
BPI / CURL Knowledge Exchange

Presentation by Marc Atkins, Director of the Institute for Juvenile Research (IJR), UIC
November 18, 2014

Mental Health Policies for Children and Families

The children's mental health service delivery system is in need of reform. Only 20 percent of children who need mental health services actually receive them, and in many cases, these services do not adequately address their needs. Poor children are less likely to have access to mental health services, which means that children with the highest level of need are least likely to receive services. Furthermore, the effectiveness of clinical interventions is debatable. There is a growing body of research that suggests that the "natural environments" in which children live, work, and play have a significant impact on a child's development. Clinical interventions that are removed from these natural environments often have limited success.

Because of the lack of available and effective community based mental health services for children and families, most children who need services must rely on their schools. School based mental health services have a great deal of potential, but most schools are ill equipped to meet this demand. Furthermore, the way that services are provided in schools replicate many of the inefficiencies of clinic-based care. For example, most schools identify children with the most serious diagnoses, and then provide individualized therapeutic interventions outside of the classroom. This approach reaches a small percentage of the students in need, does little to foster communication between teachers and mental health workers, and often fails at engaging parents.

There is a better approach to delivering school based mental health services, but it requires systematic change. IJR's Links to Learning (L2L) program proposes an ecological approach to mental health services that: 1) delivers services within natural settings 2) focuses on prevention and early intervention 3) integrates the work of teachers and mental health professionals and 4) builds on existing strengths within the school and community. Currently, elements of this program are being

"For children with intensive needs, such as those receiving special education services, the advantages of linking mental health services to schooling are considerable.....

Teachers and other school staff often do not have the resources or skills to manage high need children, especially in high-poverty communities where student-to-staff ratios are high and technology or other resources are scarce.

Therefore, classroom-wide programming for normative events such as transitions throughout the school day, or class-wide routines such as silent reading or group instruction, can often ameliorate these difficulties.

In addition, classroom or school-wide programs can serve as a naturalistic base from which individualized programs can be developed for children with more intensive needs, avoiding the stigmatization that often arises when individualized programs are implemented in isolation of other program goals"

Atkins et al. 2010. "Toward the Integration of Education and Mental Health in Schools" Adm Policy Ment Health 37:40-47

implemented in 16 Chicago schools with collaboration with the Chicago Public Schools central office.

An important additional iteration of this model is programmatic support for after school programs, which are open to all students and are often held at local park districts. While this is not a direct therapeutic intervention, it has natural therapeutic benefits by providing a safe place for students to spend time and develop relationships after school. It also reaches more students, particularly those who can be difficult to engage in an academic setting because of poor attendance or behavioral problems. The utilization of “natural settings” is also a strategy for engaging parents. For example, in the school-based project, program staff significantly increased parental involvement by relocating meetings from the school to a nearby Dunkin Donuts.

IJR is also working to develop classrooms that promote better mental health by increasing communication between teachers with community and school social workers, and working with teachers to create supportive classroom environments. This approach is effective because it reaches all students, and is able to prevent problems before they manifest as mental health diagnoses. In order to implement this strategy, IJR researchers engaged key informant teachers—the respected teachers that are the “opinion leaders” within the school. Research has shown that these teachers can effectively disseminate information to their colleagues to encourage innovative school and classroom practices.

Key teachers can also recommend and recruit school staff, such as cafeteria and involved parents to become part of a paraprofessional team that provide supportive services for students and their families. Paraprofessionals who live in the child’s community can have a significant impact on mental health outcomes. For example, the recent city-wide initiative to provide safe passage workers are a positive force in the community and are ideal candidates for promoting school involvement among community parents.

Pairing community agencies with schools is another effective strategy, especially if mental health workers from local organizations are willing to work within schools. This can be a cost-saving tool because Medicaid pays for services provided by many of these agencies. However, communities have different levels of organizational capacity, so this strategy may not be as effective in communities that have limited organizational resources. However, changes in health care funding with the Affordable Care Act may provide new opportunities to involve community social service agencies in early intervention and prevention programs.

Finally, it is extremely important to engage with parents to create more supportive home environments. In addition to establishing meeting times and places that are easier for parents, IJR researchers have adapted a weekly student report card to provide regular feedback to parents and improve parent-teacher communication.

There are many programs and curriculums that have been designed to improve mental health and student outcomes. Some are more effective than others, but IJR’s approach is more focused on systematic change, rather than creating educational programs that can become expensive (and sometimes ineffective) products designed to be sold to school systems.

Discussion Summary

How can this approach be scaled up to have a greater impact?

IJR is studying the L2L program to determine how this approach improves three outcomes—academic performance, school and home behavior, and parental involvement. The results of an initial study suggests a foundation for expanding this approach to more schools. However, developing effective programs is not enough—bringing this approach to scale will require a fundamental shift in how we educate teachers and how we provide mental health services; most notably by expanding our understanding of who and what matters most to children and families. Mental health practitioners and social workers need to shift from individualized therapeutic interventions to supporting the creation of healthy and supportive environments that prevent mental health problems. This reconceptualization of mental health practice will make it easier to integrate mental health into teacher education curriculums and school practices. In addition, parents are an extremely important part of this equation. This approach is designed to help parents be the best parents that they can be, and if they are actively engaged, it will be much easier to bring this approach to scale.

How does this approach differ from trauma-informed practice and socio-emotional learning programs?

Socio-emotional learning programs were introduced in several Chicago Public Schools, but often teachers were given little support to implement the curriculum. The Chicago Public Schools have a high number of students in need of services, but a shortage of trained providers. The teachers are also stretched thin, and many do not have enough free time during the day to figure out how to incorporate the social emotional learning curriculum. The L2L approach provides support to teachers by training paraprofessional staff and engaging community organizations to assist in service provision. Furthermore, social emotional skills can be difficult to teach. Rather than using specialized social emotional curriculum, L2L creates classrooms where these behaviors are modeled in everyday interactions.

Trauma-informed practice can provide a very useful lens for practitioners; give insight into the problems faced by students in poor communities; and can encourage supportive (rather than punitive) school policies. However, trauma-informed practice can also set up a dynamic which assumes that the student is damaged. Furthermore, trauma-informed practice can be focused on the individual, rather than school systems, communities, and families in which the children are embedded.

Additional Resources

The Chicago Parent Program provides a good model for parent engagement:
<http://www.chicagoparentprogram.org/>

The National Center for Children in Poverty provides an example of efforts to incorporate mental health practices across multiple sectors: <http://www.nccp.org/about.html> schools.

Atkins, Marc S. and Stacy L. Frazier. 2011. "Expanding the Toolkit or Changing the Paradigm: Are We Ready for a Public Health Approach to Mental Health?" *Perspectives on Psychological Science* 6(5): 483-487.

Atkins, Marc S. and Davielle Lakind. 2013. "Usual Care for Clinicians, Usual Care for their Clients: Rearranging Priorities for Children's Mental Health Services" *Administration, Policy and Mental Health* 40: 48-51.

Atkins, et al. 2010. "Toward the Integration of Education and Mental Health in Schools" *Administration, Policy and Mental Health* 37: 40-47.

Formoso et al. 2010. "Gentrification and Urban Children's Well-Being: Tipping the Scales from Problems to Promise" *American Journal of Community Psychology* 46: 395-412.