

Usual Care for Clinicians, Unusual Care for Their Clients:
Rearranging Priorities for Children's Mental Health Services

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Garland et al.'s comprehensive review of the state of clinic-based community-based mental health care for U.S. children highlights many recent advances in usual care (UC) while also describing the continued gap between need and service provision, the limited effectiveness of services provided, and a number of other obstructions and dilemmas ranging from perceived stigma on the part of families to limited fiscal resources on the part of service providers. Based on these long-standing concerns, the review summarizes research on three foci for change and offers future directions for each: Enhanced engagement strategies to retain families in services, improved training and support to increase the use of evidenced based practices, and expanded measurement and feedback systems to monitor services in real time. Unaddressed, however, is whether these changes are sufficient to reform children's mental health care. Even if enacted extensively and outstandingly – a feat we imagine that nobody familiar with UC would realistically expect – will unmet need for care improve and effective services be available to the large number of children in need of mental health services?

As we reflected on the implications of this review it occurred to us that “usual care” is actually a misnomer for the care provided in clinic settings. There is long-standing evidence, in fact, that office-based mental health services constitute a relatively small percentage of services offered, and when offered are often inappropriate to the primary needs of children and families. In this commentary, we suggest an alternative conceptualization of usual care for children's mental health services that focuses on the settings and outcomes that matter most to children and families. Specifically, we propose

that a new understanding of usual care would: (1) deemphasize mental health care delivered in hospitals and clinics to emphasize support in natural settings; (2) expand the workforce beyond traditional mental health providers to acknowledge naturally existing mental health enhancing supports for children and families; and (3) realign mental health resources away from a focus on symptom reduction to prioritizing the key predictors that promote successful adaptation.

Supporting Natural Settings

As noted by Garland et al., there is now considerable evidence that improved retention of families in office-based services can be accomplished through a range of engagement strategies, from early and active communication between clinicians and families about barriers to attendance (Bannon & McKay, 2005), to the creative use of family peer advisors to bridge cultural gaps between providers and families (Hoagwood et al., 2010). However, the persistent and pervasive challenges to improved retention in clinic-based services – fiscal, access-related, and perceptual -- disproportionately experienced by populations with the highest need (Cohen & Hesselbart, 1993), strongly suggests that even if engagement efforts were widely adopted, the long-standing gap between need and availability would remain largely unchanged.

In addition, a focus exclusively on retaining families in clinic-based services also belies the evidence that relatively few mental health services for children are delivered in clinics. Burns and colleagues documented almost two decades ago (Burns et al., 1995) that schools are the primary venue for children's mental health services, accounting for 70-80% of services received, with medical settings and mental health clinics a distant second and third, respectively. Importantly, though, schools are not only the most

common point of entry for families seeking mental health services; those who enter through the education sector are also least likely to transition to mental health services provided in other settings (Merikangas, Nakamura, & Kessler, 2009). This may relate to the finding noted in the review and elsewhere (Padgett, Packett, Burns, & Schlesinger, 2004) that perceptual barriers are more entrenched impediments to attendance than concrete barriers such as transportation and childcare. As our own work has shown, head-to-head comparison between school-based mental health services and referral to community settings indicate a strong preference for school-based services for families living in urban low-income communities (Atkins et al., 2006); families who are often the least likely to attend office-based services and where unmet need is among the highest.

To us, the implications are clear: rather than a singular emphasis on strategies to target low engagement rates in clinics, mental health resources would be leveraged more effectively by supporting efforts to enhance the mental health promoting aspects of natural settings for children such as homes, schools, and after school programs (Atkins & Frazier, 2011).

Expanded Workforce

The need to reconsider usual care to deemphasize office-based services is made more imperative by the critical shortage of clinicians available to children and families, a shortage that is likely to grow given fiscal realities. For example, the city of Chicago recently closed 6 of its 12 community mental health clinics, eliminating services for over 3,000 residents, in part because of high per-client costs for mental health care (costs for which are higher, in fact, than any other health conditions (Soni, 2009)). As Garland et al. note, citing a study by Schoenwald et al., 2008, a third of providers with site-specific

budget data reported that their agency had run at a budget deficit for each of three years prior.

Thus, formulating and fostering alternatives to office-based care by professionally trained clinicians is of high priority. To that extent, we worry about the costs of the more extensive training proposed for mental health providers. Rather than focus exclusively on modifying the practices of clinicians working in offices, limited community and research resources could be stretched farther if reallocated to emphasize the important adults in children's lives, and to mobilize a paraprofessional workforce indigenous to children's communities (Schoenwald, Hoagwood, Atkins, Evans, & Ringheisen, 2010). Within the domains of homes, schools, and after school programs, there are many adults who can make a difference to children's development. Although these natural mentors may at times lack the knowledge or resources to support children most effectively, we propose that equipping them adequately could represent a cost-effective and sensible mechanism of optimizing their positive impact on the mental health of the children with whom they are already in frequent and meaningful contact. This is especially compelling in communities of high poverty, where the need is highest and resources most limited, and where existing evidence-based models are least likely to be effective or sufficient to serve these communities well.

Focus on Key Predictors

As we have noted previously (Atkins & Frazier, 2011; Atkins, Hoagwood, Kutash, & Seidman, 2010), contextualizing mental health services within the existing functions and structures of existing significant ecological settings such as home and school would realign mental health resources to affect the key predictors that promote

successful adaptation within the settings that matter most to children's development. A natural extension from prevention to intervention could emerge, with universal prevention focused on enhancing natural setting goals, and targeted intervention to promote positive adaptation for those with greatest need. By example, our ongoing work has focused on leveraging scarce mental health resources to enhance the mental health promoting properties of schools and after school programs (Atkins et al., 2008; Cappella et al., 2012; Frazier, Mehta, Atkins, Hur, & Rusch, in press).

To be sure, there are children for whom treatment in specialized settings is appropriate. Just as in medical care, children may need to see a specialist when something severe or unexpected happens, and specialists can be similarly essential for children with severe mental health needs. But for most children with disruptive behavior and attention problems – the most common presenting problems in UC as noted in this review – not only is there little evidence for effective office-based models, but there is strong evidence for interventions in schools (DuPaul & Eckert, 1997), and evidence for the superiority of home-based versus office-based parenting interventions (Wahler, Carter, Fleishman, & Lambert, 1993). In addition, there is emerging evidence for paraprofessional implementation of parenting programs to overcome long-standing problems of poor attendance in office-based parenting programs (Frazier, Adil, Atkins, Gathright, & Jackson, 2007; Hoagwood et al., 2010; Sanders, 2008).

In regard to embedding mental health programs in natural settings we will note two trends for advancing mental health service goals in schools that, with adjustments, can be vehicles for innovative mental health practices. First, school-based mental health clinics have emerged as viable community mental health services largely to overcome

poor attendance in office-based services (e.g., Flaherty, Weist, & Warner, 1997). However, as we and others have noted (Atkins et al., 1996; Cappella, Frazier, Atkins, Schoenwald, & Glisson, 2008; Ringeisen, Henderson, & Hoagwood, 2003; Rones & Hoagwood, 2000), individual counseling remains the dominant modality in school based mental health clinics, and few programs are integrated with school goals and routines. Not surprisingly, outcomes rarely impact schooling directly. We have suggested a reorienting of school mental health programs similar to what we are suggesting in this commentary, to realize a larger potential for school-based mental health services in which school goals are understood to be primary mental health goals, and natural supports within schools are activated and supported (Atkins et al., 2010).

The second trend that is occurring largely within schools, often with the assistance of community mental health staff, is the advancement of social emotional learning programs (SEL; Greenberg et al., 2003). As respite from the over-emphasis on test scores and the resulting restriction of teaching and learning goals (Cochran-Smith & Lytle, 2006), SEL programs are well aligned with the longstanding concern of educators for children's emotional adjustment (e.g., Carnegie Council on Adolescent Development, 1989). They are also an effective organizing model for the numerous and often competing programs that schools can select to enhance children's social cognitive skills and peer and adult relationships (Payton et al., 2000; Zins, Weissberg, Wang, & Walberg, 2004).

However, notwithstanding claims for program effects on achievement (e.g., Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011; Payton et al., 2008), there is limited evidence that these programs have enhanced children's school performance overall and conflicting findings for their effectiveness (Social and Character

Development Research Consortium, 2010). Irrespective of one's reading of the evidence, the emphasis on *programs* rather than school *processes* is a missed opportunity to activate natural supports to enhance children's mental health and school adjustment. To that end, SEL programs are perpetuating some of the same myths that the current mental health system perpetuates: that children's mental health and development can be addressed effectively outside the context of their daily lives, and that effective programs can overcome ineffective practices in schools and homes. As we have suggested previously (Atkins, Shernoff, & Martinez-Lora, 2009), there are opportunity costs associated with any program implementation, and it is critical, therefore, that programs establish their unique contributions over and above those already in place. Most importantly, research is needed to understand the natural conditions under which these programs are implemented and the extent to which they are impacting the daily routines in schools and homes.

Summary

Seymour Sarason, writing about his experiences at the Boulder Conference which founded clinical psychology in the U.S., stated that his "single, most serious misgiving" (Sarason, 2003, p. 101) for the conference was the decision to place mental health services in clinics and hospitals. He noted, with reference to the early work of John Dewey and William James, the obvious advantages for children's mental health of placing services and providers in schools. His concerns in 1948 were prescient; our model for mental health services was detached from children's lives and so our service models have developed accordingly. As Garland et al. note, more than two-thirds of community services are provided in clinics with services poorly aligned with presenting

need, with evidence based interventions rarely implemented or implemented poorly, and with little or no evidence for effectiveness.

In this commentary, we propose a redefinition of the term “usual care” to acknowledge the settings and people that matter most to children’s mental health and development. We suggest that as currently configured, the only thing *usual* about office-based mental health services is that families rarely use them and outcomes rarely align with children’s needs. A reorienting of mental health resources to focus on the natural – that is, *usual* – settings and people with the greatest impact on children’s mental health would promote services in schools, homes, and after-school programs, to support the key people in these settings who often lack the knowledge and resources to support children adequately, and to impact the key predictors that promote children’s success where it matters most. *Usual* care in *usual* settings by *usual* people: these are the real parameters that define “Usual Care.”

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