

SCHOOL PSYCHIATRIC CONSULTATION MANUAL PEACEFUL SCHOOLS PROJECT

The Mental Health Consultant (MHC) is to form an alliance with school personnel (e.g., principal, teachers, school psychologists) to improve the performance of children who are displaying emotional and/or behavioral difficulties in the school setting. The MHC will form this alliance through attending weekly Student Resource Team (SRT) meetings, meeting individually with teachers and other school personnel, observing children in the school setting, and helping design and evaluate interventions.

This manual describes the basic structure and principles for the consultation model to be followed in Intervention B of the project formally known as the Peaceful Schools Project. In addition, the manual entitled Student Improvement Team (SIT) Training. Participant Handbook provides an in-depth discussion of the overall collaborative model to be promoted by the consultant. The SIT manual also includes a number of useful measures, forms, and technical strategies for developing an effective school-based team to address the needs of children who exhibit significant behavioral or psychological disturbances at school.

JOINING THE STUDENT RESOURCE TEAM (SRT)

Children exhibiting behavioral, emotional, or academic problems in the target schools are reviewed by a team, which usually includes a school counselor or social worker, a teacher, a school psychologist, and the school principal. This team is called a Student Resource Team (SRT) in the Topeka Public Schools; however, the Student Improvement Team model described in the above-referenced training manual is very similar in goals, operation, and techniques. The MHC is not trying to introduce a new model for operating the SRT in the target schools. Instead, the MHC is trying to enhance the performance of the SRT by adding a level of psychiatric expertise far beyond that typically available.

To this end, the MHC will become an integral member of the SRT, attending weekly SRT meetings (one hour) and providing three hours of onsite consultation per week. The precise focus of effort for the MHC at individual schools is expected to vary, depending on the types of problems faced by the SRT, needs identified by the team, and the consultant's expertise. Common presenting problems include noncompliance, aggression, academic failure, and emotional lability. A significant number of children are likely to meet diagnostic criteria for one or more DSM-IV diagnoses. The MHC is expected to be asked to help develop a plan to assess the nature and extent of the children's difficulties, devise strategies for helping individual children, and help determine the effectiveness of these strategies. Central contributions of the MHC include improved conceptualization of the causes and maintainers of children's difficulties, consideration of a more comprehensive range of interventions, and increased sophistication in implementing intervention plans.

Because the SRT sometimes discusses children whose difficulties are limited to academic achievement, it may be necessary to structure the SRT into two sections, one which would include children with emotional and behavioral concerns and another solely for achievement concerns. This structure would best utilize the time of the MHC in focusing on children for whom his or her expertise would most likely be needed. For instance, a child who is generally compliant in following directions, gets along well with peers, but has difficulty in completing work at grade level would in most cases need the expertise of special education specialists. However, if the school staff felt that emotional or behavioral difficulties exacerbated the students learning problems, the MHC would be asked to be present for the child's conference at SRT. *It will be the primary responsibility of the SRT coordinator (who will be identified by each individual school) to establish which students are in most need of the MHC's expertise.*

An important role for the MHC on the SRT is to make recommendations regarding a child's need to access outside mental health services. These services may be

required when the team feels family and community factors, or psychiatric disorders, may be influencing the child's behavior at school. Referrals may be made but not limited to the following services: family counseling, individual counseling, medication evaluation, and psychological evaluation. The MHC will help the SRT identify community resources that can be accessed by the child's family.

The MHC will also help communicate with mental health professionals regarding referred children's adjustment and treatment. For example, the MHC may communicate with prescribing physicians about the use of psychoactive medications in the school setting. These contacts may include discussion of diagnoses, effectiveness of the medication in producing desired changes in functioning, and side effects observed in the school setting. The MHC's ability to monitor children's adjustment over an extended period in a natural setting should prove invaluable in adjusting clinic-delivered treatments, both pharmacological and psychotherapeutic, for maximum effectiveness.

DIRECT CONSULTATION WITH TEACHERS AND OTHER SCHOOL PERSONNEL

Direct consultation with the student's primary teacher or other school personnel (e.g., counselor, nurse, principal) is a second important role for the MHC. Direct consultation is expected to account for 2-3 hours of the consultant's 4-hour weekly allocation of effort. The consultations should focus on helping to decide how the intervention plans discussed in the SRT are implemented in the classroom setting.¹ To carry out this role successfully, the MHC is expected to observe the child and teacher in the classroom, work cooperatively with the teacher in setting up a feasible implementation of the intervention, follow-up with the teacher on how the intervention strategy is working, and reinforce the teacher's progress in implementing the intervention plan.

¹ The term "teacher" is used in this section for the sake of brevity. However, this consultation process also applies to other school personnel, such as counselors, special service providers, recreation personnel, and administrators.

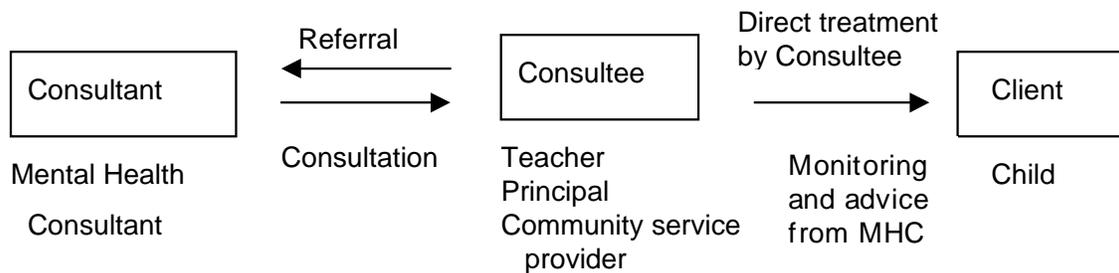
For most teachers, interventions designed for one student can decrease the amount of time they have to support the educational needs of other students. Therefore, the MHC needs to be cognizant of the needs of the teacher and other students in the class setting. *A guiding principle for this consultation model is that the intervention strategy should, in the long run, increase the amount of time the teacher has for instruction of the whole class and increase the overall learning environment.* When observing in the classroom, the consultant will need to take data on the overall amount of time devoted to educational needs as opposed to behavioral needs. Taking data on education instruction versus behavioral instruction can illustrate the possible benefits of the proposed intervention strategy. For instance, if the teacher is currently spending 20% of time in instructional periods addressing behavioral difficulties of the target child (e.g. redirecting child to seat, redirecting child to start assignment), the intervention plan should, over time, consume less than 20% of the teacher's instructional period.

Forming a Consultant Relationship with Teachers

The MHC should strive to establish a *non-hierarchical relationship with the teacher* in the consultation process. The MHC must form a relationship where the teacher is free to share information with the consultant and accept feedback from the consultant. To facilitate this flow of information the *MHC must insure the confidentiality of information discussed with the teacher in the consultant relationship.* This confidentiality insures that what the teacher shares with the MHC about difficulties in his or her classroom is not shared with others without the teacher's previous knowledge and consent.

The MHC must also communicate to the teacher that consultation is a process in which both parties work jointly to alleviate the difficulties occurring with the student. The consultant is not there to provide direct service or intervention; rather, the consultant is trying to help the direct service providers carry out their roles more effectively. Therefore, the consultant cannot arrive with an 'expert' attitude and give the impression to

the teacher that he or she will take care of the problem and fix everything. Since the teacher may already be feeling overwhelmed because of a student's behavior problems, the 'expert' approach will most likely decrease the likelihood of forming a collaborative relationship with the teacher. The consultation process involves working jointly on interventions that can be effective for the teacher. The figure below gives a representation of the MHC's role in collaborating with the teachers and school personnel about students with problem behaviors.



Initial Consultation Meeting

During the first consultation meeting with the teacher, the MHC should leave with *specific knowledge of the problem behavior* which is to be targeted, establish the *role of the consultant*, and inform the teacher about the *confidentiality of issues* discussed in the consultant relationship. Information about the problem behavior should include when the behavior occurs most often, what immediately precedes and follows the problem behavior, where the behavior most likely occurs, the frequency of behavior, and the severity or intensity of the behavior. If data have not already been taken on the problem behavior the MHC should work with the teacher in developing a manageable system to collect this information (the *SIT Training Manual* offers numerous tools to accomplish this). The consultant should also set a time to observe the child directly within the next week to get a better understanding of the problem behavior and classroom

structure. The teacher should be informed about the amount time the consultant expects to devote to the consultation, when meetings will occur, the purpose of observations, the type of data to be collected, and when feedback will be given. Further, a strategy for supplying data recording instruments to the teacher should also be established at this point. Finally, the limits of teacher-consultant confidentiality should be noted (e.g., suspected child abuse).

Observations in the Classroom

The observation component of the consultation process is an important ingredient in developing an appreciation of the difficulty a child's problem behavior poses for the teacher, discovering possible explanations for the recurrence and persistence of the problem behavior, and assessing factors affecting the selection and implementation of effective intervention strategies. Observational information should be gathered in the following areas:

1. Classroom Variables- physical arrangement of the classroom, seating arrangements, routines procedures, and expectations, rules, and consequences.
2. Instructional Arrangements- grouping of children, individualized instruction, structure of activity centers, and seat work monitoring procedures
3. Teaching Style and Strategies- use of student ideas in teaching and goal setting, use of questions, probes, use of reinforcement and punishment, clarity of presentation, and special programming for exceptional children
4. Target Student's Work Behavior- participation, task completion, interaction with peers (e.g., approaches, disrupts, avoids, rejects), interaction with teacher (e.g., seeks help, withdraws, does not answer questions of teacher, sits away from teacher)
5. Emotional Behavior- typical mood, emotional reactions to work and social interactions, typical energy level, expression of anger, affection, and fear
6. Nature of Interactions- the frequency and quality of interactions with peers and adults.

The preceding information gathered from observation will assist in the assessment and development of the intervention plan for the target behaviors. This information will need to be shared with the teacher in order to come up with a mutually acceptable intervention strategy. The observation procedure is not complete until feedback is shared with the teacher.

Giving Feedback to Teachers and Developing an Intervention Plan

The stage for giving feedback should be set from the first meeting with the teacher when the MHC discussed the purpose and nature of observations in the consultation process. Feedback needs to be given in an effective manner in which both parties, the MHC and teacher, clearly understand the behavior problem and observation data. The consultant should query the teacher if the time the child was observed was typical for the child, if the teacher's response to the child was typical, and if the resulting child behavior was typical. Through the feedback session the MHC may offer opinions on how the teacher's interaction with the target child, or how other students' behavior, may contribute to an ongoing problem behavior. When giving feedback the MHC needs to be sensitive to the teacher's needs and feelings, and present information in a manner the teacher will find helpful and supportive, rather than critical or judgmental.

After data from the observation are exchanged, the MHC and teacher begin forming an intervention plan. During the development of the intervention plan, the consultant suggests possible solutions to the problem and encourages the teacher to also make suggestions. The teacher will ultimately be responsible implementing the program; therefore, the teacher needs to feel some ownership of the strategy developed. After the intervention has been agreed upon, the MHC and teacher should discuss how data will be continued to be collected and when the MHC will follow-up with the teacher on progress.

Implementing Intervention Plans

Teachers and other personnel often have difficulty implementing interventions proposed by treatment teams for a number of reasons, including unforeseen barriers, lack

of skill or confidence in carrying out one or more components of the intervention, and reservations about the content or process of the intervention plan. Follow-up by the consultant is needed to insure that the intervention is being implemented correctly, to identify barriers to implementation, assess whether improvements have occurred, and modify or extend the intervention plan as needed.

Implementation requires meeting with the teacher again to review progress through the use of objective data and the teacher's perceptions. Follow-up may include additional observations if difficulties persist in implementing the program or if positive results have not been found. Regardless of the effectiveness of the intervention or the ability of the teacher to carry out the intervention as planned, the teacher needs to be given ongoing praise for efforts to implement the plan. This is especially important if the original plan was too ambitious or results have not occurred as quickly as expected. It is helpful to remind the teacher at this time that intervention is often an extended process and revisions to interventions are often needed.

Extending the Scope of Intervention Plans

In some instances, school-based interventions have a limited impact because much of the child's problematic behavior is driven by psychosocial stress (e.g., family dysfunction, stressful life events, residential instability), psychiatric disorders, or both. When well-executed modifications in the school environment fail to achieve desired improvements in child behavior, the MHC may recommend interventions extending beyond the school setting, such as medication evaluation, referral for family or individual psychotherapy, or social services. In such instances, the MHC plays a valuable role in helping the SRT develop a comprehensive, integrated treatment plan. Equally important, the MHC can help school personnel understand the nature and causes of the child's difficulties. Often this understanding leads to greater empathy for a child whose behavior is a source of considerable stress and strain for teachers and other school personnel.