

KARITANE TODDLER CLINIC (KTC)

Abstract

The KTC was established in response to an identified need to provide interventions for families with children aged 15 months to 4 years, displaying severe behavioural disturbances and psychopathology. The KTC uses the Parent-Child Interaction Therapy (PCIT) model and is the only Parenting Centre in Australia to implement a specific Toddler Behaviour Program. Current thinking about early intervention increasingly accepts the premise that early childhood experience crucially determines health and wellbeing and the attainment of competencies. The investment in the early years will be reflected in improved education, employment and even national productivity (Keating and Hertzman, 2000) reflecting the Strategic Direction of: Make prevention everybody's business.

Aim

To facilitate positive changes in child behaviour by enhancing the parent-child relationship.

Nature of the problem

Many parents have difficulties managing behaviour in the challenging toddler years. Research shows that children with severe behavioural problems during the toddler years are more likely to go on to develop conduct disorders, delinquency during adolescence, and psychopathology during adulthood. For these reasons early identification and intervention is paramount. If parent-child attachment styles can be improved, and if behavioural problems can be modified before becoming entrenched, then this brings gains for children, parents, family functioning and the community in general. This addresses the NSW Health Plan Goal of: Keeping people healthy.

Extent of the problem

Karitane has focused on very young infants but from extensive literature review and consultations with families a need identified for a program to help address parenting difficulties in the 15 month to 4 year age group. The extent of the problem is evident with the clinic currently seeing 10 families a week and a growing waiting list for families to be assessed. Clients are referred by diverse range of health professionals including General Practitioners, Pediatricians, Child & Family Health nurses, Community Health Centres, Speech Pathologist and Karitane services

Strategic Importance

The NSW Health Plan

Issues addressed:

Goals:

1. Keep people Healthy
 - A healthy start to life
2. Provide the health care that people need
 - Fair access to health services
3. Deliver high quality services
 - Appropriate care in the right setting
4. Manage health services well
 - Sound resource management
 - Strong client and staff participation

Strategic Directions

1. Make prevention everybody's business
 - Decrease child behaviour problems
 - Increase parenting skills
 - Establish a positive parent-child attachment
2. Create better experiences for people using health services
 - Build the capacity to deliver culturally and linguistically diverse appropriate health care
 - User friendly service which involves the whole family
3. Strengthen primary health in the community
 - Acknowledge early intervention
4. Be ready for new risks and opportunities
 - creating better futures for families
 - working in partnership with families

Planning and implementing solutions

The KTC was established in February 2005 at the Karitane - Carramar site and currently operates 3 days a week. The KTC team comprises a Clinical Nurse Consultant (a highly trained PCIT professional), a Registered Nurse and two (2) Enrolled Nurses all of who have a wide range of experience, skills and qualifications. The Clinic is also supported by a social worker, psychiatrist, psychologist and research officer.

The referral criteria are toddlers presenting with early behaviour problems such as physical and verbal aggression, non compliance, anxiety and withdrawal and sibling rivalry. Referred clients attend an assessment to identify the nature of the presenting problem, parental goals and to discuss realistic expectations with the parents. Clients are seen weekly once the program is commenced for 10 to 12 weeks.

Clinicians work in partnership with parents and utilise the consistent approach of the PCIT model. The approach incorporates other evidence based programs that increase pro-social behaviour to offer diversity in delivery to meet the client's needs. The integrated approach increases parental skills and confidence while decreasing parental stress via promotion of a positive parent-child relationship.

The program comprises two main phases. First, child-directed interaction (CDI) is a therapeutic intervention in which the parents are taught to praise positive behaviour and ignore negative behaviour. The emphasis is enhancing the parent-child relationship, increasing the parent's sensitivity to the toddler and increasing child and parents self esteem.

The second phase is called parent-directed interaction (PDI) in which parents are taught to give clear directions and reward compliance. The parents learn the importance of being consistent, predictable and to follow through.

Both phases of treatment are conducted around a dyadic play situation; with the clinician acting as a coach for the parent. With this support parents undergo a strong skill acquisition.

It is important that early interventions are provided for toddlers displaying behavioural problems, as long term negative outcomes associated with early childhood behavioural problems have been well established through research.

Outcomes and evaluations

Evaluation measures are administered pre and post treatment. Statistically significant improvements in child behaviour are evident in the measures collected. See Figure 1 and Table 1 for results of Child Behavioural Check List (CBCL) and Eyberg Child Behaviour Inventory (ECBI). See Table 1 for ECBI – Problem Intensity

Statistically and clinically significant improvements are shown in maternal functioning, see Figure 2 and Table 1 for results of Depression, Anxiety, Stress Scale (DASS), and Parenting Stress Index (PSI-SF). See Table 1 for results of the PSI-SF. Results also show high levels of consumer satisfaction with treatment using the Therapy Attitude Inventory. See Table 2.

The KTC intervention is associated with a range of statistically and clinically significant improvements in child behaviour and maternal distress. However, as shown in Figures 1 & 2, a number of clients remained in the clinical ranges, highlighting the complex nature of many of the clients seen at the KTC. For many of these families, after treatment has been completed at the KTC, referrals are made to other organizations so that longer term interventions can be received.

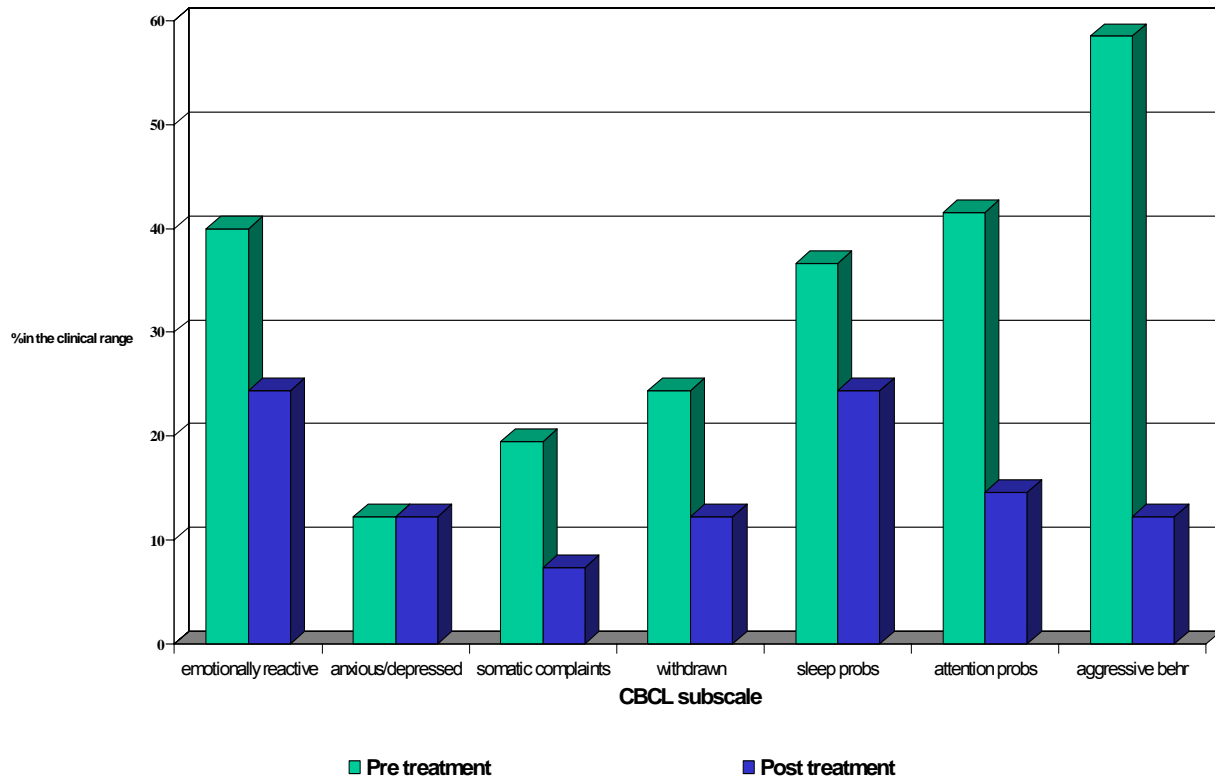


Figure 1: Percentage of clients – 41 families - showing clinically significant child behavioural problems (CBCL) pre and post treatment (n=41)

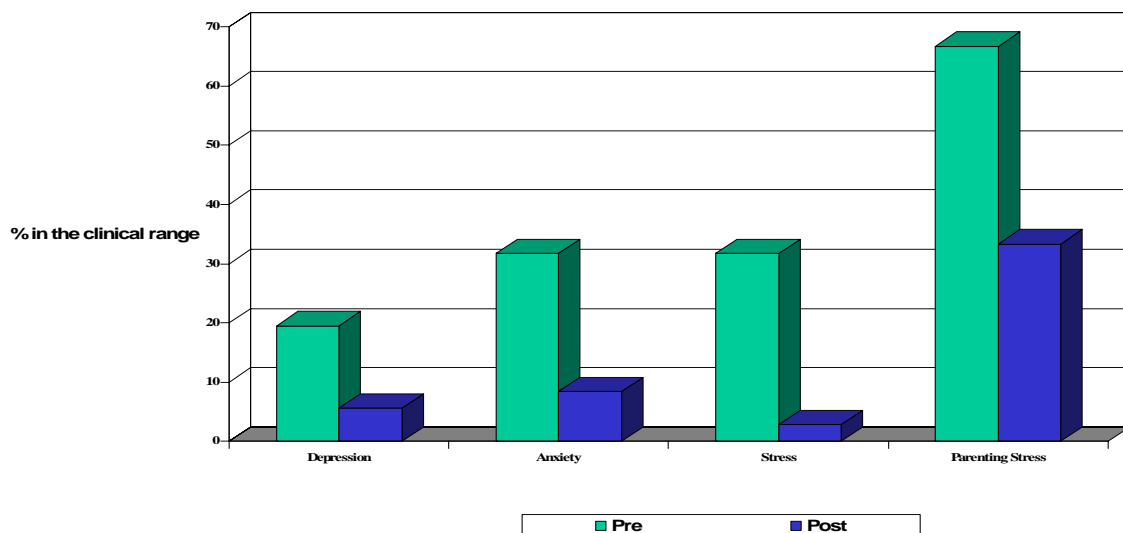


Figure 2: Percentage of mothers showing clinically significant maternal distress *

* Distress is indicated by Depression, Anxiety & Stress Scale (DASS) scores being moderate, severe or extremely severe & the Parent Stress Index (PSI-SF) total >90 pre and post treatment (n=41)

Table 1. Mean scores pre and post treatment (n= 41)

	Pre-treatment mean	Post-treatment mean	t	p
Child Behaviours				
CBCL Emotionally reactive	5.0	3.1	4.3	0.000
CBCL Anxious / Depressed	3.8	2.5	2.9	0.005
CBCL Somatic complaints	3.2	1.7	4.4	0.000
CBCL Withdrawn	3.0	1.8	3.5	0.001
CBCL Sleep problems	5.9	4.0	3.0	0.005
CBCL Attention problems	5.0	3.0	4.5	0.000
CBCL Aggressive behaviour	22.7	13.2	7.8	0.000
EBCI Problem intensity	146.1	114.2	6.4	0.000
Maternal distress				
DASS Depression	7.3	4.4	2.7	0.012
DASS Anxiety	5.7	2.6	3.3	0.002
DASS Stress	14.8	9.7	3.7	0.001
PSI-SF Parenting Stress	103.1	87.8	3.4	0.002

Table 2. Parental attitude after therapy

Regarding the relationship between myself and my child, I feel that we get along	54.1% very much better than before 37.8 % somewhat better than before 8.1 % the same as before 0 % worse than before
Regarding my confidence in my ability to discipline my child, I feel	59.5 % much more confident 29.7 % somewhat more confident 10.8 % the same as before 0% less confident
I feel that my child's compliance to my commands or requests at this time is	43.2 % greatly improved 51.4 % somewhat improved 2.7 % the same 2.7 % somewhat worse 0% considerably worse
My general feeling about the program I participated in, is	81.1 % I liked it very much 16.2 % I liked it somewhat 2.7 % I feel neutral 0% I disliked it

Supporting families with young children and promoting healthy emotional and social environments reduce anti-social behaviour and produces effective and nurturing parent-child relationships. This gives children and families a much brighter future through a strong primary health service and continuing care in the community

Sustaining change

The program is designed to empower parents allowing for strong skill acquisition and problem solving ability. Discharge planning is commenced from the first point of contact, allowing clients to be aware of follow up plans. One month after discharge the client is contacted by telephone, and is also given the KTC telephone number which they can ring for support. Extra sessions are available on completion of the program

Future scope

In response to the positive outcomes families are experiencing, state of the art equipment including purpose built rooms and two-way mirrors are planned for KTC. The KTC is a leader in early intervention with education being viewed as a priority. Continued education plans include further overseas specialist training for the Clinical Nurse Consultant. As part of the strategic direction, workshops will continue to be offered to local and state-wide health professionals, and to Karitane staff. This uses the principles of "prevention is better than cure" by early intervention before behavioural problems are entrenched.

References;

Abidin, R. (1995). Parenting Stress Index 3rd Edition – Professional Manual. Psychological Assessment Resources Inc, Odessa, USA.

Breston, E., Eyberg, S., Boggs, S., Algina, J. (1997). Parent-child interaction therapy: new directions in research. *Cognitive and Behavioural Practice* 9, 9-16.

Eisenstadt, T., Eyberg, S., McNeil, C., Newcomb, K., Funderbunk, B. (1993). Parent-child interaction therapy with behaviour problem children: Relative effectiveness of two Stages and overall treatment outcome. *Journal of Clinical Child Psychology*, 22 (1), 42-51.

Eyberg, S. & Robinson, E. (1982). Parent-child interaction training: Effects on family functioning. *Journal of Clinical Child Psychology*. 11, 130-137.

Eyberg, S. (1988). Parent-Child Interaction Therapy: Integration of traditional and behavioral concerns. *Child & Family Behaviour Therapy*, 10 (1),33-46.

Eyberg, S. (1992). Consumer satisfaction measures for assessing parenting training programs. *Innovations in Clinical Practice: A Source Book*, 12, 277-382.

Herschell, A., Calzada, E., Eyberg, S., McNeil, C. (2002). Parent-child interaction therapy: New directions in research. *Cognitive and Behavioural Practice*, 9, 9-16.
Keating, D & Hertzman, C (2000) *Developmental Health and the Wealth of Nations: Social, Biological, and Educational Dynamics*. Guildford Press

NSW Department of Health, (2007) *A New Direction for NSW State Health Plan Towards 2010*

Schuhmann, E., Foote, R., Eyberg, S. et al. (1998). Efficacy of parent-child interaction therapy: Interim report of a randomized trial with short term maintenance. *Journal of Clinical Child Psychology*, 27(1), 34-45.