CHILDREN, YOUTH & FAMILY CONSORTIUM

The Interaction of Education and Health Disparities: The Mental Health Perspective

Staff from The Center For Excellence In Children's Mental Health (CECMH) interviewed Marilyn Larson, Supervisor of Early Childhood Programs (Head Start, ECFE, and School Readiness) for Duluth Public Schools, for this article.

Consortium Connections, Summer 2010

Disparities in children's mental health and education are evident as early as the preschool years. For the last fifteen years, Marilyn Larson has been a leader in the Duluth Public Schools in an effort to illuminate these disparities, and to help teachers, families, and school systems best meet the needs of young children. Larson is the Supervisor of Early Childhood Programs for Duluth Public Schools. She generously provided her perspective about the overlap in health disparities and educational disparities for this article.

In the last decade, Larson notes that not only have children's mental health needs increased, but that these needs have also seemed more severe. The needs of children are inevitably displayed in the classroom and affect the child's ability to learn. "Initially, we were concerned about kids who had mental health issues. In the classroom, staff felt overwhelmed and needed some direction on how to approach children who could not self-regulate emotional states, could not sit for extended periods of time, and could not communicate their wants and needs in a healthy manner." Through a Safe Schools/Healthy Students grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), Duluth Schools were able to introduce mental health consultants to early education settings in order to enhance understanding of the specific needs of young children and the best ways to accommodate those needs in the classroom. A significant component of this program was to engage teachers, mental health professionals and parents in a collaborative effort to improve learning.

The Children, Youth, and Family Consortium (CYFC) has identified four fundamental ways in which mental health and education interact. The first is that early health status influences later educational success. Larson states: "Take, for example, a child with a history of acute or

prolonged trauma. We know that when the brain is occupied with working with trauma, children aren't able to learn. We need strategies to help children lower cortisol (a hormone released in the body during periods of high stress and trauma) levels in the brain, to help children become more comfortable and trusting, and to help them learn readily." If these early health needs are not identified and addressed, it could become increasingly difficult for the child to learn. "Children who feel understood and competent are better able to learn."

In its most traditional form, the classroom can be unequipped and unprepared for the child struggling with both internally and externally displayed mental health issues, according to Larson. The Safe Schools/Healthy Students program provided the resources for teachers to contact a mental health consultant when they feel a child needs it. The mental health consultant serves as a neutral observer, evaluates the child's needs, and produces a report that outlines the findings. Then the teacher, mental health consultant, and parent meet together to identify how to translate the child's needs into adaptations in the classroom. For example, a child may be referred to special education. Or, a child who has experienced trauma may have difficulty with transitions, and is given a pocket schedule with pictures of the day's events to help him/her anticipate what is coming next. Another child who has experienced the loss of a parent may be encouraged to carry a picture of this person in their pocket during school. "We want to help staff and parents see what it means to provide a therapeutic environment for children," Larson states. "We want them to think critically about behavior in the classroom and at home, and to consider behavior as a form of communication. The questions at hand are, 'What is the child trying to communicate?' and 'How can we structure the environment (in the classroom) to address the children's needs?'" These types of adjustments are often simple and can help children in the classroom relax, feel safe, and learn more effectively.

The second way that children's mental health and education interact is concurrently. "You can't do one without the other," Larson states. "Language development, expression of ideas and concepts, and especially the communication of needs and wants is critical for education, but they cannot happen without social-emotional development." Trying to educate children without acknowledging mental health needs can stunt their learning and foster educational disparities. Larson appreciates the cyclical nature of the link between education and mental health. She understands that learning does not occur in a vacuum, nor does it happen in a linear fashion. Learning is constantly influenced by the ebb and flow of relationships. Larson calls on the work of Hart and Risley[1], which indicates the importance of early communication at home in helping children become the best possible learners and achievers in the classroom. The Safe

Schools/Healthy Students program emphasizes the need for the adults children care about to foster regular, thoughtful communication with them, particularly by asking open-ended questions, listening carefully, and valuing their opinions. For the children who participate in this type of regular communication, relationships become deeper and more comforting, and learning can happen more readily.

Another way that mental health and education interact is through common root causes. Of the children enrolled in Head Start programs in Duluth, Larson estimates that close to 15% have elevated scores on the ASQ-SE social-emotional screen. In addition, individuals from the lowest socio-economic status are three times more likely to develop a mental disorder than those from the highest socio-economic status[2]. These statistics are significant, and need to be considered when creating interventions. Larson is quick to point out that it's not all about trauma. While there are common root causes for health and educational disparities, there are also common root causes for school success, among children with mental health needs and the general population. Children with healthy concepts of communication and the tools to relay wants and needs are apt to excel in the classroom in both academic and social-emotional contexts. "Hearing language at home at an early age is vital." Larson points out that ideas must be elicited, children must be presented with choices, and challenging concepts must be explained. "Hearing language in a scattershot or negative manner is inefficient and unproductive." Rather, Larson notes that explanations and collaborative dialogue between parent and child can provide the best opportunities for success in both mental health and education.

Finally, the fourth way that mental health and education interact is in prevention and intervention. "All parents want to be good parents," believes Larson. "The earliest education of parents is best, because helping parents feel comfortable, empowered, and welcomed pays dividends in both their parenting and in their own lives." Larson says that parents involved in the Safe Schools/Healthy Students program are learning not only about their children, but also about how they can be the best parents possible, and how they can use their own skills to achieve a sense of mastery and competency in their daily lives. Larson outlines some of the features of the work in the Duluth Public Schools that are perhaps most useful:

- Accessible resources for the classroom teacher, including mental health consultants. This helps the teacher know he/she is not alone and has support to meet the needs of the children. It also increases the teacher's skills in identifying specific needs of each child, and in turn helps him/her teach the children that everyone has needs and they are all different.
- Home visits by the mental health consultant in order to observe the child in their home setting and to work with the parent-child dyad.
- Parent groups that focus on the child's behavior at home and needed social and emotional support.
- Reflective supervision with all staff. When adults who work with children can reflect on their own feelings and their responses to children's behavior, they can come up with creative ways to better work with that behavior.

REFERENCES

[1] Hart, B., & Risley, R. T. (1995). Meaningful differences in the everyday experience of young American children. Paul H. Brookes Publishing Co.: Baltimore.

[2] "Overview of Cultural Diversity and Mental Health Services." Surgeon General Public Health Service. US Government, 2009. Web. 2. Apr 2010. http://www.surgeongeneral.gov/library/mentalhealth/chapter2/sec8.html