Complete Summary

GUIDELINE TITLE

Practice parameter for psychiatric consultation to schools.

BIBLIOGRAPHIC SOURCE(S)

Work Group on Schools. Walter, HJ, Berkovitz IH. Practice parameter for psychiatric consultation to schools. Washington (DC): American Academy of Child and Adolescent Psychiatry (AACAP); 2004. 21 p. [69 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Mental health disorders

GUIDELINE CATEGORY

Counseling
Evaluation
Management
Prevention
Risk Assessment

CLINICAL SPECIALTY

Pediatrics
Psychiatry

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To review the topic of psychiatric consultation to schools
- To provide an introduction to the special vocabulary, knowledge, and skills that are important prerequisites for successful consultation in school settings

TARGET POPULATION

School children and adolescents with potential mental health disorders

INTERVENTIONS AND PRACTICES CONSIDERED

Psychiatric Consultation to Schools

1. Advising school personnel and parents regarding appropriate accommodations, special education and related services, and placements for students with psychiatric disorders
    - Following provisions of the Individuals with Disabilities Education Act (IDEA)
    - Performing special education evaluation; developing a written Individualized Education Program (IEP)
    - Developing a behavioral intervention plan (BIP) if necessary
2. Comprehensive assessment/treatment planning
    - Obtaining written consent from appropriate parties
    - Meeting with school personnel to clarify the nature, extent, and circumstances of the student's problems
    - Student assessment
    - Observation of the student in several school settings
    - Preparation of the written report
    - Face-to-face presentation of the report to the student support team, the student and his/her parents
    - Periodic follow-up of the recommendations of the report
3. Conducting a needs assessment to guide the development of school-based mental health interventions
4. Universal prevention programs (i.e., establishing clear classroom rules and procedures, managing transitions without undue interruption, improving time on-task, communicating competently, and improving achievement and behavior with contingent rewards)
5. School-based selective prevention programs
6. Advising school personnel about the appropriate use of rating scales to identify symptomatic students who may be in need of psychiatric assessment
7. Collaboration with school personnel to deliver effective school-based indicated prevention and treatment programs
    - Development of cognitive skills

    - Relaxation exercises
    - Cognitive re-structuring
    - Gradual exposure
    - Contingency management
8. Collaboration with school personnel to develop and implement a school crisis plan

MAJOR OUTCOMES CONSIDERED

- Academic performance
- Behavior
- Signs and symptoms of mood disorders

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The list of references for this parameter was developed by searches of *Medline* and *PsycINFO*, by reviewing the bibliographies of book chapters and review articles, and by soliciting source materials from colleagues with expertise in school consultation. The search covered the period 1995 through 2003 and yielded approximately 200 articles and chapters. Full-length books also were reviewed. Each of the references was reviewed and only the most relevant were included in this document.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review
Review of Published Meta-Analyses

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Each recommendation in this parameter is identified as falling into one of the following categories of endorsement, indicated by an abbreviation in brackets following the statement. These categories indicate the degree of importance or certainty of each recommendation.

[**MS**] "Minimal Standards" are recommendations that are based on substantial empirical evidence (such as well-controlled, double blind trials) or overwhelming clinical consensus. Minimal standards are expected to apply more than 95% of the time (i.e., in almost all cases). When the practitioner does not follow this standard in a particular case, the medical record should indicate the reason.

[**CG**] "Clinical Guidelines" are recommendations that are based on empirical evidence (such as open trials, case studies) and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time. These practices should always be considered by the clinician, but there are exceptions to their applications.

[**OP**] "Options" are practices that are acceptable, but not required. There may be insufficient empirical evidence to support recommending these practices as minimal standards or clinical guidelines. In some cases, they may be the perfect thing to do, but in other cases should be avoided. If possible, the practice parameter will explain the pros and cons of these options.

[**NE**] "Not endorsed" refers to practices that are known to be ineffective or contraindicated.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This parameter was reviewed at the member forum at the 2003 annual meeting of the American Academy of Child and Adolescent Psychiatry (AACAP). During March to May 2004 a consensus group reviewed and finalized the content of this practice parameter. The consensus group consisted of representatives of relevant American Academy of Child and Adolescent Psychiatry components as well as independent experts. This practice parameter was approved by the American Academy of Child and Adolescent Psychiatry Council on September 1, 2004.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Recommendations are identified as falling into one of four categories of endorsement. These categories, which are defined at the end of the "Major Recommendations" field, indicate the degree of importance or certainty of each recommendation.

Recommendation 1: Psychiatrists should understand how to initiate, develop, and maintain consultative relationships with schools [CG].

Consulting psychiatrists should always remember that they are guests in a system where other professionals function with a high level of expertise. The psychiatrist should enter this system with an attitude of courteous, respectful collaboration and a sincere willingness to help, rather than direct.

Recommendation 2: Psychiatrists should be knowledgeable about school administrative procedures, school personnel, and the sociocultural milieu of the school [CG].

Consulting psychiatrists must be sensitive to the competing priorities faced by school board members and administrators, who face vigorous pressure from diverse constituents to improve the academic competencies of students. Moreover, few state or federal mandates exist to support the implementation of comprehensive mental health services in schools, and conventional categorical streams of funding inhibit coordination of intervention efforts. Recommendations made by the consultant must be made in the context of these constraints.

Recommendation 3: Psychiatrists should be knowledgeable about legislation that establishes and protects the educational rights of students with mental disabilities [MS].

There can be considerable local variation in the interpretation of the federal educational rights legislation. For example, states and localities may vary in their criteria for eligibility, procedural safeguards, and availability of services. Psychiatrists consulting to schools must be knowledgeable about the laws and regulations for the state and locality in which they practice. Administrative codes interpreting the federal legislation and specifying procedures can be obtained from the education agency of each state and locality.

Recommendation 4: Psychiatrists should be able to advise school personnel and parents about appropriate accommodations, special

education and related services, and placements for students with psychiatric disorders [MS].

Refer to the original guideline document for discussion of the Individuals with Disabilities Education Act (IDEA) and description of the provision of services.

Recommendation 5: Psychiatrists should be able to conduct a comprehensive assessment of a student with an emphasis on understanding barriers to learning, and participate in comprehensive treatment planning with clinical, school, home, and community components as indicated [MS].

The first step of an assessment of a student in which the intent is to provide information to the school is to obtain written consent from appropriate parties, as mandated by federal and state law. The consent form should be standardized and reviewed by legal advisors to the school and consultant, and should explicitly state the purpose of the consultation, how the information obtained during the consultation will be used, and what information (if any) will be kept confidential. It should be made clear to the guardians that the information derived from the assessment could result in educational programming or placement changes for their child.

The second step ideally involves meeting with school personnel to clarify the nature, extent, and circumstances of the student's problems and the specific consultation question. If a face-to-face meeting is not feasible, the consultation question can be communicated to the consultant in writing, preferably on a special form created for that purpose. The initial communication should include a request for relevant information for the consultant to review, including the academic, disciplinary, attendance, anecdotal, and health records of the student; special education service plans (i.e., Individualized Education Program (IEPs), 504 Plans); vision/hearing test results; previous psychological, educational, neuropsychological, and/or speech/language evaluations; and standardized teacher- and parent-completed rating scales. These documents must be perused carefully, as they can provide critical information about previously identified barriers to learning (e.g., learning and language problems).

The third step involves the assessment of the student, which for the most part can follow the format described in the Practice Parameters for the Psychiatric Assessment of Children and Adolescents. However, additional information may facilitate the identification of important barriers to learning. Such information includes the child's cognitive, emotional, social, and physical strengths; parental relationships and communication with school personnel; parental attitudes toward and responses to school disciplinary actions; reasons for habitual absences; parental expectations for their child's school performance; and details about situations that could influence their child's school performance, such as physical or medical status, health practices (e.g., sleep, nutritional, and exercise patterns), afterschool care and scheduling, usual summer activities, and peer relationships.

The fourth step could involve observation of the student in several school settings (e.g., classroom, hallway, playground), if the psychiatrist is invited to do so by the school. For older students, the consultant should attempt to observe at least two different academic classes as well as one or more non-academic settings,

such as the lunchroom or gym. Observation will enable the consulting psychiatrist to assess the student's cognitive, linguistic, emotional, behavioral, social, and motor functions in an educational environment.

The fifth step involves the preparation of a written report that can be presented to school personnel and the parents. The substance of the report should be a concise explication of the barriers to learning experienced by the student (including psychiatric diagnoses), culminating in precise and helpful educational and therapeutic recommendations. It should be written in a clear, concise style that is easy to understand. The consultant should be aware that this report may be the most comprehensive assessment in the student's entire school record, and as such may have the greatest impact of any assessment on the student's educational placement and programming. The consultant also should be aware of who might have access to this report, and should avoid including detailed personal information that is not relevant to the purposes of the assessment.

The sixth step ideally involves face-to-face presentation of the report to the student support team, the student and his/her parents. The focus of this meeting should be achieving consensus regarding the identified barriers to learning and regarding appropriate, feasible, and acceptable educational and therapeutic interventions. The school will decide whether to implement the recommended school-based interventions informally, or within the context of 504 or IDEA programming. A member of the student support team (often the social worker) should be designated to coordinate the various school-based interventions. At this point, the consultant may be called upon by the coordinator to provide additional assistance (e.g., identify appropriate home-, clinic- or community-based services, consult with a physician regarding a medication trial or a specialized referral, consult with a therapist regarding salient treatment issues, consult with a psychologist or speech/language pathologist regarding additional testing). It should be made clear that decisions regarding therapeutic interventions should be made by the parents, child, and treating clinician.

The final step of the case consultation involves periodic follow-up of the recommendations of the report. Periodic meetings should be scheduled with the student support team to review each of the prior case consultations and the progress to date of the recommended interventions. Modifications may need to be made as the student's performance progresses or declines, as available resources are enhanced or diminished, or as the feasibility and/or acceptability of the interventions to the school personnel or family changes.

Recommendation 6: Psychiatrists could collaborate with school personnel to conduct a needs assessment to guide the development of school-based mental health interventions [OP].

Specific pertinent information to be derived from a needs assessment may include prevailing knowledge and attitudes pertaining to mental health issues, degree of confidence in the ability of school personnel to handle mental health situations (e.g., identifying a student who may be depressed, implementing a behavior management plan, managing a crisis); prevailing beliefs about the major mental health problems facing the school and the biggest barriers to overcoming those problems; and available mental health resources.

Recommendation 7: Psychiatrists could collaborate with school personnel to deliver effective school-based universal prevention programs [OP].

Because of the primacy of classroom management among factors influencing student comportment and learning, school personnel may consult the psychiatrist about effective classroom management techniques. A number of these strategies have been catalogued, and include establishing clear classroom rules and procedures, managing transitions without undue interruption, improving time on-task, communicating competently, and improving achievement and behavior with contingent rewards (see Table 9 in the original guideline document). School personnel also may ask the psychiatrist to plan a series of presentations for school staff that convey information about mental health needs across developmental stages, the association between academic achievement and mental health, the most common child and adolescent psychiatric disorders, "warning signs" that may help to identify youths in need of services, effective treatment strategies, and easily accessible linkages to service providers.

Parents may be interested in many of these same topics, which could be addressed by the consulting psychiatrist at parent association meetings. The psychiatrist also could plan a series of presentations about effective parenting techniques, using contingency management strategies that parallel those used by the teacher in the classroom. In addition, parents could be provided with information about enhancing collaboration between home and school, including communicating effectively with teachers, volunteering at school, reinforcing school-related rules at home, and addressing school-related concerns with their children.

Recommendation 8: Psychiatrists could collaborate with school personnel to deliver effective school-based selective prevention programs [OP].

Undetected psychiatric disorders often underlie the overt presentation in high-risk students.

Psychiatric consultants can inform school personnel about these interrelationships so that referrals for psychiatric assessment can be made more effectively.

High-risk students who are found upon assessment to be free from major psychopathology may respond well to group interventions led by the school social worker, guidance counselor, nurse, or other trained school staff in collaboration with the consulting psychiatrist.

Recommendation 9: Psychiatrists could advise school personnel about the appropriate use of rating scales to identify symptomatic students who may be in need of psychiatric assessment [OP].

Several protocols should be in place before the implementation of a screening program: a protocol to train gatekeepers (e.g., school social workers or nurses) to understand and appropriately use the rating scales; a protocol to obtain parental consent and to notify parents of screening results; a protocol to protect the confidentiality of students' responses to self-report rating scales; a protocol to initiate appropriate school-based services if indicated; and a protocol to provide

appropriate, timely, and convenient linkages to external service providers for students in need of further assessment.

Recommendation 10: Psychiatrists could collaborate with school personnel to deliver effective school-based indicated prevention programs [OP].

Indicated prevention programs are targeted at students who exhibit symptoms of emotional, behavioral, or social problems but do not meet full diagnostic criteria for a specific disorder. Most of the existing programs of this type have targeted students with symptoms of aggression, depression, anxiety, or trauma, and were designed for delivery in group settings by trained school personnel (e.g., psychologists, counselors) in collaboration with clinicians. Only a small number of indicated prevention programs have been rigorously evaluated for evidence of effectiveness in school settings. Refer to the original guideline document for discussion of types of school-based indicated prevention programs.

Recommendation 11: Psychiatrists could collaborate with school personnel to deliver effective school-based treatment programs [OP].

Refer to the original guideline document for discussion of school-based treatment programs.

Recommendation 12: Psychiatrists could collaborate with school personnel to develop and implement a school crisis plan [OP].

Many schools have developed crisis response and mental health recovery plans to facilitate the school's effective management of a crisis situation. Psychiatrists consulting to schools can play an important role in the development and implementation of these plans. The primary goals for the consultant will be to help the school (1) resume a normal routine as quickly as possible and (2) plan to address the needs of students and staff beyond the immediate crisis period. Successful consultations build on pre-existing relationships with school personnel, and involve collaborations with organizations beyond the school, such as departments of health and mental health, law enforcement agencies, and other organizations skilled in crisis response.

Crisis response and mental health recovery plans should be highly organized and centralized in the school or district administrative office. The roles, responsibilities, and required training of both school staff and other collaborators should be specified in the plan, and it should contain a framework for the coordination of and communication with all collaborative entities. It also should contain guidelines for interacting with the media.

Immediately following a crisis, interventions should focus on providing social and emotional support to students and school personnel, and information about normal responses to traumatic events to school personnel, parents, and other caretaking adults. Teachers can be provided with guidelines about developmentally appropriate ways to discuss the events with students, and how to model appropriate coping strategies. Following the immediate crisis period, school personnel should be taught to recognize the signs and symptoms of trauma-

related disorders in students, and arrangements should be made for the appropriate treatment or referral of students or staff.

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CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated. In general, the recommendations are based on evaluation of the scientific literature and relevant clinical consensus.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Psychiatric consultation to schools can greatly facilitate the early identification and referral of troubled students, thereby helping to reduce the barriers to mental health services encountered by these children.
- Psychiatric consultants can partner with schools in a broader effort to help schools develop policies and procedures that can enhance mental health throughout the school community. In doing so, consulting psychiatrists can play a major role in improving students' chances for a successful educational experience.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

American Academy of Child and Adolescent Psychiatry (AACAP) practice parameters, based on evaluation of the scientific literature and relevant clinical consensus, describe generally accepted approaches to assess and treat specific disorders or to perform specific medical procedures. These parameters are not intended to define the standard of care; nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The clinician - after considering all the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources - must make the ultimate judgment regarding the care of a particular patient.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Work Group on Schools. Walter, HJ, Berkovitz IH. Practice parameter for psychiatric consultation to schools. Washington (DC): American Academy of Child and Adolescent Psychiatry (AACAP); 2004. 21 p. [69 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004

GUIDELINE DEVELOPER(S)

American Academy of Child and Adolescent Psychiatry - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Child and Adolescent Psychiatry

GUIDELINE COMMITTEE

Work Group on Schools

Work Group on Quality Issues

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format from the American Academy of Adolescent and Child Psychiatry (AACAP) Web site.

A CD-ROM containing all parameters is available for a fee. See the AACAP Publication Store for more information.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

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Date Modified: 11/3/2008