Does it Work for Them — Does it Work for Us? Evaluating a New Model of Team Practice

Ingeborg Stiefel, Jennifer Cohen, Karen Moorhouse and Carren Hopkins

This article describes a change in team practice from a model targeted at individual families to a combined model that supplements family therapy with group programs for children. Unacceptably long waiting lists for family counselling services, high levels of stress in clinicians, and consumer dissatisfaction motivated this change. Robust quantitative data and a qualitative analysis of the project confirm that the change has made a positive impact and the new treatment model deserves to be continued. The article concludes that internal team changes are insufficient in a treatment context which requires more profound changes beyond the boundaries of the team.

The Central Coast of NSW, which reaches from the Hawkesbury River (the northern boundary of Sydney) to the southern boundary of Newcastle, is one of the most charming coastal regions in New South Wales. Affordable housing, at least until recently, and the release of new land, all in close proximity to Sydney, have led to a vast increase in population. Between 1996 and 2001, the population grew to 284,581, which represents a 9.4% increase compared with the overall population increase in New South Wales of 5.3%. Of the total population, 21.5 % are children within the 0 to 14 age range. Population statistics also provide some more alarming figures. The Central Coast has the second highest number of domestic violence incident reports, and the Wyong Shire (northern sector of the Central Coast) ranks among the highest in regard to child protection notifications in New South Wales (Central Coast Health, 2004–2005). Other regional characteristics include limited access to public transport, and long working hours for 36,000 commuters, who work or study in either Newcastle or Sydney. The Wyong Shire also has higher than State average unemployment rates and a high proportion of residents are receiving government subsidies, including the sole parent pension (Central Coast Health, 2004).

Four teams within Central Coast Health provide counselling services for children and adolescents. The Family Care Cottages (FCC) offer pre-natal counselling and therapy services to parents of young children (0 to 5 year age range). An 'acute' team, the Child and Adolescent Mental Health Service (CAMHS), provides crisis assessment of children and adolescents and brief intervention to adolescents with acute 'mental health' issues. The psychological and psychosocial needs of primary school aged children and young adolescents (age 5 to 13) are addressed by a Child and Family Counselling Team, a team with a strong systemic and developmental focus. A Youth Health Team caters for adolescents (14 years plus), and offers counselling and therapy within a Solution Focused treatment framework.

Despite population growth and complexity of clinical presentation, the Child and Family Counselling Team has not received additional funding for staff since

left: **Ingeborg Stiefel**
centre: **Jenny Cohen**
right: **Karen Moorhouse**

Ingeborg Stiefel is a senior clinical psychologist, Child and Family Counselling Team, Northern Sydney Central Coast Health. Contact address: Erina Community Health Centre, 169 The Entrance Road, Erina, NSW 2250.

Jenny Cohen is a clinical psychologist with Northern Sydney Central Coast Health

Karen Moorhouse is a clinical neuropsychologist, Child and Family Counselling Team, Northern Sydney Central Coast Health.

Carren Hopkins is a social worker with Northern Sydney Central Coast Health.

1997. With referral rates nearly doubling between 1999 and 2003, waiting lists at the start of this project were between 6 and 12 months. Waiting list length has also resulted in increasing pressure on staff, especially for those working in the northern shire of the region. Long waiting lists frustrate consumers and among team members there was a concern that consumers' inability to access the services within reasonable time would lead to an increasingly negative reputation for the service.

The pressure on some clinicians provided the impetus to change our model of service delivery. The three pioneers, Nicole Kinnaird, Natalie King and Nikki Grant, took time off their usual clinical work to develop group programs for the most common referral problems, and to set up a group team database. Prior to 2001, groups had been offered by some clinicians but in an ad hoc way. At the time, the team was far from being united on the imposed changes, which involved some more standardised approaches to assessment and treatment. However, to the team's credit, over time members have been able to cope with the changes imposed and to integrate new ways of working in a flexible and collaborative manner.

Treating Childhood Psychological Disorders in Groups

The pressure on Central Coast child, adolescent and family counselling services is far from unique. Compared with 20 years ago, children and youth in today's world are more likely to develop a mental illness, or to experience problems of adjustment. There are clear indications that the severity of presentation is changing, with more challenging mental health problems presenting earlier in life. According to Australian figures, 10–15% of children and adolescents experience a mental health problem (NSW Health, 2003). Prevalence rates are higher for children living in low income, blended or single parent families (Sawyer et al., 2000). Anxiety disorders are the most common form of psychological distress in children (Barrett, Webster, & Turner, 2000), whereas conduct problems are the most frequent reason for clinical referral to child and adolescent counselling services (Kazdin, 2001; Gabel 1997; and Klein & Pine, 2002). There is mounting evidence that antisocial behaviour is increasing in Western societies (Angold & Costello, 2001) and that untreated conduct and internalising problems carry a huge long-term social and economic burden to society.

Child mental health problems, such as anxiety, depression and externalising disorders, may significantly interfere with a child's ability to tackle many everyday activities with confidence. Both internalising and externalising disorders may also be associated with difficulties in interpersonal relationships (including peer relationships at school), social competencies, and academic achievement. It is therefore vital that prevention and early intervention services be offered to treat the earliest symptoms of distress (NSW Health, 2000). Child and family health services must be equipped with adequate resources to help build resilience and to assist children and their families acquire effective strategies to cope with stress, uncomfortable feelings, or behavioural alterations, that may result from today's life challenges.

"There is now increasing evidence to suggest that group treatment is as effective in reducing psychological symptoms in children as treatment that is provided individually to children and their families."

A number of different approaches have tried to address the issues of cost-efficiency and waiting list reduction, including single session therapy (Boyhan, 1996) and group treatment. There is now increasing evidence to suggest that group treatment is as effective in reducing psychological symptoms in children as treatment that is provided individually to children and their families (Rapee, Wignall, Hudon, & Schnierig, 2000; Shechtman & Ben-David, 1999). Group treatment also offers the benefit of normalising the child's experience. Further, it provides a sense of belonging, and allows for active training and application of new skills within the safe environment of the group setting (Geldard & Geldard, 2001). Therefore, the introduction of group treatment in addition to family and child therapy seemed logical and sensible and was supported by the service director.

Group Programs

The group programs developed by the Central Coast Child and Family Team employ community-oriented cognitive-behavioural interventions. These are based on a solid theoretical model which addresses cognitive, behavioural and physiological processes that interact in the development, experience and maintenance of anxiety and anger problems, and associated self-esteem and social-skills deficits. These and similar programs are

supported by clinically validated evidence-based research across Australia and overseas. Programs were developed according to the most frequent clinical presentations to our team, excluding programs that were already available to the community, for example, groups for grief issues and universal parenting programs. Four programs were developed to run over nine weeks, in two versions appropriate for younger (six to nine years) and older children (nine to 13 years), a total of eight groups. All programs had some parental participation, except for the anxiety groups, which for the older children had parallel groups for adults and children, while the younger group was designed for parents only, due to the intellectual demands of CBT. CBT principles and examples were adapted to reflect the developmental level of the children. These adaptations included hands-on and game-like activities, visual materials and opportunities to practise new behaviour with peers in the session.

Anxiety Group. Programs were designed for children experiencing fears and worries to a degree that interfered with their everyday activities, such as attending school, sleeping over at a friend's house, or sleeping in their own beds. Children in the group were taught to use cognitive and physical strategies to challenge anxious feelings, and helped gradually to expose themselves to anxiety provoking situations.

Social Skills Group. The program included a wide range of training components, such as friendship skills, interacting effectively in social situations, being aware of and practising communication, together with social problem solving skills, skills dealing with anger, assertiveness, and ways of enhancing self-esteem. The group format allowed the children to practise new skills initially in a supportive and encouraging environment and later in real life situations.

Anger Group. Treatment components included recognition of early physiological indicators of anger, assessing and monitoring degrees of distress and anger, and problem solving as a way of dealing more effectively with situations that trigger negative feelings. The program also covered assertiveness training and safe expression of anger.

Self-Esteem Group. The program assisted children to build self-esteem through more accurate assessment of their strengths and weaknesses, using empowering thoughts, training in assertiveness, and development of skills in self-care.

Referral Procedure during the Research Period

After telephone intake, initial screening, and a waiting period of several weeks, families were offered an initial one-off consultation session, usually conducted by two clinicians. Based on this assessment, decisions were made as to the most appropriate service for the presenting concern: minimal intervention/no treatment, group or individual therapy for the child, family therapy, psychological testing, psychiatric consultation, or referral to other services within/outside Central Coast Health. Whether or not group treatment was suggested depended on numerous factors, including the requested mode of therapy, number of issues in the family, clarity and complexity of problems, quality of family relationships, setting in which problems occurred, age and developmental level of child, and suitability of the child for group treatment. Some children were referred to both the group and the family therapy team. Exclusion criteria were also applied, for example, extreme violent behaviour. Waiting time for groups depended on availability of places, availability of sufficient numbers of children within certain age ranges, and flexibility of the families attending programs in different locations and on particular days. In the final session of group treatment, the family's needs were again reviewed, and where indicated, appropriate referrals were made.

Research Instruments

Instruments were administered for quality assurance purposes at the beginning of the program, and at the end of the last group treatment session. Where required, parents and children were assisted with reading the instruments.

Parent Rating of Child: Child Behaviour Checklist

The Child Behaviour Checklist (Achenbach, 1991; Griffin, 2002) is a 100-item questionnaire completed by parents pre- and post-treatment with reference to their child's behaviour and competencies. The CBCL rates a range of problem behaviours for severity and frequency and compares the ratings to a normative sample of children of the same age and sex. The CBCL contains an Internalising (Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints) and an Externalising (Rule-Breaking Behaviour and Aggressive Behaviour) Scale, and also provides a Total Problem score.

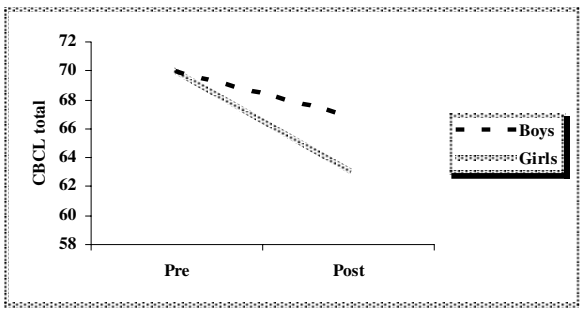
Child Self-Report Rating: Beck Youth Inventories

The Beck Youth Inventories of Social and Emotional Impairment (Beck, Beck & Jolly, 2001) contain five self-report measures that assess a child's experience of self-concept, depression, anxiety, anger and disruptive behaviour. Four of the five BYI inventories (Depression, Anxiety, Anger and Self-Concept) were utilised to assess

TABLE 1

Age of Children in Group Programs

Age in years	*N* (%)
7	29 (15%)
8	31 (16%)
9	31 (16%)
10	38 (20%)
11	32 (16%)
12	23 (12%)
13	11 (5%)
Total	195 (100%)



GRAPH 2

Changes in CBCL total scores for boys and girls.

degrees of depression, anxiety and anger and the children's self-esteem pre- and post-treatment.

Parent Self-Report Rating: Depression, Anxiety & Stress Scale

The Depression, Anxiety & Stress Scale (Lovibond & Lovibond, 1995), is a set of three (42 item) self-report scales designed to measure states of depression, anxiety and stress experienced during the past seven days. Self-assessment pre- and post-treatment measures the change in parental psychological state over time.

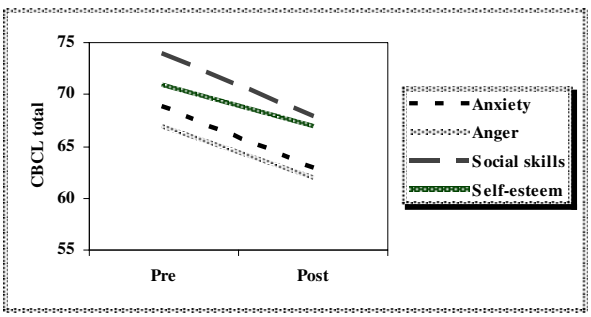
All instruments are widely used in clinical and research contexts and have sound statistical properties. The use of questionnaires for both children and parents recognises the importance of gathering multiple perspectives about a child's difficulties, including the child's own.

Results

Of the 400 children referred to the group programs, 300 enrolled in the groups and complete data was collected from 195 young people, aged between seven and 13 years, who participated in one of the eight groups. There were 125 boys (64%) and 70 girls (36%). For statistical analyses, age groups were combined for the four treatment programs. Of the total research sample of 195 children, 42 completed the anxiety program (22%), 67 completed the anger program (34%), 45 completed the social skills program (23%), and 41 completed the self-esteem program (21%). The age distribution of the children is depicted in Table 1.

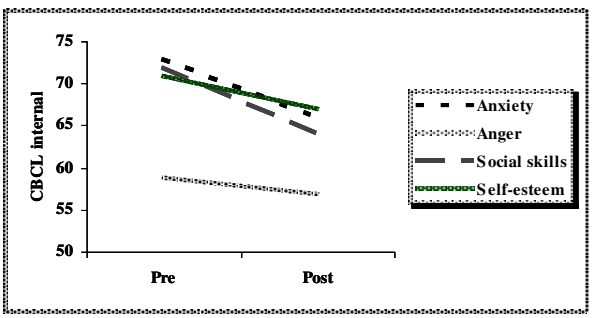
Repeated measures analyses of variance were conducted to evaluate the effectiveness of the programs. Response to treatment was considered according to child gender as well as content of group program.

There was a statistically significant level of improvement in the overall level of behavioural problems, as measured by the CBCL total score (F = 48.93, p = .000). The overall mean CBCL score prior to treatment was 70.0 (SD = .81), which corresponds to the clinical cut-off score. This indicated high levels of problem behaviours perceived by the parents prior to group participation. The overall mean CBCL score at the time of completion of the program was 64.9 (SD = 1.03). Therefore, a young person who had completed a group program was likely to display a score that reflected a reduced level of problem behaviour. This pattern of CBCL total scores is depicted in Graph 1.



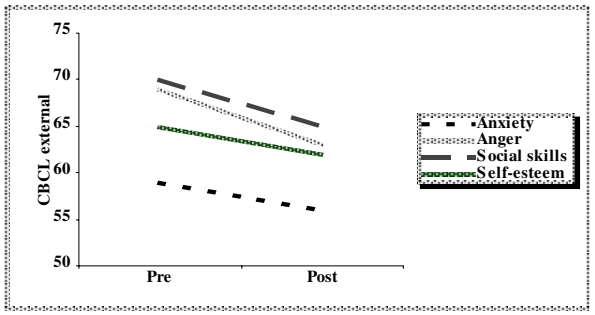
GRAPH 1

Changes in CBCL total scores for each group.



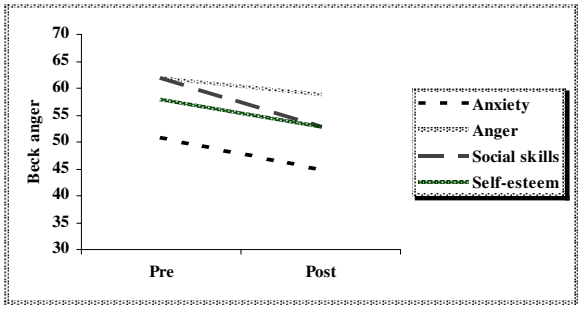
GRAPH 3

Changes in CBCL internalising factor scores for each group.



GRAPH 4

Changes in CBCL externalising factor scores for each group.



GRAPH 6

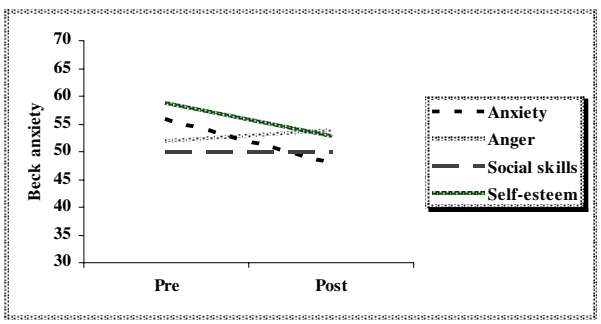
Changes in Beck anger scores for each group.

There was also a significant gender effect. Although both boys and girls demonstrated significant improvement at the completion of their particular program, girls were likely to improve more (F = 7.25, p = .008). A summary of obtained mean group scores is depicted in Graph 2.

Responses to participation in the group programs were also investigated according to the CBCL internalising and externalising factor scores. For the CBCL internalising factor scores, overall improvement was again achieved at a significant level (F = 39.12, p = .000). Overall mean internalising scores reduced from 68.7 (SD = .92) prior to group participation to 63.8 (SD = 1.03) after completion of the group program. A significant gender effect was again obtained, with girls displaying more improvement than boys (F = 4.87, p = .03). A complex gender and group interaction effect was observed. Girls were more likely than boys to improve their anxiety-related problems after involvement in the social skills groups (F = 5.9, p = .001).

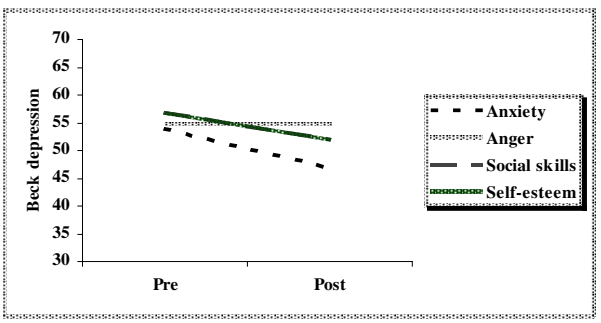
For the CBCL externalising factor scores, overall improvement was again achieved at a significant level (F = 27.88, p = .000). There were no significant group or gender effects for the CBCL externalising factor scores. A summary of these profiles is displayed in Graphs 3 and 4.

Response to treatment was also investigated by examining the changes in scores for the Beck Youth Inventories subscales. An overall significant level of improvement was obtained for each of the four Youth Inventory scales. For anxiety, the overall mean reduced from 55 (SD = 1.6) (mildly elevated range) to 51 (SD = 1.4) (average range). For anger, the overall mean reduced from 58 (SD = 1.8) (mildly elevated) to 52 (SD = 1.3) (average); for depression, the overall mean reduced from 55 (SD = 1.7) (average) to 52 (SD = 1.3) (average); and for self-concept, the overall mean improved from 44 (SD = 1.2) (lower than average) to 46 (SD = 1.3) (average). A significant group interaction was also obtained for the anxiety subscale. Young people who had participated in the anxiety or self-esteem groups displayed significantly more reduction in their level of anxiety than those who had completed the anger or social skills groups. For children in the anger management group, we found a slight increase in their level of anxiety. The patterns of changes in Beck scores are displayed in Graphs 5 to 8. This interesting observation may relate to the fact that



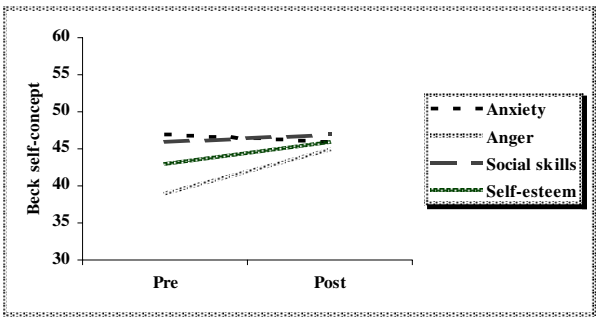
GRAPH 5

Changes in Beck anxiety scores for each group.



GRAPH 7

Changes in Beck depression scores for each group.



GRAPH 8

Changes in Beck self-concept scores for each group.

the group addresses a wide range of feeling states, thus helping the child becoming more aware of the range of possible emotions. Further, the expression of anger, in particular, may have a defensive function, covering up for other, underlying feelings, such as anxiety, which may only surface once the child understands and controls feelings of anger more efficiently.

Changes in maternal self-rating of levels of depression, anxiety and stress, as indicated by the DASS, were assessed with repeated measures analyses. Mothers' level of depression and stress significantly reduced after the completion of their child's program. Mothers' depression scores reduced from a mean of 8.2 (*SD* = .96) (mildly depressed) to 5.9 (*SD* = .80) (normal range) ($F = 11.79$, $p = .001$). Mothers' stress scores reduced from a mean of 13.2 (*SD* = .90) (mildly stressed) to 11.2 (*SD* = .82) (mildly stressed) ($F = 6.95$, $p = .01$). There was no significant change in the mothers' anxiety scores, from a mean of 5.1 (*SD* = .69) (normal range) to 4.7 (*SD* = .61) (normal range).

Qualitative Evaluation of Change in Team Practice

Team members completed a survey to evaluate the impact on the team of introducing the group program. Of the 10 clinicians who responded (100%) there was unanimous support for the continuation of the group program. All team members found it helpful to have the option of referring clients to a group. Eighty per cent said it was extremely helpful, and 20% rated it as helpful. Nine out of 10 said that the ability to refer clients to groups reduced the pressure on the family team waiting list. Ninety per cent thought that being able to refer to groups reduced individual worker's stress. Three colleagues felt that the level of team and individual stress was lower than prior to the introduction of the group program, two said it was about the same, and one thought it was higher. The remaining four said they could not say, as they had joined the team after the group program started. Seven team members said they were unconditionally prepared to participate in running groups in the future, two gave qualified support and one was unable to commit. Additional comments from team members on the survey form also supported the introduction of the group program.

Discussion and Conclusion

The results indicate clear benefits for the children who completed the groups, and for their carers. The children displayed improvement in externalising and internalising problems, as indicated in both self and parental ratings. This was especially true for girls. The data also supports the commonsense understanding that an improvement in the child's functioning may have benefits for the parents, as their level of stress and depression decreased. These positive, statistically significant changes resonate with most, though not all, of our clinical impressions.

Overall, the team felt most confidence in the anxiety program. The possible reason is that anxiety issues are often present in other family members and this program included a parallel parent group, thus directly addressing both child and parental anxiety issues. Further, these families, despite being somewhat enmeshed, impress as responsive and conscientious, with a high level of motivation and commitment to change.

Children with features of Autism Spectrum Disorder (ASD) need to be carefully matched with their group. We felt clinically that they gained most from social skills training, and struggled in the anxiety group, which emphasises shared experiences and the group process.

Our anger management program has remained most controversial, despite promising statistical outcomes, and has undergone several revisions since 2004. The main reasons for the controversy are the lack of appeal of the 'classroom learning' format, parental stress and hopelessness, questionable motivation and commitment to change (especially in parents), the presence of high levels of psychosocial stress within the family, the parents' own difficulties with intense negative emotions, difficulties shifting parent focus from the child as the sole problem, and the increased occupational health and safety issues. Each of these issues would require intervention in its own right, a task that exceeds the capacity of the Child and Family team. These findings are in accordance with research evidence suggesting that externalising disorders are most difficult to treat and often require long-term multimodal treatment (Madden, 2001).

For the team the introduction of a comprehensive group program had distinct benefits, including reduced worker stress, increased choice of treatment

options, and reduced waiting list pressure. Team members also emphasised the benefits of group programs for children, as groups help normalise the experience of the presenting difficulties, and offer chances to role-play and practise new skills, and learn from each other. Some workers felt that children could learn more in treatment groups than in individual family sessions, through interacting with each other and being exposed to new ideas.

A further benefit was that the new way of working offered more opportunity for co-therapy and mutual support. We believe the implemented changes may have led to higher team cohesion and a greater openness to the role of different therapeutic approaches

> "Our anger management program has remained most controversial, despite promising statistical outcomes, and has undergone several revisions since 2004."

when working with children and families. Finally, comparison of client statistics between 2001 and 2003 indicate a higher throughput, with 893 more people attending programs, reflecting the more efficient and streamlined approach to assessment and the larger number of clients treated in groups.

One shortcoming of this study is that treatment effects were not compared with a control group, such as a waitlist group. Therefore, we do not know if similar improvements would have occurred over time, without treatment. However, if the team had chosen a controlled research design, research requirements such as random allocation would have caused serious constraints on crucial clinical decisions and significantly increased the waiting time for half of the clients.

Another limitation is that treatment outcome was only assessed immediately after completion of the groups. We do not know if the overall gains for the eight treatment groups will be maintained over time. Future research is needed to investigate the long-term effects 12 to 24 months post treatment. Whittington (2004) followed up a small sample of 10 children who completed anger management groups in 2002, using qualitative and quantitative research designs. Whittington describes an enormous challenge in undertaking post-treatment research 12 months after completion of treatment, due to the low response rate of clients to standard research practice (i.e. returning questionnaires by pre-paid envelopes). Results were mixed, with younger children (six to eight years) maintaining their treatment gains more than older children (nine to 13 years). For both age groups, qualitative indicators revealed that according to parental report, approximately two thirds of the children were functioning at a more adaptive level, compared with their pre-treatment level of functioning, and 75% of all participants were still using the strategies learnt in the anger management courses. The author argues that one limitation of the anger management program was that it focused primarily on the child as having the problem, largely ignoring social context variables as contributing factors; she recommended a strong parenting component in future groups (Whittington, 2004). Whittington's finding is consistent with the literature and the growing evidence that multifaceted treatments with multiple participants, provided over an extended period of time, deliver the best treatment outcome (Prinz, 1998). As a result, we have since included a parallel parenting component in the anger management program, which takes the focus off the child as the problem. We have also started offering a targeted parent group intervention for parents of children with challenging behaviours.

Our informal impression is that our waiting time for treatment has reduced as a result of the introduction of the group programs. Further research would be required to confirm this hunch. The initial single session consultation has become a standard part of our repertoire, and because of this, waiting time for service access has reduced, due to the more rapid decision making process regarding the type of intervention required. The usual waiting time for an initial consultation is approximately 10 weeks, and groups are usually offered with the start of each new school term. Recent consumer feedback from parents and children indicates that the groups have assisted the whole family. As such, they form an important component of an integrated systemic approach. We strongly believe that group therapy cannot always substitute for family therapy and there will always be families that will respond best to the expertise of a family therapist. Yet groups also have something distinct to offer.

The introduction of the group program has not, however, reduced the length of time clients have to wait for family therapy. Clinicians running groups means fewer clinicians able to provide family therapy. Families requiring family therapy present issues that are more complex and family dynamics that are more challenging, resulting in longer treatment duration. In addition, the growing rate of referrals continues in the absence of any increase in clinician numbers. Finally, with rising

public awareness and increasing popularity of the group program, direct referrals for groups are increasing.

As we close the door on one problem, doors open on new challenges, inviting the team to continue its creative problem-solving approach to escalating pressures. These new challenges include increasing complexity in clinical presentation, serious 'mental health' issues presented earlier in life, and more acute referrals. Therefore, as a team, we constantly shift our attention between urgent cases, endeavouring to select the one that seems most pressing, while placing another to one side, until that too becomes acute. Systemically speaking, we are constantly applying internal change strategies to our team, where in fact larger systems changes are required. The larger systems change would involve increased funding for child 'mental health' services, which might allow us to follow or extend 'best practice' guidelines, a term the Department of Health much cherishes. With larger systems change secured, we could perhaps even venture into less charted clinical research areas, and undertake clinical evaluation of our family therapy intervention with 'real families' on the Central Coast.

Acknowledgments

We wish to thank Dr Philip Watt, service director, for his consistent support in the establishment and evaluation of the group program. We also like to acknowledge the input of the families involved in this Quality Assurance Project and the perseverance of our colleagues in collecting data, which has enabled us to complete this project.

References

Achenbach, T. M., 1991. *Interpretative Guide for the 1991 CBCL/4-18, YSR, and TRF Profiles*, Burlington, University of Vermont.

Angold, A. & Costello, E. J., 2001. The Epidemiology of Disorders of Conduct: Nosological Issues and Comorbidity. In J. Hill & B. Maughan (Eds), *Conduct Disorders in Childhood and Adolescence*, Cambridge, University Press.

Barrett, P., Webster, H. & Turner C., 2000. *Friends Group Leader's Manual for Children* (Edition III), Bowen Hills, Qld, Australian Academic Press.

Beck, J. S., Beck, A. T. & Jolly, J. B., 2001. *Beck Youth Inventories of Social and Emotional Impairment*, Harcourt, NJ, The Psychological Corporation.

Boyhan, P. A., 1996. Clients' Perception of Single Session Consultations as an Option to Waiting for Family Therapy, *ANZJFT,* 17, 2: 85–96.

Central Coast Health, 2004. *Central Coast Regional Health Profile 2004*, Division of Health Improvement and Information Services, Gosford, Central Coast Health.

Central Coast Health, Violence, Abuse and Neglect (VAN) Services, 2004. *Strategic Plan 2004–2005*, Gosford, Central Coast Health.

Gable, S., 1997. Conduct Disorder in Grade-School Children. In J. Noshpitz (Ed. in Chief), *Handbook of Child and Adolescent Psychiatry*. Vol. 2. In P. F. Kernberg & J. R. Bemporad (Eds), *The Grade School Child: Development and Syndromes*, NY, Wiley.

Geldard, K. & Geldard, D., 2001. *Working with Children in Groups. A Handbook for Counsellors, Educators and Community Workers*, Basingstoke, Palgave.

Griffin, Michael, 2002. Family Research and Therapy: Three Achenbach Scales, *ANZJFT*, 23, 2: 112–113.

Kazdin, A. E., 2001. Treatment of Conduct Disorder. In J. Hill & B. Maughan (Eds), *Conduct Disorders in Childhood and Adolescence*, Cambridge, University Press.

Klein, R. G. & Pine, D. S., 2002. Anxiety Disorders. In M. Rutter & E. Taylor (Eds), *Child and Adolescent Psychiatry* (Fourth Edn), Oxford, Blackwell.

Lovibond, S. H. & Lovibond, P. F., 1995. *Manual for the Depression Anxiety Stress Scale* (2nd Edn), Sydney, Psychology Foundation.

Madden, S., 2001. Evidence for the Treatment of Conduct Disorders, *The Clinician,* 1, 2: 86–87.

NSW Health Department, 2000. *Prevention Initiatives for Child and Adolescent Mental Health,* NSW Resource Document, NSW Department of Health, http://www.health.nsw.gov.au

NSW Health, 2003. *NSW Parenting Partnerships. Resource and Literature Review*, North Sydney, NSW Department of Health.

Prinz, R. J., 1998. *Conduct Disorders*, Elsevier B.V., http://www.Science Direct (2004).

Rapee, R. M., Wignall. A., Hudson, J. L. & Schnierig, C. A., 2000. *Treating Anxious Children and Adolescents: An Evidence-based Approach*, Oakland, CA, New Harbinger.

Sawyer, M. G., Arney, F. M., Baghurs, P. A., Clark J. J., Graetz, B. W., Koskey, R. J., Nurcombe, B., Patton, G. C., Prior, M. R., Raphael, B., Rey, J., Whaites, L. C. & Zubrick, S. P., 2000. *The Mental Health of Young People in Australia: The Child and Adolescent Component of the National Survey of Mental Health and Well-being*, Canberra, AusInfo.

Schechtman, Z. & Ben-David, M., 1999. Individual and Group Psychotherapy of Childhood Aggression. A Comparison of Outcomes and Processes, *Group Dynamics: Theory, Research and Practice, 3*, 4: 263–274.

Whittington, M., 2004. *An Angry Epidemic: Evaluating the Temper Taming and Staying Cool Group Programs for Children with Aggressive Behaviours.* Unpublished thesis submitted in partial fulfilment of the requirements for the Bachelor of Social Work with Honours in the School of Social Work, Charles Sturt University, Wagga Wagga.