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Case Report

Integrating Psychiatry into the Coordinated School Care Initiative: A Case Study of Two High-Need Schools

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Abstract

This paper describes a year of efforts to establish psychiatry residents into a Coordinated School Care Initiative (CSCI) being enacted in several high-risk urban schools located in the South. A four-phase model of school site selection is presented and a child referral pathway is described. This is followed by a case study of two similar high-need elementary schools "A" and "B". Each school was served by a Caucasian 5th year child psychiatry resident. Four factors associated with the relative success of School "A" versus School "B" were delineated: administrator buy-in and active support; advance logistical preparation by the school; a previously established therapist to serve as the referral agent, and low staff turn-over. In contrast, School "B" also suffered with exceptionally low parent involvement. School "B" staff were frequently observed to administer inconsistent and harsh disciplinary practices. These latter factors were associated with a particularly negative school climate. In keeping with the Plan, Do, Check, Act model, lessons learned were articulated. As a result, the Year Two focus will include concerted efforts to move from a co-located to an integrated experience among all members of the child's environment: administrators, teachers, school nurses, therapists, and parents. This will bring the CSCI in line with the Coordinated School Health Model articulated by the CDC.

INTRODUCTION

The training of child psychiatrists necessitates programmatic involvement with troubled children, most of whom spend considerable time within the school environment. In fact, the average child in the United States spends 33.2 hours per week in school, which is substantially more time than they spend in any other setting (U.S. Department of Education, National Center for Education Statistics,Schools, and Staffing Survey (SASS), [1]. Consequently, most child psychiatry residency training programs collaborate with local public school systems. However, these collaborationsoften consist ofscripted communication aboutthe assessment and treatment of children who require modified educational programming, remediation, or special placement. Fewer programs offer rotations that include directinteractionwithin the school environment, with staff, teachers, counselors, and the student body. Even fewerdirectly promote and enact a model of coordinated school care in high-need schools, perhaps due to the inherent training challenges [2]. This paper describes our efforts to establish psychiatry residents into a Coordinated School Care Initiative (CSCI) being enacted in several high-risk schools located within an urban environment. Our program specifically sought to improve high-need children's access to psychiatry care, in an area that has a noted shortage of child psychiatrists.

Our effort toadd psychiatry to the CSCI relied upon a collaboration among the Mobile County Public School System (MCPSS in Alabama), the Gulf Coast Behavioral Health and Resiliency Center of the University of South Alabama (GCBHRC), and the AltaPointe/University of South Alabama (USA) Child Psychiatry Residency Program. This paper is a description of the Psychiatry Resident component of the CSCI (Figure 1)which occurred in threeimpoverished schools geographically located in the Southeast Region of the United States. We describe the selection process for pilot schools (Figure 2) and the student referral process used. In the case studies that follow, we describe the program's initial implementation in pilot school "A" and "B". The discussion section of this paper focuses on continued challenges, lessons learned, and plans for Year Two.

Background

In areas where family incomes and property values are high, schools benefit from local and state funding and tend to

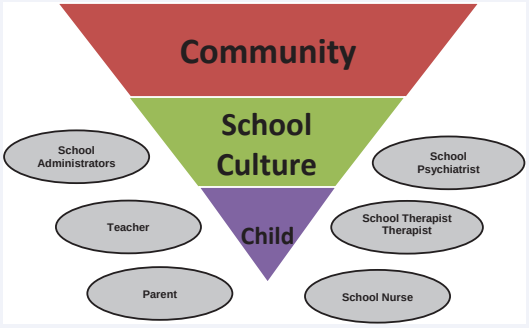

Figure 1 Model of Coordinated School Care that is Child-Centered but also Enacts Change at on the School Climate and Ultimately the Community.

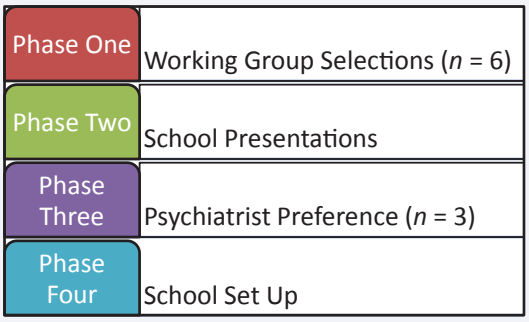

Figure 2 Four Phase Process of School Site Selection.

thrive [3]. In contrast, inner city schools in many urban areas are particularly troubled. In Mobile, Alabama, such is the case, where many inner city public schools have to stretch very limited resources to best serve students from impoverished families [4]. Many of these children live in substandard housing in areas frequented by criminal activity, and are without basic resources for transportation and health care. The problems faced by these students are well documented [4,5] . Students facing these stressors tend to express increased behavioral and emotional distress. Bringing integrated health care to these children as they obtain their education, rather than relying on family support and transportation to traditional and typically separate health and mental health care is the hallmark of the coordinated school care modelthat underlies the CSCI [6]. The CSCI is also consistent with current efforts to include a public health focus in psychiatry training [7]. The model is predicated on the Coordinated School Health Model articulated by the Centers for Disease Control (CDC).

Training Experience within the Child Psychiatry Program

With funding from the Mental and Behavioral Health Project-Alabama, a component of the Gulf Region Health Outreach Program (GRHOP, 2012) , and AltaPointe Health Services, the Department of Psychiatry at USA applied for and received provisional accreditation for a Child and Adolescent Psychiatry Fellowship Program in 2013. Continued accreditation was awarded 2016. Specific to CSCI, thetraining curriculum requires aschool consultation rotation. Child psychiatry residents in their second (final) year of training are placed in a selected school for one day per week. Within their school, residents work in concert with school administrators and staff, on-site counselors, and nurses to provide mental health services and consultationto children, teachers, and administrators.

Core competencies in patient care, medical/psychiatric knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice are addressed in this rotation [8]. Moreover, at the outset, all partners agreed to consider the addition of psychiatry residents to the CSCI aperformance improvement project. The CSCI utilizes a PDCA methodology (Plan, Do, Check, Act). As such, residents were expected to be intimately involved all phases of the process. This paper describes the initiation of the CSCI psychiatry addition with the first three 5th year child psychiatry residents at USA.

According to the plan, all schools interested in participating were required to apply to be a resident placement site. Residents then interviewed the school staff and attended on-site presentations prior to selection. Once a particular school was chosen, a referral process was established. Each resident also completed a daily account of activities, including consults completed and patient contacts. Continued resident placement in the particular school was explicitly contingent on quantity and diversity of services delivered.Information concerning utilization was gathered weekly and processed iteratively through the GCBHRC. Utilization of the Child Psychiatry resident served as the proxy measure of both the school's receptivity to the psychiatry addition to the CSCI and the resident's skill in developing an organizational working alliance. Supervision did not occuron-site, but a clinical supervisor was available during all hours of the rotation. All residents attendedrequired school-focused didactics. These sessions presented school consultation liaison models, including, for example, the strengths-based, community-oriented model for child psychiatrists in schools [9]. Issues relating to both specific cases and general school consultation were frequent topics of case conferences and didactics. The primary source for the didactics was the *Practice Parameter for Psychiatric Consultation in Schools* [10].

Usingthisstructure,residentswereexpectedtogainexperience providing collaborative school care. They learnedconsultative practices and receivedhands-on opportunities to observe and examine child and adolescent development within the context of the child's school. Residents were expected to develop individualized interventions for children with learning disabilities and/or those who were exhibiting a broad spectrum of behavioral disturbances. They were also required to consult with teachers, staff, and administrators as requested. By design, this rotation exposed residents to normally developing children in addition to those with psychiatric and developmental disorders. In addition to patient care, quality improvement in the school climate, with regard to both the educational environment and student access to mental health services, was a focal goal.

School Selection Process

As the initial year was staffed by three 5th year residents, three initial schools were selected to pilot the program. The school selection process is described below and depicted in Figure (2).

Phase I: Prior to the school year, a working group was convened. Meetings were held which includedschool system staff; community mental health center leadership; the USA Psychiatry Fellowship Training Director; and the GCBHRC Director, a clinical psychologist. These meetings identifiedsix schools most likely to benefit from the addition of on-site psychiatric consultative services. During year one, only schools currently receiving part-time services from an on-site community mental health counselor were considered. Each school wasalready part of a long-term effort to increase Coordinated School Care in high-risk schools [8]. Selection criteria included:perceived need of enrolled children, location in an urban area with high poverty/low access to healthcare, and the existence of a designated referral agent. After these schools were identified, the Director of Social Services within the Public School System requested that each school prepare a presentation articulating why they should be chosen as a CSCI pilot site for adding on-site child psychiatry services and consultation.

Phase II: On-site meetings were then held with principals, teachers, counselors, and members of the school consultation working group. School psychiatric consultation services were discussed, and as the three child psychiatry residents attended these meetings, the school staff had a chance to meet the residents and ask questions.

Although each of the six schools were high need, their presentations revealed clear differences in readiness. Evaluation criteria included perceived receptiveness, level of need (as generated from the school's estimate of the number of enrolled children who could benefit from psychiatric services), and general school climate. Impressions of the school's climate were based on the number and type of staff and administrators participating in the presentations and on-site tours, the observed morale of teachers and administrators, and staff's implicit and explicit beliefs about the mental health of their student body.

Using the above criteria, it was clear that some schools saw little benefit to including on-site psychiatry. Although unspoken, some schools seemed to consider mental health an intrusion into the educational system. Other schools were much more welcoming, practically begging for placement of a child psychiatry resident. Logistic criteria were also considered prior to the final selection. In particular, schools were asked: Where did they expect to locate the psychiatry resident? Was there consistent access to a phone and internet (necessary for patient notes and case documentation)? How active was the already placed school counselor and would this personserve as the CSCI referral agent?

Phase III: After the presentations, the residents met to consider their impressions of the presentations and tours. Based on their preferences and after a robust discussion with the school consultation working group, three schools were identified as suitable placements for the three residents, and arrangements were made for them to begin their work assignments in the schools one day per week.

Phase IV: Initiating the placement required tackling logistical challenges. These included getting a space that was conducive to services, being provided a working phone, having a site that included internet access, and developing a referral pathway to the psychiatric resident.

Student Referral Process

In the urban area in which the CSCI is located, most children receive outpatient and inpatient mental health care from one local community mental health provider, AltaPointe Health Services. AltaPointe offers a full continuum of mental health careand also is the employer for faculty in the University of South Alabama, Department of Psychiatry. Due to the significant numbers of students referred from inner city schools, AltaPointe arranged to place trained therapists in some particularly troubled high-poverty schools. These therapists were initial elements in the CSCI. They provide brief on-site therapy and facilitate referral along the continuum of care as indicated. In the expanded CSCI that we enacted, these therapists were the referral point from the school system to the psychiatry resident.

Prior to this initiative, most psychiatry referrals were toan off-site outpatient clinic, located in another part of town. However, this referral process often took considerabletime. Child psychiatry residents are not allocated full time to this clinic and there are limited hours for new appointments. Long waiting lists for appointments are common.

In addition, there was a substantial no-show rate for appointments. This rate was elevated for children referred from areas of poverty and high-risk school feeder patterns. No-shows generated considerable frustration for clinic staff, particularly in considering the long waiting list. Reasons for failure to follow through with the appointment are numerous, but include the following: lack of transportation; lack of finances; conflicts with parent's or guardian's work schedules, (which often involved multiple jobs); children in unstable living conditions/homeless; stigma associated with going to the mental health center; and cultural factors.

As such, referral through the CSCI established a process that is beneficial to students, parents, teachers, and psychiatry fellows. In this model, the student is referred to the psychiatrist from the school counselor or existing therapist. Counselors accept referrals from parents, teachers, and school administrators. The referring counselor is responsible for obtaining parent/guardian consent for treatment and for opening a case file. Case files are electronically linked to the community mental health center, which allows billing to occur whenever possible. Parent(s)/guardians benefit from this model because they do not have to travel to an off-site mental health center, resources are retained, and mental health care is received more quickly and efficiently. Teachers benefit from this model because they become a direct referral agent. They are also substantially more likely to be included in the evaluation process, as informants and by providing sites where the child can be observed naturalistically. This later benefit is particularly important when determining whether or not a child meets criteria for an Attention Deficit Disorder. Finally, the child psychiatry resident benefits, not only by having a rich educational experience, but also by substantially reducing the no-show rate that typically occurs at the outpatient clinic serving this population.

CASE PRESENTATION

As the school year came to a close, feedback sessions were held with the three graduating child psychiatry fellows, the school consultation working group, and school staff at the pilot schools. Factors that were understood to either contribute to the success or failure of the school placements were reviewed as part of the performance improvement aspect of the rotation. Several common factors emerged. Aggregating these factors,

we describe two contrasting experiences inSchool "A" versus School "B". Aside from the factors noted below, School "A" and School "B" were similar. Both served elementary students from the same urban area. Each school was located in the same feeder pattern leading to the identical middle school and high school. Both schools were located in areas of high poverty and crime. The majority of children in both schools were African American. In contrast, the child psychiatry residents serving all of the schools were Caucasians in their early thirties.

School "A":

School "A" staff expressed an eagerness to receive services. An established therapist had been working in this school for several years, providing both on-site brief therapy and access to the continuum of off-site mental health services through a referral process. Per observation, this therapist was already successfully embedded into the school culture.

Factor 1. School "A" adequately prepared for the resident:

Preparations had been made for the presence of a psychiatric consultant in the school facility prior to the start of the rotation. Office space was made available, in an area where quiet and confidential meetings could take place with students, parents or guardians, teachers, and counselors. A telephone, internet connection, and a laptop computer were put in place and functional. School resources allowed for the residents to use their laptops to access the electronic medical record via encrypted channels. This made on-site record keeping possible. Using this electronic pathway, the children's psychiatric assessments were immediately integrated into the medical record that was managed by the off-site community mental health center. Parents of students already in care were asked if they preferred their child to receive continued treatment at the off-site location or at the school site.

Factor 2. School leadership buy-in:

The principal at School "A" was convinced that psychiatric consultation would provide benefits to students, teachers, and the school culture. The principal was eager to enact the CSCI and expected the school staff to share this expectation. Support for the CSCI was communicated to the school staff on several occasions, contributing to a greater likelihood of staffwelcomingand utilizing the child psychiatry resident.

Factor 3. In-school therapist previously established:

As previously noted, the established presence of a dedicated school therapistwas important for placement success. This individual served many roles: establishing contact with children and families referred by school staff, providing brief therapy services to children prior to initiating a psychiatric referral, gathering information on the referral question, inputting information into the electronic medical record, and scheduling appointments for psychiatric consultations. School "A" viewed the resident as an enhancement to existing services. Perhaps as a consequence, this resident received significantly more referrals and consultations than did the resident at School "B".

Factor 4. Low school staff turnover:

School "A" had low turnover rates among teachers and administrative staff. There are many obvious advantages to low turnover rates, but one in particular may not be evident. Among those schools with low turnover, the staff comes to know the community and the surrounding area very well – the streets, the homes, the families, and in many cases, the extended histories of the lives of the school's children. It was not uncommon for teachers to know the details of each child's life circumstances. The school staff, being aware of a stressful home situation, seemed to be more understanding of a child's behavioral issues. Knowing that a child was faced with a difficult transition or complicated home situation allowed school staff to anticipate behavioral issues and respond proactively in many cases. Thus, the referrals to the child psychiatry resident seemed to be more appropriate, in terms of necessary levels of care. In addition, because of their increased knowledge of the children's lives, the school staff was less likely to blur therapeutic boundaries by requesting confidential information from either the school-based therapist or the psychiatry resident.

School "B":

At the outset, School "B" expressed a similar eagerness for school consultation services from the child psychiatry fellow. At the initial meeting, the principal assured the working group that although CSCI was a new and unfamiliar program, it seemed to have potential. While the principal acknowledged that this was his inaugural year in this school, there was a hopeful mindset for improvements in the existing school climate. Unfortunately, however, many factors in School "B" impeded successful implementation ofCSCI.

Factor 1. Resources unavailable at the initiation of the program:

Compared to School "A", School B was resource-poor. For example, School "B" was unable to locateprivate space for the resident to hold confidential meetings. Moreover, the space that was initially made available had no working telephone and internet access was inconsistent. Limited internet access meant limited access to the off-site electronic medical record. Without connectivity, routine documentation was difficult and at times, impossible.

Factor 2. School leadership neglect:

While this school was initially receptive to our involvement, there was a lack of follow-through on the part of the school leadership. To our knowledge, there were no public occasions in which CSCI was explained to school staff. Day to day management of extremely challenging circumstances prevented prioritizing the program and solving on-going logistical issues. Without adequate support from the new administration and in turn the staff, referrals and consultation requests were at times non-existent. This resulted in a greater experience of a co-located rather than integrated service.

Factor 3.High staff turnover:

High turnover among the staff was noted in School "B". Many teachers and administrators were in their first year in this school. Most did not live in the community served by the school. Perhaps because of this, relative to School "A", the staff of School "B" was less likely to be knowledgeable about students' lives. Referral information was often incomplete. When referrals were made, teachers and staff were more likely to attempt to cross boundaries. They routinely wanted access to confidentialinformation obtained from students and their

families. School staff became frustrated when they were denied access to such information. They did not fully appreciate the confidential nature of psychiatric information.

Factor 4. Inconsistent behavioral intervention at school level:

In School "B", where referrals were sparse and engagement with the psychiatric resident was less than optimal, the level of disruptive behavior, both in terms of frequency of events and severity of behaviors, was substantial. While observation suggested that none of the CSCI schoolsutilized a consistent school-wide behavior management strategy, many teachers in School "B" were described by the resident as complacent at best, and combative at worst. On many occasions, the resident observedteachers raising their voices and becoming angry, frustrated, or argumentative when dealing with difficult students. This contributed to a negative school climate.

Factor 5. Inadequate parental involvement:

Across the CSCI, schools in which the psychiatric consultants struggled were generally schools with particularly low parental involvement. This became a major impediment, as informed consent to provide psychiatric assessment and treatment must be granted by the parent or guardian prior to providing services. Numerous appointments made the in-school therapist were missed by the parent or guardian. Attempts to contact parents/guardians were similarly unsuccessful. Phone calls were unlikely to be returned and numbers were out of service or routinely changed. Many parents/guardians lacked access to consistent phone service. These issues were shared by all of our psychiatric consultants in the inner-city schools, but substantially more so in School "B".

DISCUSSION

Because we placed our residents in schools already served by an on-site therapist, there was potential for an established caseload. In addition, all children already in treatment could now have their appointments at school rather than off-site. Families with limited resources found that school appointments provided welcome relief from the difficulties of acquiring transportation and making job and childcare arrangements. Residents appreciated the reduced no-show rate, which in turn benefitted the outpatient clinic's bottom line. Most importantly, high-need children had increased access to mental health care that could be coordinated with their educational plan.

Continued Challenges

However, we found that some parents resisted or declined access to psychiatric services for their child. Appointments to discuss child behavior with parents or guardians were frequently missed, with no explanation. Resident psychiatrists were initially dismayed by refusal of free services, but school staff members pointed out that parental non-involvement is a long-standing problem within inner city schools. Service refusal may also represent on-going stigma related to mental health or concerns about their child's privacy.

Another challenge routinely faced by the residents was the need to avoid dual agency. The residents were taught that, for a particular child, they could either be consultants to school staffor the treating psychiatrist, but they could not be both. Problems most often occurred when a child was referred to CSCI by a teacher. Once referred, teachers wanted to know the child's diagnosis and treatment plan. They considered this appropriate since they had both made the referral and were continuing to cope with difficult classroom behaviors. However, since the child now had established a patient-psychiatrist relationship, a signed consent was needed for information release to the school. Quite often, parents or guardians were unwilling to sign such releases. This placed the resident in an uncomfortable position, withholding information from the teachers and administrators who were referring the child for care.

Finally, residents desired more comprehensive assessments of the child's presenting problems, particularly when asked to prescribe medication for children referred for Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, and/or Conduct Disorder.

Lessons Learned

We have come to the end of the first year of the CSCI, a program which now includeson-site child psychiatry residents. Through ongoing conversations among working group partners and with residents, we learned that it was difficult for our residents to move away from traditional service delivery (i.e., providing psychiatric evaluations, medication monitoring, and brief consultative services). Although residents were encouraged to observe classroom behaviors, attend staff meetings, and more generally engage in the school environment, this level of interaction was atypical. Instead, we learned that residents must be consistently encouraged and systematically supported tofully immerse themselves into a school's culture. As a first step, they need to be included when school staff are developing individual education plans for high-need children. Greater immersion might also be enhanced if residents could beassigned to particular teachers who agree to include the resident in a variety of classroom related activities. This would provide greater opportunity to observe typical and atypical school behavior. In this context, the resident might have greater influence on classroom management strategies.

As noted, the importance of administrative support became obvious, residents may need to engage in intentional efforts to garner and maintain buy-in from all levels of school staff. Enhancing intentional interactions with teachers, school counselors, administrative staff, and school nurses is likely to greatly improve the likelihood that the CSCI will be increasingly successful and sustainable. Placing at-risk students at the center of these interactions is the crux of the model and requires a move from co-located services to truly integrated care.

To this point, careful selection of school sites is imperative. Schools deemed appropriate for placement of a psychiatric consultant across the next years of this project will still be assessed based on demonstrated need for services, but also for levels of preparedness as well as school leadership, staff, and teacher receptivity. Going forward, physical space, telephone and Wi-Fi access, and the existence of a pre-established and centralized full-time staff member who agrees to facilitate referrals, including obtaining parental consent for services, will all be taken into account prior to placement of the psychiatric consultant into any particular school. These school-specific selection factors may be particularly important at the inception of this type of project. Finally, in an effort to address the residents' concerns about being asked to quickly provide medication to

"acting out children", discussion has commenced about how to include a doctoral Psychology student in the CSCI. This student could provide in-depth assessments to children in need of a differential diagnosis.

Nonetheless, across this initial year, residents continuously reported that this rotation was a vital part of their training. This provided a unique opportunity to observe the profound difficulties faced on a day-to-day basis by educators located in inner city schools with limited funding. Residents indicated that many teachers can best be described as heroes, while noting that too many teachers are suffering from burnout and lack of support. The residents noted that many teachers were experiencing stress associated with mounting pressure to do more with less. Residents felt that mental health interventions and stress prevention strategies were as needed for school staff as they were for the school children.

Residents universally reported a greater understanding of the school environment and its challenges for children. They had greater empathy for students, families, and teachers as a result of their time spent walking the halls, seeing the children, and observing the day to day difficulties presented in these schools. While our initial goal was to provide greater access to psychiatric services along with standard school consultation liaison serviceswithin a CSCI, we learned the limited impact of providing an on-site resident one day per week. It is our contention that changes in the school environment and improved health care for all, will require more intentional collaboration among school personnel and educators, system wide administrators, nurses and primary care doctors, psychiatrists and mental health providers, parents, families and children. To disseminate and advance this program, it will also be essential to intentionally measure the success of the project. Project success will be best understood from multiple perspectives including the degree to which the training proved beneficial to the child psychiatry residents, the extent to which school teachers, administrators, and staff felt supported in their work with children, and, most importantly, the impact on the children served. As of Year One, the school consultation rotation was viewed positively by all child psychiatry trainees. Unanimously, the trainees reported increased knowledge of issues relative to the school environments in which their patients spend a large percentage of their waking hours, and likewise increased appreciation for the challenges faced by teachers and other school staff members. Practically, the degree to which placing a psychiatric consultant within a high-need school setting increases access to psychiatric care, and resulting benefit to troubled children and families requires intentional assessment. These will be our primary goals in Year Two.

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