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Clinical
Guideline

Speech
Pathology
Australia

Speech Pathology in Mental Health Services

The Speech Pathology Association of Australia Limited
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CONTENTS

SUMMARY

- It is the position of Speech Pathology Australia (the Association) that assessment, diagnosis and treatment of communication and swallowing impairments of individuals with, or at risk of, mental health conditions is essential and within the scope of practice of speech pathologists. (Speech Pathology Australia, 2003).

- The Association recognises that speech pathologists play a critical role in mental health services given the high correlation between mental health disorders and communication and swallowing disorders.

- The Association acknowledges that working in mental health is an advanced area of practice. Therefore it is recommended that speech pathologists have knowledge of theoretical and intervention models specific to this area of specialised practice.

- The Association supports speech pathologists' role in prevention and early detection of communication and swallowing problems in mental health services.

- The Association strongly supports speech pathologists providing education and consultancy services to professionals, the broader community, clients and carers to improve the understanding of communication and swallowing disorders in mental health.

- It is essential that speech pathologists work collaboratively as part of a team to aid in the assessment, diagnosis and intervention of individuals in mental health services.

- It is the position of the Association that speech pathologists working in mental health engage in ongoing professional development and seek professional support and supervision as required.

- It is recommended that speech pathologists working in mental health be conversant with the *Mental Health Act* and mental health standards relevant to their state or territory.

- The Association recommends that speech pathologists be recognised as qualified and eligible service providers within specific government funded programs for the prevention and treatment of mental health issues.

1. ORIGINS OF THE PAPER

This Clinical Guideline has evolved from the Speech Pathology Australia Position Paper, *Speech Pathology in Child and Adolescent Mental Health Services (2001*). The expansion of evidence that supports the role of speech pathology in mental health services has been the impetus to update the position paper into this current document. This Clinical Guideline is supported by the Speech Pathology Australia's Position Statement *Speech Pathology in Mental Health Services* (under preparation).

The terms *mental health services* and *mental health settings* are utilised in this paper to refer to any agency involved in the provision of services to individuals with mental health illness or disorders.

The paper aims to (a) improve the understanding of communication and swallowing in the context of mental health, (b) highlight the need for early intervention and prevention programs and (c) outline the role of speech pathologists in mental health services.

This paper has been informed by a National Advisory Working Party (established in September, 2009), current available best evidence (derived from a critical review of both published and grey literature), international position statements, policies, guidelines and consensus opinion.

This paper provides a guide for effective speech pathology practice in mental health services in Australia. The audience for this paper includes:

- speech pathologists;
- mental health services;
- consumer groups;
- service providers and
- researchers.

2. SCOPE OF PRACTICE

It is the position of Speech Pathology Australia that the assessment, diagnosis, and treatment of individuals with a communication and/or swallowing problem in mental health services are within the scope of practice for speech pathologists. The Association recognises that specialist knowledge of both communication and swallowing disorders in mental health is required. Specialist knowledge includes an understanding of the reciprocal relationship between communication, bio-psycho-social development, psychopathology and the impact of adverse psychosocial contexts. Specialist speech pathology practice requires a capacity to:

- evaluate communication and swallowing competence;
- analyse the impact of communication and swallowing vulnerability in the context of psychosocial adversity;
- select management responses relevant to the communication and swallowing needs of the individual;
- achieve improved psychosocial functioning;
- ensure continuity of care around the individual and carer's communication and swallowing needs.

Speech pathologists working in mental health services require a wider knowledge of models of intervention such as:

- behavioural theories;
- cognitive theories;
- cognitive-behavioural theories;
- social-learning theories;
- social skills theories;

- attachment theories;
- trauma theories;
- family systems theories;
- frameworks that draw on psychological/psychiatric theories eg., psychodynamic, narrative and interpersonal theories;
- frameworks that draw on socio-cultural and ethnic and religious studies.

2.1 Assessment

Assessment is a process that ideally involves the speech pathologist in partnership with the individual, their parent(s)/caregiver(s) and other members of the multidisciplinary team. The mental health and views of the parent(s)/caregiver(s) and/or carer(s) need to be taken into consideration in the assessment process.

The aims of the assessment process are to:

- identify the concerns of the individual, parent(s)/caregiver(s) and case manager;
- link the observed communication patterns with the presenting communication problem;
- identify causes or influences in the individual's life which are affecting his/her ability to communicate and/or swallow effectively;
- provide information to assist in differential diagnosis;
- form a comprehensive picture of the individual's communication and/or swallowing functioning to facilitate the development of a management/recovery plan;
- provide a baseline for monitoring changes in the individual's communication and/or swallowing functioning;
- provide information to other members of the team to contribute to the most appropriate form of management and necessary adaptations to traditional mental health interventions;
- determine eligibility for additional funding and/or access to special resources;
- determine which evidence-based treatment approach(es) will be most likely to yield benefit to the individual concerned.

Assessment may take place over a number of sessions within a variety of settings, for example, inpatient, outpatient, community, home or educational setting. Whenever possible, assessment should occur in the most appropriate environment for the individual to optimise accurate data collection and observation of behaviours and performance. The speech pathologist may be required to undertake joint assessments and contribute to the development of a comprehensive case history for the team.

Assessment may utilise both formal and informal tools and include observational data collection, using both formal and informal rating tools. Observational assessment may consider:

- attention;
- impulse control;
- concentration;
- emotional literacy/use of language to support thoughts and feelings;
- play;
- pragmatic awareness and use (both verbal and non-verbal)
- social communication skills;
- interaction with parent(s)/caregiver(s) and clinician;
- parental/caregiver dyad/attachment, interactions both verbally and non-verbally;
- extraneous bodily movements;
- dysarthria;
- dysphagia and/or impaired saliva control;
- Co-morbidities;
- Medication profile.

Formal assessment includes a comprehensive case history and may include specific areas of:

- language expression;
- language comprehension;
- social skills/pragmatic skills (verbal and non-verbal);
- theory of mind development and social cognition skills;
- language/phonological awareness/literacy abilities;
- discourse;
- critical thinking skills/verbal problem solving abilities;
- speech (phonology/articulation);
- voice: volume, fluency, prosody, tone;
- parent(s)/caregiver(s)-child interaction;
- play and imaginative skills;
- oromotor skills and swallowing ability.

2.2 Diagnosis

The speech pathologist's assessment makes an important contribution to the diagnostic process. A comprehensive communication and swallowing assessment will be utilised by a multidisciplinary team to assist with differential diagnosis, and where appropriate classification of psychiatric diagnosis.

2.3 Treatment

The process of intervention also involves an interdependent relationship with the individual, parent/caregiver(s), family and other members of the multidisciplinary team. Intervention is based on a shared understanding of goals and outcomes. Intervention may include:

- consultation with other workers regarding a client's communication;
- interpretation and scaffolding of standard mental health intervention to enable clients who are communicatively impaired or who come from communicatively diverse backgrounds to participate effectively;
- individual therapy;
- group therapy/program;
- parent-child relationship therapy;
- education to parent(s)/caregiver(s) regarding the psychological, behavioural and social impacts of communication disorders;
- consultation to educational personnel (in mainstream, special education, and vocational sectors and at primary, secondary, and tertiary levels);
- suggestions for the individual's educational or vocational setting regarding behavioural or psychological management;
- group programs eg. psycho-educational, skills-based and vocational training;
- programs devised for home intervention;
- case management.

2.4 Education & Consultancy

Speech pathologists play a key role in educating other professions working in mental health and provide consultancy services to the broader mental health system of care. Individuals with language/learning disorders and co-existing mental health problems have particular therapeutic needs. Speech pathologists need to advise relevant professionals regarding an individual's communication profile to ensure interventions are modified appropriately. For example, psychological interventions involve discourse that is language-based and assume comprehension and interpretation of sometimes quite abstract information. Meta-cognitive skills (usually verbal, such as knowing when to initiate communication) and an ability to appropriately respond using expressive language may prove difficult for the child or young person with a communication problem.

Education and consultancy services may be provided to a range of professionals across a diverse range of settings including but not limited to:

- speech pathologists working in mental health settings, specialist child development teams and educationalists;
- other professionals working in mental health settings. eg. doctors, psychologists, youth workers, social workers;
- educationalists at the early intervention, early childhood, primary, secondary and tertiary levels including teachers and assistants;
- agencies that have high prevalence rates of undetected communication disorders e.g., youth justice and detention centres, trauma agencies and child protection;
- agencies that provide services to individuals with mental health issues e.g., Centrelink, refugee centres;
- research students;
- student speech pathologists;
- the general community.

3. PRINCIPLES OF PRACTICE

3.1 Impact of mental health conditions on practice

Speech pathologists have a responsibility to ensure that all services are provided in a manner that is appropriate to the individual's presenting needs and are culturally and linguistically sensitive. In mental health services speech pathologists also need to modify their practice to take into consideration presenting psychiatric symptoms and/or trauma, medications, parental/caregiver(s) mental illness/substance abuse and the beliefs regarding mental illness by cultural groups. For example, mental health in some cultures is externalised as being a reflection of "an evil spirit." Consequently, an understanding of the cultural background and religious beliefs is necessary if effective intervention is to be provided. Please refer to Appendix three for website links on cultural issues in mental health.

3.2 Collaborative Practice

Individuals receiving mental health services frequently require the expertise of a range of professionals. Speech pathologists represent one of many professionals that may contribute to an individual's care. The Association recognises the need for and endorses speech pathologists working collaboratively with team members in the provision of services to individuals in mental health settings.

3.3 Evidence-Based Practice

In order to achieve optimal functioning and outcomes for individuals receiving mental health services individual assessment and management is necessary. Speech Pathology Australia supports and promotes evidence-based approaches to assessment, diagnosis and treatment of individuals serviced by speech pathologists in mental health.

Speech Pathology Australia does not endorse the exclusive use of one intervention type or program. Speech pathologists should be aware of the guidelines for effective, evidence-based practice for individuals and their families in mental health settings. They should draw on empirically supported approaches that meet the needs of individuals receiving mental health services. They should also promote and encourage the development of practice-based evidence.

4. COMMUNICATION AND SWALLOWING DISORDERS AND MENTAL HEALTH

There is an expanding body of evidence demonstrating a strong relationship between communication and swallowing problems and mental health. This growing body of literature adds further support for the involvement of speech pathologists to inform policy making and provide services in prevention programs and mental health services. To advocate on behalf of this client group speech pathologists need to be cognisant of the impact mental health issues have on the client and service delivery models. For example, Bercow (2008) identified that the service provision needs of individuals with life-long communication disorder adds significantly to mental health service delivery costs. Snow (2009a) identified that socially disadvantaged groups in society are at a greater risk for both communication and mental health problems along with the potential for intergenerational transfer of such problems.

To support speech pathologists in their advocacy and knowledge, the evidence demonstrating the links between communication and swallowing disorders and mental health is provided below.

4.1 The correlation between communication disorders and mental health

Longitudinal studies have indicated an increased likelihood of mental health problems in those who initially presented with significant speech/language impairments as a child (Beitchman, Brownlie, Ingliss, Wild, Ferguson, Schachter, Lancee, Wilson & Matthews, 1996; Beitchman, Wilson, Johnson, Young, Atkinson, Escobar & Taback, 2001a; Clegg, Hollis, Mawhood & Rutter, 2005). Giddan & Milling (1999) indicated that children who presented with significant communication disorders at an early age do not typically outgrow their disorders. Studies have also demonstrated a continuing risk from childhood into early adulthood of behavioural, social and emotional problems (Beitchman et al, 2001a; Clegg et al, 2005 and Conti-Ramsden & Botting, 2004). Research studies have demonstrated a remarkably high prevalence of communication impairments in children who present for psychiatric treatment (Caplan, 1996; Cohen, Menna, Vallance, Barwick, Im & Horodezky, 1998) and similarily for adolescents with a psychiatric diagnosis (Clarke, 2006; Perrott, 2010; Perrott, 1998; Segrin & Flora, 2000). A correlation between poor communication profiles and self-harming in adolescents has been demonstrated (Clarke, 2006) and a relationship between adolescent suicide attempts and social-skill deficits has also been found(Spiriro, Hart, Overholser & Halverson, 1990).

4.2 Language impairment and mental health

A prime example of potentially life-long disability is language impairment. The prevalence of language-learning disability (LLD) in children and adolescents is estimated to be between 10 and 15% (Conti-Ramsden, Simkin & Botting, 2006) and is considered a lifespan issue (Nippold & Schwartz, 2002). School-aged children and adolescents with LLD are reported to be at an increased risk for significant academic, social, emotional and behavioural problems. They are also likely to exit school early, often with minimal marketable work skills and little prospect of successful engagement in further education (Starling, 2003). Early receptive and expressive language difficulties have also been shown to be associated with problems of later literacy acquisition, and psycho-social developmental problems (Beitchman et al, 2001a; Catts, Fey, Tomblin & Zhang, 2002; Tomblin, Zhang & Buckwalter, 2000).

Language competence is a variable which can be modified when addressed at the infant, early intervention and preventative stages. Language competence becomes less modifiable and harder to effect as the developmental windows close across childhood and adolescence. Poor language ability and social, emotional and behavioural problems have been correlated with psychopathology and psychosocial problems (Baltaxe & Simmons, 1990; Beitchman et al, 1996; Cantwell & Baker, 1987). Specific populations such as juvenile young offenders have also been found to present with oral language problems (Snow & Powell, 2004a; Snow & Powell, 2004b; Snow & Powell, 2005;

Snow & Powell, 2008) and pragmatic disorders (Sanger, Hux & Ritzman, 1999). Children with language impairment who were followed through to adolescence demonstrated that early experiences of peer group rejection provide negative feedback to the child and affects interactional expectations (Vocci, Beitchman, Bronwlie & Wilson, 2006). The presence of behavioural, emotional and social difficulties in children with speech and language disorders persisted over the eight to twelve year-old period (Lindsay, Dockrell and Strand, 2007). In addition developmental language disorders have been found to contribute to the development of personality disorders in adulthood (Mourisden, Hauschild, 2009). Successful peer relationships have been found to be positively related to a child's pragmatic language abilities (Lindsay, Dockrell & Strand, 2007).

4.3 Psycho-social, emotional and behavioural issues

Speech pathology assessment in mental health considers the psycho-social functioning of the child and its impact on language development. Expressive language delays in pre-school children tend to be correlated with social-emotional problems and receptive delays typically fall into the group identified as having a pervasive developmental disorder (Tervo, 2007). The literature has reported a significant relationship between reduced social competence and psychopathology (Burgess & Younger, 2006; Burt, Obradovic, Long & Matson, 2008; Cohen, Vallance, Barwick, Im, Menna, Hordezky & Isaacson, 2000; Fujuki, Brinton & Clarke, 2002; Ripley and Yuill, 2005). Children with language impairment during the primary school years have been identified as being lonely and rejected by their peers (Asher & Gazelle, 1999; Fujiki, Brinton, Fitzgerald, 1999).

Psychological difficulties experienced by children with speech and language problems included relationship problems (Fujuki, Brinton, Issacson and Summers, 2001) and reduced self-esteem (Jerome, Fujiki, Brinton & James, 2002). Different types of communication disorders and specific behavioural problems have been correlated at a young age (Van deal, Verhoeven & van Balkom, 2007). For example, phonological problems have shown a relationship to externalising (aggression) problem behaviour. Semantic language problems were related to internalising (depression and anxiety) emotional problems (Van deal et al (2007). Comprehension problems in children have also been associated with emotional and social problems (Beitchman et al, 1996; Rutter & Mawhood, 1991; Lindsay & Dockrell, 2000). Impairments in psycho-social, emotional and/or behavioural function with associated language problems in children has been reported to affect family functioning and contributes to family stress (Long, Gurka & Blackman, 2008; Lundervold, Heimann & Manger, 2008; Tervo, 2005).

Behavioural disorders may indicate undiagnosed communication, learning, literacy and/or attention/concentration problems. A high percentage of children, including toddlers and preschoolers, referred to welfare services have been reported to have developmental and behavioural needs (Stahmer, Leslie, Hurlburt, Bath, Webb, Lansverk, & Zhang, 2005). Research has indicated that pre-school children with behavioural problems are more likely to have language deficits than their peers (Kaiser, Hancock, Cai, Foster & Hester, 2000). Disruptive behaviour in children has been shown to become more severe over time rather than to resolve of its own accord (Neary & Eyberg, 2002). More specifically, conduct disorder and language problems have been found to be strongly correlated (Cohen et al, 2000; Lim, 2006). Children with severe behavioural problems are likely to continue demonstrating problems into the school years (Gesham, Lane & Lambros, 2000) compromising both academic achievement and the formation of positive peer relationships. Longitudinal studies have indicated that language impairment in boys is a significant risk factor for antisocial behaviour in adolescence (Beitchman et al, 1996, Beitchman et al, 2001a; Bor, McGee & Fagan, 2004). Attention deficits may also limit a child's ability to "tune in" sufficiently to learn the rules of communicative discourse. Often Adolescence is the period when communication problems begin to be masked by antisocial or other deviant behaviours, substance abuse, depression, anxiety and other indicators of mental illnesses (Snow & Sanger, 2010). Additionally, there is a substantial cross-over from child protection services to youth justice services in populations with underlying language impairments (Dais, Howell & Cooke, 2002; Stewart, Livingston, & Dennison, S. 2008).

Speech dysfluency (or stuttering) can significantly impact social interactions and has been found to be associated with an increased risk for mental health disorders in childhood (Davis et al, 2002) and adulthood (Iverach, 2009). Addressing mental health issues such as self-efficacy for changes, stress management and coping skills in combination with speech fluency treatments is recommended (Iverach, 2009).

4.4 The effect of early psychological trauma on communication competence

The impact of psychological trauma on language development is well recognized (Klapper, Plummer & Harmon, 2007). Early maltreatment and consequent compromised language and mental health outcomes have also been identified (Snow, 2009b). Subsequently, speech pathology input into minimising adverse outcomes of complex trauma cases has been recommended (Ball & Khan, 2009). Emotional neglect has been found to be correlated with poor auditory comprehension and expressive language ability (Allen & Oliver, 1982 and Culp, Watkins, Laurence and Letts, 1991). The impact on social relationships included a need for control, attachment difficulties, poor peer relationships and unstable living situations reducing learning and engagement at school (Downey, 2007). Factors impacting on academic performance included reduced cognitive ability, sleep disturbance causing poor concentration and delayed receptive and expressive language development (Culp et al, 1991; Downey, 2007).

Refugees who have experienced trauma are a new group of individuals being referred to mental health services and speech pathologists. Communication and psychological issues may present in this population, such as the need to learn English, trauma associated with experiences in the individual's country of origin, the immigration process and subsequent detention and adaptation to the new country. Child and adolescent refugees have been reported to have a higher incidence of depression, anxiety and post-traumatic stress disorder (Crowely, 2009). To better understand the needs of this population further research is required.

4.5 Swallowing disorders and mental health

Individuals with psychiatric disorders are reported to have a higher risk of choking than the general population (Fioritti, Glaccoto & Melega, 1997; Regan, Snowman & Walsh, 2006). One study demonstrated that 35% of patients admitted to a psychiatric inpatient unit and 27% of patients attending a day hospital service present with some form of dysphagia (Regan et al, 2006). Patients with psychiatric problems have been reported to have higher rates of aspiration and are more likely to develop pneumonia and die secondary to aspiration when compared to the general population (Bazemore, Tonkology & Anath, 1991). Possible causes for this higher prevalence rate have included the adverse effects of antipsychotic medications (known as neuroleptic exposure), institutional conditions such as dependency and routines, the presence of co-morbid neurologic disorders and the mental illness itself (Bazzemore et al, 1991). For some individuals, traditional antipsychotic medications may result in side-effects such as tardive dyskinesia which may involve muscle spasms of the tongue, face, jaw and neck. Pseudoparkinsonism (symptoms that resemble Parkinson's disease) may present causing tremors and muscular rigidity. Further probable risk factors reported in the literature that may lead to dysphagia in individuals with mental illness include seizures, poor dentition and poor eating habits (Regan et al, 2006).

5. DEFINING MENTAL HEALTH DISORDERS

In addition to the literature demonstrating a relationship between communication and swallowing disorders and mental health, communication impairments are also reported within mental health disorders.

The following diagnostic categories, which include communication impairment in the criteria, are recognised by the American Psychiatric Association (2000), and the World Health Organisation's *International Classification of Diseases (1993).*

- attention deficit disorders (ADHD, ADD);
- autism spectrum disorders;
- selective mutism;
- language-based leaming disabilities;
- developmental language disorders;
- developmental speech disorders (dyspraxias);
- behavioural disorders (conduct disorder, oppositional defiant disorder, disruptive behavioural
- disorder);
- schizophrenia and psychosis;
- anxiety disorders (separation anxiety, reactive attachment disorder);
- infant/child abuse/maltreatment/neglect;
- trauma;
- major depressive disorder/dysthymia;
- intellectual disability;
- dementias;
- relational problems (parent-child, partner, sibling);
- feeding and eating disorders.

In addition to the above diagnostic classifications there is the National Center for Clinical Infant Programs: Zero to Three Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (1994). This classification is aimed at clinicians specialising in the infant to toddler age group. The framework is intended to complement the American Psychiatric Association (2000) criteria. Ongoing training, data collection and field testing are currently in place for this diagnostic classification.

Clients may present with multiple and complex problems that fall across a number of diagnostic categories. Many mental health issues may not meet the full diagnostic criteria and may be listed as symptoms. Alternatively, symptoms of one psychiatric disorder may be included with an identified disorder, for example, childhood depression with features of Attention Deficit Disorder with Hyperactivity (ADHD) and a past history of child sexual abuse and/or reactive attachment disorder.

6. IMPACT OF COMMUNICATION IMPAIRMENT

The consequences of communication impairment cross all developmental and environmental aspects of infancy, childhood, adolescence and adulthood, and impact upon families, carer(s), educational staff and fellow students, workplace colleagues and the community. Such consequences may be interrelated and influence each other.

6.1 Lifespan consequences

- Intergenerational transfer of problems for families not receiving early intervention, screening or education.
- Language and mental health problems for children exposed to maltreatment and trauma at an early age.
- Increased need for welfare and child protection services at early ages.
- Increased risk of criminal/justice involvement in adolescence/early adulthood.
- Illegal activity and substance abuse in young people/early adulthood.
- Early parenting/unplanned pregnancies creating further strain on families/communities.

6.2 Vocational consequences

- Difficulty securing and maintaining employment due to social communication and language challenges.
- Loss of employment opportunities and prospects.
- Reduced employment options for carers due to increased demands to care for an individual.

6.3 Familial consequences

- Family tension and conflict.
- Strained parent-child roles impacting attachment and emotional attunement with off-spring.
- Family violence and subsequent trauma impact.
- Reduced sibling and extended family contact.
- Secondary psychiatric problems of other family members.
- Difficulty in managing life transitions and a young person's move toward autonomy and independence.
- Difficulty with developing and sustaining intimate (non-sexual) and romantic relationships.
-

6.4 Psychological consequences

- Social isolation and loneliness are consequences of communication impairment and are known precipitants of depression.
- Impact on personality development.
- Reduced tolerance for and avoidance of social communication.
- Specific psychological consequences-aggression, irritability, limited attention/concentration/ impulsivity, reduced responsiveness/lack of spontaneity, anxiety, depression and self-harm.
- Reduced sense of self-worth/self-identity, loss of hope and optimism and reduced self-advocacy.

6.5 Social consequences

- Problems coping with social situations, resulting in reduced social contacts, community involvement, recreational activities and social status.
- Difficulties with establishing peer relationships.

7. SERVICE DELIVERY TO SPECIFIC POPULATIONS

In Section Four of this paper the evidence demonstrating the relationship between communication and swallowing disorders and mental health was discussed. This section builds on this evidence and discusses the role of speech pathologists working with specific client groups.

7.1 Early intervention and prevention

Speech pathologists have a role in early identification of and early intervention for infants and children at risk of communication impairments where a parent suffers a mental illness. Early identification and intervention are also important for infants, children or adolescents who have suffered trauma, abuse and/or neglect. Targeted prevention needs to focus on "at risk" populations and education to professionals at the post-birth and early childhood periods. Parent, caregiver and community education is essential for effective prevention programs.

7.2 Infant mental health

The focus on mental health from the time of birth onwards is now recognised as a significant period in which early intervention can positively impact on developmental processes:

> "There is powerful new evidence from neuroscience that the early years of development from conception to age six, particularly the first three years, set the base for competence and coping skills that will affect learning, behaviour and health throughout life." (Mustard & McCain, 1999, pp 34)

In the first few months and years of a child's life, children learn about emotions and social interactions. From birth onwards they ideally develop attachments. The process of attachment is made up of thousands of social interactions between child and caregiver which then become an internal working model that serves as a base or inner behavioural core from which the child acts in future relationships. Both attachment disorders and communication disorders have the same risk factors and share a reciprocal relationship. The presence of a communication disorder has implications for the parent-child and child-family relationships, as well as more general social relationships. Infant mental health is synonymous with healthy social and emotional development (Zeahan, 2000).

Parent-child interactions form the foundation for positive parent-child relationships and also facilitate speech and language development. At times, parent-child interactions are not optimal for normal child development. This may occur as a result of infant vulnerability, social factors, and environmental stressors and/or be due to parental inability to interact with the child effectively. This may create the potential for future developmental delays and mental health problems in a child. These families are often only managed from a psychiatric or social welfare framework. Dysfunctional parenting and impoverished language development and/or language impairment are all risk factors for maltreatment (Zeanah, 2000).

7.3 Young people and mental health

Youth mental health problems are a huge economic burden on Australian communities. In 2004-05, 7% of the Australian population aged 0-17 years was reported as having mental or behavioural problems with the prevalence increasing with age. Problems of psychological development (2.8%) and emotional and behavioural problems with onset in childhood and adolescence (3.0%) were prevalent amongst the 0-17 year olds (Australian Institute of Health Welfare, 2006a).

Longitudinal studies highlight the long-term outcomes of language impairment affecting young people and young adults. Adolescent depression has been identified as being associated with long-term maladjustment and interpersonal problems (Frombonne, Wostear, Cooper, Harrington &

Rutter, 2001b). In a further longitudinal study following children (males) with developmental language disorders from childhood through to youth and adulthood, psychosocial adaptation and social relationships were found to be significantly impaired (Clegg et al, 2005).

Language and pragmatic disorders have been identified as the most commonly observed communication disorders in an adolescent psychiatric inpatient unit in Australia. It has been observed that;

> " In a number of cases where the presenting disorder has been psychiatric, it has later been found that a communication disorder preceded the episode of mental illness. It can be expected, then, that the communication disorder may persist after remission of the psychiatric illness." (Rowland, 1995, pp 34).

A study of the relationship between pragmatic behaviours and depression in adolescents indicates that depressed adolescents perceive they have multiple pragmatic problems as compared to their peers who are not depressed (Perrott, 2010; Perrott, 1998). From a preventative point of view, programs involving the teaching of pragmatics and communication skills should be a consideration for adolescents both with and without depression (Perrott, 2010). The communication of long-stay inpatients in an Australian mental health adolescent unit demonstrates a variety of previously masked communication problems. Listening skills, verbal profiles, reading and problem-solving scores varied between patient disorder types with psychosis representing the most negative scores overall (Clarke, 2006).

Poor interpersonal relationships have been reported in adolescents who drop out of school, juvenile and adult offenders and other psychiatric populations (Brownlie, Beitchman, Escobar, Young, Atkinson, Johnson, Wilson & Douglas, 2004 and Sanger, Hux & Ritzman, 1999). Depression and anxiety are over-represented in young offenders (Ryan & Redding, 2004 and Weisz, Hawley & Doss, 2004). Recent Australian evidence (Cantwell & Baker, 1987; Snow et al, 2004b; Snow et al, 2005 and Snow et al, 2008) shows that high-risk males (youth aged 13-19 completing community based youth justice orders) are at high-risk for unidentified, but clinically significant oral language disturbances. In a recent study 52% of a community sample of young offenders could be classified as having language impairment (Snow et al, 2008). Of this subgroup, over half had been identified as needing early intervention services in the first three years of school but only one young person received speech pathology services. This study suggests that early intervention, though known to be effective if provided in a timely manner with adequate intensity and duration, is failing to alter the risk trajectories of boys with co-morbid language-learning and behavioural disturbances. Importantly, such boys are typically identified as having behavioural disorders by the third or fourth year of school, but their language skills are not routinely investigated by speech pathologists. There are many roles that speech pathologists can fulfil within forensic settings such as youth detention units (Caire, 2009).

7.4 Adults and mental health

Approximately one in every five Australians from the age of 16-85 years had experienced a mental disorder in 2007 according to the Australian Bureau of Statistics (ABS) 2007 National Survey of Mental Health and Wellbeing study. Young adults aged 16-24 years presented with the highest prevalence of mental health disorders of 26% (ABS, 2007). Bryan and Roach (2001) reported the incidence of speech and language problems in individuals receiving mental health services to be higher than the general population. Whitehouse (2009) identified that mental ill-health was highly represented in adults with communication impairments. Higher rates of dysphagia, aspiration and choking in psychiatric patients when compared to the general population have also been documented (Bazemore et al, 1991, Fioritti et al 1997; Regan et al, 2006).

Speech pathologists have a role in the assessment, diagnosis, intervention and effective management of clients presenting with communication and swallowing problems in adult mental health settings. Speech pathology assessments, intervention, advice and support can optimise the impact of other professional's intervention and management. Speech pathology interventions can

be used to address a wide range of speech, language and communication problems to maximise the client's potential to communicate more effectively in daily interactions, in treatment programs, work place and social settings. The speech pathologist's role in establishing safe and effective eating, drinking and swallowing facilitates adequate nutrition, reduces risk of infection and illness and contributes to the general physical and mental well being of individuals.

The skills, knowledge and expertise that speech pathologists can bring to adult mental health services was outlined by Muir (1996). Muir (1996) aimed to raise awareness and highlight the importance of speech pathologists in the multidisciplinary team. France & Muir (1997) and France (2001) reported on the valuable contribution speech pathologists can provide to the mental health service multi-disciplinary team by diagnosing speech and language problems and assisting with differential diagnosis. Muir, Tanner & France (1991) reported differential diagnosis of schizophrenia from dysphasic speech was more reliable with speech pathology assessment. The value of speech pathologist descriptions of language in schizophrenia has been reported by Faber, Abrams, Taylor, Kasprison, Morris & Weisz (1983).Language assessment has been reported to contribute to differential diagnosis of dementia type (Snowden & Griffiths, 2001) and facilitates early diagnosis (Garrard & Hodges, 1999). Heritage & Farrow (1994) recommended individuals with suspected dementia should have access to speech pathology assessment and management as part of a multidisciplinary team. Differential diagnosis has been reported as essential for effective management of dysphagia eg iatrogenic (side effect of drug therapy) versus psychological (Bach, Pouget, Belle, Kilfoil, Alfieri, McEvoy & Jackson, 1989). Regan et al (2006) recommended screening for dysphagia of new clients to mental health services due to the link between swallowing problems and mental health.

8. HUMAN RESOURCE MANAGEMENT

8.1 Education and Training Qualifications

Speech pathology within mental health settings is a specialist field of expertise and an advanced area of practice. Less experienced clinicians working in this field should be provided with access to a speech pathologist experienced in the area of mental health for supervision, training and support. Speech pathologists should work within a multidisciplinary team that is able to offer ongoing professional supervision, support and debriefing. The extent and types of specific training available to speech pathologists in mental health will be dependent on individual organisations' structure and training policies.

Speech pathologists are encouraged to be members of relevant professional groups to participate in a forum for sharing and exchanging clinical expertise and the development of research and other projects. Professional groups may include those groups available within the workplace with a multidisciplinary team or with speech pathologists in the field. There is a National Peer Review Group for senior speech pathologists working in mental health (refer to Speech Pathology Australia website).

To increase the awareness of the potential roles of the speech pathologist education is required at tertiary training levels, organizational and community settings and government.

8.2 Eligibility to Practice

Speech Pathology Australia endorses the requirement that all speech pathologists employed in Australia are required to be eligible for Practising Membership of the Association, and where required registered with the registration body of the state in which the person practises.

8.3 Professional Development

It is the position of the Association that speech pathologists working in the area of mental health engage in ongoing professional development. This may occur through:

- attendance at workshops/seminars/Continuing Professional Development (CPD) provided by Speech Pathology Australia;
- upgrading of professional qualifications;
- attendance at workplace based discipline meetings, case presentations, literature reviews;
- attendance at relevant mental health and related topics conferences and workshops;
- attendance at supervision or mentoring sessions.

Speech pathologists working in the field of mental health are recommended to develop a working knowledge of the range of disorders prevalent in child, adolescent and adult psychiatry. Models of intervention of relevance to speech pathologists working in mental health may include:

- counseling skills;
- psychotherapy;
- family therapy;
- developmental psychiatry;
- infant mental health;
- adolescent/young people focused skills, eg., youth-work related areas;
- trauma counseling;
- cultural/ethnic competent based practice.

8.4 Supervision and Debriefing

Professional supervision is considered an essential component of speech pathology practice in mental health. Supervision allows for the debriefing and planning of cases, reflective learning, and regular review on how the clinician is managing and maintaining professional best practices. Supervision reduces the likelihood of stress, burn-out and stress related illnesses (Speech Pathology Australia, The Role and Value of Professional Support, 2007).

Speech pathologists who supervise should have current knowledge of:

- supervision models;
- best teaching practices and knowledge transfer models;
- adult teaching models and skills;
- and receive supervision/debriefing for their supervision practice.

Debriefing of an incident should be available to speech pathologists working in mental health settings. Debriefing post a specific incident typically involves engaging with a person(s) identified in the organisation to undertake this specialist skill. The speech pathologist should adhere to the organisations' policy and procedures regarding debriefing.

9. LEGAL ISSUES

9.1 Code of ethics

Speech pathologists should adhere to the Speech Pathology Australia *Code of Ethics* (2000) and to any codes, policy and procedures relevant to their employing body.

9.2 Legislation

It is recommended speech pathologists be conversant with the *Mental Health Act* that applies in the state or territory in which they practise. This is the act that provides guidelines relating key legal issues that pertain to the management of people with acute mental health needs. For example, voluntary and involuntary admission in the case of informed adolescent suicide risk or other situations that may assist the decision making and intervention choices.

The ACT mental health (treatment and care) act:
http://www.legislation.act.gov.au/a/1994-44/default.asp
The New South Wales mental health act:
http://www.austlii.edu.au/au/legis/nsw/consol_act/mha2007128/
The Northern Territory mental health act:
http://www.nt.gov.au
The Queensland mental health act:
http://www.health.qld.gov.au/mha2000/
The South Australia mental health act:
http://www.health.wa.gov.au/mhareview/resources/legislation/SA_Mental_Health_Act_1993.pdf
The Tasmania mental health act:
http://www.austlii.edu.au/au/legis/tas/consol_act/mha1996128/
The Victorian mental health act:
http://www.health.vic.gov.au/mentalhealth/mh-act/index.htm
The Western Australia mental health act.
http://www.health.wa.gov.au/mhareview/resources/legislation/wa_mental_health_act_1996.pdf
Reviews of all state and territory mental health acts:
http://www.health.wa.gov.au/mhareview/resources/index.cfm

9.3 Duty of care

Duty of care is a legal term describing the relationship, in this case, between the individual and parent/caregiver and the speech pathologist. The speech pathologist owes a duty of care to his/her client and caregiver. A breach of duty of care leaves one liable to civil action for a claim of damages (compensation) if legal action is taken by the individual under your care or parent/caregiver(s) or carer. A breach of duty of care may result from one or several specific actions whilst under the care the speech pathologist. For example, a failure to act when action was required, or a statement made that in the eyes of the law amounts to a "negligent misstatement." The duty involves using the same degree of care that a "reasonable" speech pathologist would exercise in the circumstances. Whether or not there has been a breach would be determined by what other speech pathologists working in the same field would have done in the circumstances. Consequently, it is the duty of the speech pathologist to be aware of recent literature in their field, current practices carried out by peers, adhering to workplace policies and procedures and being conversant with the Speech Pathology Australia Association documents.

9.4 'Proxy' interventions

Where a speech pathologist does not carry out the intervention but has instructed and supervises someone else i.e., student speech pathologist carrying out the intervention, the law would hold the advising/supervising speech pathologist liable just as if they were carrying out the intervention themselves. The law refers to this as "vicarious liability." In other words, the same standard of care would be required if the speech pathologist was holding him/herself out as the person with the knowledge and skills. The fact that he/she did not actually carry out the intervention would be irrelevant in the eyes of the law. Therefore it is necessary for "proxies" to exercise the same standard of care as that required of the speech pathologist instructing or supervising them, and for all documentation (i.e. Individual Education Plans, progress notes, negotiated contracts) regarding "proxy" interventions to be maintained. In addition, the service plans must include adequate time and resources to train "proxies" and monitor programs.

9.5 Consent for speech pathology involvement

Informed consent refers to the client and/or parent(s)/caregiver(s) being fully informed and aware regarding the service, assessment, interventions, treatments and role of the speech pathologist in mental health. For young people who are at an age of being able to consent, if there is the presence of an intellectual disability or a mental health problem that in the opinion of the speech pathologist does not allow for the ability to consent to services this needs to be resolved in line with organisational policy/procedure. In such circumstances, the parent(s) /caregiver(s) may be required to consent. Service provision should not commence without consent being formally clarified.

Consent requirements vary in different states and territories. A young person may provide consent depending on the particular state's laws of age of consent. In some states and territories the attendance at an appointment is implied as consent.

Situations may arise during the treatment process where verbal consent is requested of the client or parent(s)/caregiver(s). For example, a case being handed over to another clinician for a one-off session or a young person's request that the clinician make contact with their educational setting without written consent being initially arranged. Ideally, written consent should be obtained in these instances but where verbal consent has occurred then this should be documented by the speech pathologist in the individual's file.

Informed consent for speech pathologists undertaking research in mental health requires that the speech pathologist make contact with the appropriate governing Ethics Committee of the service. Research should not be undertaken without full ethics approval.

9.6 Indemnity Cover and Insurance

It is the responsibility of the speech pathologists to ensure they have appropriate professional indemnity cover and public liability. Professionals should be aware that there may be instances where the employing body will not necessarily indemnify them for their actions. It is recommended that all practicing Speech Pathology Australia members have professional indemnity insurance.

Speech pathologists should clarify the insurance situation for accidental loss, theft or damage to resources during transport with their insurer.

9.7 Service guidelines

It is recommended that speech pathologists adhere to the approved guidelines of the employing body in terms of clinical and service management.

10. FUTURE DIRECTIONS

The evidence to support the role of speech pathologists in mental health services is substantial and is growing. This evidence needs to be utilised to advocate with government, policy makers and funding bodies for an increased presence of speech pathologists in mental health prevention and mental health services. In particular, the establishment of prevention and intervention programs for at risk populations i.e. juvenile young offenders.

To support the prevention process future directions for speech pathologists may include;

- collaborative practice and formation of partnerships with other service providers;
- introducing speech pathologists into mother-child units to support parent/child issues such as attachment, feeding and/or interactional skills;
- assessment and follow-up of mothers with post-natal depression and premature infants;
- working alongside parents and teachers to aid school transition for children with identified mental health/communication problems;
- provide education and preventative based programs to pre-school and early primary school staff and parents;
- work alongside education-based speech pathologists for identification of "at risk" children;
- assessment and treatment of young people in juvenile detention centres, under judicial orders based in the community and forensic units, secure welfare, drug and alcohol services and trauma related youth programs;
- assessment and management of speech, language and swallowing problems in adults and the elderly with mental health issues, and education of health professionals and carers regarding the impact of mental health conditions on communication and swallowing.

The critical interrelationship between mental health and communication and swallowing needs to be introduced into graduate entry speech pathology training courses. Education regarding speech pathology roles in mental health settings and the importance of early prevention and intervention is strongly supported by the Association.
To support the education process of government and the broader health and education sector future directions of speech pathologists may include;

- Involvement in the development of education curriculum for other health professionals and teachers;
- Involvement in the development of speech pathology training courses curriculum content;
- Involvement in development of organisational, local and federal government policies and protocols.

11. CONCLUSION

The Association contends that speech pathologists play a critical role in mental health services given the high correlation between mental health disorders and communication and swallowing disorders.

The aims of this clinical guideline are to improve the understanding of communication and swallowing in the context of mental health, improve the understanding of the roles of speech pathologists in mental health settings and to highlight the speech pathologist's role in prevention and intervention programs. This has been achieved by providing evidence from the literature demonstrating the prevalence of communication and swallowing disorders in mental health, discussing the reciprocal relationship between communication, bio-psycho-social development, psychopathology and the impact of adverse psychosocial contexts on development and highlighting the perceived benefits of speech pathology involvement in prevention and intervention and in mental health settings.

It is the position of the Association that the assessment, diagnosis, and treatment of individuals with a communication and/or swallowing problem in mental health services are within the scope of practice for speech pathologists. It is also the position of the Association that working in the area of mental health is an advanced area of practice that requires specialist knowledge. The Association recommends that speech pathologists work in a multidisciplinary team and have access to a speech pathologist experienced in the area of mental health for supervision and support.

The evidence from the literature highlights prevention and early detection as key factors to support individuals and families. The Association supports this key message and recommends training institutions, policy makers, funding bodies, and mental health services incorporate this message into their future planning for services. It is considered essential that speech pathologists are included in the prevention and intervention for at-risk populations.

12. REVIEW

This paper should be reviewed in five years from the date of ratification by Council.

APPENDIX 1: GLOSSARY OF PSYCHOLOGICAL TERMINOLOGY

Glossary of Psychological Terminology
http://priory.com/gloss.htm

APPENDIX 2: STATE AND TERRITORY RESOURCES

The following resources and web sites provide information specific to a state or territory.

Australian Capital territory (ACT)

ACT government link. http://www.act.gov.au

ACT mental health workers listings. http://www.goodtherapy.com.au

Migrant resource centre. www.mrccanberra.org.au

New South Wales (NSW)

Children's Hospital at Westmead Education Research Institute (CHERI) conducts research into the educational and psycho-social aspects of children with learning problems and provides resources to families and professionals. www.cheri.com.au

Emotional Health Clinic: Macquarie University, NSW. http://emotionalhealthclinic.com.au/index.cfm

Migrant Resource Centre. www.eccnsw.org.au

NSW Centre for the Advancement of Adolescent Health: The centre provides access to relevant publications, such as "Spinning the Web: Better connections between services working with young people. http://www.caah.chw.edu.au

NSW "Friends for Life" Program: Anxiety prevention and treatment for children aged 7-11 and youth aged 12-16. www.friendsinfo.net

NSW Government health link. http://www.health.nsw.gov.au

NSW School-Link initiative is a collaborative partnership between the NSW Department of Education and Training and NSW Health that is being implemented state wide to promote mental health and improve prevention, treatment and support for adolescents with mental health problems.
http://www.health.nsw.gov.au/pubs/2003/well_schoollink.html

NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)
http://www.startts.org.au

Inquiry into children and young people 9-14 years in NSW: Julia Starling, 2008.
http://www.parliament.nsw.gov.au/Prod/parliament/committee

Queensland (Qld)

Qld Education Services. http://education.qld.gov.au/schools/healthy/framework/introduction.html

Australian Childhood foundation: links to child abuse laws for each state/territory & research.
https://secure.childhood.org.au/smartonlinetraining.aspx?pageid=1074

Migrant Resource Centre. www.health.qld.gov.au/multicultural/health.../migrants

South Australia (SA)

Centre for Health Promotion. www.chdf.org.au

Directory of mental health Services (SA). www.adelaide.edu.au

Public Health information development Unit. www.publichealth.gov.au

SA Department of Health. www.health.sa.gov.au

SA Community Health Research Unit. http://som.flinders.edu.au/FUSA/SACHRU/

Migrant Resource Centre. www.mrcsa.com.au

Tasmania
Anglicare Tasmania: Mental health community services www.anglicare-tas.org.au

Australian Clearing House for Youth Studies: Research & statistics aimed at a variety of audiences. www.achys.info

Headspace: Northern Tasmania: Free health services for 12-25 years. www.headspace.org.au

Mental health Council of Tasmania: Representing non-government mental health organizations. www.mhct.org.au

Migrant Resource Centre. www.mrchobart.org.au

Tasmania Government health/community link: Department of Health and Human Services. http://www.dhhs.tas.gov.au/mentalhealth/welcome_to_mental_health

The Northern Territory

Refugee Council of Australia/Migrant Resource Centre. www.refugeecouncil.org.au

Victoria
Anxiety Disorders Association of Victoria. www.adavic.org.au

Autism Victoria. www.autismvictoria.org.au

ABIA: Autism Behavioral Intervention Association. www.abia.net.au

Because mental health matters: Victorian mental health reform strategy 2009-2019. www.health.vic.gov.au

Child Development and Trauma guide (Victorian Government, Office for Children, Dept of Human Services).
www.cyf.vic.gov.au

Foundation House: Victorian foundation for survivors of torture. www.foundationhouse.org.au

Kool Kids Positive Parents (KKPP): A school-based early intervention and prevention program for children with challenging behaviour and emerging conduct disorder www.kidsmatter.edu.au

Migrant resource centre www.eccv.org.au

St Luke's Anglicare: Innovative Resources & support services. Victoria & rural Victoria. www.innovativeresources.org

The Royal Childrens Hospital: Centre for Community Child Health: Policy briefs from Centre for community Health, RCH Melbourne: translating early childhood research evidence to inform policy and practice. www.rch.org.au/ccch/resources.cfm?doc_id=10885

Victorian Early Years Learning and Development Framework: Birth to 8 years, 2009. www.vcaa.vic.edu.au/early years/index.html

Western Australia (WA)

Government of Western Australia: Mental Health.
http://wa.gov.au/governmentservices/health/mentalhealth/

Government of Western Australia : Mental Health.
http://www.health.wa.gov.au/mentalhealth/home/

Migrant Resource Centre. www.mrcwa.org.au

Protective Behaviours WA: Western Australia's leading prevention education organisation working in WA and internationally to prevent child abuse. http://www.protectivebehaviourswa.org.au/

WA Association for Mental Health:. http://www.waamh.org.au/

APPENDIX 3: NATIONAL RESOURCES

The following resources and web sites provide information to national mental health issues and other generic resources.

Australian Infant, Child, Adolescent and Family Mental Health Association. www.aicafmha.net.au

Australian Institute of Health and Welfare. www.aihw.gov.au

Australian Child and Adolescent Trauma, Loss and Grief Network. www.earlytraumagrief.anu.edu.au

Australian Childhood foundation: links to child abuse laws for each state/territory & research. https://secure.childhood.org.au/smartonlinetraining.aspx?pageid=1074

Beyond Blue: The national depression initiative. http://www.beyondblue.org.au

Beyond Blue Youth: A separate website link for young people. http://www.youthbeyondblue.com

Calmer Classrooms: A guide to working with traumatized children, Child Safety Commissioner, June 2007.
www.ocsc.vic.gov.au

CASEL: Collaborative for academic, social, and emotional learning. Non-profit organization providing the latest research in mental health areas. http://www/casel.org/home/php

Child Adolescent Mental Health Services (CAMHS) Research Digest: New research, developments and other clinicians perspectives. It also acts as a type of blog whereby comments are able to be posted. www.camhs.wordpress.com

Child development & trauma guide. www.dhs.vic.gov.au/everychildeverychance

Children of mentally ill consumers. www.howstat.com/comic

Children of parents with a mental illness. www.copmi.net.au

Circle of Security website: for secure attachment between care-giver and child www.circleofsecurity.org

Child Trauma Academy. www.childtraumaacademy.com

Early Childhood Australia. www.earlychildhoodaustralia.org.au

Infant mental health: 0-3 years mental health and development. www.zerotothree.org

International Society for Traumatic Stress studies. www.istss.org

Mental health: problems & diagnoses. www.mentalhealth.org.au

Mental health information: about children and young people. www.headroom.net.au

Mindmatters: Australian Government Department of Health & Aging.
http://www.mindmatters.edu.au/about/about_landing.html

Multicultural Mental Health Australia. www.mmha.org.au

Parenting website: parenting advice. www.cyh.com

Reach Out Australia: An organisation of the Inspire Foundation, with the aim of providing information and support to young people with a range of mental health and other issues. http://au.reachout.com

Reach Out Pro: a website that provides access and advice for health-care professionals on a range of technologies and online resources that can be used to enhance the effectiveness of psychosocial support and mental health care provided to young people. www.reachoutpro.com.au

Reach Out Teachers Network is a website for teachers to get the latest information and curriculum resources that support promoting mental health and wellbeing in the school setting. http://teachers.reachoutpro.com.au

Selective Mutism Information & Research Association. www.selectivemutism.co.uk

Separation & divorce: A website for children and young people whose parents have separated or divorced. www.chatfirst.com.au

Talaris Developmental timeline: development from 0-5 years www.talaris.org

TEACCH: An American website for current information and developments in the field of autism spectrum disorders. www.teacch.com.

The Australian Association for Infant Mental Health www.aaimhi.org

The Autism Spectrum Magazine www.autismspectrum.net

The Black Dog Institute: The Black Dog Institute is an educational, research, clinical and community-oriented facility offering specialist expertise in mood disorders. The Institute is attached to the Prince of Wales Hospital and affiliated with the University of New South Wales. http://www.blackdoginstitute.org.au

The Raising Children's Network: parenting information for 0-8 years. www.raisingchildren.net.au

The Resilience Doughnut is a model for building resilience in children and young people. This model is being used by practitioners all around Australia, and is quickly spreading to other countries, including Japan, South Africa and the UK. The 7 factors that resilient young people and adults have in common are illustrated in the shape of a doughnut. Ways of helping a young person through stressful times and building their resilience are shown using the simple common sense formula: "If something is working, do more of it". Lyn Worsley has created this model as a resource that can be used for anyone experiencing the difficulties that life inevitably brings." http://www.theresiliencedoughnut.com.au

Traumatic Stress Institute/Centre for Adult & Adolescent Psychotherapy: US based centre for treatment & research. www.tsicaap.com

Victorian Transcultural Psychiatry Unit: A state wide unit for mental health support services for CALD consumers and carers. www.vtpu.org.au

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