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Case management of young children with behaviour and mental health disorders in school

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Abstract

When young children with behaviour and mental health disorders do not receive appropriate specialised support their problems can escalate over time. Their parents find the transition to and early years of schooling stressful and difficult. This paper argues that case management can be an effective strategy for this group of children. Although there is a body of literature on the topic of case management in schools, most of it supportive of this as a strategy, the bulk of the literature consists of policy discussion and anecdotal evidence; there is very little research in the area. This is especially true of the critical area of early childhood and the transition to and early years of schooling.

Key Words

Preschool, School, Case Management, Behaviour Disorder, Mental Health Disorders.

Word Count 6,306

Case management of young children with behaviour and mental health disorders in school

Background

Educating children who are at risk because of behaviour and mental health problems is an important issue. In Australia there is a commitment from educators, from individual teacher to school and public policy level, to support young children with behavioural and mental health disorders (NSW DET Student Services and Equity Programs, 2000; NSW DET, 2009). Unfortunately, this group of children continues to have very poor social and academic outcomes (Bradley, Doolittle & Bartolotta, 2008; Larmar, 2008). There is a growing body of research showing that the most promising school-based interventions reach beyond the classroom to families and peers (Hoagwood, Burns, Kiser, Ringeisen & Schoenwald, 2001; De Jong & Griffiths, 2008; Larmar, 2008).

It is challenging for schools to help children with behaviour and mental health disorders reach a level of academic competence and control over their behaviours. This issue is worth addressing, as longitudinal studies have shown that, without support, children's behavioural/mental health disorders persist over time and often with increasing severity (Malmgren & Meisel, 2004). The association between such problems and later social and academic failure has been made by researchers in education and mental health (Brame, Nagin & Tremblay, 2001; de Jong, 2005b; Larmar, Dadds &Shochet, 2006).

Lack of support for and/or interventions with these children can mean they develop short- and long-term problems. In the short term they are likely to interfere with the learning of other children, disrupt teachers and class instruction, and often demonstrate aggressive, confronting and unsafe behaviours. In the long term, they have reduced high school completion rates, experience poor employment outcomes, are more likely to become involved with juvenile justice system, become involved in substance abuse, and have mental health problems (Wagner, Kutash, Duchnowski & Epstein ,2005; Wagner, Kutash, Duchnowski, Epstein &Sumi, 2005).

Since children with these disorders commonly engage in rule-breaking, and anti-social and aggressive behaviours, they are likely to be treated as school discipline problems and subjected to behaviour management measures rather than being provided with needed services (Forness, Kavale, MacMillan & Asarnow, 1996). Children with behaviour and mental health disorders come to the attention of mental health services later than any other group. That is, they tend to be older than other special needs groups in spite of demonstrating troubling behaviours at a very early age (Hayling, Cook, Gresham, State & Kern, 2008). This late identification makes helping the child and their family more difficult because the disruptive behaviours become routine (Malmgren &Meisel 2004).

Researchers investigating behaviour and mental health disorders with 145 children from Grades 1–12 found that risk factors rarely occur in isolation and more often tend to cluster (Gutman, Sameroff &Cole, 2003). Children often experience recurring stressors, or risks that that are multi-factorial in nature. If left without intervention, the conditions often become worse (Fraser, Richman & Galinsky, 1999; Gutman et al., 2003). In analyses of multiple risk factors, it is has been found that a single environmental risk factor does not increase the probability of a behaviour or mental health disorder, but rather that a constellation of risk factors or the strength of the cumulating stressors contribute to increased problems (Masten et al., 1999; de Jong, 2005b).

Similar findings were made by Caughy, Nettles & Campo (2007) in a study that examined the impact of community characteristics, and parent/child relationship characteristics, on the behaviour and school adjustment of 362 children in their first year of school. The study used structural equation modelling to estimate the effects of community and parental characteristics on child outcomes. Results indicated that adjustment to school is influenced by a complex interaction between the family and community (Caughy et al., 2007).

Young children identified with behaviour and mental health issues often have relationship problems and aggression. Children who demonstrate early onset physical aggression are more likely to demonstrate adolescent high-level physical aggression (Brame et al. 2001; Broidy, Nagin, Tremblay, Bates, Brame et al., 2003).

Conroy and Brown (2004) have asserted that children with behaviour and mental health disorders experience more rejection by peers, increased likelihood of drug abuse, clinical depression and delinquency, and perform poorly at school compared to students with other learning disabilities and their non-disabled peers.

Transition to school and parenting

Transition to school is a challenge for many children. For children at risk of/with behaviour and mental health disorders, the challenges can be greater. In a longitudinal Australian study, Margetts (2009) noted a correlation between early adjustment in kindergarten and later (Year 5) success in school. There was a statistically significant correlation on all the subscales of social skills, problem behaviour and academic competence. Success in this transition from the relatively more supported preschool environment to school is critical to children's ongoing success.

Using a stress scale developed by the researchers, a study of 120 parents of children and young adults (2–17 years) with autism indicated that parents found transitions to different schools and from one year to the next stressful. On a scale of 1–10, with 1 being not stressful and 10 very stressful, the mean for the 120 participants was 7.37 (Newsome, 2000).

The combination of challenging behaviours and transition to school is a time of opportunity and risk. If children with behaviour and mental health disorders can be supported, negative consequences could be ameliorated (Brame et al., 2001; de Jong, 2005b; Larmar et al., 2006). There is evidence that support from health professionals can help. Sanders, Ralph et al. (2008), in an evaluation of a large-scale introduction of a Triple P-Positive Parenting Program delivered in Brisbane, Australia, found a significant reduction in behaviour and emotional problems in children (4–7 years old) whose parents had undertaken the program. They also found that parents were less stressed in their parental role. For the study, parents in Brisbane were used as the intervention group and matched to parents from Sydney and Melbourne who were used as the control. The study used questionnaires and telephone interviews to evaluate the Triple-P program. The trained interviewers telephoned the randomly chosen participants booked into the program before it

began, and again two years later (Experimental group n = 1499 T1 and 1504 T2; control n = 1500 T1 & 1500 T2). The parents telephoned in the second interview were not necessarily the same as in the first (Sanders et al., 2008). Many parents can benefit from education about and the opportunity to discuss their parenting.

A large study such as the one above identifies general trends but is not sensitive to individual differences. Generally, parents respond well to support and training regarding their parenting, but not all parents can take advantage of the resources on offer. Some, whose parenting is complicated by their own mental health problems, relationship conflict, substance abuse, or their inability (because of motivation or availability) may not be able to benefit from parenting programs (Sanders et al., 2008) and need more specific and targeted support if they are to help their young children succeed in school (Tough, Siever, Benzies, Leew &Johnston, 2010).

The parents of children with behaviour and mental health problems often find their children's challenging behaviours difficult to deal with and stressful (Braet, Meerschaert, Merlevede, Bosmans, Van Leeuwen et al., 2009). In a study evaluating the effectiveness of a parenting education program (Parent Management Training) for helping parents manage young children (aged 4–7 years) with anti-social behaviour, results indicated that the parents who did the training had less stress and improved parental skills (Braet et al., 2009). Similarly, a longitudinal study by Cooms-Ronto et al. (2009) found that parenting is a complex interaction between the child and parents which, together with parenting style, impacted on the disruptive behaviours. These studies indicate that, with appropriate and ongoing support, parents can learn to manage the relationship and better support their children's social, emotional and behaviour development so they can handle the demands of school and especially the transition from preschool to school.

Bradley et al. (2008), in a paper that reviewed the literature and data from two longitudinal studies (Special Education Elementary Longitudinal Study (SEELS) and the National Longitudinal Transition Study-2 (NLTS2)), supported by the U.S. Department of Education's Office of Special Education Programs (OSEP) found that, although most children with disabilities have better outcomes than in the early 1980s, children with behavioural/mental health disorders have made only small gains

(Bradley et al., 2008). Some of the contributing factors were: teachers in the US are often not qualified to help younger children with behavioural/mental health disorders; teachers can have a negative and reactive approach; and these children lack social support and change schools more often. Another factor was that there is little united effort to help children with behavioural/mental health disorders (Bradley et al., 2008). It is plausible that the parents of these children have more difficulty negotiating the complex health and education systems.

In Queensland an early intervention program was developed to address the perceived increase in young children's conduct problems (Larmar et al., 2006). A randomised control study evaluated the effectiveness post-intervention and again months after it was delivered. The program targeted young (*n* = 455, aged 4–6 years) children and their families from 10 schools in Brisbane. The schools were matched in pairs on the basis of socioeconomic status and size, and then randomly assigned to the experimental or control group. The experimental group was given the program; the control group received no interventions. Pre-school teachers screened the children at risk of conduct problems. The participating children had no serious physical disorder, developmental disability, or untreated ADHD (Larmar et al., 2006).

The school component of the program focused on developing teachers' skills in helping children in the areas of communication, friendship formation, socialisation and self-control, and was offered in a one-day training workshop. A parenting program held at home included reflection on parents' values, beliefs and experiences; skills in handling authority; child development; communication; rules and limits; parent consistency; reinforcing appropriate behaviour and consequences; problem solving and ownership; assertiveness; managing anger; quality time; and self-preservation. The program was offered over three 120-minute sessions (Larmar et al., 2006). The results of the early impact evaluation lend support for the school component of the program in reducing the incidence of challenging behaviour over time, with the experimental group having significantly reduced challenging behaviours when compared to the control group ($F [2,236] = 4.28$, $p < 0.05$). Teachers were highly engaged in the program. Parents, on the other hand were less likely to engage, with only 34 per cent attending one of the three training program sessions, with very few (percentage not reported) attending the whole program.

There was a significant difference in the father's education level ($F = 5.3$, $p < 0.05$) between the parents who attended and those who did not, with the higher education level associated with more sessions attended (Larmar et al., 2006). Although it appears that this program can be effective, parents need to be engaged in a different way.

Many demands are made on teachers. Their training and expertise is in teaching, not mental health care. They do not necessarily have the time or background to assess, select and implement appropriate behaviour management strategies/therapeutic interventions for children with mental health problems, emotional disorders, or conduct/behaviour disorders etc. (Grossman, 2005).

Case management

Gifford, Wells et al. (2010), in a paper describing a service in North Carolina USA, argued that, when children are struggling in school, underlying causes often include physical or behavioural health problems, poverty, abuse and/or neglect. It was proposed that children with behavioural problems are much more likely than others to have lower grades, miss school, be suspended or expelled, and drop out. Access to needed health and human services is critical for these children's success. The authors' experience was that available services are often fragmented, making it difficult for families to access and utilise them effectively. It was argued that, given their primary role in children's lives, schools are a logical base for such coordination (Gifford et al., 2010). Gifford and colleagues went on to describe a successful program in which nurses and social workers collaborated in case management. Unfortunately, this program was not formally evaluated. Clearly, though, the argument that case management can be helpful is worth further consideration.

To explore the literature on case management, the databases ERIC, Education Research Complete, PsychInfo, Sociological Abstracts, CINAHL, Medline and Pub Med were searched from 1990 to the present. The findings from this search seem consistent with other reviews in this area; there is a body of literature mostly agreeing that case management is a useful strategy. The literature, however, is mostly policy discussion and anecdotal evidence. There is a paucity of research in this domain and thus evidence of effectiveness.

In the Australian context, a review has revealed a limited amount of published literature (de Jong, 2005b). De Jong ran a two-round Delphi Method (Linstone & Turoff, 2002) project to build a consensus on what are the principles and practices of case management in schools. The participants were service professionals from the health and education sectors, and included 15 Australians, five from the US and one from the UK (de Jong, 2005b).

A questionnaire addressed the four key areas identified in the literature review. They included: defining effective case management, establishing a system for effective school case management, principles of effective case management, and strategies of effective case management. There were two rounds of data collection/collation. Thirty-three questionnaires sent out with 21 returns (15 Australians). There was a high level of agreement on 70 per cent of the items in the first round. Only nine people responded in the second round, with a 77 per cent agreement.

The participants in this study agreed that the processes involved in effective case management require high levels of collaboration between all parties. Case management should be guided by five principles: the promotion of the student's health and wellbeing through empowerment and family involvement; an individualised process; maintenance of legal and human rights, privacy and confidentiality; be non-discriminatory; and exhibit culturally appropriate practice (de Jong, 2005b).

Other authors described similar principles for the delivery of case management services, although with a greater emphasis on the individuality of the child and involvement of the family, especially with younger children (Barrett 2000; Farrior, Engelke, Collins & Cox 2000; Reel, Morgan-Judge, Peros &Abraham 2002; Smith & Prelock 2002). Case management also implies a longer-term relationship with the child and family, it is more than crisis management in that it includes health promotion and illness/disorder prevention (Reel et al., 2002). The individual focus of case management may be helpful in getting the parenting support to the parents of children with behaviour and mental health problems.

Gulchak and Lopes (2007) reviewed the literature on interventions with children with behaviour and emotional disorders from outside the U.S.A. They concluded that there was an established body of literature on interventions with children with behaviour and emotional disorders but there was a paucity of actual research on the topic. This was concerning as research reports the prevalence of behaviour and emotional problems at 22 per cent in the U.S.A. As children with behaviour and emotional disorders mature, the research indicates that they have a very high dropout rate (50%) and are often excluded from school (72%), with these obvious difficulties impacting negatively on their lives, their families and schools (Gulchak & Lopes, 2007).

In an opinion piece Barrette (2000) argued that having a case manager can contribute positively to the outcomes for children with special needs. The author, to argue her case, described a project in which a US college implemented a case management program that used student nurses as case managers for part of their clinical practice. The students were allocated a child for the semester and attended meetings with health and welfare services, schools and the families in their homes. Barrette reported a perception that the families valued the rapport developed with the students. Also, having a case manager (even though they were students) meant that there was better coordination between services, that is schools, individual teachers, health care agencies, health care providers and families (Barrett, 2000).

Although not formally evaluated, the C-STARS model for school-based inter-professional case management was, at the time of publishing in the late 1990s, established in 32 schools across the south-western USA (Smith, Oaks, Washington Univ &Teaching of At-Risk, 1992; Smith, Armijo &Stowitschek, 1997; Smith Jr &Stowitschek, 1998; Stowitschek, Smith Jr &Armijo, 1998). The C-STAR model of case management was developed to maximise the opportunities for children at risk of failure in elementary/primary school. It involved partnerships between schools; community-based agencies that serve families and children residing in the schools' attendance areas; and universities responsible for preparation of school and community-based professionals. C-STARS defined school-based inter-professional case management as a series of logical and appropriate interactions within a comprehensive service network of schools, social service and health agencies responsible for the wellbeing of common client populations of children and families. These interactions were aimed to maximise opportunities for children and their

families to receive a variety of needed services in a supportive, efficient and coordinated manner while empowering parents and guardians (Smith, Oakes et al., 1992). Because each school and its community are unique, each case manager developed a plan suited to the individual, school and community.

In the C-STAR program the school-oriented case manager worked with at-risk children, their families and their teachers to identify the types of help needed, support families to identify and overcome barriers to using that help effectively and intervened directly as necessary to overcome these barriers. The case manager connected families and their children with potential help and facilitated and monitored the delivery of needed services in close communication with parents, teachers and other case management team members. This is an interesting model and its use seemed to be expanding at the time of publishing in the late 1990s (Smith et al., 1992; Smith et al., 1997; Smith Jr &Stowitschek, 1998; Stowitschek et al., 1998); unfortunately there is no formal evaluation of the project to provide evidence regarding its effectiveness.

In a study that used structured interviews to explore the practices of 20 social workers acting as case managers of children with behaviour and mental health disorders, Werrbach (1996) found social-work-trained case managers had a variety of approaches to their role. Generally they emphasised empowerment of families with a focus on active partnership between case managers and families and acknowledgement of the families' strengths. In the study the participants were given a case scenario and asked to comment on how they would respond, the data were transcribed and the data analysed for emerging themes. Although this study is small the findings indicated the participants in the study focused on the strengths of the family and worked using a model of collaboration.

A study by Werrbach (2002) described a training program for parent employees of a service that provided case management and wraparound services for children with serious emotional problems. Wraparound service is a term for a model for supporting children with emotional and behaviour problems and involves an intensive case management approach that emphasises aggressive outreach and care that is flexible. It is also child- and family-centred and aims to include all aspects of the child's life in the planning. This study was limited by a lack of description of the method used.

In the evaluation of a Wraparound Care program in Vermont, the authors found case management could be of use (Yoe, Santarcangelo, Atkins & Burchard, 1996). The program aimed to support children and families with severe emotional or behavioural disturbances. The participants were 40 children/young people referred to the program; their ages ranged from seven to 20 years (85% under 18 years, mean age 16). Many were in care outside their homes (78% in substitute care) and were receiving support to stay in school or in special schools (Yoe et al., 1996). After 12 months of case management, the participants were living in significantly less restrictive environments and exhibiting fewer total problem behaviours. There was no significant change in their truancy, contact with police, suicide attempts, or alcohol use (Yoe et al., 1996). Perhaps if the services had been offered earlier, they would have been more effective in helping these young people.

Parents appreciate being part of the process of their very young children's transition to preschool. In-depth interviews in a study that evaluated a model of case management indicated that the parents valued being part of the decision-making process (Appleton, Böll, Everett & Kelly, 1997). Participants in the study were parents of 20 children (2.5–3.5 years) with complex needs. The model used a named case manager, a professional chosen by the family, in its aim to empower the parents. The finding that parents appreciate that case management helped them feel empowered is of interest.

Engagement of parents is critical to the success of any strategy that aims to support children with behaviour and mental health problems. Case management by professional mental health workers can both engage parents and help them develop parenting skills and creative ways to work with their child. A study by Colvin, Lee et al. (2008) evaluated a case management approach referred to as a Partners in Prevention program. There were 606 children aged 4–13 years (mean 8.06) referred for a range of problems that included academic issues, emotional difficulties, social issues, and disruptive behaviours. Most frequent were academic issues, followed by emotional problems which included grief over loss of a parent. Commonly the children referred had more than one of these problems. The model of case management was task-orientated; it focused on changing behaviours that impact negatively on school performance. It aimed to engage the child and parents in the

identification of goals for change. Interestingly, if there is not an agreement on the goal, the final say is left to the child (Colvin et al., 2008). Results indicated a statistically significant improvement on all measures, including school academic results and behaviour as reported by teachers and parents (Colvin et al., 2008).

In Australia approximately one-quarter of the approximately 14 per cent of children with mental health problems receives professional help (ABS, 2007). Because schools have a significant role in the lives of young people, the Australian Guidance Counselling Association and the Australian Principals' Associations Professional Development Council established a national Australian initiative called MindMatters Plus in 2002. It aimed to improve the capacity of secondary schools to cater for students with high support needs in health and wellbeing (De Jong &Griffiths 2008) and to improve mental health outcomes for all children and young people. One of the objectives was to establish case management for adolescents with mental health problems. Further, the Australian Ministerial Council on Youth Affairs established the Student Behaviour Management project in 2003 in response to concerns about discipline problems in schools (de Jong, 2005). The project reviewed behaviour management projects in government and non-government schools across Australia and New Zealand. Only 20 per cent of the programs had any formal evaluation. De Jong concluded there is a lack of 'hard' evidence of what works (2005).

With reference to schools in particular, de Jong (2005; 2005b) highlighted four main reasons case management should be applied in these settings: 1. Case management offers a coordinating mechanism; 2. Case management empowers the student and all stakeholders to participate collaboratively; 3. Case management encourages clearer processes of accountability; 4. Case management contributes to the successful retention of students with high support needs (de Jong & Kerr-Roubicek, 2007).

Conclusions

In Australia there is a commitment from educators, from individual teacher to school and public policy level, to support young children at risk. Schools and preschools have strategies in place to support some children with special needs; for example, children with developmental disabilities and children with long-term physical health

problems. For children with behaviour and mental health disorders, it must be noted that schools and preschools do attempt to support all students, but teachers are not mental health professionals and their understanding and skills are limited. Unfortunately, many of these children's needs are not well met in the early years of schooling. If children with behaviour and mental health disorders are not identified until later grades, then helping them can be much more difficult as their behaviours are more entrenched. Existing school psychologists or counsellors in most states have high workloads and, although usually heavily involved with such students, case management is beyond their role.

The research presented above would suggest that children with behaviour and mental health disorders are likely to benefit from case management by clinicians with expertise in child and youth mental health, and further investigation is warranted. This assertion seems consistent with the commitment of respective departments of education to intervene early with children at risk.

There seems to be a consensus in the literature (although with little hard evidence to support it) that case management should be seen as a long-term commitment to effecting change. It is more than immediate crisis intervention and it should include not only the child but also support for the family, teachers and school, as well as coordinating other services. It is proposed in the literature that school-based case management not only benefits identified children and their families but has a flow-on benefit to society in potentially reducing costs associated with unemployment, ongoing mental health problems, delinquency, and reduced productivity.

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