A system of clinical school care

A SYSTEM OF CLINICAL SCHOOL CARE
Alkmaar - NL

-a framework for pedagogical and didactical care for children in psychíatrical institutions and children will behavioural disorders

INTRODUCTION

In the following lecture I will describe to you the trajectory that has been passed through by the teaching staff of the "De Spinaker", a school for behaviourally disoriented and in- house treated children at Alkmaar. Over the years, we have developed a complete package of educational services and clinical attendance for the children in our care. That is why my contribution may also be relevant to teaching staff who want to function, in their respective areas, in a didactically more professional way.

EARLY HISTORY AND SOME FACTS

As I said before, the Spinaker is a school for children with behavioural disorders, and who have psychiatric symptoms. The school now has about 180 pupils in the age groups of 4 to 18 years. In its present composition, the school has been in existence for 3 years now after the merger of parts of the clinical schools of Amsterdam and Haarlem and a small school for children with disordered behaviour at Alkmaar, all from the same region (Noordholland) in the Netherlands.
Lessons that are given at the bedside, or bedside tuition, we do not provide at the Spinaker. In this respect, we do not offer what you would normally expect from teaching in a clinical environment; nor is this necessary since, under the new formula, somatic disorders are not treated in our clinic.
The school has its own building at a small distance of some 25 meters from the psychíatrical clinic.
The building is new, and accommodates 17 classrooms as well as separate classrooms for cookery lessons, technical trades, biology, music, game therapy, art and textiles, and physical training. There are also office rooms for the school's Management, for a Psychologist, for a Remedial Teacher, and for a Social Staff of the school.

SKETCH OF THE PRESENT SITUATION

The school population consists of two groups of pupils:
A. Children who are admitted to the psychíatrical clinic, or children who are in day care at the clinic
B. Pupils coming from schools in the environment. Pupils from this latter group are
submitted to De Spinaker by the schools or their parents, and will be admitted to De Spinaker if the Admission Committee decides there is sufficient ground for placement relative to the seriousness of any case. To determine in any particular case whether some sort of disordered behaviour offers sufficient grounds for admission to the Spinaker, the Admission Committee uses a set of "objective" criteria. They investigate and only on the basis of test results will they take a decision over the placement of any child. In addition, on the basis of the results obtained, the Admission Committee will usually provide the first indications for some definite form of treatment or action plan.

For pupils who are admitted to the psychiatrical clinic, admission automatically means placement in the school. The length of stay in the psychiatrical clinic varies from 6 weeks to about two years. In the regional arm of the school pupils tend to stay at school for at least several years.

The two groups of pupils remain physically separated from each other by the lay-out of the building and the rooms' division. This physical separation reflects a choice. Pupils who belong to the group with behavioural disorders often act out their behaviour in such a way that children from the psychiatric group will experience this behaviour as aggressive.
Children in the psychiatrical clinic display the following psychiatrical disorders. The overview that 1 will show to you now, applies to the situation as ¡t was on 16 February 2000. The total number of pupils who were admitted to the school year 199912000 was 130.

When three years ago De Spinaker started off, the teaching staff of the psychiatrical clinic was formed people who knew their jobs from practice. Together, they formed the hard core of the new team. When the merger effectively got underway, a large group of psychiatrically experienced teaching staff in Haarlem and Amsterdam did not wish to join in the transfer to the new school at Alkmaar, and opted out.
Then, the number of pupils rose dramatically during the first year. These two facts combined have forced the school to appoint and train a large number of new teaching personnel without previous experience in clinical schools.
Over two years, the school welcomed 16 part-time or full-time new teachers. We then decided to choose for a new, professional and systematic, approach, which would guideline not only any new teaching staff but would set out rules of behaviour for the teaching staff collectively. Also in that respect, we have turned a new way.
I will now inform you further on the why and the how of this way.

OUR PRESENT CARE SYSTEM AND WHAT NEXT?

The problem that was facing the managing board of De Spinaker some two years ago was how to set a well-intentioned group of teaching staff on a professional track. They all shared a good measure of idealism but, in practice, they could function only on the basis of their intuition in their relationships to pupils.
Please note that everyone was whole-heartedly trying to do their best for the target group, but found it frustrating to have to work without the help of some sort of systematic guideline.
We first directed our efforts to arrive at a systernatic form of approach to the area of orthopedagogical and orthodidactical care.
We wanted our new system to satisfy a nurnber of certain preconditions, and we agreed to the following formulation:
1. teaching staff would have to find the new care system intelligible and transparent
2. It would have to offer something more than just a number of diagnostic instruments put together

3. and, in consequence of this second condition, it would have to provide direct links with teacher performance in everyday practice.

Subsequently, we were able to establish that these preconditions were met in the instrumentation as used in the POBOS package.
Before I present this package to you in detail, I will go briefly into what perhaps was the single decisive factor that made us choose for the POBOS package.

Normally, a school obtains its pedagogical care package from the editor/publisher, without any form of intensive support at school, let alone any active help with the implementation of the package itself at school. The developer/editor of the POBOS system, Jos Haartmans, on the other hand, includes this kind of support in the package.
Now to set down the POBOS instrument in one comprehensive phrase, or paraphrase really (it's more than one sentence), let me quote the author himself: it "comprises the whole of conventions, rules and organisational structure that exists within institutionalised clinical school care for children in the widest sense of the word. One may think of intake/admission research, pedagogical observations, didactical testing periods, action plans, parent counselling, probation periods, ambulatory counselling, pupil items on the agenda of staff meetings, sequential tests, and send-on referrals."

In broad lines, the POBOS system falls down into two parts:

1. the pedagogical check system
2. the didactical check system

I will continue my talk concentrating mainly on the (oath) pedagogical part of POBOS; treatment of the didactical component would take up too much (of our valuable) time.

THE (ORTHO)PEDAGOGICAL CHECK SYSTEM
1. For a start, all teaching staff members will create pupil files, or pupil maps, or dossiers that have a general part as well as a specific part, which contains the pedagogical check list. The general part has on overview of classroom protocol, and contains the names and addresses of the pupils.

The specific part is formed by the pedagogical check list. This is a symptoms marking list for socio-emotive behaviour at school. On the basis of his observations in the classroom and outside, the teacher will enter marks, or scores, relative to :

pedagogical guidability
other-pupil relationships
pupil-teacher interaction
motivational factors & general well-being at school
work attitude
work approach

The list is also used when testing for the existence of problems that are group-related.

2. In addition, diagnostic means are needed to establish what constitutes problem behaviour, and to measure children's' aptitudes in a standardised way.
I quote Jos Haartmans for a second time-. "Diagnostics means result in a more objective picture, and often provide a deeper insight, especially when one hits on the right combination of instruments."
The test used by the school is the CBCL, or, in full, the child-behaviour-check-list-test. I would like to stress that further diagnosing takes place only in case there are sufficient indications to do so.
To that end (when further diagnosing takes place) we use one or more of the following: o the CBCL the parent list
o the TRF teacher report form
o the home and family questionnaire

On the next sheet, you see displayed an example (only in part) of the TRF.

When after testing with aid of the CBCL instrument, somebody's pupil profile leaves too 4 many questions undecided, then further and deeper investigation will take place These further investigation instruments at our disposal are the following:
· the GARS or, in full, the Gillian Autism Rating Scale
· the ADHDT or Attention Deficit Hyperactivíty Disorder Test
· the SQ or school experience questions list
· the YSR or youth self report

The ADHDT is a screening instrument designed to chart systematically the symptoms of ADHD, or hyperactivity disorder.
The test diagnoses the child for various signs it may display that are derived from the three main categories of ADHD, namely:
a. hyperactivity
b. impulsivity
c. and lack of attention
The ADHDT is given and scored by teaching staff members. The diagnosis is performed by a behavioural specialist. Together, they set cut the outlines for a first action plan.

As I am not a behavioural specialist,. myself, it would take us too far if I also discussed the other test instruments I mentioned with you. That is why, on the next sheet, I have confined myself to a (partial) display of the ADHDT.

Finally, for each pupil what is called a Pedagogical Dossier Card (PDC) is created, and kept up for future reference. ¡t is a record that contains all factual information supplied to the school, combined with any objective test results.

The PDC functions as an overview of all possibly relevant personal information and investigation results. it gives us the opportunity to spot significant relationships between the data on the card at a glance, as, for instance, one is looking at the data on intelligence, didactical progress, home situation, psychological testing, etc.

3. For each pupil an action plan is drawn up. No further investigation takes place, as I said earlier, in the case when a solid action plan already recommends itself on the basis of the PDC, or Pedagogical Dossier Card. However, in practice, in view of the severity of the problems we encounter with our pupils, we often find that subsequent testing is necessary.

At the next stage, on the basis of the PDC, the CBCL, and all supplementary tests, some form of approach and one or more goals Will be agreed to, and formulated by teaching staff, in collaboration with the behaviourist-psychologist. At this point, teaching staff performance will have to come into play. Teachers acquire over time, a store of knowledge about children with disordered behaviour and psychíatrical symptoms. This kind of knowledge usually soon finds its way into the action plan.
I will illustrate this point by one example:
When some child's observes behaviour reflects a pervasive development disorder (the child is restless and over-active most of the time), teaching staff action would naturally respond to this by some inclusion in the action plan like: structure situation in advance, identify factors that seem to actuate hyperactive behaviour, use insight in avoiding these factors.
To practically assist teaching staff, subject as they are in their daily schedule to a wide range of psychíatrical symptoms, we have composed a Practical Observation- and Action Guideline, which falls down into:
a. an overview of psychíatrical disorders
b. the actual Guideline specifying symptoms as well as actions. What do you observe, and what will you do for that particular child?
c. references to books in the staff library

From the next sheet, you will get a more precise impression of what the Guideline looks like.

At the last stage, the final treatment or action plan for any particular pupil will be put in its definite form. In some cases, when group processes in the classroom seem to come into play, the need for a plan may arise that will account for group factors.
I have shown the broad outlines of such a group plan on the next sheet.

STAFF TRAINING

To conclude my story, I will relate some particulars on staff training, how the team got on with the system, and the implementation of the system in the school. We began our training with a two-day introduction course, during which the POBOS pupil-check-list system was explained to us in detail by its personal originator. Subsequently, we had our first plan-making session, in the course of which teaching staff members directed their efforts at the creation of a first pedagogical dossier card (or PDC), in some cases filled in the CBCL-form, and wrote a provisional action plan.
All teaching staff were visited in the classroom by the specialist from outside for the purpose of classroom observation. Together, teacher and outside specialist, or supervisor, focused their attention on factors that influence classroom atmosphere, didactical approach, and organisational and administrative task aspects.
These consultations were concluded with a critical¡ discussion that also evaluated the PDC and the action plan produced by the teacher. In necessary cases, advice was brought forward, and ideas suggested that might help improve. Some teacher response tended to betray a certain degree of anxiety which it would be interesting to also

discuss but the source of which can be easily guessed at. In the time that followed teachers produced various PDCs and Action Plans, in addition to an occasional CBCL, and, sometimes, further investigative testing. Personal guidance by the external expert continued, especially for teaching staff that experienced some difficulties in handling the new system.
We plan to hire in specialist help and supervision from outside for at least another year to maximally assist teachers in the use of the system.
In addition, and at the same time, the school organisation underwent some changes. In the following areas, adaptations were made:

1. We wrote a school care program that specifies the tasks that have to be performed by the teaching staff. ¡t is a sort of new protocol.
2. We appointed a school care POBOS Co-ordinator who, like a spider in its web, will guard the system, and supply support to teachers when necessary.
3. A school care Internal POBOS Supervisor was appointed to assist teaching staff in classroom organisation
4. Other school resources, as the Psychologist's, Social Staff, Speech Therapist's, and Game Therapist's were assigned a well-defined place in the system
5. Once a week teaching staff will devote some after-hours to the further build-up and improvement of the care system in collaboration with the Co-ordinator as well as the Internal Supervisor.

The external supervisor will visit the school every two weeks. He will check teacher performance in using the system, and throughout will try to play a stimulating role (or even de-stimulating, and corrective), as the case might be.
He also consults with the co-ordinator and the internal supervisor on matters of progress, and will provide suggestions.

We believe that the choice of the POBOS package meant a firm step for us on the way to higher professional standards in pedagogical care, and that we are that much better equipped to help the children in our care on their difficult way ahead.