



Partnership with Education: What Value to Rehabilitation and Mental Health Services?

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It is now well documented that collaborative practices increase effectiveness and efficiency in response to service needs (Miller & Ahmad, 2000). Hospital School Services (HSS) is one of four Statewide Specialist Services within the Department of Education Western Australia and provides teaching and education services to both government and private school students whose physical and/or mental health presents difficulties in accessing their regular education program and also facilitates their entry or return to a program that best meets their ongoing needs. For inpatients and outpatients with chronic health needs referred to HSS, liaison with schools and families promotes and supports consistent communication between student, family, school and health service. It also provides a bridge for the school to access the specialist knowledge of the health team and for that team in turn to better understand the challenges the students is facing in the regular school setting. The development of the 'Liaison Teacher' role over the last decade has been the key conduit to facilitating this for many students with chronic illness in health settings across WA, including rehabilitation and mental health conditions. This presentation will describe the education services available to patients from rehabilitation and mental health services in Western Australia and give an example case study.

HSS in Context

To put Hospital School Services in context, Western Australia is a rapidly growing population of about 2.2 million people across a geographical expanse of approximately 5,500,000 km² – an area covering the size of Western Europe. There is significant cultural diversity, living conditions and access to services from small rural and remote communities to large urban centres like the capital, Perth. The challenges in providing an effective, seamless service are therefore geographical and cultural. To ensure our services are cohesive across all contexts, we have adopted this credo. "When services are not integrated with a common goal, a common paradigm for understanding the social problems, a common language of how to work together, families and children fall prey to fragmented services and interagency debates about mandates and responsibilities" (Moretti, 1997).

Development of HSS Liaison Services

A defining moment in HSS's development was the establishment of a Memorandum of Understanding (MOU) in 2005 between the Director Generals of both the Departments of Education and Health. This forged the way for greater inter-agency collaboration, the signing of Service Protocols between HSS and a wide range of WA Health Services (currently 40+ programs in 20+ health sites statewide) and the inclusion of Liaison Teachers in many of the inter-disciplinary health teams in these hospitals and community CAMHS clinics. We now service an average of 4300 students/year (40% primary, 60% secondary) and, as programs have shown evidence of their inherent value and been maintained, HSS staffing has increased now to 72 teaching and support staff (many part-time), with assistance from approximately 40 volunteers.

Four HSS Outcomes and Evidence for Collaboration

At HSS, we value most highly four outcomes in our work - providing a relevant educational program; collaborating with schools of long-term or chronically ill students; collaborating within inter-disciplinary teams and with other agencies to support educational, medical and psychosocial needs; and facilitating a student's transition back to school or toward another study or career path. These goals have been



considered and reinforced repeatedly by evidence gathered on effective collaboration by education services in health settings and are the basis for development of our liaison services. The references provided at the close of this transcript provide examples, but to note a few:

- Closs & Norris (2001) found a positive educational outcome more likely for a chronically ill student when: partnerships existed, planning was conducted as early as possible, professional learning was conducted for enrolled school staff and the student's enrolled school had a positive ethos to support the student.
- Farrell & Harris (2003) highlighted five overarching themes for effective policy and practice as: mainstream ownership (for connection), collaboration (for consistency), flexibility (for practical solutions), responsiveness (for timely delivery & good process) and clarity (of roles & boundaries).
- A Western Australian survey (Gardiner, 2006) followed these findings by asking teachers what they worried about when it came to students in their schools with chronic illness and teachers wanted: greater knowledge and understanding of the health condition and its impact, access to assistance in addressing the student's changing health related needs and support from someone who understands the classroom context.
- Most recently Payne & Valentine (2010), both accomplished paediatricians, acknowledged the importance of education staff in health teams by stating that "current models of interdisciplinary care should incorporate education staff as a matter of course."

Liaison Teacher Roles

Liaison Teacher in Mental Health Teams The Liaison Teacher role is obviously very similar across all specialty health teams but some differences arise according to the nature of the conditions supported, so in the time available I will highlight two as examples. Liaison Teachers were piloted and established in several mental health settings/CAMHS teams after recommendations from a 2004 review of the Western Australian Education system and students with psychiatric disability. Within these specific teams they have been given the acronym CELT (CAMHS and Education Liaison Teacher).

CELT Role

The following define the role of a CELT:

- Consultancy to CAMHS clinicians on educational matters
- Direct consultation to government & private schools for students who are "active" clients with CAMHS and have signed parental consent for CELT support
- Liaise with schools and 'Student Services' teams regarding individual students
- Broker professional learning with health clinicians for schools and district education offices
- Make educational assessment in collaboration with CAMHS & through liaison with school & regional services
- Offer generalist mental health advice, including classroom observation & modelling
- Facilitate a student's transition planning
- Support schools with funding applications for Severe Mental Disorder
- Help schools understand how CAMHS services work
- Facilitate flexible service delivery by clinicians.

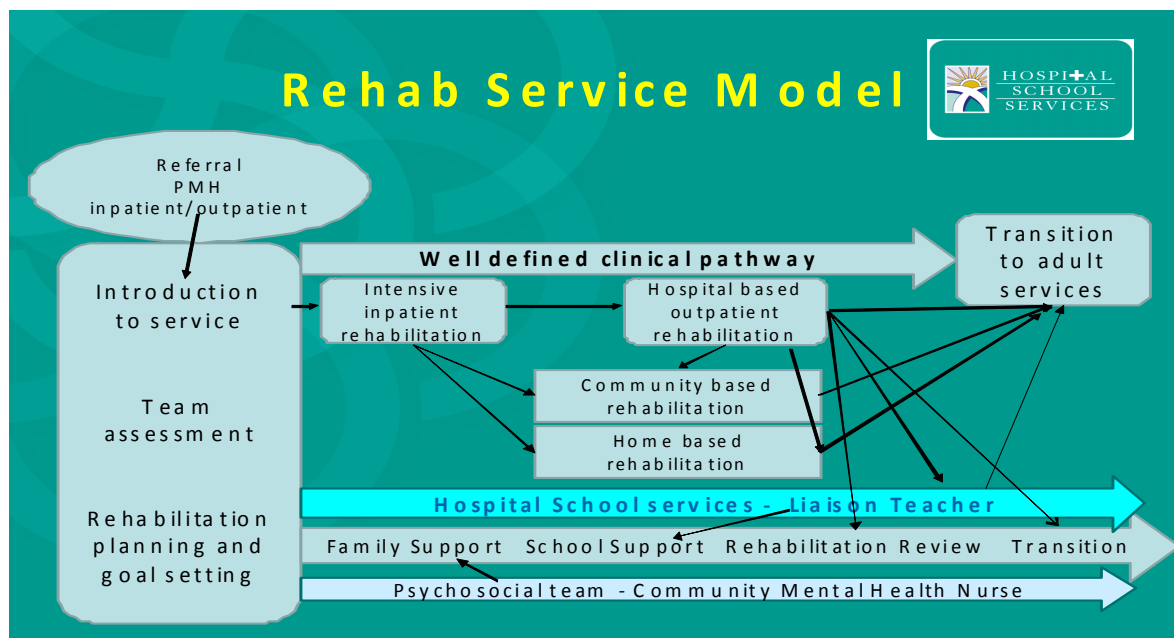
The CELT role has now expanded into CAMHS teams state-wide in response to the extremely positive feedback received from the health and education sectors through various evaluations. For example, one Consultant Psychiatrist commented that 'it functions as an extremely useful and beneficial service to help coordinated management in what is an extremely complicated overlap between Education and Health.' Most recently Grant Wheatley, Principal Hospital School Services, was recipient of the 2010 University of Western Australia Dr Mark Rooney Award for 'Improved Outcomes in Child and Youth Mental Health'. This recognised him as a driving force behind initiatives like CELT services and demonstrates that these



projects have led to improvements not only in the way the education sector manages students with mental health problems, but has significantly enhanced the collaboration between these sectors.

Liaison Teacher in Rehabilitation Teams

The Acquired Brain Injury (ABI) and Spinal Rehabilitation Teams also have well established Liaison Teacher roles in their interdisciplinary health teams, who work closely with Consultants, Liaison Nurses, Allied Health, Clinical Psychology and Community Mental Health Nurses. These Liaison Teachers follow the Rehabilitation Team principles of being: holistic & child/family centred, evidence based with intervention, working towards meaningful, objective and functional goals within the neurocognitive rehab approach and aiming to minimise complications of the condition while maximising access, independence and transition to school/community. The most common conditions of young people in the Rehab Teams are either congenital (eg Spinal Dysraphism) or acquired (eg brain and spinal injuries from accidents, tumours or infections etc). The long term clinical pathway after referral for a young person is always underpinned by support for the family, the school and any transitions, as seen in this model:



Common Factors to Consider at School

As the brain and spine are essential to so many aspects of functioning there are many factors a young person might experience and that a Liaison Teacher would assist the student and school with. Each individual is different but may involve:

- Cognitive impairment - intellectual, new learning, executive function, processing speed, poor attention & memory, impulsivity & perseveration
- Physical & functional impairment - toileting and continence, gross & fine motor weakness effecting ADLs like mobilising, fatigue, writing, meals and socialization • Communication & language difficulties
- Personality and behavioural change
- Higher risk of mental health issues
- Direct impact on the family, their education and future career pathways.
- School Considerations for Students with an ABI The following is some information to better understand ABI and the school considerations a Liaison Teacher assists with:



- An ABI is Australia's leading cause of acquired disability and death in childhood and adolescence, approx 1:650 young people • Incidence peaks twice, less than 5yrs and during adolescence with more males than females (Khan et al, 2003)
- Outcomes of an ABI are very complex and heterogenous with potential contributors being the injury severity & location, age at injury, pre-injury social & mental health, environmental and family factors and access to rehab services
- A 5 year review of HSS data for moderate to severe ABI students showed approx 50% of children required educational assistance (EA in class or in SEN/ES unit) to manage school participation • Survivors of an ABI experience numerous "invisible" disabilities that many people won't recognise (McLure & Abbott, 2009) (Hawley, 2004).

School Considerations for Students with Spinal Conditions

The following is some information to better understand Spinal conditions and the school considerations a Liaison Teacher assists with:

- Frequently have Neurogenic Bladder &/or Bowel (nerve supply interrupted through trauma or congenital abnormality) requiring management at school. Failure to empty brings significant renal complications so the aim is to prevent complications & achieve social continence, in turn minimising accidents & bullying. School management includes planning toilet routines, catheterisation, EA support and working towards independence.
- Use of various equipment to maximise mobility (wheelchair, walker, AFOs).
- Verbal communication is usually considerably higher than their actual literacy.
- Overall intelligence is usually in low average range eg 75% IQ < 80. (McLone, 1992).

Rehab Liaison Teacher Role

The role of a Rehab Liaison Teacher is primarily to ensure participation in a student's enrolled school despite the impact of their health condition. Before any intervention, the most important requirement is to gain signed consent from the parents/carer for exchange of information on school related issues. This allows them to maintain confidentiality while keeping open and consistent communication between the parents, rehab team, school, regional office and other community agencies involved.

The tasks a Liaison Teacher may be involved in are:

- Provide closer links between health and education by offering access to specialist knowledge from the health team and assisting health teams to understand school and education processes
- Attend case conferences & review meetings
- Facilitate transition planning
- Monitor long term student progress via school and hospital outpatient clinics
- Facilitate professional learning for school staff
- Provide documentation from health team eg medical diagnosis letter, therapy reports, neurocognitive assessment, teacher information
- booklets
- Assist school in planning & accessing funding (from Education or Insurance organisations)
- Consider equipment or assistive technology needs
- Clarify young person's physical activity capabilities and limits on high risk sport
- Offer the school practical strategies to apply in each context such as: a gradual increase in attendance/workload during transitions, allowing time between classes to leave early or arrive late, provision for small rest breaks as needed for fatigue, use of a 'buddy system', change of seating arrangements and involvement of an Education Assistant (for mobilising & transfers, toileting, hygiene, organisation, help to summarise learning, scribe for longer tasks and to assist with books/bag/equipment).



Rehabilitation Case Study

This case study outlines the journey of a rehabilitation patient. It provides an example of how the support of a Liaison Teacher assists young people with chronic health conditions to experience as much school normality as possible and access the best possible educational opportunities in their enrolled school.

Background of young person - TC

- 13 yrs old, Yr9 student, 'average', active, good social network but hx of bullying
- Family - Mother (PA) & Father (fly in/fly out mining), 16yo sister
- Lives ~30km from Perth centre and hospital
- Accident - passenger in off-road motorbike accident on his birthday
- Emergency - CPR, severe (GCS 3), ambulance to hospital
- ICU - 2/52 in coma/intubated/ventilated/NG tube fed
- Resulting diagnosis
 - Severe Traumatic Brain Injury (ABI)
 - Pulmonary contusion
 - # spine at T3 stabilised
 - # R ribs & # R forearm
 - L Hemiparesis (left sided weakness)
 - L Hemianopia (limited vision complicates mobility/function)

Inpatient Rehabilitation for TC

- Transfer to ward and referral to team, later introduction of Liaison Teacher
- Obtained signed parental consent to exchange information
- Intense interdisciplinary rehab with daily school session included
- Collaborate with therapists to coordinated inpatient teaching times
- Initiate a link with enrolled school and request pre-injury questionnaire and outline of school program (to be modified for TC's present capabilities)
- Contribute to regular team meetings
- Keep ongoing communication with school for understanding of student, family & health considerations
- Suggest opportunities to foster peer connections through school
- TC remained an inpatient for 10/52.

Prior to Discharge from Hospital

- Independent ADLs but needing assistance for transfers & mobilising
- Could walk short distances with side assist and using K-walker
- Wheelchair necessary for distance
- L side blindness permanent (Hemianopia)
- Fatigue and sometimes impulsive, resulting in falls
- L hemi meant fine motor difficulties & ataxic gait
- Changed hand dominance due to injury (learn use of R instead of L)
- Communication difficulties (slurred speech and word finding)
- Poor executive functioning (organising himself through day)
- He was very insightful into effects of injury and the social implications/bullying
- This resulted in increased anxiety about school return and some school refusal
- Mother also experienced anxiety and had expectations of school.



TC's Transition to School

- Meeting to plan discharge from inpatient stay
- Arranged short period of home teaching (~2/52) till school more prepared
- Facilitated school visit for OT to report on accessibility of grounds
- Arranged school case conference re: transition planning by school
- Liaised with Vision Education Service & District's inclusion team for input
- Provided school with documentation from health team including medical diagnosis letter, school info booklet (condition, symptoms and advice) and therapy recommendations
- Assist school with their health care plans, IEP's and funding applications for EA
- Guided teachers & EA on strategies eg assisting with mobility/transfers, compensatory strategies in the classroom
- Linked staff to related professional learning
- Directed school on level of physical activity he could participate in
- Arranged TC a first school visit, only a few peers/teachers for gradual exposure
- Conducted class talk to peers prior to TC's return so they knew what to expect and could be supportive environment
- Rehearsed school/social scenarios with TC to prepare for entry
- First day attending, I was present at school to 'pep talk' with TC and give classroom support/modeling where needed
- Coordinated timetabling between hospital therapy and school as attendance stepped up
- Regular communication with parents and school to ensure all happy
- Repeated school visit coming weeks of transition to 'trouble shoot' & encourage TC's success/engagement
- Over time TC no longer needed wheelchair/walker, gained more independence
- Reduced school visits to periodical.

Support Continued Through Outpatient (OP) Rehabilitation

- Monitored progress in OP clinic and contact with school
- Relay academic/social/emotional/mobility progress to health team
- Attended periodic school review meetings
- School allowed TC continued support from student services as required
- As additional supervision ceased, initiated buddy system with suitable peers
- Neurocognitive assessment conducted @ 12mths post injury, so ensured school had access to this valuable information
- Provided school with regular health/therapy progress
- Assisted school with modifying TC's program & funding reviews
- School awarded TC an achievement award for his courage and determination
- TC managing better in academic subjects
- Shifted EA priorities to subjects with high writing & practical demands
- Issues between family and school arose over time through misunderstanding of health progress etc so mediated resolutions, consulted Rehab Team as needed
- Work placement opportunities arose (bricklaying, mechanics) – asked OT to assess function & processing skills to reassure school he could participate
- Changed to community based therapy, so ensured they were linked to school
- Recommended parents apply for Ronald McDonald Learning Program (RMLP)
- Guided school on government's special examination arrangements
- Provided TC with guidance on education, training and career pathways



TC Today, 2 Years Later

- Full time school participation
- Has been able to maximise his rehab & health outcomes
- Has regained much of his adolescent independence
- Maintained and built positive social relationships
- Has good attitude towards school
- Recently completed Yr10 studies
- Is preparing to engage in work/training pathways

Case Study Summary: Collaboration - What Worked Well?

This case study demonstrates how the intervention of a liaison service leads to very positive outcomes for students not necessarily achievable otherwise. It is noteworthy that the Liaison Teacher ensured mutual understanding between the education and health contexts through free flowing information and prompt, supportive & flexible interagency responses. TC and his family felt supported during pivotal transition periods, enabling them to overcome unfamiliar obstacles. Another factor of success was that the school kept ownership of TC as their student and also identified a case manager at school to monitor & report issues to Rehab Team through HSS. This meant the school were able to receive valuable documentation and access support to formulate and implement effective plans for TC. Finally, it was very important that the health team recognised school as an important setting for TC to achieve his long term rehabilitation goals and the Liaison Teacher could help communicate this sense of value as well as useful strategies to the school.

Conclusion: HSS Model of Collaborative Service Delivery

Evaluation of HSS in 2008 reinforced that the service effectively supports schools, such that students can continue to attend/participate in their school program (Bauer, Crosby, Hughes & Sharp - 2008). Feedback received has highlighted the importance of collaboration in reaching our desired outcomes. One health professional who has worked closely with HSS commented that, "every time HSS is involved, this supports a successful outcome. We all share a philosophy of the value of education; the school is the biggest resource we have in terms of trying to make changes."

For More Information

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