



The mental health Risk Assessment and Management Process (RAMP) for schools: I. The model

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Abstract

Recent national surveys have indicated that there is a significant level of unidentified and untreated mental health problems in children and young people. This represents a chronic missed opportunity to ameliorate these problems by early identification and intervention. Schools are the obvious setting in which to improve mental health in this population, but there is a service gap between whole-school mental health promotion programs and individual service provision by mental health professionals. The Risk Assessment and Management Process (RAMP) has evolved after extensive piloting with schools as a response to this service gap. It is a systematic set of processes for schools that promotes early identification and intervention for children and adolescents at risk of mental health problems. It uses a three domain risk and protective factor framework, a team-based approach to pastoral care, structured team processes, protocols and solution focused strategies tailored to the school setting, and provides professional development in mental health to school staff. These interconnected components work together to provide an early identification and response process for at-risk students which encompasses within-school support and linkages between the school, the family and community organisations and agencies.

Keywords

risk assessment, schools, school mental health program, early intervention, early identification, risk and protective factors

Introduction

The period since the Ottawa Charter for Health Promotion (World Health Organization [WHO], 1986) has seen a marked increase in the attention that government and non-government organisations have paid to the issue of mental health in children and adolescents. This has been driven by better data about how common mental health problems are in young people (Sawyer, Arney, Baghurst et al., 2001; WHO, 2001), a realisation that the current and future burden has been underestimated and the awareness that

early intervention can minimise the consequences for both young people and their communities (Commonwealth Department of Health and Aged Care, 2000; McGorry & Yung, 2003; WHO, 2003).

The clear evidence that learning is impeded by emotional, behavioural or health problems (Masten, Roisman, Long et al., 2005; Paternite, 2005; World Bank, 1993) and the potential for education, health and wellbeing to be improved through interventions in the school setting, led WHO to develop the concept of health

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promoting schools (WHO, 1998). This has led to the development of a number of mental health promotion interventions targeting schools, of which the MindMatters program (Wyn, Cahill, Holdsworth et al., 2000), Gatehouse Project (Patton, Glover, Bond et al., 2000) and the *beyondblue* Schools Research Initiative (Spence, Burns, Boucher et al., 2005) are significant Australian examples.

These programs use a whole-school approach to adapt the curriculum, school policies and environment, while encouraging links and partnerships with services outside the school, in ways designed to increase mental health and wellbeing. The *beyondblue* Schools Research Initiative is a whole-school approach designed for students in years 8 to 10 to prevent depression by enhancing evidence-based individual and environmental protective factors. These prevention approaches operate at the top two levels of the WHO framework for comprehensive mental health promotion in schools (see Figure 1) (Hendren, Birrell-Weison & Orley, 1994). A number of other school-based intervention programs have been developed as prevention and early intervention programs for students who fall or could fall in the lower two

levels of the framework. Examples of these types of programs are RAP - the Resourceful Adolescent Program (Shochet & Osgarby, 1999), ACE - Adolescents Coping with Emotions (Kowalenko, Wignall, Rapee et al., 2002); and Friends (Barrett, Moore, & Sonderegger, 2000). There are also indicated intervention programs such as CASEA - Child and Adolescent Mental Health Service (CAMHS) and Schools Early Action Program (Corboy, 2006; Costin & Brann, 2006; Hayes, 2006; Pietrzak & Makros, 2006). Unlike MindMatters and the Gatehouse Project, the other school based programs target particular age groups and/or particular mental health issues such as depression (RAP, ACE, *beyondblue* Schools Research Initiative), anxiety and depression (Friends), or emerging conduct disorder (CASEA).

All of these programs have been developed because of an awareness that, notwithstanding the services provided by school psychologists (guidance officers), student welfare coordinators, primary welfare officers, school nurses and CAMHS, there is a significant unmet need for prevention, early intervention and service delivery for young people who have mental health problems.

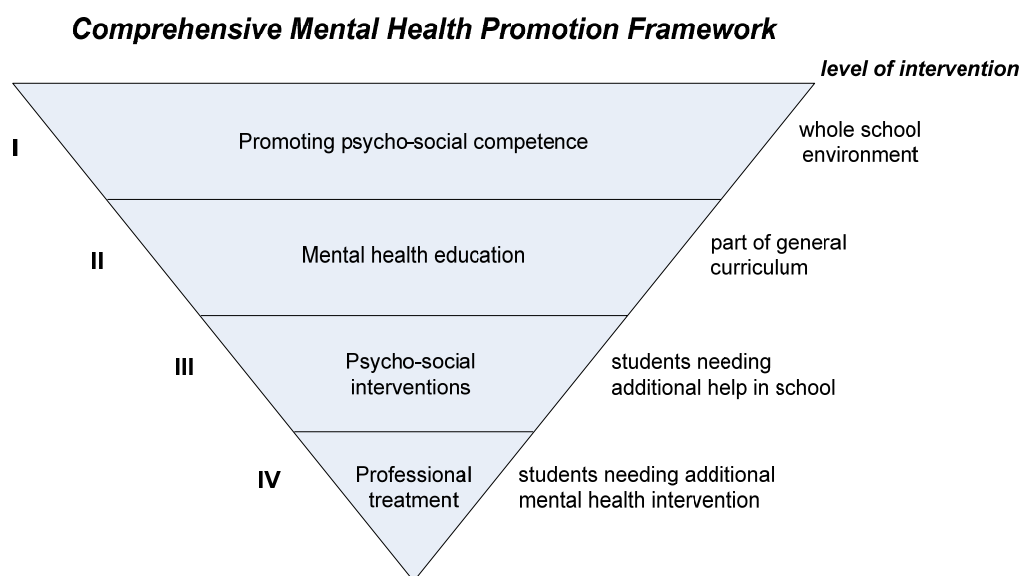


Figure 1. The World Health Organization framework for comprehensive mental health programs in schools

The extent of this need was quantified by the Australian National Survey of Mental Health and Wellbeing (Sawyer et al., 2001) which found that 14% of school-aged children had clearly identifiable mental health problems. It also found that only 25% of those identified as having a mental health problem had received any care in the previous six months, and when they had it was predominantly from school counsellors and general medical practitioners. These data indicate that at any given time as many as 10% of the school-aged population have untreated and possibly unidentified mental health problems. Having approximately 300,000 young people in this situation represents both a significant lost opportunity for early intervention and a large and potentially persistent service gap for this population.

In Australia, CAMHS represent the highest concentration of mental health expertise in the health system for children and young people, yet they mostly deal with only a small proportion of those who could benefit, and mostly only after the problem(s) have become serious enough to justify allocation of their limited resources. Although CAMHS do provide services to schools through primary and secondary consultation, these are mainly focused on clients of the service and increasingly policy directs service provision to the 2% in greatest clinical need. In the absence of extraordinary increases in resources, it is unlikely that traditional models of mental health service delivery, through CAMHS and other service providers can adequately address the unmet need in this population identified by Sawyer et al. (2001).

This paper presents the Risk Assessment and Management Process (RAMP) that has been developed in response to the clear gap in the provision of services for students who have or may be at risk of mental health problems. The RAMP model approaches the problem of the service gap by focusing on the processes and infrastructure of pastoral care in order to build capacity in schools for the early identification and response to students who have a mental health problem or who are at risk of them. The focus of RAMP is an 'upstream' level of intervention (Murphy, 2004): the goal is not to replicate models of primary service delivery in the school setting, instead mental health

expertise has been applied to the service gap at a system level with a focus on sustainable processes and infrastructure. RAMP is entirely complementary to whole school prevention approaches and other intervention programs such as the RAP and Friends. A process evaluation of RAMP is reported in the companion paper in this issue (Shortt, Fealy & Toumbourou, 2006).

The Risk Assessment and Management Process (RAMP) for schools

RAMP is designed for the 20-30% of students that WHO has estimated will require some kind of psychosocial support in schools, including the 14% of students who have mental health problems. RAMP integrates the evidence-based recommendations of WHO: intervene early, reduce known risk factors, and enhance protective factors with a systematic set of processes for pastoral care. RAMP comprises four components:

1. use of an evidence-based, multiple domain, risk and protective factors framework;
2. an emphasis on a team-based approach to pastoral care;
3. clear, structured processes and protocols; and
4. professional development in mental health.

These interconnected components work together to provide an early identification and response process for at-risk students which encompasses within school support and linkages between the school, the family and community organisations and agencies (see Figure 2).

RAMP has been developed as a model by a clinical psychologist in consultation with regional school psychologists (guidance officers), school staff and other school system support officers at schools in six local government areas in Melbourne in Victoria, Australia. An early risk and protective factor framework and screening for risk was trialled in 2002 and 2004 in eight volunteer schools (three secondary and five primary) when the first author was employed by Austin CAMHS with funding support from Boroondara School Focused Youth Service (SFYS). RAMP developed as a systematic sustainable process, taught using a two-day training program and a whole school professional development session

in 2005 in three secondary and six primary volunteer schools across five local government areas in Melbourne, involving the Southern and Alfred Hospital CAMHS with support from three SFYS regions. RAMP has now been implemented in a total of 25 schools, and been supported by three metropolitan CAMHS. Implementations now occur with an e-learning based training package to promote consistency and sustainability for schools as staff change.

The five year development process, involving regular and intensive consultation with schools, is consistent with the deployment-focused model of intervention development and testing proposed by Weisz, Chu & Polo (2004). This model aims to develop interventions that fit seamlessly into ‘real world’ conditions in schools. Weist (2005) has similarly argued for the development and evaluation of user friendly *empirically supported practice* on the grounds that most treatments developed in research clinics have little evidence to support their effectiveness in real world settings. The

development and refining of RAMP within its treatment context has also been consistent with Wandersman’s (2003) proposal for a community science approach which defines best practice as *process*. Wandersman argues that engagement of stakeholders in the implementing, evaluating, sustaining and improving process is a legitimate way of defining and evaluating such best practice.

1. Evidence-based risk and protective factors framework

The risk and protective factors framework is operationalised by a checklist of evidence-based risk and protective factors. The conceptual underpinning of these factors is resilience: protective factors can reduce the risk of a poor outcome for young people facing stress or adversity (Werner & Smith, 1989) and reduce the risk of a poor outcome even when risk factors remain (Bond, Toumbourou, Thomas et al., 2005; Borowsky, Ireland & Resnick, 2001; Donald, Dower, Correa-Velez & Jones, 2006).

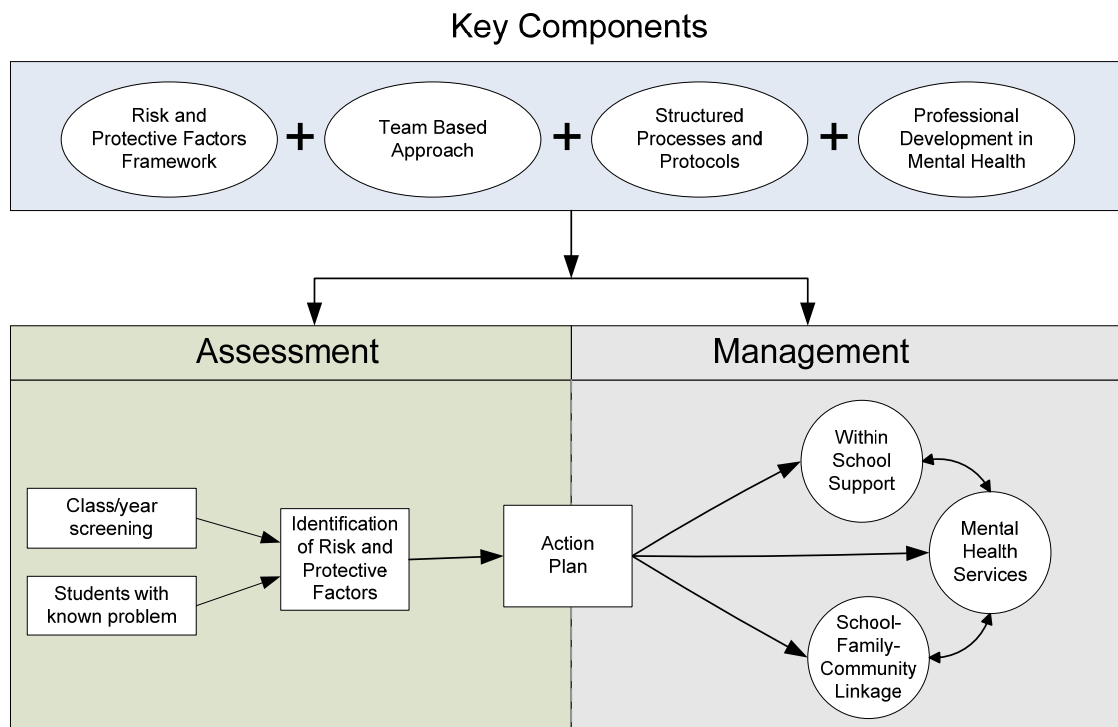


Figure 2. Schematic diagram of the Risk Assessment and Management Process (RAMP)

The checklist, used as the monitoring form in RAMP, provides a measure of risk on a continuum whereby an elevated number of risk factors and a low number of protective factors is associated with one or more poor outcomes for young people. Poor outcomes can include depressive symptoms, substance use, substance abuse, early school exit, risk of homelessness, antisocial behaviour/involvement with juvenile justice, and suicide. A range of outcome studies for youth and at risk youth that were cross-sectional or long-term prospective were utilised to develop the items on the monitoring form (e.g., Achenbach, Howell, McConaughy & Stanger, 1998; Blum & Ireland, 2004; Bond et al., 2005; Bond, Thomas, Toumbourou et al., 2000; Borowsky et al., 2001; Catalano, Berglund, Ryan et al., 1998; De Leo & Heller, 2004; Donald et al., 2006; Ezpeleta, Granero, De Le Osa & Guillamon, 2000; Feehan, McGee, Williams & Nada-Raja, 1995; Fischer, Barkely, Fletcher & Smallish 1994; Piko, Fitzpatrick & Wright, 2005; Prior, Sanson, Smart & Oberklaid, 2000; Prior, Smart, Sanson & Oberklaid, 2001; Resnick, Bearman, Blum et al., 1997; Rutter, 1990; Vega, Aguilar-Gaxiola, Andrade et al., 2002; Werner & Smith, 1989; Zweig, Phillips & Lindberg, 2002).

The monitoring form is not intended to have psychometric properties nor is it intended to cover all possible evidence-based risk and protective factors that impact on outcomes for young people. The monitoring form was further developed in 2005 and 2006, drawing conceptually from resilience literature (Gordon & Song, 1994; Harvey & Delfabbro, 2004; Luthar, 1993; Masten, 1994). Protective factors were refined to be consistent within a conceptual framework for resilience in which protective factors are those which contribute to the mastery motivation system and its associated cognitive construct of self efficacy ('I can do it', empowerment of the self: Bandura, 1982) and facilitate connection with others, particularly pro-social others. Within this model, self-esteem, empowerment and optimism are facilitated by these two protective processes. The selected evidence-based protective factors are those that mediate these protective processes and so ameliorate risk. The selected evidence-based risk factors are those which can erode protective factors and protective processes.

A further important goal in creating the monitoring form was to assemble those evidence-based risk and protective factor items into a face-valid protocol that was easily completed by school staff and, for the most part, related to areas that can be responded to within the school. The primary school version of the monitoring form has 33 items and the secondary school 35 items covering three relevant domains: individual factors (e.g., self-regulation, self-efficacy, mood, social skill), school factors (e.g., new to school, academic achievement, school attendance, relationship with teacher, engagement with curriculum), and family/peer/community factors (e.g., belonging to a friendship group, at least one close friend, involved in a structured group in the community, recent stress or loss). The monitoring forms have been trialled from preparatory grade to Year 12.

2. Emphasis on a team-based approach

CAMHS routinely use multi-disciplinary teams to support and mentor staff in their work with clients. These teams provide staff with a range of perspectives, experience and expertise, support from their colleagues and a reflective space for addressing challenges. Schools also routinely use collaborative teams to direct and manage their teaching activities. In many schools pastoral care is also team-based and where it isn't, schools' collegial culture has long encouraged a level of informal staff support around pastoral care. RAMP emphasises the advantages of a team-based approach and so can build on existing pastoral care teams, as well as promote their creation and thus provides the opportunity to focus on at-risk students by merging the best practices from CAMHS and schools. A team-based approach is able to offer more support to at-risk young people through processes that promote a shared view of the issues, shared management and mutual support for staff.

The first goal of the team-based approach in RAMP is to regularly bring together relevant staff so that communication can be effective and so that management plans within the school can be clear and consistent. Depending on the school, RAMP teams typically consist of school staff such as the student welfare co-ordinator, assistant principal, a regional school psychologist (guidance officer) and the year co-ordinators and class teachers who have identified

at-risk students. Other pastoral care staff such as the school chaplain, school nurse and primary welfare officer also attend regularly, while reading readiness or new arrivals teachers may attend as appropriate.

RAMP meetings are an opportunity for staff to feel affirmed, to debrief and to have pastoral care workload and roles monitored and reviewed. The team-based approach to pastoral care builds capacity because it promotes ongoing professional development by providing a forum in which school staff can learn from and support each other.

3. Structured processes and protocols for assessment and intervention

In primary schools, the class teacher uses the RAMP monitoring form to screen all students in their class. In secondary schools, all poor school attenders, students who have a behavioural incident record and new students are screened, because these are three indicators for early school exit. Teachers are asked to tick the box to indicate the presence of a risk or protective factor and can put two ticks in boxes next to factors they perceive as significant or highly influential for that student. Teachers are not asked to make a judgement about mood disorder, as this is a clinical diagnosis, but they are asked to tick the box if they perceive that the student has a persistent negative feeling (anxiety, irritability or sadness) that is causing impairment to their learning or their social connection at school.

Teachers are in a unique situation for early identification of at-risk students in the school context. The earlier an at-risk student can be identified the more quickly that student's protective factors can be built and the risk factors can be reduced. Early identification of at-risk students makes the possibility of early intervention more feasible and more effective for teaching staff. Further, involvement of school staff to strategically build resilience in at-risk students is most possible when identification can be linked to methods of supporting at-risk students through *feasible* action plans.

While the class teacher and the year co-ordinator have the main role in the identification of the student, the broader school team also makes a

significant contribution. When the student's monitoring form is brought to a team meeting, other members of the team are invited to contribute. If there are differences of perception about the student, the team decides how to complete the form. The forum and tools to develop a shared and consistent view of the student are designed to facilitate a consistent and holistic management approach.

The risk and protective factor profile of a student helps a school to ascertain who may be most at risk and to prioritise the delivery of limited pastoral care resources. Through RAMP, guidelines for screening students at different year levels are provided together with monitoring protocols that provide a means of measuring change in the student over time. RAMP implementation is supported by clear and accessible pathways for further information about mental health problems. The guidance officer (school psychologist) is an important member of RAMP meetings and depending on the implementation model, a CAMHS clinician attends RAMP meetings during this period or is available to provide specialist consultation to the school staff about mental health problems. At the identification stage, this consultation may comprise advice about timely referral options for high risk students and clarification about which type of student problems suggest a crisis referral to a specialist agency.

The risk and protective monitoring form provides a shared language to talk about at-risk students and a cognitive map that guides responses to these students. The goal of RAMP meetings is to develop and monitor *action plans* for identified at-risk students. The participating class teachers or year coordinators bring one or two completed monitoring forms to each meeting. Those chosen from screening generally have the most risk factors and fewer protective factors, although some schools also include some students at moderate risk.

The monitoring form is used to develop an action plan for each student. Using their shared understanding of risk and protection, the RAMP team works together to build the student's resilience by identifying ways to reduce risk factors and increase protective factors. The training program helps the pastoral care team to

develop skills in using the risk and protective factor profile using a systematic method to plan and review intervention. Considering safety issues is the first step of this method. This is followed by steps to maximise change using the student's risk and protective factor profile. For example, a student who has a range of risk factors and low number of protective factors may have poor school attendance identified first for intervention because until this issue is addressed all school protective factors will remain low. The RAMP team will seek to increase school attendance by looking at how the student's existing protective factors can be used to improve attendance. An analysis of the student's other risk factors will determine whether these are also contributing to poor school attendance. Where school-home communication is low (a risk factor), this may need to be addressed in order to improve school attendance. In another situation, recent stress or loss (a risk factor) may be contributing to the poor school attendance and may need a specific response. The focus is on setting achievable goals using within-school resources where possible.

Change in a student's risk and protective factor profile combined with monitoring guidelines are used to evaluate the effectiveness of the intervention and to assist schools to decide when to modify the action plan and when to discuss out-of-school help with the student and their family. The RAMP monitoring form is designed to promote action plans for at-risk students with minimum encroachment on the privacy of the student. For example, if a student is experiencing stress or adverse events, the details are not discussed without student consent. However, the need to modify work requirements and build in additional support structures for a stressed student, especially one who has several other risk and few protective factors, falls within the school's duty of care. Detailed confidentiality guidelines have been developed in consultation with schools to provide a framework that fits within privacy legislation while also addressing the school's duty of care to its students.

4. Professional development in mental health

Professional development in mental health is provided in the RAMP training program. Training in 2005 was provided by a partnership

orientated two-day group training program for senior pastoral care staff in several schools (primary and secondary) and CAMHS staff. School staff and school psychologists have since requested more structured training that is more accessible to a range of staff. RAMP training is now targeted at school staff and school psychologists (guidance officers) and comprises an e-learning training package which has seven training modules and printable documents and forms to use RAMP processes. The training, which includes three worked through case examples, comprises: Introduction, Identification, Developing Action Plans, Monitoring and Referring, Implementation, High Risk, and Capacity Building. A whole school professional development session is part of the implementation protocol. Secondary consultation from the CAMHS clinician on site during some or all of the implementation sessions (depending on the model of implementation) provides further professional development in mental health. Moreover, the team structure (pre-existing or built during implementation) increases opportunities for a range of school staff to access professional development in mental health through mentoring and sharing information within the team and through the increased engagement between schools, school psychologists (guidance officers), other school support system officers and CAMHS, facilitating further opportunities for training and professional development around student mental health issues.

Linkages between the student and the school, family and community

The student's risk and protective factor profile and the monitoring of the school intervention, using the risk and protective factor profile, provides an effective way of communicating with the student (when developmentally appropriate), their parents and (with consent) other agencies, about the student's progress. It builds a shared framework for all to use in monitoring and planning further intervention to build resilience. RAMP provides guidelines which map out criteria to use to decide when to provide support for the student within the school and when referral to outside service providers for further assessment and assistance is indicated. RAMP guidelines, augmented by secondary

consultation from the school psychologist and, when appropriate, from CAMHS clinicians, can add to the knowledge in the team about how and when to refer to which agencies.

In addition to providing professional development about the way in which mental health issues can affect school performance, RAMP increases the number of school staff who have knowledge about local referral options and provides regular access within the team to discuss referral options with senior pastoral care staff. When families and students seek help from class teachers or from year co-ordinators about referral options, RAMP teams can help to effect a timely and effective response.

Students who are already linked with a number of agencies are likely to be those at highest risk. The RAMP risk and protective factor framework provides a shared language of risk and resilience and a shared set of evidence-based goals for building resilience which, with consent, can help to co-ordinate a clear and consistent intervention plan for the student across a number of settings including the school. The RAMP team can provide an efficient means of establishing staff roles and clear pathways for communication within the school and between agencies and the school.

RAMP team meetings provide a forum in which the risk and protective factor framework can be used to examine school organisation and processes and decide whether support for a student within the school, or linkages between the student and family, school or community, could be more easily effected by a change in one or more of those processes and systems. For example, a student's poor attendance (a risk factor) can prompt the team to review how the current school system of monitoring school attendance can further support the goal of early identification. The exploration of how a student can be supported to join a friendship group (a protective factor) may lead to the school further enhancing the current structures that promote peer connectedness. The use of the risk and protective factor framework at the organisational and system level of the school is designed to further build school capacity for pastoral care of at-risk students but it is also likely to have a positive impact on the wellbeing of all students.

Conclusion

RAMP promotes the use of evidence-based risk and protective factors to develop an early identification and intervention process for at-risk students in schools that integrates within school support with linkages for the student between the school, family and community organisations and agencies. RAMP is designed to provide better assessment and to establish processes, protocols and a shared language that harnesses school staff's concern for and motivation towards helping at-risk students. The essence of the approach of RAMP is to address the unmet needs of at-risk young people by making the best use of the existing, limited resources: to do the best we can with what we have. There is potential for RAMP to help meet the needs of the many at-risk young people who are currently not receiving services and the positive findings of the process evaluation reported in the companion paper (Shortt, Fealy & Toumbourou, 2006) represent the first important step towards ascertaining this potential.

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