A Mental Health Outreach Program for Elementary Schools

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Abstract

Introduction: Expanding linkages between mental health services and schools is one strategy to improve early access to help children with emerging mental health problems. However, there are few descriptions of such outreach efforts in Canada. This report describes one model used in Alberta, Canada. **Method:** Key aspects of the organization and operation of the Community Outreach in Pediatrics/Psychiatry and Education (COPE) program are described. **Results:** The COPE program provides child psychiatric and paediatric consultations to families and schools throughout the elementary school systems in the Calgary and Rocky View School Districts in Alberta, Canada. Participating schools refer prioritized children with emotional, behavioural and/or developmental problems. After an inter-professional screening process, most children go on to a physician-based assessment within the school setting which involves the child, family and key school personnel. Following assessment, an action plan is developed and attempts are made to link children and families with needed services. **Conclusion:** The COPE program represents one approach to linking mental health services with students through schools. Further study is required to determine the range of such models used in Canada. In addition, evaluation of these and other models are sorely needed to better determine the cost-effectiveness of these approaches.

Key words: schools, school based interventions, mental health services

Résumé

Introduction: Améliorer le lien entre les services de santé mentale et les écoles permet aux enfants qui présentent les premiers signes de maladie mentale d'avoir rapidement accès aux services nécessaires. Ces initiatives sont toutefois peu connues au Canada. Cet article présente un modèle utilisé en Alberta. **Méthodologie:** Les auteurs décrivent les grandes lignes d'organisation et du fonctionnement du programme COPE *(Community Outreach in Pediatrics/Psychiatry and Education).* **Résultats:** Le programme COPE propose des consultations de pédopsychiatrie et de pédiatrie aux familles et aux écoles élémentaires de Calgary et de Rocky View (Alberta). Les écoles qui ont participé à l'étude ont référé en priorité les enfants qui avaient des troubles émotionnels, comportementaux et/ou développementaux. Après triage par une équipe multidisciplinaire, les enfants étaient évalués par un médecin à l'école dans une démarche impliquant l'enfant, la famille et le personnel clé de l'école. Un plan d'action mettait ensuite les enfants et les familles en rapport avec les services dont ils avaient besoin. **Conclusion:** Le programme COPE est l'un de divers programmes offrant des services de santé mentale aux élèves par le biais des écoles. La pertinence et la rentabilité de ces programmes devront faire l'objet d'études complémentaires.

Mots clés: écoles, interventions à l'école, services de santé mentale

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Introduction

Mental health disorders in children are common with an estimated median prevalence of 12% in the general population (Costello, Egger, & Angold, 2005). The majority of these children do not receive any formal mental health services (Angold et al., 2002; Leaf et al., 1996; Offord et al,, 1987). However, when children are seen, schools may be the most frequent site of service delivery and receipt and thus serve as the de facto mental health system for children (Burns et al., 1995).

Schools have several characteristics that make them an ideal partner in the attempt to deliver services to children with mental health needs. First, almost all children, at least at the lower grades, attend school. Second, teachers, given their training and exposure to large normative samples, are in an excellent position to identify possible deviance from normal child development. Third, most children in Canada continue to attend community schools which may decrease distance and travel barriers for families if mental health contact is located within the school. Fourth, the school setting may be less stigmatizing than formal child mental health service settings.

However, despite all these advantages, schools are not adequately resourced to meet the needs of children with mental health problems within their system (Cohen, Linker, & Stutts, 2006; Cooper, 2008). One example of this gap is reflected in teachers' frustrations with the lack of follow through by parents when they have identified a need, particularly when recommending an external service (Williams,

Horvath, Wei, Van Dorn, & Jonson-Reid, 2007). There is therefore a need to consider models that enhance the extent to which mental health providers work collaboratively with schools to expand access to mental health services to children in need.

Various collaborations between the mental health system and schools exist in Canada. However, those identified in the peer-reviewed literature are predominately reports of specific research interventions (e.g., the Tri-Ministry Project - Hundert, Boyle, Cunningham, Duku, Heale, McDonald et al., 1999; the Montreal Longitudinal Experimental Study - Boisjoli, Vitaro, Lacourse, Barker & Tremblay, 2007). While these are critical for advancing the field, there is also a need to understand the types of services that are actually delivered through ongoing "real-world" programs in Canada. One exception is a brief description of two pilot programs in Alberta: (i) one, an early version of the program to be detailed in this report, and (ii) a school mental health nurse program (Clarke, Balance, Bosetti, & Archer, 2002). In the latter program, a full time school-based mental health nurse was employed to provide assessments, referrals, case management and interventions for children in one school district. A clinical case review suggested 66% of the 131 students seen in one school year experienced some improvement (Clarke et al., 2002).

Several other examples of mental health service collaborations with schools were identified in the peer-reviewed literature, but were for programs outside of Canada. In order to provide some comparison with the program we present in this report, we restrict this brief review to examples which describe interventions that (i) focus on younger children (e.g., primary school), (ii) focus on early identification and intervention for emerging problems versus intensive interventions for severely ill children, (iii) provide clinical or indicated interventions (i.e., not solely universal interventions – see explanation of different types of interventions in Offord, Kraemer, Kazdin, Jensen, & Harrington, 1998), and (iv) are not restricted to a research intervention offering only.

Child and Adolescent Mental Health Service and Schools Together (CAST) is an Australian program aimed at the prevention, early identification, and treatment of disruptive behavioural disorders in the early school years (Corboy & McDonald, 2007). Their program includes teacher training, classroom strategies, a screening and triage process, parent training, group therapy, home support, and a mechanism for referrals for more comprehensive assessment and treatment. Qualitative interviews with school personnel identified challenges and positive aspects from program implementation (Corboy & McDonald, 2007).

The Fast Track program is a comprehensive combination of a universal and indicated program developed in the United States aimed at young children at risk for antisocial behaviours. It includes a classroom-wide program, social skills training, academic tutoring, parent training, and home visits (Conduct Problems Prevention Research Group, 2000). Outcomes revealed lower rates of serious conduct problems in the intervention group at three year follow-up (Conduct Problems Prevention Research Group, 2002). Though initially provided only through a multi-site randomized controlled research trial, it is now offered as a service in a variety of sites including Canada.

In an example of an attempt to provide services to a broader array of schools, Walrath, Bruns, Anderson, Glass-Siegal and Weist (2004) reported that Baltimore was able to deliver school mental health services to 44% of its public schools at the time of their study, approximately half of which were elementary schools. Services were delivered by both school-employed professionals and providers from outside the school with individual therapy being the most common type of service contact (Walrath et al., 2004). Using an evaluation design with matched schools with and without this service, Bruns, Walrath, Glass-Siegel and Weist (2004) found that teachers in the intervention schools were less likely to refer students to special education for emotional and behaviour problems than those in comparison schools, though there was not a difference in the overall referral pattern. In addition, they found higher staff ratings on a subscale of positive mental health climate when compared to the matched schools, though not on the overall climate score (Bruns et al., 2004).

Though significant learning is possible from these non-Canadian examples of school mental health programs, additional information is

required as to how school mental health programs in the Canadian system are functioning. This is critical given substantial organization and funding differences for both child mental health and school services between countries. This report describes aspects of one ongoing school-mental health partnership service in Alberta, Canada.

COPE

Background:

The Community Outreach in Pediatrics/ Psychiatry and Education (COPE) is a partnership program aimed at helping children who have emotional, behavioural and/or developmental problems which are negatively affecting their learning. COPE was initially a pilot demonstration project through the Health Transition Fund for primary health care projects in Alberta in 1998-2000 with the aims of (i) early identification of children with emotional and behavioural problems, (ii) early medical consultation and provision of comprehensive assessment of psychosocial and health status to better match needs and interventions, (iii) improvement of access and linkage to existing health and mental health services, (iv) more effective utilization of health and education resources to identify and direct children to more appropriate interventions, and (v) improvement in psychosocial outcomes of children served by the program.

After the completion of the pilot demonstration project, partnerships were forged between the Calgary Board of Education and the Calgary and Area Child and Family Services Authority (regional body for the Alberta Ministry of Children's Services). This allowed the clinical component of the demonstration project to continue to deliver services to students. There was then a steady expansion to include all elementary schools within the Calgary Board of Education. The program also spread to cover all elementary schools within the Calgary Catholic School District, the Rocky View School Division (a district composed of a larger horseshoe shaped jurisdiction around Calgary), and the independent schools of the Calgary Rocky View area.

Governance/Staffing/Funding

The COPE program is overseen by a Working Group composed of representatives from each of the four school boards, as well as representatives of the Calgary Health Region and Calgary Child and Family Service Authority. They meet on a monthly basis to maintain joint responsibility of this partnership, ensure that it operates within its mandates and approve pilot projects.

Staffing details are presented in Table 1.

Table 1: Current staffing of the COPE program

Staff type	Staff Role	FTE
Medical Director	Provides leadership to overall COPE program, represents physicians on steering committee, leads physician recruitment, supports community linkage and seeks funding opportunities.	0.2
Coordinator	Manages flow of referrals, liaises between multiple school jurisdictions and COPE staff, and manages day-to-day operation of the office.	1.0
Office Assistant	Manages physicians' school consultation schedules, tracks referrals, and manages data flow	1.0
Family Therapist	Provides direct family therapy service and clinical consultation to family liaisons	1.0
Family Liaison	Provides case coordination for each referral, assists in linking families to services, and provides some support services	5.85
Psychologist	Provides socio-emotional assessment	0.7
Child & Family Service Worker	Provides consultations with regard to child protection issues and child welfare services, including determining eligibility for developmental disability support services	0.5
Specialist Physician	Provides direct patient assessments, consultation to parents and schools, and some follow-up services	0.54
TOTAL		10.79

There are currently eight consulting physicians (four child psychiatrists, three developmental paediatricians and a general paediatrician) each providing from one to four consultations per month. There are twelve family liaisons who provide case coordination. The extent of their role and time allotment varies across school districts. The family therapist and child and family service staff member work across school districts. The latter is a new position to help with situations involving social services such as abuse and neglect issues and access to government support for children meeting disability criteria.

There are several sources of funding to cover the cost of the COPE program. Until recently, most physicians' time had been reimbursed through a traditional fee-for-service system through Alberta Health, with the exception of those involved with the University of Calgary's Pediatric Alternative Funding Plan (AFP). Recently, an Alternative Relationship Plan (ARP) has been approved covering those physicians not on the AFP. This new development allows reimbursement for no-shows, a slightly higher rate of reimbursement for follow-up appointments, and coverage for referrals that come forward without a physician referral. This helps to partially offset the physician loss of income due to non-reimbursable travel time for physicians not on the AFP.

Some non-physician funding is provided by the Calgary Health Region to cover costs of the COPE coordinator and the family therapist. The

Figure 1. Student flow into and through the COPE program

Schools identify students whose emotional, behavioural and/or developmental difficulties are impacting their learning. (This is an existing activity within schools that precedes COPE involvement).

↓

Identified students are presented at school resource meetings. A determination is made as to whether the student is appropriate for a COPE referral

↓ → *Non-COPE referral (e.g., child may be seen by internal school personnel such as a school behavioural specialist or referred to in-home support)*

Consent Forms are obtained and COPE School and Parent Referral Forms are completed for discussion with COPE

↓ → *Parents may decline school's request to move forward with a referral.*

School personnel present the referred students to the COPE Screening Team and recommendations are made as to how to proceed with the student

↓ → *A minority of referrals do not go on to physician assessment. Parents may decline a physician assessment or the family may be referred to a community service (e.g., parent training program).*

A COPE physician-based assessment is provided in the school with direct involvement of the student, family and school personnel with feedback and recommendations provided to both parents and school

↓ → *Parents may decline recommendations.*

The COPE family liaison provides support for follow through with the recommendations

↓

COPE physician follow-up is provided if required

child and family worker position is contributed by the Calgary Child and Family Service Authority. Schools use some of their School Health Partnership (SHP) funds towards COPE to cover portions of the secretarial, family liaison and psychology positions. The SHP program is a cross-ministry project in Alberta aimed at improving service delivery to students and includes the ministries of Education, Health & Wellness, and Children's Services. Participating school districts also contribute some of their educational dollars to help with some positions and various office expenses.

Process

Various steps related to the flow of patients into and through the COPE program are illustrated in Figure 1. Prior to entry into the COPE program, staff within the school system identifies students with emotional, behavioural and/or developmental problems. Those with the most significant concerns are presented at the schools' resource meetings. One option from this meeting is referral to the COPE program. Additional options are the involvement of internal school resources and/or recommendations for other outside services. As COPE has limited capacity, the school teams must prioritize which children will be forwarded to the COPE program. Children thought to need physician involvement are preferentially directed towards this resource.

If the recommendation is to refer to the COPE program, the school must obtain consent from the parents. If parents are in agreement, parent and teacher referral forms are completed. These are parallel instruments which contain basic socio-demographic information, key questions the parent and teacher have for the consultant, and service information (e.g., questions about previous assessments).

The parent and teacher versions of the Strengths and Difficulties Questionnaires (SDQ) are embedded within the referral form. The SDQ is a brief mental health screening tool which provides an index of common mental health problems (Goodman, 2001) and has been used in the school setting (Levitt, Saka, Romanelli, & Hoagwood, 2007). Preliminary analysis has been conducted on teacher referral SDQ data for a sample of 126 children from January 2005 to June 2006. Based on teacher ratings, all children were rated in the abnormal range on one or more SDQ subscales with the highest percentage of abnormal ratings on the hyperactivity (72%) and conduct problems (67%) subscales (McLennan, Huculak & Kowalewski, 2007). Sixty-seven percent were rated in the abnormal range on three or more subscales.

Most referrals are brought to a Screening Meeting. This entails school personnel, who are referring the child, presenting information to the COPE Screening Team in a face-to-face meeting. The team may include one of the COPE physicians, a COPE family liaison, personnel from student services (e.g., a psychologist), the COPE coordinator and, at times, the COPE family therapist. A decision is made at this meeting as to how to proceed. Most screened cases, about 90%, go on to a COPE physician-based assessment. Those not requiring or wanting a physician assessment may be referred to other community services. A briefer screening process is used in some cases.

For physician-based assessments, COPE physicians go to the child's or another designated school to conduct the consultation or assessment. Physicians are given flexibility as to how best to structure this process. This can include a combination of meeting with the student, parents, and/or school personnel alone and/or in combination. This can occur in one or more sessions. The sessions may entail a full diagnostic assessment of the child and/or a consultation primarily to the school on approaching the child's challenges.

From the physician-based assessment, several recommendations may flow depending on the issue and needs identified. These may be activities within the school system (e.g., academic testing, behavioural management strategies), linkages to other services (e.g., family therapy), or further assessments outside of the school.

Though COPE is primarily an assessment and consultation service with support to link families with needed community services, some limited services are offered within COPE. For some, this may be needed as the family may not otherwise link with existing services. In addition, there is the ongoing problem of lack of services available from community agencies in a timely manner. On a limited basis, service

provisions have included (i) medication treatment, particularly for ADHD, (ii) short-term family therapy, and (iii) short-term consultation to the school with regard to behavioural management in the classroom. In addition, there are ongoing efforts to help form closer ties with various service providers to facilitate more timely access to services.

Key information derived from the 2006-7 annual report is detailed in Table 2. Consistent with most mental health service patterns for younger children, boys predominate in the refer-

Table 2. Information derived from the COPE program for the 2006-7 school year

Characteristics of new referrals (n=135)	**% (n)**
Gender (male)	76.3 (103)
Grade	
K	7.4 (10)
1	27.4 (37)
2	13.3 (18)
3	15.6 (21)
4	14.1 (19)
5	8.9 (12)
6	8.9 (12)
7-10*	4.4 (6)
Most common referral concerns**	
Attention	63.7 (86)
Behaviour	51.9 (70)
Family	42.2 (57)
Social interaction	42.2 (57)
Learning	37.8 (51)
Possible autism	25.2 (34)
Anxiety	19.3 (26)
Gross and/or fine motor	18.5 (25)
Speech and language	14.8 (20)
Delayed development	9.6 (13)
Service patterns for all referrals	**% (n)**
Referral type	
New	49.8 (135)
Reactivated***	50.2 (136)
Total	100 (271)
Receipt of a physician assessment by referral type†	
New (n=135)	91.1 (123)
Reactivated (n=136)***	79.4 (108)
Total (n=271)	85.2 (231)
Physician consultation type	
Child psychiatry-new assessment	20.0 (84)
Child psychiatry-follow-up	39.9 (168)
Paediatrics-new assessment	14.0 (59)
Paediatric-follow-up	26.1 (110)
Total	100 (421)
COPE physician initiated medication trial	
New referral (n=135)	25.2 (34)
Reactivated patient (n=136)	41.2 (56)
Total (n=271)	33.2 (90)

* though the program is primarily for elementary schools, there are some extended elementary schools and middle schools

** in many cases there was more than one concern per child

*** "reactivated" refers to children who have received a COPE consultation in a previous school year and the case needs to be reopened due to new or ongoing concerns. Reactivated cases represent an increasing percentage of total cases each year partly as a function of the lack of community resources to meet students mental health needs.

† reasons for not having a physician assessment included (i) family turned down service, (ii) family seeing or soon to see a community physician or other health/mental health professional, or (iii) family had moved.

ral sample. Consistent with COPE's focus on early intervention, there is a tendency to see more children in the lower than higher grades. Attention and behavioural problems were the most common referral concerns. There were 271 referrals divided between new students to the services and returning ("reactivated") students.

There is a set number of COPE physician assessments allotted each year as a function of available physician time. All available slots are filled each year typically months before the end of the school year. No formal waitlist is maintained. It is difficult to determine relative wait times for this program versus typical care provided outside of the program. However, many of the families do not have a family doctor and if they do, they would typically experience a long wait time prior to being seen by these types of specialist physicians through a typical referral process.

Discussion

There are several potential positive aspects to the approach taken within the COPE program. A key factor is increasing access for children and their families to assessment and resources which they might not otherwise receive or may not receive in as timely a fashion. However, there are potential limitations to this model that should be considered.

This approach does not address the overall resource shortage in child mental health services; rather, it redistributes some existing resources. The redistribution may address some inequities in the system. For example, the nature of the service linkage may result in more marginalized families being linked to services. However, it does not directly increase capacity in the overall system. There is even the risk of decreasing capacity through the creation of less efficient decentralized services. For example, physicians may be able to see more patients back-to-back in a centralized clinical setting versus offering a similar service across a variety of schools. This has to be balanced, however, with the potential for increased capacity in other aspects of the program. For example, school personnel may take learning through one consultation on dealing with a child with disruptive behaviours and apply it to other students with similar needs who do not come for a direct consultation.

A second resource-related limitation is the reliance on specialist physicians (i.e., paediatricians and child psychiatrists) as key consultants. Both specialists are in substantial shortage in Canada which restricts the capacity to expand the program. Other practitioners, e.g., child psychologists, could provide diagnostic assessments and consultations in such a model. However, these professionals are also in shortage. In addition, many of the existing school psychologists' schedules are heavily consumed by high demands for psycho-educational assessments. Further consideration is required as to how other personnel may be able to expand the capacity of the program.

A third limitation related to resource shortages is the ongoing problem of not having sufficient community intervention resources to address problems identified within the consultation. As the model is primarily weighted to assessment and consultation, it relies on a level of community capacity to provide relevant interventions. For example, a child diagnosed with an anxiety disorder may benefit from cognitive behavioural therapy, but this treatment may not be readily available within the community.

Beyond resource limitations, other factors need to be considered. For example, is this program's structure preferentially more advantageous for some issues, while less so for others? Given that referrals are generated by school personnel, the program may be particularly good at identifying children whose difficulties are most obvious within a school setting. For example, ADHD and other disruptive behavioural problems might be particularly well served by this arrangement. In contrast, teachers may have more difficulties identifying children with emotional disorders, though findings of this pattern are mixed (Auger, 2004). Consideration should therefore be given to the relative strengths and weaknesses of this model's approach across problem areas.

Ideally, the adoption of a given school-mental health program should be driven, at least in part, by empirical evidence of effectiveness and preferably cost-effectiveness. This is particularly true for resource-demanding interventions which may incur substantial opportunity costs. Though there has been a preliminary evaluation of an earlier version of

the COPE program (Clarke, Archer, Bosetti, & Foulkes, 2000), a further and more extensive assessment of the current version of the program is needed. This is not unique to this particular school-mental health program, but a general need within the school mental health services field (Hoagwood & Erwin, 1997).

A final point of discussion surrounds the issue of consent and confidentiality. Evans (1999) raised consent as a key issue for school mental health programs, particularly the need for parental consent. While a broad discussion of consent and confidentially is beyond the scope of this paper, we briefly raise some aspects in the COPE process relevant to this issue. The school must obtain parental consent prior to the submission of a referral to the COPE program; hence no child is seen by the COPE program without his or her parent's knowledge. Though parents are made aware of the COPE process including that at least some information is shared with the school as a partner in the process, there may be some challenges to the extent of confidentially of the process. First, the child and family are seen in the school setting. Though it should not be obvious that a given child may be receiving a mental health assessment, staff or students not involved in the process may notice the student going in and out of meeting areas. Second, verbal feedback on aspects of the consultation is often provided to parents and key school personnel together in order to develop a joint plan of action. Third, the family liaison completes a summary note at the end of the consultation and a copy of this enters the student's school file, though the parent must sign and agree to this step. Despite these measures, further consideration and debate is required about this and similar processes in school mental health services to ensure that consent and confidentially processes are not violated and procedures are in the best interest of the student.

Conclusion

We have offered a description of one type of school mental health program offered in a Canadian district to stimulate further discussion and debate about school mental health service delivery in Canada. Though there is much promise in partnering with schools to provide child mental health services, further descriptive and evaluative work is required to help move this field forward to maximize efforts to improve effective child mental health services delivery in Canada.

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