toddlers be at risk of developing mental health problems. Many of these children present with severe and complex needs. The following list is by no means comprehensive but rather a compilation of resources used extensively by clinicians in Queensland, Victoria and South Australia. It covers resources for both group and individual work across a range of ages.

1   Clipart, colour printer, and laminator

Clipart is invaluable for designing individualised handouts, visual programs and schemas, and therapeutic stories. These can then be used as a standalone therapeutic tool or to reinforce face-to-face intervention.

2   CYMHS/CAMHS speech pathologists

Speech pathologists in CYMHS/CAMHS are proactive and creative and have designed many innovative resources including intervention programs, handouts and therapeutic stories. Schemas for teaching social skills and problem-solving, handouts to support development of emotional literacy, and a range of therapeutic stories to facilitate management of emotional disorders or to effect behavioural change are among those available. For further information contact Narelle Anger, CYMHS, QLD: narelle_anger@health.qld.gov.au

3   Getting to Know You – Recognising Infant Communication & Social Interaction

This DVD of infants and their parents was filmed and produced by Northern Beaches Child and Family Health Services and NSW Institute of Psychiatry, Australia, (2006). The DVD highlights the ways babies communicate and interact from birth and the importance of the attachment relationship. It aims to help parents recognise infant communication and is a useful tool when working with parents or for use in training other professionals. An extended teaching version which comes with a facilitator's manual is also available. Contact the NSW Institute of Psychiatry on tel: 61 2 9840 3833 or http://www.nswiop.nsw.edu.au to purchase.

4   Baby Talk

by Sally Ward (2000), UK: Random House Publishing; ISBN: 0099297205. Available from http://www.thenile.com.au/books

Dr Ward, a leading British speech pathologist, designed and developed the Baby Talk program to maximise children's learning. This companion book describes child development in an enjoyable and meaningful way. Each chapter is devoted to a particular age group, and includes 30-minute activities to promote the development of speech and language. It's a great therapy resource for speech pathologists working with babies, toddlers and preschoolers.

5   Talkabout – A Social Communication Skills Package

by Alex Kelly (1996), UK: Speechmark Publishing. Available from Speechmark http://www.speechmark.net/pages/store/products

This is an essential resource for running social skills groups. It consists of a comprehensive photocopiable manual which can be used with children and adolescents. Also available is the Talkabout DVD and Activities handbook which can be purchased separately but which are designed to complement the Talkabout resource. The DVD contains acted scenarios to complement social skill programs. The Activities book has practical activities to facilitate discussion or to teach social skills.

6   Children with Emotional and Behavioural Difficulties and Communication Problems

by Melanie Cross, (2004). London & New York: Jessica Kingsley Publishers; ISBN 9781843101352. Available from the publishers http://www.jkp.com/catalogue/speech

This text explores ways children and young people's language and emotional development are linked and considers why behavioural and communication difficulties often occur together. Practical guidelines for identifying and assessing communication problems are provided and a range of strategies for speech pathologists, teachers, and health professionals is given.

7   The Selective Mutism Resource Manual

by Maggie Johnson and Alison Wintgens (2001). Oxon, UK: Speechmark Publishing.

The manual enables teachers or clinicians working with a young person with selective mutism to understand the disorder and it provides practical tools for assessment and intervention. It includes excellent handouts for family and school staff.

8   Hanen Centre programs and publications

Visit the Hanen Centre website: www.hanen.org.

You Make the Difference Parent-Child Interaction program (YMTD; 2005). This is a group program for parents which aims to enhance positive parent–child interaction, thereby facilitating both speech and language development and a secure relationship between young children and their parents. YMTD resources include a DVD and parent handbook.

More Than Words – Helping Parents Promote Communication and Social Skills in Children with Autism Spectrum Disorder (1999). This is a group program for parents which aims to empower them by giving them tools

to facilitate their children's interaction and communication skills.

Talk Ability: People Skills for Verbal Children on the Autism Spectrum – A Guide for Parents. This book targets children aged 3 to 7 years with autism spectrum disorders or social difficulties. It is a practical guide, supported by pictures and examples, to aid parents in understanding how to help their child tune in to others, socialise and develop friendships.

9 Tasks of Problem Solving: Elementary

by Linda Bowers, Rosemary Huisingh and Carolyn LoGiudice (2005), Linguisystems.

This program is designed for students with impairments in language and problem-solving skills. The activities are arranged in a hierarchy and aim to improve expressive language, critical thinking, reasoning, and problem-solving skills. They are designed to facilitate generalisation to a range of settings. The resource contains an excellent number and variety of photographic social and problem scenarios. The pictures are also useful in facilitating social skills, emotional regulation and narrative programming. A CD-ROM is included, enabling activity sheets to be easily printed.

10 Puppets and games

Puppets are wonderful for group work and individuals alike. They are a useful tool to engage children. Puppets can reduce anxiety by taking the focus or attention off the client. Puppets can have personalities, can "take turns" and can express feelings and ideas that may normally be difficult for a child to talk about. Puppets can model skills to be learnt and are great for narrative, storytelling, conversation and role play.

Giddy – "Team member" Future Families Program

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participat10n melbourne 2010

Speech Pathology Australia National Conference

Crown Promenade Conference Centre, Melbourne
Sunday 16 – Wednesday 19 May 2010

Participation 2010 will showcase the innovative contributions of speech pathologists in advancing choices, knowledge and access. The Conference Planning Committee is pleased to introduce the two keynote speakers plus the presenter of the Elizabeth Usher Memorial Lecture.

Keynote Speakers

Carole Pound originally trained as a Speech and Language Therapist and throughout her career Carole has championed the role of people living with aphasia in designing, developing and delivering innovative services, training and resources.

Dr Emma Hayiou-Thomas is from the University of York. Emma's primary research interests are in language and literacy development and their associated disorders. She is also continuing her long term collaboration with the Twins Early Development Study and is currently involved with the Wellcome Language and Reading Project.

Elizabeth Usher Memorial Lecture

Professor Susan Balandin has vast clinical and research experience in the fields of lifelong disability and complex communication needs, as well as in several other areas.

To read more about their background and Conference presentations, please visit www.speechpathologyaustralia.org.au and the 2010 National Conference link.

The full program and online registration will be available from 8 February 2010.
For accommodation, air travel and tours, bookings can be made now at the 2010 National Conference website.

Pamela Richards
National Conference Manager

Burnout in clinicians

Deborah Perrott

"Who provides the therapy is a much more important determinant of success than what treatment approach is provided" (Miller, Hubble, & Duncan, 2008, p. 15).

HIGH JOB STRESS AND BURNOUT AMONG CLINICIANS has become a topic of interest due to its financial impact on communities. Health and community services have undergone changes to health-care delivery models, staff reductions and longer working hours (Sauter et al., 2002). This is parallel to high stress levels which directly affect health practitioners (Michie & Williams, 2003). Stress is a well-established phenomenon. We know that role-stress (conflict or ambiguity of role) (Ortqvist & Wincent, 2009) and coping styles (Ben-Zur, 2009) are determinants of workplace stress. However, little attention has been given to the notion of burnout.

What is burnout?

Burnout is a work-related stress, first observed in human service workers and health care sectors (Maslach, Jackson, & Leiter, 1996) and now recognised in all occupational groups. It is composed of three primary elements: (1) feelings of exhaustion (physical, cognitive, and affective strain), (2) disengagement: distancing from work, work objects (including clients, computers) or work content (providing your service); this is seen as a way of distancing an individual from work, and (3) reduced professional accomplishment or reduced professional efficacy (Peterson et al., 2008). The causation for burnout is multi-factorial including work, lifestyle and personality factors which may overlap with mixed presentation.

Prevention of burnout

An inclusive approach to burnout is recommended. At the individual level, adopting healthy eating, sleeping, and exercise patterns are essential. Learning to understand and manage

Factors contributing to burnout		
Work-related factors	**Lifestyle causes**	**Personality factors**
Working in a high-pressured or chaotic environment	Continuous work tendencies	Perfectionist
Engaging in repetitive work regimes	Poor sleep patterns	Negative self-evaluation and view of others
Expectations of your role are either beyond attainable or unclear	Lack of leisure and relaxation	A need for control
A sense of lack of control with little reward(s)	Poor relationships with limited supports	High achieving and high expectations of self and others
Constant negative feedback		
Long hours of work		
Lack of support/supervision/professional or personal development		

Source: adapted from Smith, Jaffe-Gill, Segal, & Segal, 2008

your stress is critical, along with employing coping strategies. Positive workplace cultures allow optimal functioning. Clarification of your role(s) and attendance at professional development courses allow for new learning and support. Engage in one or several of the following on a regular basis, particularly if you are a clinician working in isolation or mental health: debriefing, individual supervision, group supervision, peer support, mentoring (regardless of your level of expertise).

Summary

Burnout is a reality for clinicians, but preventable by utilising evidence-based skills and strategies. Workplaces are governed by variables so often out of our control. With a greater understanding of burnout, we can empower ourselves, staff, and colleagues to seek reassurance and support. Consequently, we can engage with our clients, and the various roles we undertake, feeling worthwhile and effective as clinicians.

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Deborah Perrott is a speech pathologist and psychologist, and is completing a PhD in linguistics at Monash University. She is a psychologist in private practice and is currently the project officer for Speech Pathology Australia for the review of the position paper *Speech Pathology in Child and Adolescent Mental Health Services*.

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Deborah Perrott

Mental health and stuttering

Lisa Iverach*

Lisa Iverach

RECENT LITERATURE HAS SUGGESTED THAT ADULTS who stutter may be at an increased risk for developing psychological problems (Craig, 2003), yet no previous studies have assessed mental health status in stuttering populations. Therefore, the Australian Stuttering Research Centre has undertaken a program of research aimed at investigating the psychological impact of stuttering, including the assessment of mental health disorders among adults who stutter.

Assessing mental health

In order to assess mental health status, adults who stutter completed a battery of psychological measures during their initial assessment for speech restructuring treatment,[1] including: (1) Composite International Diagnostic Interview (CIDI-Auto-2.1) (World Health Organization, 1997); and (2) International Personality Disorders Examination Questionnaire (IPDEQ) (Loranger, Janca, & Sartorius, 1997). The CIDI-Auto-2.1 is a standardized computer interview designed to comprehensively assess and diagnose mental health disorders according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association, 2000) and the *International Classification of Diseases* (ICD-10) (World Health Organization, 1993). The IPDEQ is a self-report measure designed to screen for nine ICD-10 personality disorders. Both measures were used to screen for mental health disorders in the Australian National Survey of Mental Health and Well-Being (ANSMHWB) of 10,641 adults.

Prevalence of anxiety disorders

In an initial study (Iverach, O'Brian et al., in press), the rate of anxiety disorders among 92 adults seeking treatment for stuttering was compared with the rate for 920 age- and gender-matched controls from the ANSMHWB. Adults in the stuttering group were found to demonstrate six to seven-fold increased odds of meeting criteria for a diagnosis of any ICD-10 or DSM-IV anxiety disorder, as well as 16 to 34-fold increased odds of meeting criteria for a diagnosis of social phobia. This high prevalence of anxiety disorders was unexpected, and indicates the potential for adults seeking treatment for stuttering to experience debilitating anxiety. It also corroborates previous evidence of a high rate of social phobia among adults who stutter (Stein, Baird, & Walker, 1996).

Mental health and treatment outcome

In a further study (Iverach, Jones et al., 2009), the presence of mental health disorders, including anxiety, mood and personality disorders, was assessed among 64 adults seeking treatment for stuttering. Post-treatment outcomes, including stuttering frequency (%SS) and situation avoidance, were significantly worse for adults with mental health disorders when compared with those with no mental health disorders. In fact, only those adults without a mental health disorder maintained treatment gains for six months. These results indicate that treatment outcomes are less successful for adults who stutter who have mental health disorders.

Clinical implications

This is the first body of research to show that stuttering is associated with a greatly increased risk for a range of mental health disorders, including the potential for these disorders to significantly impact the ability to maintain fluency after speech restructuring treatment. These results highlight the importance of addressing mental health disorders in combination with speech treatment in order to facilitate the best possible outcomes. They also suggest future lines of research for improving treatment responsiveness and reducing relapse.

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1 Participating research sites included: (1) Australian Stuttering Research Centre, The University of Sydney; (2) School of Human Communication Sciences, La Trobe University; (3) Discipline of Speech Pathology, The University of Sydney; (4) Department of Linguistics, Macquarie University; (5) School of Humanities and Social Science, University of Newcastle; (6) Royal Prince Alfred Hospital, Sydney; (7) Stuttering Treatment and Research Trust, Auckland, New Zealand.

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The Toddlers Without Tears study

Jordana Bayer

BEHAVIOUR AND EMOTIONAL
problems affect 1 in 7 Australian children
(Sawyer et al., 2000). These problems
include aggression, disobedience, anxiety,
social withdrawal and depression. Around
50% of preschool children's problems
continue through the childhood years
(Campbell, 1995). The Toddlers Without
Tears program aims to prevent children from developing
behaviour and emotional problems (Hiscock, Bayer, & Wake,
2005). This program of research for young children's mental
health, led by Dr Harriet Hiscock and Dr Jordana Bayer,
comprises a multidisciplinary team of psychologists,
paediatricians, a biostatistician and a health economist.[1] This
research is supported by the Australian Research Council,
Australian Rotary Health, Equity Trustees, National Health
and Medical Research Council, and Telstra Community
Development Fund.

In 2004, 733 families with 7-month old babies enrolled in
Toddlers Without Tears across six Victorian local government
areas (Bayer, Hiscock, Morton-Allen, Ukoumunne, & Wake,
2007), representing 69% of all eligible babies at maternal
and child health centres in these areas. In 2005, half of the
families in each area were invited to parenting groups when
their children were 12 and 15 months old. In 2006, half of
these families were offered an extra parenting group when
their child was 2 years old. All parents in the study were
invited to fill out questionnaires at child ages 7, 12, 18, 24
and 36 months. Parents' response rates have been high,
with 96% completing the questionnaire at 12 months, 92%
at 18 months, 89% at 24 months, and 80% at 36 months.

When all children turned 2 years old, results showed that
families who had been offered the parenting groups used
less harsh discipline with their young children (e.g., yelling
and smacking) compared to families who weren't offered this
program. They also had a better understanding of what is
normal for young children's behaviour (Hiscock, Bayer, Price,
Ukoumunne, Rogers, & Wake, 2008). However, we believe
this parenting program was too brief, because the parenting
benefits faded out by the time children turned 3, and the
program didn't impact on child behaviour problems.

Evaluation of questionnaire data from infancy through to 3
years identified contributing factors to the development of
behaviour problems over time. Results showed that toddler
and preschool children were more likely to develop behaviour
problems in families where parents felt stressed, and used
yelling and smacking with young children. Children were more
likely to show early emotional problems when their parents
felt anxious or stressed too (Bayer, Hiscock, Ukoumunne,
Price, & Wake, 2008). We believe that the Toddlers Without
Tears program needs to do more to support parents feeling
stressed and anxious with children who are showing early
signs of behaviour and emotional problems. Most parents
(85%) reported the parenting groups were useful and helpful
with their children; 89% said they would recommend the
program to other families (Hiscock et al., 2008).

A new study was funded for 2009–14 to improve the
program. In the new study more strategies have been
added for parents to manage feelings of stress and anxiety
and to practise new positive parenting skills to reduce early
behaviour and emotional difficulties. This new randomised
controlled trial involves nine different local government areas.
The trial will provide the Toddlers Without Tears parenting
groups as well as extra family support for those under most
stress. The new study aims to show whether early childhood
mental health problems can be prevented
more effectively and cost efficiently by offering
prevention universally (to all families), or
targeting prevention only to families at
highest risk (Mrazek & Haggerty, 1994).

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Around the journals

Expanding the ports of entry for speech pathologists working in mental health

Geller, E., & Foley, G. (2009). Expanding the "Ports of Entry" for speech-language pathologists: A relational and reflective model for clinical practice. *American Journal of Speech-Language Pathology*, *18*, 4–21.

Melanie Hall

This article outlines an expanded framework for clinical practice in speech-language pathology. Specific mental health constructs are described and their application in traditional and contemporary models of clinical practice is discussed. Two case scenarios are presented to compare and contrast these approaches. The article focuses on young children with language impairment but the authors state that the mental health principles described can be applied to clinical practice with clients and families with different types of communication disorders across the life span.

The authors introduce the notion of "ports of entry" which refers to the intervention approach that is employed to gain access into the client's psychological or linguistic system in order to target particular goals. They state that speech pathologists often work on the observable patterns of behaviour of the child or parent and that this port of entry can be characterised as working from the outside in. In contrast, some practitioners in allied disciplines use a port of entry which involves working from the inside out. This approach focuses on understanding the parent's internal feeling states, and representations of his or her child, and how these affect the developmental growth of the child. While this port of entry is more often seen in psychodynamic and relationally oriented interventions, there are some contemporary language intervention programs that emphasise aspects of relationship-based practice.

The specific mental health constructs presented in this article include: attachment theory, working dyadically, reflective practice, transference–counter transference, and the use of self. Discussion of these principles is comprehensive and includes insights from other authors. Speech pathologists are encouraged to create a therapeutic environment that slows down the clinical process and allows time for observation and careful thought.

This article invites speech pathologists to enhance their interventions by expanding the ports of entry. As well as educating parents about development and growth, and assessing and developing skills (working from the outside in), therapists can pay attention to the less visible forces at play (working from the inside out), be mindful about the experience for the client and the family, be aware of their own responses and reactions, consider the therapeutic relationship and highlight the strengths and capacities of each parent–child relationship. This article is relevant and thought-provoking and may inspire others to further investigate mental health models and interventions.

Autism spectrum disorder assessment needs to consider factors other than social-communication deficits

Brian, J., Bryson, S. E., Garon, N., Roberts, W., Smith, I. M., Szatmari, P., et al. (2008). Clinical assessment of autism in high-risk 18 month olds. *Autism*, *12*(5), 433–456.

Vivien Williams

The prevalence and severity of autism spectrum disorders (ASD) makes them a health care priority which has recently been financially acknowledged by both state and federal governments in Australia, with the introduction of significant funding for diagnosis and early intervention. This longitudinal study explored the application of the authors' own scale – The Autistic Observation Scale for Infants (AOSI) in combination with the ADOS (The Autism Diagnostic Observation Schedule) in diagnosing ASD in infants aged 18 months. The AOSI is a semi-structured observational measure with standardised activities using a variety of toys. Participants included a risk group of infants (155 siblings of children already diagnosed with ASD) and compared these with a control group (73 infants). These infants were then assessed again at age 3 using the ADOS.

This study identified a number of behaviours present at 18 months which predicted a diagnosis of ASD at 36 months. These included those from the social and communication domains, such as eye contact and shared enjoyment, and also from the behavioural domain. Items unique to the AOSI which emerged as good predictors of ASD included over- or under-reaction to objects and motor difficulties (impacting upon overall fluidity).

The authors concluded by stressing the value of considering social-communication deficits as well as temperament and motor control when assessing toddlers for early signs of autism. They emphasised the importance of early screening as well as the need for early initiation of intervention, even if a diagnosis is not confirmed.

Risk and protective factors for mental health of refugee children

Crowley, C. (2009). The mental health needs of refugee children: A review of literature and implications for nurse practitioners. *Journal of the American Academy of Nurse Practitioners*, *21*(6), 322–331.

Catherine Quin

This article explores the literature regarding the mental health needs of refugee children settled in the US and practice implications for nurse practitioners. The three commonly cited phases of the refugee experience (premigration, migration, and postmigration) and the associated stresses of these phases are outlined. The author highlights that much of the research about children and young refugees focuses on mental health problems rather than on "resiliency". Questions about the applicability of western psychiatric classifications to a diverse refugee population and the view

that refugee children and young people's responses to extremely adverse situations may be normal are also raised.

It is suggested that the child and adolescent refugee population has high rates of poor psychological outcomes, including depression, anxiety, and post-traumatic stress disorder, but the reported rates vary across different studies. Some studies reviewed in this article argued that, despite these poor psychological outcomes, many of the refugee children functioned well at school in their new country and demonstrated resilience during all stages of the migration process. A positive relationship with at least one parent and environmental support from teachers are identified as protective factors for positive mental health outcomes. Risk factors for poor mental health outcomes included separation from caregivers, combat experience or inability of parents to cope with stress. The author discusses the importance of supporting families in the early stages of resettlement and discusses four types of interventions to address mental health needs.

Investigation of risk factors for mental health problems in preschool children

Robinson, M., Oddy, W. H., Li, J., Kendall, G. E., DeKlerk, N. H., Silburn, S. R., et al. (2008). Pre and postnatal influences on preschool mental health: A large-scale cohort study. *Journal of Child Psychology and Psychiatry*, *49*(10), 1118–1128.

Kate Desborough

This article investigates risk factors for mental health problems among pre-school children. The authors utilised behavioural data from the Western Australian Pregnancy Cohort Study to examine a range of antenatal, perinatal and postnatal risk factors and their influence on problem behaviours in early childhood. The multiple risk factors for childhood behavioural problems were analysed together within a prospective pregnancy cohort to eliminate issues of bias, reliability and validity.

Almost 2,870 children were available for longitudinal follow-up, with 69% of children participating at 2 years and 76% participating at 5 years of age. Research data were collected at 18 and 34 weeks gestation, at birth, and at 1, 2, 3 and 5 years of age. Child mental health was assessed using the Child Behaviour Checklist (CBCL), which provided measures of overall behaviour in addition to internalising and externalising behaviours.

Results indicated that multiple stress events, such as smoking, ethnicity, and economic hardship during pregnancy were significant antenatal risk factors for child mental health. Lower gestational age and male gender, as well as the presence of "baby blues" in mothers postnatally were found to indicate greater risk of mental health morbidity. Some protective effect on children's mental health status included having more siblings and access to breastfeeding for longer periods. These results provide a greater understanding of the determinants of child mental health problems and highlight the need to intervene in the antenatal, perinatal and postnatal periods to support positive mental health in early childhood.

Childhood predictive factors in adult depression

McCarty, C. A., Alex Mason, W. A., Kosterman, R., Hawkins, J, D., Lenguna, L. J., McCauley, E. (2008). Adolescent school failure predicts later depression among girls. *Journal of Adolescent Health*, *43*, 180–187.

Angela Clarke and Camille Vickerson

This article outlines a study that traced the origins and permutations of depression in 808 participants from age 10 to 21. Participants were mainly from low socioeconomic and high crime areas, and almost half the group came from single-parent homes. The retention rate to age 21 was 95%.

The authors selected a "cascade" model to map factors that may contribute to adult depression. This model proposes that a dysfunction in one domain of adaptive behaviour spills over to influence another domain and so on. The potential depressive factors that were initially considered were depression, low school achievement, and social and conduct problems at the age of 10. The authors assessed maladaptive factors evident in adolescence, including school failure, delinquency, and social problems, and determined their contribution to a major depressive episode (MDE) in early adulthood. Questionnaires were used as assessment tools.

The cascade effect for depression was found in girls but not in boys. For girls, depression and low academic achievement at age 10 predicted poor schooling in adolescence, with high school failure leading to MDE at age 21. However, the cascade model did not explain the findings that, for girls, conduct problems at age 10 directly correlated with MDE at age 21. For boys, early childhood factors were predictive of maladaptive adolescent behaviours such as school failure, delinquency and social problems – but these did not contribute to MDE at age 21.

The authors proposed two possible explanations for the identified gender differences in the risk for depression. As conduct problems and school failure are relatively atypical and less accepted for girls than for boys, when present they may signal more impaired functioning and hence have more severe consequences. It is possible that both boys and girls with conduct problems and school failures have vulnerability. However girls become more prone to internalising problems while boys' vulnerability manifests more broadly in externalising behaviours, substance use, etc.

In contrast to findings from other studies, the authors did not identify a link between early social problems and MDE in adulthood. The study also found no link in boys between early conduct disorders and MDE in adulthood, even though many studies have found early conduct problems in boys to be predictive of later depression.

From a speech pathologist's perspective, a major limitation of this study is that there was no investigation of the role of language impairment on the development of depression, low academic achievement, conduct problems or social problems. The authors only broadly acknowledged this by suggesting that alternative constructs or measures could account for the relationship between poor adaptation in childhood and adolescence, and depressive symptoms in young adulthood.

Speech pathologist to mental health clinician in paediatric oncology

Diana Russo

Diana Russo

I AM A CLINICIAN WITH MANY YEARS OF EXPERIENCE as a paediatric mental health speech pathologist and as a child and adolescent mental health clinician. At the commencement of 2008 I took on the challenge of providing a mental health service to paediatric oncology, at Southern Health's Monash Medical Centre in Melbourne. This position at the Children's Cancer Centre (CCC) was funded for three sessions a week by the Kids Oncology and Leukaemia Action Group (KOALA). KOALA is a philanthropic group formed in 1992 and is run by parents and carers for children who are, or have been, treated for cancer.

The CCC previously had input from the Child and Adolescent Mental Health Service (CAMHS) consultation liaison team but was keen to create a dedicated mental health paediatric oncology position to provide support to current patients in addition to consultation and liaison. They also wished to provide case management for the children and adolescents including those in remission and those siblings needing psychosocial support. The position was integrated into the medical team with the support and expertise of CAMHS. As the mental health clinician, I provided a key role in supporting the medical team and children of the CCC. Close working relationships exist with the CCC nurse coordinator, social worker and allied health team, which includes a music therapist and procedural pain therapist. I often worked jointly with all members of the allied health team. Most intervention consists of consultation and liaison with team members. When more support is needed, the children and their families receive comprehensive psychosocial assessment and case management.

Referrals are spread across the age range with the majority of referrals for children under 5 years. Referrals of children in active treatment are taken from all members of the team but discussed with the social worker who meets with all families in active treatment and acts as the first point of call for most children. Often children in active treatment have issues with procedural pain, compliance, behavioural issues, adjustment, anxiety or depression. For example a young boy was referred for ongoing sadness and lack of interaction and engagement with the medical team when attending appointments, and a 3-year-old child was referred who did not respond to distraction techniques when undergoing procedures causing great distress to the child, his mother and the nursing staff.

For children in remission, referrals come from the medical staff and are not known to the rest of the team so are taken on directly. These children are often referred with issues around behaviour, anxiety and depression post treatment. For example the child who was struggling with the return to school where he had lost his place as the "smartest kid in the grade" and with fitting back into "normal family life" where he was no longer "special". These issues were causing behavioural issues at school and at home. Another adolescent was referred 12 years into remission

for depression and anxiety following major trauma for her and her family around her original diagnosis and treatment. After a year of treatment her mother commented that her daughter lost her smile at 4 years of age but now has it back!

The most common type of leukaemia in children and at the CCC is acute lymphoblastic leukaemia (ALL). Current treatment is very successful; however, some children relapse or move into palliative care. Referrals for psychosocial support for these children and their families are also made with an additional role being to support team members. Referrals are also accepted for siblings' issues around loss, grief, anxiety and depression. One young girl, a sibling of an adolescent, was referred for her apparent "withdrawal from school and family life" following her sister's relapse, with the fear she could die.

A major part of the position is the prevention and promotion of mental health during treatment for a significant medical illness. The most difficult group to engage are those in active treatment as children and families do not have the emotional space at that time to deal with emotional issues. A lot of "holding of issues" is done with this group as engagement tends to be better post treatment once children are in remission. Therefore, it is essential to maintain links throughout the two years of treatment to engage children and families if and when they are ready.

As a communication specialist, I think about my mental health clinician work from a communication perspective. For example, children and families are initially engaged with "telling their story", the narrative component of the journey. Communicating what has happened is also important for the child and family as a therapeutic tool to help them process where they are at and assist me in treatment planning. It is important to give space to listening to the child and family about their journey at various stages. At initial diagnosis, grief, fear and trauma are explored. At remission the loss of the close intense relationship with staff comes to an end and is worked through. Topics discussed might include how the child and family get back to normalcy; how the child slots back into life after being absent from school, from peers, and from family. As the mental health clinician it is important for me to be available to hear how the young person and the family are managing and to respect when they are ready to communicate. Often my role with the children involved understanding what the children needed to communicate to their families and the medical team but they couldn't say in person.

The procedural pain therapist provides diversion strategies for children undergoing procedures. In consultation with the child and family a plan is devised where the child has some choice in how procedures are delivered. I found a significant benefit in using therapeutic stories. Hospitals are scary places; the child is in pain, subjected to painful procedures and exposed to scary looking equipment. Parents are also

worried and it is difficult for them to explain to their children what is going on. Working with the procedural pain therapist, therapeutic stories were written for procedures. For example, for one child who refused to have a CAT scan, a therapeutic story successfully assisted and prepared the child and the family by explaining what a CAT scan is and what would happen.

It is also essential to give siblings space and an opportunity to talk to someone. They may be worried about their ill brother or sister but feel unable to share this with their parents. Being a conduit back to the family is important. For example, the toddler who is suddenly left with grandparents because the parents are in hospital with her baby sister who has a tumour starts to have major separation anxiety from her parents. I also have a role in recognising what is normal sadness and what requires more psychosocial intervention.

I believe my communication specialist background provided complementary skills for my role as a mental health clinician that in turn benefited children and families at the CCC. Such a role, while greatly satisfying, is emotionally

very challenging so I have now moved on. I consider myself as privileged to have had the role in the CCC, working alongside the incredible medical team and sharing such a personal journey with these children and their families.
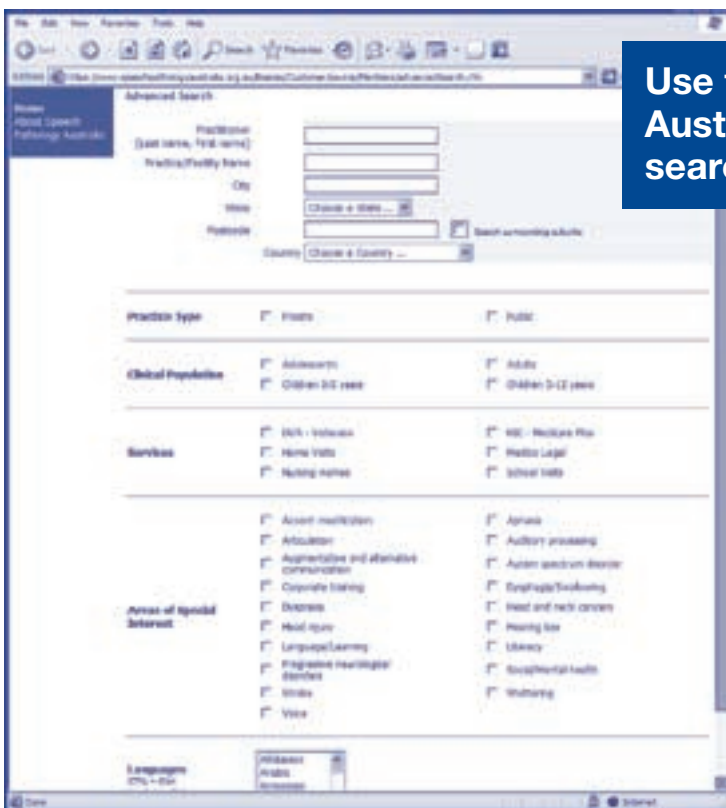
Diana Russo has experience as a paediatric speech pathologist in early intervention and education but her major work experience has been in child and adolescent mental health. She has a Masters Degree in Health Sciences (Infant & Parent Mental Health) and a Graduate Diploma in Mental Health Sciences. She is currently the senior speech pathologist and a mental health clinician at Southern Health CAMHS in Victoria.

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Speech pathology resources

Goodwin, J., & Prince, A. (2005). *MagneTalk Match-up Adventure Kit (with barrier)*. Greenville, SC: Super Duper Publications. $109.00; www.brainstormed.com.au

Nicole Watts Pappas

The Magne Talk Match-up Adventure Kit is a commercially produced set of barrier games for use with children from 3 - 9 years of age. The feature that makes this resource particularly motivating for children is its use of colourful magnets as the items to be manipulated. The kit includes five different scenes: 'camping', 'grocery store', 'outer space', 'under the sea' and 'picnic'. The kit includes a collapsible magnetic stand which can also be used as a portable white board. Both the barrier game stand and the adventure kit are sold with handy carry bags, so whilst the resource is bulky, it is easily transported.

The adventure kit includes a reproducible workbook that outlines activities for each of the scenes. The activities focus on a number of different language skills including: vocabulary (receptive and expressive), basic concepts (e.g., take the fish <u>out</u> of the stream), rhyming (e.g., Do boat and coat sound the same?), deductive reasoning (point to/name the animal that has feathers and flies in the air), auditory memory and storytelling, and categorising (which things go in the water?). Many of the activities can be adjusted to allow the child to work on either following or giving directions. The workbook also includes ideas for extension of the activities.

The activities can be used in a number of ways: a) with one adult giving directions to a child, b) with one child and one adult giving directions to each other whilst using identical scenes and magnets on opposite sides of the barrier stand, c) with two children using the barrier stand and, d) with a group of children directed by an adult using photocopied versions of the materials. The reproducible worksheets in the workbook are appropriate to be given to parents as a take-home activity, thus extending the learning from the therapy session to home. The workbook is also provided on a disc in PDF format so the individual worksheets can be printed out as well as photocopied.

Some of the scenes and activities contain vocabulary that may be unfamiliar to Australian children such as 'cooler', 'soda' and 'shopping cart'. However, the worksheets could easily be modified to include Australian terms for most of these items. Overall, the kit is a useful tool for language therapy that is appealing to children and includes good resources for home follow-up.

Harper-Hill, K., & Lord, S. (2007). *Planning to learn: Creating and using a personal planner with young people on the autism spectrum*. Suffolk: Printwise (Haverhill). ISBN 978 1 84310 5619; pp.160. $51.95; www.footprint.com.au.

Beverley Joffe

Young people on the autism spectrum stand to benefit from assorted practical strategies described in this book. The many useful suggestions highlight, in a user friendly way, how to help such young people learn functional skills to deal with a variety of situations.

There is valuable advice on ways to reduce tension in situations and thereby reduce disruptive behaviours related to inflexible responses. Logical coping devices are recommended such as becoming aware of physical sensations and actively using breath, exhalation and touch. These are explained and supported by cue cards and short helpful, 'visually rich' messages. Demonstrations of individualized planning and sheets for photocopying are included. Aspects of the material are portable.

The clear manner in which the book is written, (including uncomplicated grammar, informal phrases and manageable chunks of information to process, together with a consider-able number of uncluttered line drawings), is likely to assist in understanding and imparting particular concepts. Many of the ideas shared by the authors in this important workbook appear to have been put into action in actual settings.

Notwithstanding sparse coverage of theoretical issues in this book, the authors have accomplished much in producing such a constructive resource to guide young people with autism and their caregivers in taking a proactive approach to being prepared for and dealing with real life challenges. The book also offers meaningful insights, as well as worthwhile and sensible ideas, for professionals and students working with people with autism.

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ACQuiring Knowledge in Speech, Language and Hearing is a major publication of Speech Pathology Australia and provides a professional forum for members of the Association. Material may include articles on research, specific professional topics and issues of value to the practising clinician, comments and reports from the President and others, general information on trends and developments, letters to the Editor and information on resources. Each issue of *ACQ* aims to contain a range of material that appeals to a broad membership base.

ACQ is published three times each year, in March, July and November.

Issue	Copy deadline (peer review)	Copy deadline (non-peer review)	Theme*
July 2010	8 December 2009	4 March 2010	Working with Families
November 2010	15 April 2010	1 July 2010	Syndromes, Accessible Healthcare Environments
March 2011	3 August 2010	15 October 2010	Language Disorders

* articles on other topics are also welcome

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