National Partnership Project 2012-2013

Best Educational Practice for Adolescent Mental Health

NSW Government Education & Communities Public Schools NSW
**Forward**

In 2012 SSP schools were fortunate to receive National Partnership funding. This document is the product of a partnership between the Sutherland Hospital School, Cronulla High School, Endeavour High School, Heathcote High School, Kirrawee High School, The Jannali High School and the Education Project Officer from the Forensic Hospital. The project members include Jacqui Conwell (Principal), Valarie Penna (LaST), Brenda Pyett (Head Teacher, Special Education), Jane Coleman (Teacher), Judy Campbell (Support Teacher, Physical), Melissa Kenihan (Head Teacher, Welfare), Linda Gillies (LaST), and Helen Lee (Project Officer). The team is a diverse and experienced group of educational practitioners who are committed to ensuring the best outcomes for all students.

Schools are seeing an increase in students struggling with their mental health. After initial discussions, the project team identified a need to provide high schools with a resource document that is practical and relevant. The preparation for this resource was the catalyst for team members to visit Woniora Road SSP, Rivendell and the Dunlea Centre. Information from these visits along with ongoing research, discussion and collaboration led to the formulation of this document and a better appreciation of the significance of the transition process for students with mental health issues.
Best Educational Practice for Adolescent Mental Health

What is Mental Health?

The World Health Organisation defines Mental Health as a state of well-being in which every individual realises his or her potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community.¹

A mental disorder or mental illness is a diagnosable illness² that affects a person’s thinking, emotional state and behaviour and disrupts the person’s ability to work or carry out other daily activities and engage in satisfying personal relationships.

Mental health and mental illnesses are determined by multiple and interacting social, psychological and biological factors. According to figures released in 2007 by the Australian Bureau of Statistics (ABS) following a national survey of the Australian population’s mental health and well-being, one-in-five (3.2 million) Australians aged 16-85 years reported having a mental health disorder within the previous 12 months. Just over a quarter (26%) of people surveyed in 2007 aged 16-26 had a mental health disorder compared to only 6% of people aged 75-85.

Indigenous Australians are confronted by much higher levels of health risks and challenges, including mental health. The problem is particularly dire in Indigenous youth in whom it is estimated that up to 40% of those aged 13-17 will experience some form of mental illness.

This document will define and outline methods of support for students dealing with mental illnesses, such as anxiety, depression, psychosis and eating disorders.

¹ World Health Organisation, 2007
² American Psychiatric Association. (DSMiv) 2000
What is Anxiety?

Anxiety is often described by terms such as being anxious, stressed, on edge, wound up, nervous or tense.

Anxiety can vary in severity from mild uneasiness through to a terrifying panic attack. It can also vary in how long it lasts, from a few moments to many years.

Why does it happen?

Extensive research has shown that some children are constitutionally and temperamentally more sensitive. This can be due in part to genetic factors. There are particular genes that regulate our stress response system, which can be more or less highly tuned. There are some family factors that increase the risk for anxiety disorders. These include a family history of anxiety disorders, a parent with an alcohol or drug problem, parental separation/divorce and a difficult childhood (for example, experiencing physical, emotional, or sexual abuse, neglect or over-strictness).

Signs and Symptoms

Physical

- Pounding heart, chest pain
- Rapid, shallow breathing and shortness of breath
- Dizziness, headache, sweating, tingling and numbness
- Dry mouth, vomiting and diarrhoea
- Muscle aches and pains

Psychological

Unrealistic or excessive fear and worry (about past and future events), mind racing or going blank, decreased concentration and memory, indecisiveness, irritability, impatience, anger, confusion, feeling on edge, nervousness, sleep disturbance, vivid dreams

Behavioural

Avoidance of situations, obsessive or compulsive behaviour, distress in social situations, phobic behaviour, increased use of alcohol or other drugs

---

3 Physical as Anything.com 2011
4 Youth Mental Health First Aid, 2010
Educational Implications of Anxiety

- Attendance issues including illness related to anxiety e.g. Separation Anxiety Disorder, Agoraphobia
- Fear about particular school activities
- Difficulty participating fully in curriculum activities due to fatigue from hyperarousal
- Difficulty beginning or completing tasks
- Concentration and organisational difficulties
- Responding to perceived stressful situations with a range of emotions including anger, withdrawal or self-harm
- Difficulties in forming and maintaining peer and teacher relationships

What is Depression?

The word depression is used in many different ways. People feel sad or blue when bad things happen. However, everyday blues or sadness is not a depressive disorder. People with the ‘blues’ may have a short-term depressed mood, but they can manage to cope and soon recover without treatment.

Major depressive disorder lasts for a prolonged period of time and affects a person’s ability to carry out their work, attend school and usual daily activities and to have satisfying personal relationships.\(^5\)

Why does it happen?

Depression has no single cause and often involves the interaction of many diverse biological, psychological and social factors.\(^6\)

There are certain risk factors that increase a child’s risk of developing depression.

- A history of depression in close family members
- Being more sensitive, emotional and anxious
- Adverse experiences in childhood
- Family poverty and social disadvantage
- Learning and other school difficulties
- Recent adverse events in the person’s life: death in the family, accident, bullying/victimisation, chronic pain or illness
- Parental divorce or separation

---

\(^5\) Youth Mental Health, 2010
\(^6\) Joyce, P.R. 2000
• Having another mental health illness such as anxiety disorder, psychosis or substance use disorder

**Signs and Symptoms**

• An unusually sad mood
• Loss of enjoyment and interest in activities that used to be enjoyable
• Having sleep difficulties or sleeping too much
• Loss of interest in food: changes in eating habits that may lead to either weight loss or putting on weight
• Feeling worthless or feeling guilty when they are not really at fault
• Thinking about death a lot or wishing they were dead
• Change in personal appearance

**Educational Implications of Depression**

• Difficulty concentrating
• Lateness to school or frequent absences
• Difficulty commencing, completing or staying on task in class
• Difficulty completing or attempting assessment tasks
• Social withdrawal and irritability
• Difficulty maintaining friendships
• Lethargy which may mimic disinterest
• Inability to make decisions

**What is Psychosis?**

Psychosis is a general term to describe a mental health problem in which a person has lost some contact with reality.

Some young people withdraw and drift into their own world and out of the main flow of school life, interpreting the world as hostile and aggressive. They are fighting battles that no one is having with them. Others become increasingly and openly ‘odd’. Their behaviour does not endear them to others but alienates them. Each of these groups may stop attending school or behave in a way that can lead to isolation, suspension or exclusion from school.

**Why does it happen?**

Early onset psychosis may be due to schizophrenia, bipolar disorder or could be a brief psychosis triggered by extreme stress, including early childhood trauma or drugs. Less commonly, it is due to thyroid disease, head injury, neurological diseases or encephalitis. It could also be an inherited vulnerability.
Schizophrenia is the most serious of the psychological causes and has to be treated seriously and intensively from the start.

**Signs and Symptoms when psychosis is developing**

- Changes in emotion, energy and motivation
- Change in appetite
- Depression, anxiety, irritability
- Reduced energy and motivation
- Changes in thinking and perception
- Difficulties with concentration, memory and attention
- Sense of alteration of self, others or outside world
- ‘Odd’ ideas
- Unusual perceptual experiences
- Sleep disturbance
- Social isolation or withdrawal
- Change in physical appearance
- Attempts to self-harm
- Difficulty with organisational skills and planning
- Substance abuse

Although these signs and symptoms may not be very dramatic on their own, when they are considered together, they will suggest something is not quite right.

**Educational Implications of Psychosis**

- Concentration and comprehension may be severely affected.
- Parts of the brain involved in initiative, planning, motivation and organisation begin to falter.
- The student may appear lazy, chaotic, disorganised, sloppy and slip-shod.
- Substance abuse – using illicit drugs to self-medicate
- Absenteeism/truancy

Psychosis usually presents after 14 years of age and peaks in the last two years of high school.

**What are Eating disorders?**

Eating disorders are not just about food, weight, appearance or will-power but are serious and potentially life threatening illnesses. Most eating disorders occur when a young person has incorrect beliefs about their appearance, body shape and weight, leading to marked changes in eating or exercising behaviours that interfere with their life.
**Why does it happen?**

Anorexia nervosa and bulimia nervosa both have strong genetic and biochemical components. Bulimia nervosa has many more treatments that have been shown to work than anorexia nervosa, including a range of psychotherapies and medications.

The current evidence suggests that there is a cultural pressure that creates a drive for thinness. Dieting behaviour under these circumstances is common and those who have a genetic predisposition and a personal history of adversity are more likely to feel better when dieting and worse when they break the diet. A cascade of negative biochemical and psychological consequences flows from this and the vicious anorexic cycle is set up.

**Signs and Symptoms of Eating Disorders**

- Dieting behaviour
- Evidence of binge eating
- Evidence of deliberate vomiting or laxative taking
- Excessive, obsessive or ritualistic exercise patterns
- Avoidance of eating meals, especially when in a social setting
- Lying about amount or type of food consumed
- Behaviours focused on body shape and weights
- Social withdrawal or avoidance of previously enjoyed activities
- Weight loss or weight fluctuations
- Extreme body dissatisfaction
- Depression, anxiety
- Change in physical appearance – baggy clothing

**Educational Implications of Eating Disorders**

- Avoiding social times at school – lunchtimes, recess
- Avoiding certain lessons – Food Tech, PDHPE
- Marked absenteeism
- Lethargy – struggle to maintain focus on schoolwork
- Withdrawal from relationships – peers and teachers
- Teasing/bullying of the student with an eating disorder
- Reduced academic performance
- Striving for perfection – impacts on ability to complete tasks
Family Breakdown

It is important to note that family breakdown or changes in family structure can be a trigger impacting on the mental health of the students in our schools.

Educational Implications of Family Breakdown

- Behavioural changes
- Attendance/truancy
- Missing equipment – pencils, text books etc
- Change in personal appearance including school uniform
- Withdrawal, lack of motivation
- Difficulty completing tasks, assessments and homework
- Changes in emotions – anger, sadness

Facts on non-suicidal self-injury/harm

Many terms are used to describe self-injury including self-harm, self-mutilation, cutting and parasuicide. People who engage in non-suicidal self-injury do so for many reasons. These include:

- managing painful feelings
- punishing themselves
- exerting influence over others
- ending feelings of disassociation
- avoiding or combatting suicidal thoughts
- sensation-seeking
- reaffirming personal boundaries and exerting control over the body.

Self-injury is a coping mechanism, not always an attention-seeking behaviour. Therefore, ‘stopping self-injury’ cannot be the focus; instead we must look at alternative ways to relieve the distress.
Educational Accommodations, Adjustments and Strategies

All schools are governed by, and must comply with the Disability Standards for Education 2005. These standards include the making of reasonable adjustments and the effect of the adjustment on the student, including

- ability to achieve learning outcomes
- ability to participate in courses or programs; and
- independence.

Before a school makes an adjustment they must consult the student or the associate of the student. The student needs to be involved in the process of developing a plan for learning and support, so that they can successfully access the curriculum and continue their education at their local school wherever possible.

An over-riding strategy for all students with support needs is the implementation of a mentor program. A member of staff needs to co-ordinate and manage the support/transition process. This will allow for consistency and clear communication with all members of the school community.

This document will include adjustments, accommodations and strategies that provide support to enhance the best possible outcomes for students with a mental illness.

A suggested Learning and Support Plan proforma is also included in this document.

Anxiety

Most anxiety is mild to moderate and can be helped by simple interventions.

- A safe environment: The first step in dealing with unrealistic worries is to eliminate realistic worries. The classroom and playground should be as safe as possible.
- A positive focus: Focus on what is enjoyable and safe, not on what is dangerous and must not be done, produces a positive resilience.
- Ensure the transition times each day are well-negotiated.
- Reduce subject load e.g. Pathways.
- Utilise disability provisions e.g. rest breaks, reader/writer.
- Organise separate supervision for tests and exams and extra time allocated for these.
• Arrange for a delayed start or shortened day if the student has difficulty with either waking up and getting to school in the morning or becomes fatigued during the day.
• Give tasks in writing.
• Scaffold and breakdown assessment tasks.
• Decrease homework workload and teachers should check that all assignments/homework are written down in the student’s diary.
• Provide support with study organisation.
• Allow student to have a break and a safe place where there will be adult supervision.
• Develop a ‘mistake-acknowledge’ culture: Mistakes are part of everyday life. Everyone makes mistakes and those who do best learn how to use mistakes creatively, pro-actively and openly.
• Provide a second set of books so that the student has them both at home and at school in case of absence and forgetting.
• Prepare and pre-warn for changes.
• Develop a school-based strategy to inform all staff, including casuals, about the students’ support needs e.g. Personalised Learning and Support Plans, information cards.
• Normalising worries: Help the student to understand that all people worry. Teach good ‘worrying’ strategies e.g. turning one big worry into a number of smaller worries to make them more manageable, putting worries to one side that we cannot do anything about immediately. Focusing on a very tiny, easy problem often gives confidence to tackle bigger problems.

**Depression**

• Space and time: Giving young people space and time and ‘a bit of slack’ when they feel bad is good advice.
• Activity, diversion and inclusion with others who are enjoying themselves, with no expectations that they have to perform, may assist.
• Focusing on strengths and areas of interest and enjoyment while de-emphasising areas of struggle and areas of conflict in their lives can take the pressure off in the short term.
• Respect: Making clear distinctions between dissatisfaction with what young people do, versus our respect and concern for them as individuals and persons, avoids the toxicity of criticism.
• Decreased exposure to conflict: Reducing exposure of young people to conflicts between parents, teachers, parents and teachers will reduce their distress even though it does not always take away the conflict.
• ‘It is not you’: Reassure children and young people that we as adults are responsible for our actions and that children/young people are not the source of the conflict.
• Maintain a team approach. Liaise with the school counsellor and ensure that the student has access to this support.
• Ensure there are systems of communication with the student’s family or carers which are open and frequent.
• Collaborate with the medical and allied health professionals in the development of a plan for learning and support.
• Always include the student in the process of planning their support.
• Regularly review the student’s progress.
• Use alternate methods of assessment.
• Give doable tasks, achievable goals.
• Gather sympathetic descriptions of the child in different settings and with different people for a recommendation to parents to obtain treatment.
• Establish a support network within the peer group if appropriate.
• Understand the student’s medication regime and the possible side-effects.
• Provide a safe place for recess, lunch and unstructured lessons.

Psychosis

The single best predictor of positive outcome is the length of time these students are able to stay at school. So the most positive strategy we can use is to keep them in school and engaged. Other interventions include:

• School staff following recommendations made by medical/health team.
• Picking the problem – recognising the signs and symptoms.
• Time, space and lack of criticism: These young people are sensitive to criticism, they find group situations difficult and are threatened by continued questions about their illness.
• Adopting a ‘no blame culture’, without normalising substance abuse.
• Knowing who the case manager is and ensuring open communication between all school staff.
• Developing a network of informed support where no one person is taking the entire worry for the young person, but where everyone provides small regular amounts of encouragement, time, effort and hope.

• Partial enrolment and well-planned transition plan.

• Accommodations under disability provisions.

**Eating Disorders**

• Identifying ‘at risk’ young people by recognising the signs and symptoms should lead to some increased enquiries about the student’s well being.

• Student’s teachers to be aware of and implement the strategies recommended by the medical/health team.

• Establish a buddy system if appropriate.

• Be aware of student’s sensitivities and maintain confidentiality.

• Reduce academic pressure and too many competing demands.

• Alert parents to their child’s weight loss.

• Establish thresholds for action as teachers. Follow school protocols for medical emergencies.

• Remain non-judgemental. Having an eating disorder is no more choice than having diabetes. It is not possible for affected young people to actively perceive their bodies as smaller or bigger.

• Allow for partial enrolment and a well-planned transition back to school.
# Learning and Support Plan

## Student Details

<table>
<thead>
<tr>
<th>Student’s name:</th>
<th>Grade:</th>
<th>Date of birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone number if applicable:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reason for referral to LST:

Student nominated goals:

<table>
<thead>
<tr>
<th>Year Advisor:</th>
<th>Case Manager:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Parent/caregiver:</th>
<th>Address of student if different:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone number:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immediate family members</th>
<th>Relationship to student</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Family situation

Previous school/educational settings
<table>
<thead>
<tr>
<th>Diagnosis:</th>
<th>Date of diagnosis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Specialist/s:</td>
<td>Area of Specialisation:</td>
</tr>
<tr>
<td>Specialist/s recommendation/s:</td>
<td>Other agencies involved:</td>
</tr>
</tbody>
</table>

**Relevant attachments:**
- Health Care Plan –
- Disability Confirmation -
- Other documentation

## History of mental health

<table>
<thead>
<tr>
<th>Mental health issue</th>
<th>Record of intervention/s</th>
</tr>
</thead>
</table>

## Current mental health

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Support and management</th>
</tr>
</thead>
</table>
### Other medical/physical conditions

<table>
<thead>
<tr>
<th>Medical/physical condition/s</th>
<th>Treatment/Medication</th>
<th>Possible side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Student’s strengths and interests

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Behaviour

<table>
<thead>
<tr>
<th>Early warning signs</th>
<th>Triggers</th>
<th>Support and management</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Learning

<table>
<thead>
<tr>
<th>Learning difficulties/issues</th>
<th>Intervention/Strategies (including adjustments)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# Actions

<table>
<thead>
<tr>
<th>Decisions</th>
<th>Whose responsibility?</th>
<th>By when?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Mentor (if applicable):

Next review date:

**Meeting Attendees**

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Position (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Signature of Principal:**
Learning and Support Review Meeting

Date of plan:

*Refer to previous outcomes

Progress/changes

<table>
<thead>
<tr>
<th>Revised Outcomes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Decisions</th>
<th>Whose responsibility?</th>
<th>By when?</th>
</tr>
</thead>
</table>

Next review date:
<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Position (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Student Details**

<table>
<thead>
<tr>
<th>Student’s name: Sarah White</th>
<th>Grade: 8</th>
<th>Date of birth: 3/8/99</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone number if applicable:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reason for referral to LST:**
Transitioning back to school after long absence due to her anxiety.

**Student nominated goals:**
To attend school and be with my friends

**Year Advisor:** Jane Brown  
**Case Manager:** Jim Black (School Counsellor)

**Parent/caregiver:** Mrs Green (mother)  
**Phone number:**  
**Address:** 12 Yathawonga St Emerald 2222  
**Student’s General Practitioner:** Dr France

<table>
<thead>
<tr>
<th>Immediate family members</th>
<th>Relationship to student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs Green</td>
<td>Mother</td>
</tr>
<tr>
<td>James White (16)</td>
<td>Brother</td>
</tr>
<tr>
<td>Bill Green</td>
<td>Step father</td>
</tr>
</tbody>
</table>

**Family situation**
Sarah lives with mum, brother and step father  
No contact with biological father (lives in a different state)
**Previous school/educational settings**
Yellow Brick Public School from K to 6

**Diagnosis:**
Severe anxiety/OCD

**Date of diagnosis:**
2/5/12

**Name of Specialist/s:**
Dr London

**Area of Specialisation:**
Paediatric psychiatrist

**Contact number/s:**
888-888-591

**Specialist/s recommendation/s:**
Continued medication
Partial enrolment (reduced workload)
Link Sarah to School Counsellor

**Other agencies involved:**
Emerald Community Health (Deb Toto – Clinical Psychologist)

**Relevant attachments:**
- Health Care Plan – not applicable
- Disability Confirmation – not applicable
- Other documentation

**History of mental health**

<table>
<thead>
<tr>
<th>Mental health issue</th>
<th>Record of intervention/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>First symptoms of anxiety appeared in early Year 7 – for example: continual redoing of school work. Unable to attend Year 7 camp Poor attendance Arriving late Indecisive in class</td>
<td>Year Advisor instigated Student Progress Report School Counsellor Meeting with LST/parent and student (Term 1, Week 6 2012) Referral to paediatric psychiatrist</td>
</tr>
</tbody>
</table>
## Current mental health

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Support and management</th>
</tr>
</thead>
<tbody>
<tr>
<td>May not return to school and not complete her education.</td>
<td>Sarah does not pose a risk to herself and others.</td>
</tr>
<tr>
<td>Loss of social contact and support from peers (isolation).</td>
<td>Sees the Clinical Psychologist on a weekly basis.</td>
</tr>
<tr>
<td>Absconding from school and could place herself in a vulnerable and unsafe situation.</td>
<td>Continue on medication.</td>
</tr>
<tr>
<td></td>
<td>Gradual return to school plan – three half days (mornings) for first two weeks then review and adjust.</td>
</tr>
<tr>
<td></td>
<td>Case manager to meet student at 8.30 each morning and help her to transition into class.</td>
</tr>
<tr>
<td></td>
<td>Peer buddy nominated by Sarah.</td>
</tr>
<tr>
<td></td>
<td>Time out card</td>
</tr>
<tr>
<td></td>
<td>All teachers are to be advised of Sarah’s condition and strategies and make adjustments e.g. decreased homework load.</td>
</tr>
<tr>
<td></td>
<td>Mother to pick up Sarah from the School Office at the conclusion of her school day.</td>
</tr>
</tbody>
</table>

## Other medical/physical conditions

<table>
<thead>
<tr>
<th>Medical/physical condition/s</th>
<th>Treatment/Medication</th>
<th>Possible side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Student’s strengths and interests

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Art</td>
<td>Pencil drawing</td>
</tr>
<tr>
<td>English is her favourite subject – good at poetry writing</td>
<td>Reading</td>
</tr>
<tr>
<td></td>
<td>Music</td>
</tr>
</tbody>
</table>
### Behaviour

<table>
<thead>
<tr>
<th>Early warning signs</th>
<th>Triggers</th>
<th>Support and management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in rubbing out her work.</td>
<td>Maths – time restraints to complete work.</td>
<td>Reduce workload in Maths and remove time constraints.</td>
</tr>
<tr>
<td>Wringing her hands and biting her nails.</td>
<td>PE - worried about getting changed in front of her peers.</td>
<td>Establish an alternative private place to change for PE.</td>
</tr>
<tr>
<td>Poor attendance</td>
<td></td>
<td>Case manager to have regular communication with the mother.</td>
</tr>
<tr>
<td>Sick bay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent Time Outs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased isolation from peers.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Learning

<table>
<thead>
<tr>
<th>Learning difficulties/issues</th>
<th>Intervention/Strategies (including adjustments)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Falling behind with her class work.</td>
<td>Sarah’s buddy to collect worksheets and provides photocopies of her class notes (copies to be done by case manager).</td>
<td></td>
</tr>
<tr>
<td>Difficulties starting tasks.</td>
<td>Teacher prompts/peer model.</td>
<td></td>
</tr>
<tr>
<td>Difficulties completing assessments/examinations in large groups and within time constraints.</td>
<td>Disability provisions for assessments/exams – separate supervision; extra time to work and rest breaks.</td>
<td></td>
</tr>
</tbody>
</table>

### Actions

<table>
<thead>
<tr>
<th>Decisions</th>
<th>Whose responsibility?</th>
<th>By when?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect progress reports from the subject teachers.</td>
<td>Case manager</td>
<td>Fortnightly</td>
</tr>
<tr>
<td>Review the partial attendance plan and if successful extend to 5 half days.</td>
<td>LST</td>
<td>End of second week of return to school.</td>
</tr>
<tr>
<td>Maintain consistent communication with the mother.</td>
<td>Case manager</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Case manager</td>
<td>As required</td>
</tr>
</tbody>
</table>
Request report from the Clinical Psychologist.

Enrol at Hazelhurst for pencil drawing lessons.

Communicate with subject teachers about strategies for Sarah’s successful learning.

With the permission of Sarah and her mother communicate some information to Sarah’s friends about her condition.

Ms Deb Toto Clinical Psychologist to be invited to the review meeting (27/5/13).

<table>
<thead>
<tr>
<th>Mentor (if applicable):</th>
</tr>
</thead>
</table>

| Next review date: 27/5/13 |

<table>
<thead>
<tr>
<th>Meeting Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>Sarah White</td>
</tr>
<tr>
<td>Mrs Green</td>
</tr>
<tr>
<td>Jim Black</td>
</tr>
<tr>
<td>Jane Brown</td>
</tr>
<tr>
<td>Magenta Grey</td>
</tr>
<tr>
<td>Redmond Beige</td>
</tr>
<tr>
<td>Violet Gold</td>
</tr>
</tbody>
</table>

| Signature of Principal: |
Resources and Support Services

Edgeware School
Burnett St & Tennett Pde, Hurlstone Park NSW 2193
Ph: 9554 7044      Fax: 9554 7046
School email: edgeware-s.school@det.nsw.edu.au
School website: www.edgeware-s.schools.nsw.edu.au

Edgeware is a School for Specific Purposes. It is an alternative Department of Education and Communities facility mainly for Year 9 to 12 students who have been unsuccessful in mainstream schools. Enrolment applications are submitted to the St Peters Regional Office.

Redbank School
Institute Rd, Westmead NSW 2145
Ph: 9633 1030      Fax: 9687 14 25
School email: redbank-s.school@det.nsw.edu.au
School website: www.redbank-s.schools.nsw.edu.au

Redbank school, established in 1976, is located behind Westmead hospital and is part of a combined Department of Education and Communities & Department of Health facility for the treatment of children and adolescents with emotional, behavioural or psychiatric difficulties. These difficulties may include depression, eating disorders, anxiety, psychosis, trauma, complicated family problems and difficulties getting along with others at school. Although the students are predominantly from the greater west of Sydney, some parts of the program service all of NSW. Students attend Redbank School for periods ranging from one week to two terms. The school has maximum enrolment of 48 students. Redbank has three units; the Child and Family Unit, for students K-6, the Adolescent and family Unit, for students in Years 7-12, and the Acute Adolescent Unit, a locked ward for adolescents with severe psychiatric illness. Students that enrol in the school are first accepted as patients into Redbank House (PH: 9845 6577), which is Westmead Hospital’s Department of Child, Adolescent and Family Psychiatry. The school provides behavioural intervention, academic testing and remediation, support to the student’s home school and state-wide training to Education and health staff on the management in the classroom of emotional and behavioural problems of the children and adolescents.
**Woniora Road School**

83-85 Woniora Rd Hurstville 2220  
PH: 9580 6818       Fax: 9580 6376  
School email: woniorard-s.school@det.nsw.edu.au  
School website: www.woniorard-s.schools.nsw.edu.au  

Woniora Road is a NSW Government school for special purposes. It is a positive, supportive, and engaging learning environment that delivers individualised plans that promote well-being and develop each student’s talents and academic potential.

**Centennial Park School**

1/78 Avoka St Randwick 2031  
PH: 9320 0588       Fax: 9310 0480  
School email: centennial-s.school@det.nsw.edu.au  
School website: www.centennial-s.schools.nsw.edu.au  

Centennial Park School is a NSW Government School which provides short-term intensive personalised learning and support for students in Years 7-12. The school caters for 28 students and has strong links to the community.

**Cook School**

Rawson Ave Loftus 2232  
PH: 8539 7155       Fax: 8539 7462  
School email: cook-s.school@det.nsw.edu.au  
School website: www.cook-s.schools.nsw.edu.au  

Cook School is a NSW Government school which provides individual education and behaviour plans addressing targeted needs. The school aims for students to develop an understanding of personal responsibility, problem solving skills and social competencies.
Carinya School
Coleborne Ave Mortdale 2223
PH: 9580 2852      Fax: 9580 7054
School email: carinya-s.school@det.nsw.edu.au
School website: www.carinya-s.schools.nsw.edu.au
Carinya SSP provides an education for students aged 8 to 18 years, with the majority of students being secondary aged. Carinya caters for students with anxiety, various special learning needs, mental health problems and in some cases autism. It is a NSW Government School.

Rivendell School
Thomas Walker Estate Hospital Rd Concord West 2138
PH: 9743 1075      Fax: 9736 3784
School email: rivendell-s.school@det.nsw.edu.au
School website: www.rivendell-s.schools.nsw.edu.au
Rivendell is a joint Department of Health/Department of Education and Communities facility that focuses on the psychological health of young people and their families. Rivendell School provides the educational programs for these young people.

Dunlea Centre
35a Waratah Rd Engadine 2233
PH: 8508 3900      Fax: 8508 3920
School email: director@boystown.net.au
School website: www.boystown.net.au/home.htm
At Dunlea Centre families in crisis receive special attention so that they can remain intact and deal with difficult issues. Many families get help through Dunlea Centre’s intensive residential program that lasts for 6-12 months. Students return home on weekends to practice the things they have learned. The main carers attend counselling sessions every
two weeks and each family establishes a set of goals they wish to achieve. As an agency Dunlea Centre incorporates therapy, education and family support with an end goal of Family Preservation and restoration wherever possible. Dunlea Centre – Australia’s original Boy’s Town is also registered as a Year 7-10 school and so young people whose experience of mainstream schooling has been unsatisfactory get a chance to learn in a supportive atmosphere.

ReachOut.com

Website: au.reachout.com/

ReachOut.com is Australia’s leading online youth mental health service. It’s the perfect place to start if you’re not sure where to look. Each year it helps hundreds of thousands of young Australians with information support and stories on everything from finding your motivation, through to getting through really tough times. With a mobile friendly site and forums, you can access help, info and support no matter where you are. Everything on ReachOut.com is created with experts and young people, so you can be sure to find stuff that’s not only evidence-based, but is also relevant to you. It’s got tools and tips to make everyday life just a little easier, and if you can’t get the help you need on ReachOut.com, we have looks to a number of other great services that exist for young people in Australia.

SenseAbility

Website: http://beyondblue.org.au

SenseAbility is a strengths-based resilience program designed for those working with young Australians ages 12-18. It consists of a suite of modules developed to enhance and maintain emotional and psychological resilience in young secondary school aged Australians. It was created with classroom delivery in mind, however, the modules have strong potential to benefit young people in other structured environments such as TAFE and Youth Organisations. The program is based on cognitive-behavioural principles: the evidence based approached which says that our thoughts play a critical role in influencing feelings and consequent behaviour. Young people who possess sound social and emotional skills are generally better able to cope with the stressors of daily life. They also tend to have better relationships with parents, teachers, peers and perform better academically. Very importantly, having these skills makes it less likely that a young person will experience significant mental health problems in the future.
Headspace

Level 2, South Tower, 485 La Trobe Street, Melbourne 3000

Ph: 03 9027 0100      Fax: 03 9027 0199

Email: info@headspace.org.au

Website: www.headspace.org.au/

Headspace National Youth Mental Health Foundation Ltd is funded by the Australian Government Department of Health and Aging under the Youth mental Health Initiative Program. Headspace centres provide support, information and advice to young people aged 12 to 25. There are 55 centres all around Australia and they provide support with General Health, Mental Health and Counselling, Education, employment and other services, Alcohol and other drug services.

Black Dog

Website: www.blackdoginstitute.org.au

The Black Dog institute is a research and educational facility for depression and bipolar disorder. It is not a crisis centre but they do offer phone counselling.

*Mental Health and Counselling services for children, adolescents and young people living in South Eastern Sydney are located across three areas: Eastern Suburbs, St George and the Sutherland Shire. A copy of these services and how to refer a child, adolescent or young person to the service can be found at www.schoollink.chw.edu.au. Similar services are available through local health districts across New South Wales.*
References


