Mobile special needs service and the outpatient class
A model with a future in child and adolescent psychiatry and special needs education

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Introduction

In our workshop, we are presenting cooperation models set up between a large child and adolescent psychiatric outpatient care unit and the affiliated clinic school which have been developed and extended over the last five years.This network connecting outpatient care and school has developed against the background of an increasing number of patients with associated school problems. In numerous cases, it is not only the patient but also the school which is directly or indirectly affected.It is estimated that around 60 % of outpatients in a child and adolescent psychiatric unit also have serious school problems: in a not insubstantial number of cases, it is problems at school which have prompted the initial visit to the clinic.

In the first section, the objectives of the outpatient unit at the Heckscher Clinic are presented from a medical aspect. This is followed by a description of activities undertaken by mobile special needs services and rounded off by a report on the project “outpatient class” in the Heckscher Clinic which has now been operating successfully for the past four years.

Both my colleagues are experienced teaching staff members at our clinic school: they have taught day-care patients and inpatients for many years. This experience is invaluable for outpatient counselling.

Last year, the Heckscher Clinic celebrated its 80th anniversary: we moved into this light and modern new building with our principle headquarters in 2003 (we experienced a substantial expansion in space and personnel during the construction period of our new building and were already pushing our upper spatial limits again shortly after moving in). The number of patients attending the Heckscher Clinic in the outpatient department increased between 1997 and 2008 from around 1500 to 8000 patients per year and the annual number of inpatients treated rose within the same period from ca. 300 auf 1000.

Child and adolescent psychiatry has experienced a real boom during the last few years.

Possible reasons for this include:

- An increased recognition and observation of psychological disorders and additionally the increased frequency of disorders such as depression and eating disorders.
- Increase in psycho-social stress factors
- Decreased stability of family or other social framework systems
- Trend towards the early recognition of child and adolescent psychological clinical pictures: it is also possible that the threshold fears associated with the field of psychiatry have decreased.

The Heckscher Clinic and its external departments in Rottmannshöhe and Rosenheim together offer a total of around 140 inpatient and 60 day treatment places for children and adolescents and a large outpatient clinic and external outpatient clinics in Rosenheim, Wolfratshausen, Waldkraiburg and Ingolstadt.

Inpatient and day treatment only represents the “tip of the iceberg“ in the child and adolescent psychiatric services on offer; the majority of disorders can now be diagnosed and largely also treated within an outpatient setting. This is without doubt one of the reasons for the over-proportional growth of these outpatient services during the past few years.

Our local institute outpatient department (in Munich) is subdivided into a number of different functional areas:

Emergency clinic (day and night),
Specialised outpatient unit for developmental disorders (autism and linguistic problems)
Mobile service for residential institutions (outreach for GB-homes (homes for mentally handicapped pupils note of translation) such as youth welfare units),
Outpatient addiction unit,
outpatient family unit for the children of psychiatric patients
and a large general outpatient department.

Which children are seen in the general outpatient department?

The age range spans 4-18: this means that 80 to 90 % of children treated attend school and therefore numerous behavioural disorders also lead to conspicuous behaviour at school.

What problems do the children present in the outpatient department?
(Extracts from the registration forms)

The parents report that their children...

“cannot concentrate”,
“is quick to display aggression”,
“is listless and unmotivated”,
“plays computer games all day and does not do homework”,
“is awarded poor marks at school despite displaying sufficient ability at home”,
“displays conspicuous behaviour at kindergarten: is my child ready to start school?”,
“Is reluctant or unwilling to become integrated”,
“won't speak in front of strangers”,
“displays separation anxiety”,
“suffers from anxiety, has stomach ache and is unwilling to go to school”,
“is bullied”,
“is withdrawn”,
“appears to be sad”,
“practises self-harm and expresses suicidal thoughts”,
“is perhaps taking drugs”.

What do we undertake in response?

We attempt to build up a picture of the individual child or adolescent, shed light on the different causal factors of the psychological abnormalities and establish a diagnosis with the aid of detailed examinations carried out by a multi-professional team. This diagnosis phase includes psychiatric and paediatric-neurological aspects, psychological diagnosis and also psycho-social diagnosis and environmental diagnosis, i.e. procurement of external anamnestic information from the school, the child's teachers, and supervisors or from welfare authorities. The extent of each diagnostic phase is oriented to the individual case.

This multi-professional procedure demands a great expenditure of time and coordination efforts.

Currently, seven medical doctors, seven psychologists, three social education workers and two speech therapists are employed at the general outpatient department at the Heckscher Clinic. The outpatient department also employs the services of an advisory teacher and therapeutic staff from the clinical sector (child and adolescent psychotherapists – deep-psychology oriented, behaviour therapists, play and verbal therapists, systematic and family therapists, trauma therapists also utilising non-verbal therapeutic methods such as music, dance, art therapy and occupational therapy, etc.)

Without going into the individual details of all clinical disorder pictures, I would like to include a list of some of the diagnoses frequently encountered in our outpatient department.

ADHS,
Eating disorders (bulimia and anorexia),

psychoses,
anxiety disorders,
depression,
addiction disorders (concrete substances and media addiction),
Learning disabilities (dyslexia, writing disabilities and dyscalculia),
Linguistic development problems,
social behavioural developmental disorders,
post-traumatic stress disorders,
integration disorders,
attachment disorders,
children suffering from neglect, abuse or sexual abuse,
autism,
low intelligence levels and behaviour disorders
tic disorders, compulsive behaviour,
somatoform disorders,
bed-wetting and faecal soiling,
sleeping problems,
personality disorders,
self-harming behaviour, suicidal tendencies.

Following this multi-professional diagnosis process, the results of the examinations are discussed with the individual and his or her parents/guardians who are also informed about the nature, structure and prognosis of the individual clinical pictures and advised about therapeutic possibilities to be able to set up jointly planned concrete measures. These measures designed as a multi-modal process can entail the following (rough division):

child-focused psychotherapeutic measures, pharmacotherapy or other forms of therapy; family-oriented measures such as parental training or also psychotherapeutic treatment involving parents; family therapy or additionally environmentally-related social educational or social-psychotherapeutic measures, primarily with the involvement of the ASD (public social service in Bavaria- note of translation) or youth welfare services and the implementation of youth social services. Through the enlistment of our advisory teacher for special needs, the school perspective can be intensively taken into consideration and/or concrete information passed on to the home school and relevant changes implemented.

Cooperation with the school
What is the nature of this cooperation?

Since 2006, the advisory teacher has attended our weekly discussions in the outpatient department concerning children for whom advisory services related to schooling issues is required and desired by their family.

During the diagnostic phase, it can also be important for the advisory teacher to make contact with the child's current teachers in his or her home school to provide a complete picture of the clinical situation and enable a more accurate overall picture of the child's situation.

Cooperation with the advisory teacher is also vital to establish future perspectives at school. The following questions can be relevant at this point:
Which school location would be most suitable? What special requirements does the child have regarding class size and working methods? Would a change of school be recommended? Is an integration teacher required? What local resources are already available within the school environment?

The activities undertaken by our mobile service for special educational needs (MSD) are of great help for coordinating shorter- and longer-term intervention and for informing the class teacher about the relevant clinical picture. The intervention on the part of the advisory teacher permits the diagnostic results and ensuing support measures to be better integrated into school activities.

This means that the MSD becomes an interface linking the home school and the child and adolescent psychiatric unit, thereby fulfilling a "hinging function". This connection linking clinic and school is particularly essential in a crisis situation, as we frequently encounter pupils who have not received essential support over a period of several weeks and whose teachers and parents have been unable to find a suitable solution to the relevant problems encountered without some form of external help. We also experience numerous crisis situations in our outpatient department which have directly originated within the school setting (such as truancy, self-harm, harm of others and threats of running amok).

Naturally, many patients require not only medical-therapeutic help but also educational support.

Our previous experience has shown that custodians/guardians are normally extremely grateful to be offered these forms of mediation help.

Of course we also experience problems and limitations in our "interface activities":
we are for example bound to respect medical confidentiality and only break this confidentiality following the relevant specific consent on the part of the guardians.

Even if we are released from the maintenance of medical confidentiality, we always ensure that we utilise discretion when passing on any information: on the basis of the motto “as little as possible and as much as is necessary”, only information which is relevant for the interest of the child and his or her educational support will be passed on to the school.

The cooperation between the outpatient department of the Heckscher Clinic and the mobile service for special educational needs which has intensified from year to year has already demonstrated that preventative measures can lead to success: positive feedback from parents and teachers has confirmed the necessity of this service provision.

There is no doubt that the intensive specialised exchange of information between clinic and school also contributes to our continuous further training: we clinic staff learn first hand about changes in the school landscape, new ministerial resolutions passed within the educational sphere, etc; in turn, teachers also learn about new clinical advances and treatment methods and are able to employ their newly acquired knowledge in the patients’ “home schools”.

On the basis of our previous experience, the development of an overall concept spanning the fields of medicine, therapy and educational special needs for joint outpatient tasks appears not only to be worthwhile, but also essential.

The outpatient class model at the school in the Heckscher Clinic in Munich
A cooperation model between clinic and school

Current developments

- Increase in patients within the child and adolescent psychiatric field
- 60 % of outpatients seen in the department have serious school related problems
- Outpatient instead of inpatient treatment as objective.

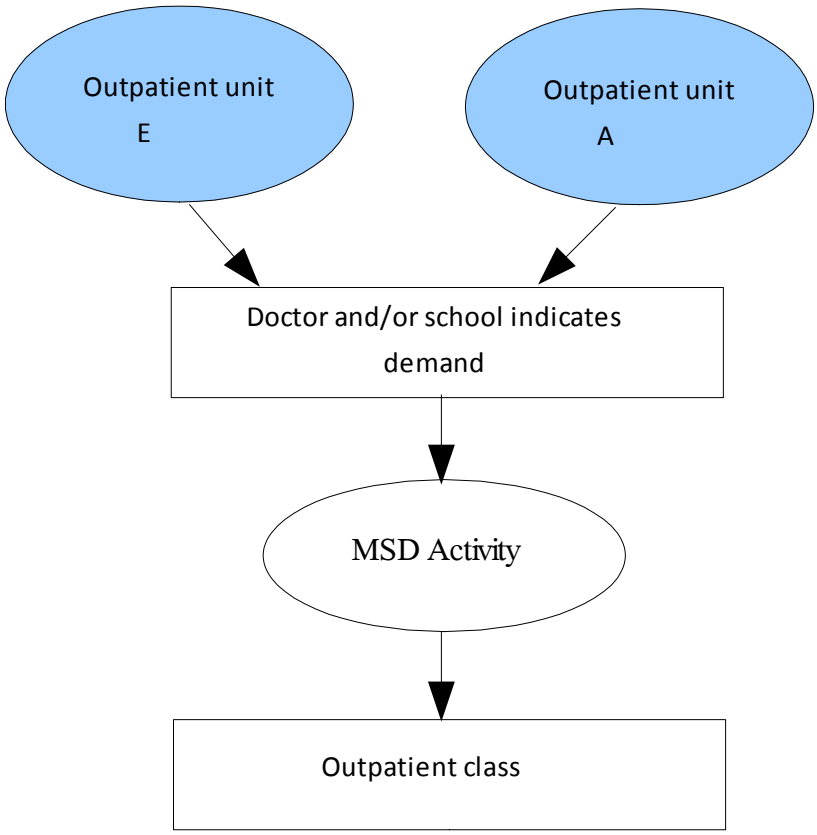
Why establish an outpatient class?

- Reaction to outpatient unit requirements
- Low threshold service with prompt treatment in view of observed reality in schools
- Closer network between school and psychiatric field

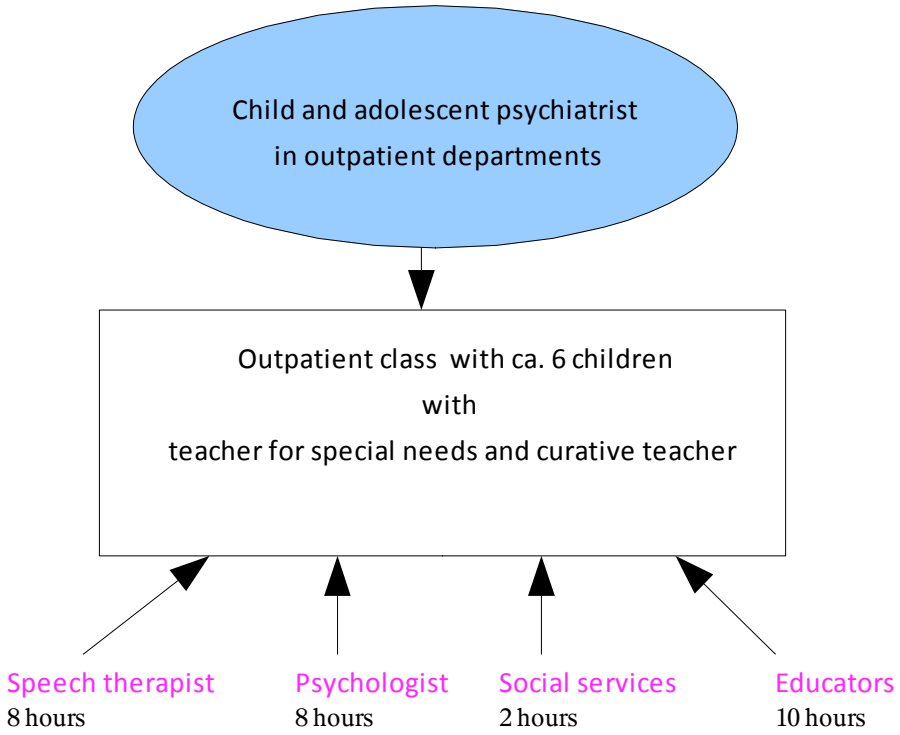
What is new?

Ward – day clinic – outpatient class – outpatient units

Concept of outpatient class at the Heckscher Clinic



The multi-professional team in the outpatient class



What can be achieved in the outpatient class?

- Comprehensive diagnostic clarification (as a team)
- Observation of learning and behaviour within a group context
- Establishment of support required and therapeutic support
- Work with parents
- Adjustment of medication
- Introduction/implementation of support measures and therapeutic approach (speech therapy, psychotherapy, dyslexia and dyscalculia therapy)
- Behavioural training (e.g. training of adequate behaviour at school; behaviour control)
- Adjustment of school career, change of school
- Coordination of measures
- Aftercare within educational framework

Organisation of outpatient class

- Age range of children between 5.5 und 9.9 years (pre-school to years 3/4)
- Pupils remain registered in home schools
- Lessons/therapy/diagnosis between 8.00 and 12.00
- Afternoon care is retained
- Children are brought by taxi or by parents
- Length of attendance between 2 and 10 weeks
- Waiting time ca. 3 weeks

Spectrum of diagnosis

- social behavioural disorders: 31%
- Emotional disorders: 35%
- ADHS: 35%
- Pronounced partial learning disabilities: 26%
- Speech disorders: 31%
- Autism: 26%
- Others (motoric disorders/Tourette/tic disorders): 5%

Statistics

- 30 to 35 children accepted in outpatient class within each school year (2007–2011)
- Average waiting time 3.5 weeks
- Average attendance period of 6 weeks
- A change of school is necessary for 45 % of pupils/patients

Supplementary measures

- Continuation and mediation of therapeutic support
- Continuing medication
- School advisory service/educational aftercare
- Link with specific parent groups
- Installation of integration helper
- Integration in outpatient department (regular WV-offers (come again offers – note of translation)/short time window)

Experiences

- Balanced blend of diagnoses most advantageous for group structure
- Highest educational relevance of described diagnosis spectrum
- Aftercare measures have proved to have been effective and relevant

Prospects

- High acceptance level on the part of clinic, parents and schools
- Qualitative improvement of outpatient care
- Significant concentration of network/aftercare between psychiatric unit and school
- Increased demand

Risks and dangers

- Creation and retention of clear profile
- No creation of “open back door” for all problem pupils
- No “waiting loop” despite already established increased demand for treatment

Children's reactions?

- Able to adjust well to new situation
- Often "released" from crisis situation
- Integration for children excluded from school/on "sick leave"
- Swift help provides relief for entire system