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DEVELOPMENT SUPPORT PROGRAM — LOOKING FOR A MODEL OF COMMUNITY CARE FOR YOUNGER CHILDREN

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pedagogical therapy
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Summary

Environmental interactions are one of the most important aspects of psychiatric care for children and adolescents with mental disorders. The report presents the experiences of the community therapy team offering community support to early school age children. The presented model of care includes psychological consultations, pedagogical therapy at school and as part of visits to cultural institutions, family therapy, multi-family groups and individual therapy. The team's activities also include consultations for teachers and school educators. In the proposed model, in connection with the reform of psychiatry of children and adolescents, there was a fundamental change related to the change in the formula of psychiatric consultations from obligatory to one resulting from individual indications. The aim of this paper is to present the experiences of cooperation related to community care at school. Among the employees of the schools the team cooperates with, a survey was conducted to evaluate the team's offer addressed to schools. The results of the study indicate a positive assessment of the team's cooperation with the school in terms of accessibility, flexibility and contact with specialists. Community care for children in such a model is beneficial in many respects.

Introduction

Environmental interactions play a key role in psychiatric care for children and adolescents, and community therapy has become the basis of the currently implemented reform of child and adolescent psychiatry. With the first community psychological and psychotherapeutic care centres for children and adolescents (referral level 1) established in the spring of 2020 and the mass-scale opportunities to work outside the office for the first time,

questions arise about the optimal model of such work and good practices. The variety of the issues of child and adolescent psychiatry makes it impossible to simply extrapolate patterns from the community psychiatry of adults, and the small traditions of community work in Poland should mobilize for conceptual work and research [1-3].

The Department of Child and Adolescent Psychiatry at the Collegium Medicum of the Jagiellonian University in Kraków has the longest tradition of community work in Poland, and from the late 1980s it adopted the environmental model as the basis of treatment. The paper will briefly refer to these significant facts, focusing on the specifics of the work of one of the environmental agencies of the department – the Child Development Support Team.

The specificity of the childhood and adolescence period is the importance of school as a place of socialization in the peer group, a space where problematic behaviours can be revealed to the greatest extent, and finally a place where the quality of functioning has a direct impact on students' mental health. This paper focuses on the school, explores the attitudes of school professionals towards collaborating with mental health professionals. It is worth remembering that its structure does not reflect the holistic thinking of the team, in which the school is a significant, but not the only point of reference – apart from school, there is family, extended family, neighbourhood, meaningful extracurricular peer groups, the online world and other contexts significant for the child.

The Department in Kraków is associated especially with work with the issues of adolescence, a period with specific and serious development challenges [4], but it also dealt with other groups of patients, with an extent increasing over time, which is reflected in the separation in 2017 from the previously existing agendas of two specialised teams, preceded by conceptual works. These included two programmes:

— Parent-infant bond therapy (children aged 0-2);

— Children Development Support (early school children).

The purpose of this report is to present the results of the work of the Child Development Support Team and the dilemmas related to this form of help. The organisation of the work of other teams is the subject of separate studies.

Historical outline of community therapy in Kraków

We can look for the origins of Polish community therapy in the initiatives of dr. Aurelia Sikorska, who in 1916 became the first assistant of prof. Piltz at the Neurological and Psychiatric Clinic in Kraków [5]. Doctor Sikorska, called the pioneer of child psychiatry, drew attention to prevention in the group of children up to 3 years of age, emphasised the specificity of psychotherapy for children, as well as the importance of pedagogical interactions [6]. The post-war tradition of community care for children and adolescents at the Psychiatry Clinic in Kraków is associated with dr. Maria Einhorn-Susułowska of the Educational and Treatment Clinic at the Jagiellonian University [7-9]. The first day ward for children was established in 1963 by dr hab. Eugenia Kwiatkowska.

At the same time, a creative ferment was taking place in the psychiatry clinic in Kraków, inspired by prof. Antoni Kępiński, which resulted in Polish initiatives that were ground-

breaking for psychiatry, such as the therapeutic community, group psychotherapy, patient club, research on the chronic impact of war trauma (Auschwitz research), co-education and open doors, and finally a psychotherapeutic model of treatment, as well as the first Polish department of adolescent psychiatry (1965). It was quickly expanded to include outpatient interactions, in which almost half of the hospitalized patients benefited from regular therapy [10].

However, the revolution took place in the 1980s under the supervision of prof. Maria Orwid, a pioneer of family therapy in Poland, founder of the Department of Children and Adolescent Psychiatry in Kraków [11]. The outpatient clinic was expanded, and psychiatric hospitalizations were reduced. In 1983, Barbara Józefik established the Family Therapy Outpatient Clinic [12, 13], with family therapy as the basis for interactions. In 1988, Ryszard Izdebski created Home Hospitalization Unit based on family therapy conducted in the patient's home [14-16]. In the same year, under the direction of Ewa Domagalska-Kurdziel, the Clinical Secondary School was established, which in time grew to include new school units, and became the basis of the Day Unit. In 1989, prof. Orwid, with an unprecedented decision, liquidated a large hospital ward, leaving only twenty beds in the Department of Child and Adolescent Psychiatry [17]. In a letter to the rector of the Medical Academy in 1987, justifying the planned reform, she wrote that this change "is consistent with the ways of working increasingly used in our Department, as well as with the directions of development of modern psychiatry" [18].

The so-called alternative forms of treatment were developed within the Department of Children and Adolescent Psychiatry, with the adolescent Day Unit created by dr. hab. Renata Modrzejewska at the initiative of prof. Jacek Bomba. They were also created outside the department, but in direct connection with it and under its substantive supervision. These included: Sanatorium and Rehabilitation Department in Rabka-Zdrój (1999), or several community centres in Kraków, which provided treatment based on contracts with the city, outside the health care system (2002). As a result, a network of institutions was established around the Department, which conducted community therapy using the nationally record-high support of the city of Kraków (in the years 2012–2017 the city paid for about 10,000 treatments per year) [19].

Finally, in 2017, at the initiative of dr. Maciej Pilecki, Department of Psychiatry of Adults, Children and Adolescents (OKPDDiM, name in force since 2012) started as one of three teams in Poland the community therapy for children and adolescents based on a contract for community care. As part of it, four programmes were selected, of which the first two were established de novo. These included two programmes:

- Parent-infant bond therapy (children aged 0-2);
- Children Development Support (early school children);
- Family Therapy Outpatient Clinic (patients requiring highly qualified family therapy);
- Home Hospitalization Unit (patients at serious risk of hospitalization, especially those at risk of suicide or after discharge from the Youth Inpatient Ward).

Kraków model of community psychiatry

The diverse experiences of the Department of Psychiatry and Psychotherapy for Children and Adolescents in Kraków and the communities associated with it seem to have several common features:

- holistic, systemic, multi-faceted understanding of psychopathological symptoms and the patient's life;
- less medical paradigm, more psychosocial one;
- psychotherapeutic model of work with recognition of the importance of family therapy, but also psychotherapeutic eclecticism;
- recognising the key preventive role of child and adolescent therapy;
- focus on the development of social competences of a child and adolescent patient;
- the importance of reality in the child's life, cooperation with other elements of the child and family support system in order to create an effective support system;
- recognising the importance of traumatic experiences in human life and working with trauma;
- home treatment (mainly in the form of family therapy);
- Reaching a patient who is not actively seeking treatment, learning to work with poorly motivated families that are reluctant to therapy;
- limitation to the necessity of 24-hour treatment and numerous, variously functioning (and providing a diverse offer) teams cooperating with each other;
- work in multi-professional teams with partial fluency of professional roles;
- emphasis on supervising clinical work and team relations [19];

These assumptions became the basis of the treatment model adopted by the Child Development Support Team.

Model of community work carried out under the Child Development Support Team

The Child Development Support Team draws inspiration from the Home Hospitalization Unit, from which it evolved. Moreover, it uses the experience of the community therapists employed in group-training methods of work that strengthen the socio-emotional competences of children (resource work). The team also uses workshop and multi-family work focused on strengthening parental resources, conducted in the dialectical-behavioural therapy paradigm. The team constructs an eclectic, multi-component model of work.

It consists of people with different educational background, therapeutic modalities and professional experience (multi-specialist teams). Effective use of the potential of such a diverse team requires efficient coordination, integration of interactions, supervision, clinical meetings, as well as interdisciplinary meetings with other professionals working with the child and family. Such tools allow for multi-axis diagnosis and treatment tailored to the needs. We offer: individual psychotherapy and family therapy, multi-family therapy, psy-

chiatric treatment, group and individual pedagogical therapy, speech therapy, art therapy, psychoeducation, parenting workshops, interdisciplinary meetings, consultations with school employees (tutors, school educators and school day care workers), Psychological and Pedagogical Counselling Centres, training for teachers. At home, at school, and in the office on the premises of OKPiPDiM. All these interactions are to activate resources in the child's environment, in order to prevent falling out of roles in the school environment or peer group. Such intense and multi-modal influence also minimizes the probability of a child's psychiatric hospitalization.

Environmental treatment is voluntary, with the consent of the child's parents (patients of this agenda are under 16 years of age). In a situation of intense cooperation with schools, a significant part of referrals comes from school educators and tutors. Some of them are related to more or less evident pressure on the family to direct the child to therapy. However, families who have contacted the team are mostly motivated to seek help, in an emergency, overloaded with stress, usually with an accumulation of problems at home, at school or kindergarten. There are also recurring difficulties in the relationship between the parent(s) and the child.

The first meetings with a psychologist in the team are of a consultative and diagnostic nature. Their aim is to conduct an initial assessment of the child's functioning and its bio-psychosocial context. These consultations are used to formulate the goals of the therapy and plan the interactions. Sometimes they are related to motivating the family to accept the proposed offer, for example, family therapy. The decision to qualify for treatment is made by diagnosticians in cooperation with the therapeutic team during joint clinical meetings. If a specialist diagnosis or therapy is needed, children are referred to institutions specialised in the treatment of a given issue.

We attach great importance to working with the family, conducting not only traditional, system-oriented family therapy, but also the above-mentioned training and workshop interactions. When necessary, we also initiate social assistance or family court actions.

Possible psychiatric treatment takes place on the premises of the centre, in an office adapted to the child's needs or at school. If pharmacotherapy is justified, it is possible to precisely monitor changes in the child's functioning, based on contact with school specialists and team meetings, with the participation of therapists involved in support for the child. The treatment programme is flexible and pragmatic, modified depending on the changing situation of the child and the family.

Special educators from the team remain in contact with teachers and employees of psychological and pedagogical counselling centres. The collaboration of schools with health systems is becoming the most common model in the world [20]. Pedagogical therapy provided by special educators takes place on a regular basis at school as part of the time-table. Cooperation with the Department of Education of the City of Kraków enables the implementation of therapeutic meetings in rooms provided by schools. Classes are held in small groups on a regular basis. In a form adjusted to age, children acquire knowledge and skills in dealing with emotions and communicating their emotional states, and they exercise social competences.

It seems that in a situation of family's resistance to psychiatric treatment of children, resulting in delayed treatment, the use of at least some of the interventions at school makes

mental health support more acceptable [21]. Literature data shows that offering help in the natural environment of a child, i.e. school, increases the probability of accepting it [22]. For children, it is an opportunity to acquire and practice skills in a familiar, natural environment. The team's cooperation with schools has also become an opportunity to educate teachers on identifying emotional issues in children and adequately directing them to consultations.

From 1 April 2020, the Child Development Support Team and part of the Home Hospitalization Unit operate as part of the Community Psychological Mental Health Centre for Children and Adolescents. Initially, psychiatric consultation was obligatory. In the new structure, it is only recommended when there are indications. This change allows for the inclusion in the interactions of children who do not yet meet the criteria of a mental disorder, but show emotional and behavioural issues. The moment of intervention falls on the earlier stage of the development of difficulties. This opens the possibility of using a wider prevention of mental disorders.

As a rule, a three-level model of interactions is adopted [23]. It includes universal, school-wide or class-oriented interventions, interventions aimed at children with clinical symptoms (the traditional domain of the health care service), and selective interventions targeting risk groups – those where the likelihood of future mental disorders is significantly higher than average. The team's activities are focused on the last two categories. We find selective interventions to be particularly important. We motivate schools with which we cooperate to identify relatively minor issues in the functioning of children at an early stage by offering them group environmental interactions. As part of them, the team cooperates with cultural institutions, including the Education Department of the Wawel Royal Castle and the Ethnographic Museum of Kraków. Special educators conduct therapeutic classes in public space, which enables children to integrate and generalise the acquired social and emotional competences into various environments.

Due to the new model of the team's work, from the very beginning of its operation, there were questions about the assessment and reception of these activities by school staff. As a result, at the end of the school year 2018/2019, a study was conducted in schools on this issue. The aim of the survey was to collect opinions on the reception of our programme.

Material and method

The study included a group of 32 employees of primary schools in Kraków, where for several months therapeutic classes for children under the care of the Community mental health service were conducted (primary schools no. 3, 113, 92, 95, 33). The study was based on a structured questionnaire consisting of eight questions regarding the assessment of the team's cooperation with the school. They had a form of a six-point scale, where 1 means that cooperation is very unfavourable, and 6 stands for very favourable, and two open questions allowing the respondents to provide additional comments, as well as new elements supplementing the current offer.

The characteristics of the studied group are shown in charts 1, 2, and 3.

Results

Respondents, when asked to give an overall assessment of the cooperation with the Team, assessed it as very favourable. On a six-point scale, where 1 means that cooperation is very unfavourable and 6 stands for very favourable, most respondents chose 6 (n = 24 $\overline{x}$ = 5.72).

School employees were also asked to rate the individual aspects of the cooperation using a scale, where 1 meant that a given aspect was irrelevant and 6 meant very important. Chart 1 presents the arithmetic means of rates of individual aspects of the team's cooperation with schools.

The most important included the possibility of organising consultations with a psychiatrist at school ($\overline{x}$ = 5.78) and systematic therapeutic classes for children supported by the Team taking place at school ($\overline{x}$ = 5.78). The fact that it is specialists who go out to patients and provide services for children in the school environment is very positively received. According to the opinion of school staff, more children can benefit from help, which would often be impossible due to the need to travel to a strange place.

The availability and great flexibility in terms of jointly setting the dates of consultations and therapeutic classes as well as short waiting periods ($\overline{x}$ = 5.75) were also appreciated.

The possibility of consulting the difficulties of children under the care of the team on an ongoing basis at school with special educators who, while conducting therapeutic classes, are well aware of the current difficulties of the children, was considered almost equally important ($\overline{x}$ = 5.59). Teachers emphasised the great importance of support in their educational activities received thanks to such consultations. This is closely related to the possibility of broadening the perspective in recognising the needs of children covered by the team's care, also assessed as very important ($\overline{x}$ = 5.63).

The following were also assessed as very important: support for the parents in the form of consultations or therapy ($\overline{x}$ = 5.59) and the possibility of cooperation between the Team and the school with various individuals supporting the child's family, e.g. a probation officer, family assistant, specialists from a psychological and pedagogical counselling centre, etc. ($\overline{x}$ = 5.47).

In conclusion, all aspects of the team's cooperation with the schools were identified as very important. The assessment did not depend on the sex of the respondents, school position or length of service. Within additional comments, the respondents expressed their conviction about the importance of this type of activities:

The cooperation is extremely necessary and fruitful. The most valuable: the professionalism and availability of the staff and the location – directly at school. This is especially important for parents – specialist consultations without the need to visit numerous institutions.

"The cooperation is very effective, greatly helps students and teachers, the therapists offer reliable knowledge and experience, children like having classes with them. Teachers are always provided with support and ideas for dealing with difficulties in students' behaviour".

"The cooperation is very good, it provides a lot of specialist help. It is a professional support in our work with students and help in solving emerging difficulties. Kindness and commitment from the staff of the University Hospital".

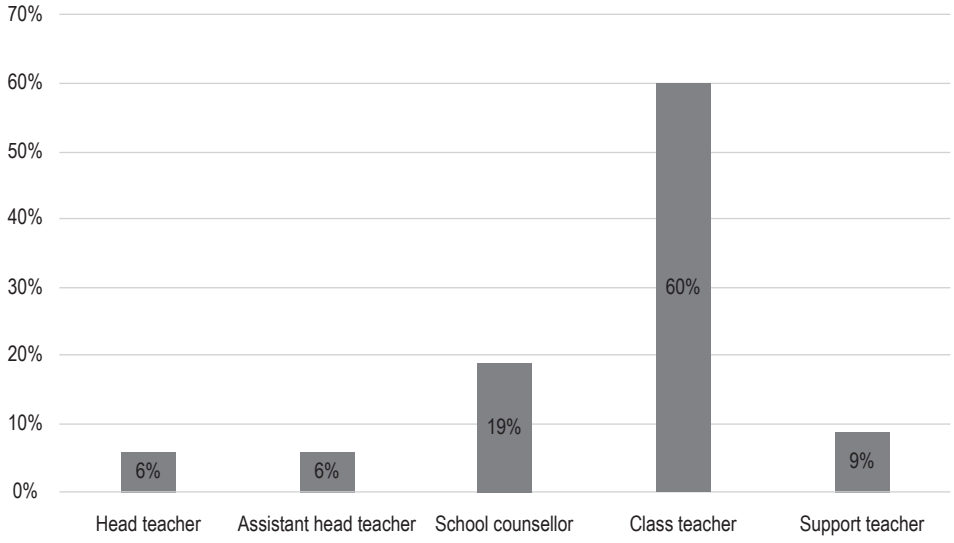

Chart 1. **Respondents according to their function at school**

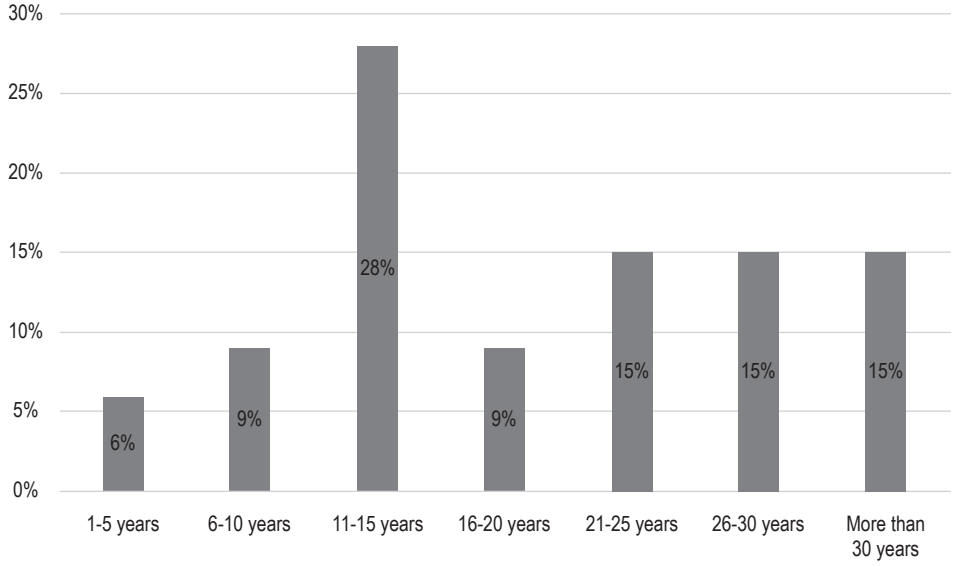

Chart 2. **Respondents according to length of service**

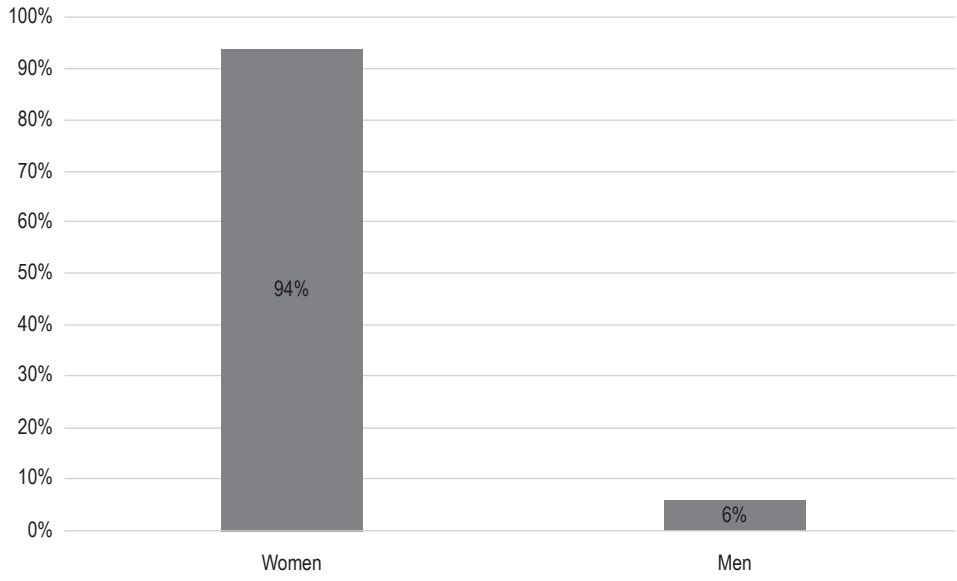

Chart 3. **Respondents according to sex**

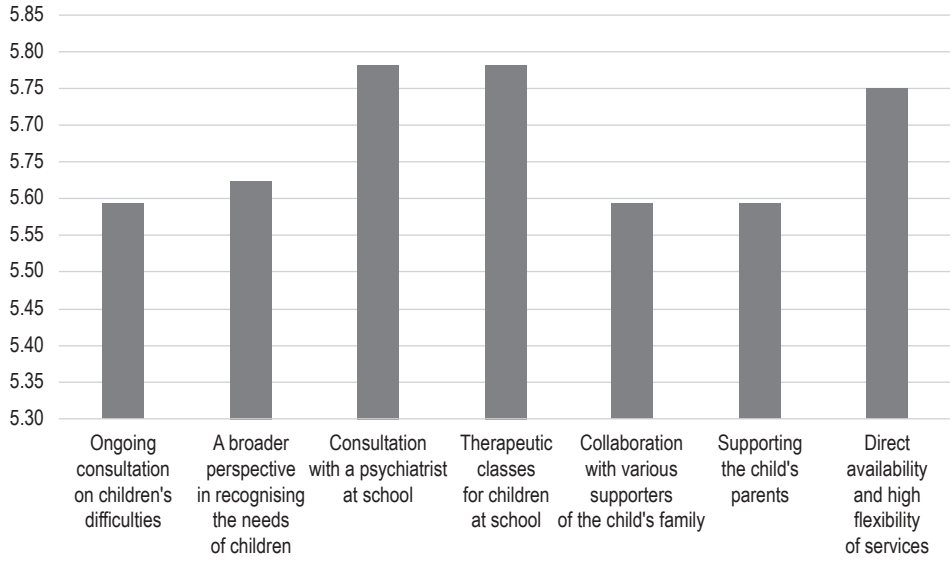

Chart 4. **Assessment of the cooperation of the Community mental health service with schools**

Consistently, the vast majority of respondents (94%) see the need to continue cooperation, only two people (4%) marked the answer "It is hard to say".

When asked about new aspects of cooperation, school employees mentioned, among other things, covering a larger number of children with care and therapeutic support, organising training courses for teachers, workshops for the whole class attended by students cared for by the team.

Discussion

The fundamental importance of school in the functioning of children and adolescents is obvious. The issues related to it are raised during psychiatric consultations by as much as 70% of children [24]. Hence the long-raised role of teachers training and broadening their understanding of issues supporting the well-being of students. The presented results show the enthusiastic reaction of school employees to the proposed programme. More important question here is whether patients themselves and their parents would give similar answers. The pragmatic benefits of the child not having to travel to the office of the Team, less risk of absences or being late for therapeutic sessions, less burden on the parent as the child's therapy is "included" in the lesson plan – all of this seems obvious. We also assume that such support gives patients a sense of security and facilitates the generalization of therapeutic goals for everyday functioning in the educational space. But how can we be sure?

School can be perceived as hostile and oppressive by children experiencing school failures and their families. Locating the therapy outside the place of intense dispute favours the perception of its autonomy and distinctiveness. Therapy at school is directly related to the conflict. The key question is how can mental health professionals avoid having to take sides? How to promote circular, non-accusing reasoning about all participants of the system?

Some patients and their families may have negative experiences when mental health specialists enter the school. Children with mental disorders are stigmatized to a greater extent than children with somatic diseases or learning difficulties, and the fear of stigmatization is one of the reasons for low willingness to use the support of the mental health care system [25]. Receiving assistance in front of class and school peers by a child can provoke shame and anticipation of rejection, especially in the group of people who internalize negative stereotypes and experience self-stigma. The fear of lack of control over the label of "mentally ill" and the fear of peer rejection can be a serious obstacle, and the threat of rejecting of children "marked" in such a way seems real. Especially that, as the research shows, identifying a child as suffering from mental disorders increases the social distance [26]. At the same time, there may occur a phenomenon described in the literature as "secondary benefits from the disorder" with the child in a special position, receiving additional, often attractive activities unavailable to others, and finally – increased attention of important adults at school. This special position can also provoke peer rejection. Questions about the reactions of children not covered by care seem to be crucial in this situation. Important dilemmas also include the confidentiality of therapeutic contact – both in the professional dimension (whether in the course of consultations regarding the child

there is unintentional disclosure of a secret), and children's fears and fantasies about possible violations related to the contact of therapists with teachers or other school employees.

All of this may negatively affect the establishing of a therapeutic relationship with the child. We are attentive to these potentially dangerous processes. Patients do not report this type of experiences during therapy. However, the matter requires further analysis.

Empirical data emphasises the importance of technical accessibility to therapy and the need to actively seek a child and adolescent patient in poorly motivated families experiencing financial difficulties and numerous problems [27]. It is likely that some families would otherwise never reach to psychiatric institutions when seeking help for their children. Should this be perceived as facilitating the access to help or as a new oppression of the school system? Is making children therapy so technically easy and "casual" for the parents always the best solution? Can it increase the risk of shifting of responsibility for the child outside, to school and therapists? In some families, many specialists are involved – probation officers, family assistants, other social workers, etc. Does it increase the risk of incapacitation of such families? One of the fundamental tasks of therapy for children and adolescents is to increase the power and sense of agency in the family. From this perspective, we undertake many activities to ensure that the support for our patients is not limited only to interactions at school, but also involves the family. Families show various willingness to accept this offer.

From the Team's perspective, the school is "just" one of the places where the child is present, and being a student is just one of the roles he/she performs, and the cognitive sphere is not necessarily the most important in the child's life. Of course, the perspective of school staff is different. This difference creates an irremediable tension in the relationship between the education and mental health systems, and intense, continuous contact places this difference in the spotlight. We are doomed to constant dialogue, getting to know and better understand our mutual perspectives, negotiating attitudes and interactions. The focus of the school on the roles related to education is conducive to the identification, above all, of children who particularly disturb the learning process, and thus present externalizing disorders, with the risk of omitting withdrawn, anxious and internalizing students. It seems, however, that with the cooperation developing in time, the precision and relevance of identifying children in need by the school improves.

Important questions relate to the possibility of generalizing the optimistic results of our research. The project conducted by an academic centre with the participation of experienced and thoroughly trained staff on the one hand and employees of leading primary schools from the centre of Kraków on the other, may be difficult to replicate in other circumstances – in more conservative communities of smaller centres, in secondary schools, where much stronger tensions can be expected around the risk of stigmatization of students referred for therapy at school. Most studies show that stigmatization increases with age. From this perspective, working in primary school with younger children seems safer [28]. Another argument in favour of activities at the school is the participation of less experienced staff of newly created community psychological and psychotherapeutic care centres.

The study was conducted before the children and adolescents psychiatrist was excluded from the team. Would the lack of an initial psychiatric consultation, which is a condition for inclusion in care, change the attitude of the respondents? This issue

remains open. Carrying out the research before the transformation period enables comparative research.

Reflection on the nature of cooperation between psychiatric care for children and adolescents and schools is still necessary. As is the empirical research on the attitudes of children and their parents to this form of interactions.

Reflections on community care during the pandemic

The COVID-19 pandemic has not fundamentally changed the way the Team works, and it seems the Team has found its way into a new reality. However, in a sense, the new and very often used form of remote contact entails specific challenges. At the beginning of the pandemic, online therapy was seen as a means of staying connected, ensuring continuity of therapy, and providing support in the crisis related to the pandemic. In recent months, online contact has become a "new normal" which – with all its advantages and disadvantages – dominates the form of working with patients. Switching to the audio-video mode requires not only technical organisation, but also establishing new principles for therapy and setting boundaries in contact. This raises ethical questions in the work of a therapist. These areas require constant reflection and appropriate action.

Conclusions

Although rooted in many years of tradition, the proposed model is an innovative concept of organising community care for children and adolescents. Diagnosis, specialist consultations and therapy take place in a widely understood community, at school, at home, in cultural institutions, adequately to the identified needs and problems of a given child. This model is sensitive to the context of the child's life and supports the integration of interactions. Cooperation of team members with school staff creates a support network for the child and parents. Communication between team members and other specialists, teachers, school day care workers, school educators, psychological and pedagogical counselling staff allows for a broader understanding of the context of a child's life and coordination of interactions and focus on supporting its development. The model met with general approval of the surveyed school employees.

Conflict of interest. The authors do not report any financial or personal affiliations with other persons or organisations that could adversely affect the content of the publication and claim the right to it.

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