Schools & Communities Working Together to Support Student Well-Being

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Learning Objectives

Participants will be able to:

• Describe the opportunities and challenges associated with cross-sector, community-based collaborations to build resilience and improve mental health for all students and their families.

• Identify key evaluation components to assess a multi-component, community-based project.

• List three essential strategies for promoting successful implementation of a multi-agency community-based project.
PDRP Background
The Pee Dee Resiliency Project works to prevent the long-term impact of poverty, mental health challenges and adverse childhood experiences (ACEs) by using schools as a resource and support for families.
8 elementary schools
8 mental health clinicians
1 family engagement specialist
3 partners
Who are the key players?

- 8 elementary schools in Pee Dee, SC Region
- South Carolina Department of Mental Health school mental health clinicians
- Family Engagement Specialist
- Steering Team
- Community Partners (Community Action Team, school staff, Pee Dee area businesses)
A Multi-Agency Effort

Funder:
• BlueCross BlueShield of South Carolina

Project Management and Implementation:
• South Carolina Department of Mental Health
• Pee Dee Mental Health Center

Project Evaluation:
• University of South Carolina School Behavioral Health Team

Community Training and Engagement:
• Children’s Trust of South Carolina
Noteworthy Goals

• Increased well-being of children and families
• Increased consistency and quality of caregiving practices
• Community-informed and data-driven policy recommendations will be developed
• Reduction in public costs and demonstrate a return on investment
“Adverse childhood experiences (ACEs) are traumatic events that occur in a child’s life prior to the age of 18. This adversity can harm a child’s brain and its development, which can result in long-term negative health and social outcomes.

ACEs include emotional, physical and sexual abuse; domestic violence; substance use and mental illness of someone in the household; being separated from parents, including incarceration and divorce; food insecurity; and homelessness.”
Why the Pee Dee?

ACEs

• 57-60% of adults report ACEs

Academics

• 62-82% of 3rd graders testing below state standards in English/Language Arts

Household Resources

• 28-39% of children 0-17 live in households with incomes below the poverty level

Children's Trust of South Carolina
SMH Workforce Development & Clinical Services
Goals

- Provide training in evidence-based practices to PDRP clinicians
- PDPR clinicians will contribute to prevention and early intervention efforts at tiers 1 and 2
- PDPR clinicians will participate in systems-level meetings (e.g., MTSS or SST meetings)
- PDPR clinicians will integrate into school functioning through participation in school events and activities
Clinical Services

- 8 School Mental Health (SMH) clinicians in 8 schools Pee Dee
  - One-to-One Model
- Clinicians are all Masters-level
  - Supervisors are licensed in SC
- Clinicians part of the community
  - All clinicians live within the region
  - Have familiarity with the region, the culture, and the challenges
## Clinical Services: Typical vs PDRP

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<tr>
<th><strong>Typical</strong></th>
<th><strong>PDRP</strong></th>
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<tbody>
<tr>
<td>SMH clinicians work in 2+ schools</td>
<td>PDRP clinicians work in 1 school full-time</td>
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<tr>
<td>Individual therapy for students</td>
<td>In addition to typical services, engages in school-wide activities</td>
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</table>
  - Occasionally provides family services, but not often | Tier 1 |
  - Engaging with parents/families |  |
  - Group therapies |  |
  - Social and emotional skill groups | Tier 2 |
  - Attends MTSS/SST meetings |  |
| Spends most time in the office | Attends MTSS/SST meetings |
  - Integration with school staff not emphasized | Participates in schoolwide events, mental health promotion |
Clinical Trainings

Clinical Skills
- Trauma-Focused Cognitive Behavioral Therapy (SC DMH)
- Zero Suicide (SAMHSA)
- Managing and Adapting Practice (MAP) Direct Services Training Workshop (PracticeWise)

Prevention and Promotion
- Protective Factors (SC DMH)
- PBIS (SC DMH) and MTSS (School Behavioral Health Team-USC)
- Compassionate Schools (USC Upstate Child Protection Training Center)
- ROLES Training (Community Resilience Initiative)
Clinical Trainings (cont.)

Family Engagement
- Family Engagement (Kim Becker-USC)
- Positive Parenting Practices (USC, Institute for Families in Society)
- Integrated Child and Family Care (National Council for Behavioral Health)

Cultural/Trauma Awareness
- Race Matters (Children's Trust)
- ACEs (Children's Trust)
- Significant others in women's recovery (SAMSHA)
- Motherhood (SAMSHA)
- Health Equity in Action (Children's Trust)
Professional Development

Conferences Attended

• Prevention Conference (Children's Trust)
• SC DMH Mental Health Symposium
• Southeastern School Behavioral Health Conference 2018, 2019
• SCDMH SMH Training Summit 2017, 2018, 2019
Interconnected Systems Framework (ISF)

- The ISF is a framework which integrates Positive Behavioral Interventions and Supports (PBIS) and School Mental Health
- PDRP did not have the resources for full-scale implementation of ISF
- PDRP practices however align with ISF model
  - Inclusion of SMH clinician in school team meetings (MTSS/SST meetings)
  - Increase visibility of SMH clinician to promote availability
  - SMH clinician participates in prevention and promotion activities
    - In addition to tier 3 services, Clinicians provided some tiers 1 and 2 services
PEE DEE Resiliency Project

Evaluation Plan: 2017-2020

Measuring how strategic collaboration and a focus on multi-tiered systems of support, prevention, and empowering community voice builds resiliency and improves well-being for students, families, and communities in the Pee Dee region of South Carolina.

USC School Behavioral Health Team
# Evaluation Themes

<table>
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<tr>
<th>Theme</th>
<th>Description</th>
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<tbody>
<tr>
<td>Translate</td>
<td>Translate broad aims into thematic goals &amp; measurable desired outcomes</td>
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<tr>
<td>Reduce</td>
<td>Reduce measurement burden</td>
</tr>
<tr>
<td>Monitor</td>
<td>Monitor progress on milestones</td>
</tr>
<tr>
<td>Provide</td>
<td>Provide actionable progress data</td>
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<tr>
<td>Focus</td>
<td>Focus on opportunities for CQI</td>
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Data Collection Strategy

• Quantitative data:
  • REDCap quantitative (email surveys, database forms)
  • HIPPA and FERPA compliant
  • Accessible through many universities

• Qualitative data collection:
  • Focus group and semi-structured interviews
  • Sought out feedback from parents, clinicians & school administrators
  • Recorded & transcribed for formal qualitative analyses

• Data collection challenges to consider:
  • MH system record system not built for extracting data -- clinicians not used to extra step of entering data into REDCap to evaluate clinical outcomes
  • Lack of parent engagement → incomplete data for parent-completed measures
PDRP Areas of Impact

**Community**
- Community Action Team (CAT)
- Community-based ACE/resilience trainings

**School**
- Continuum of services (MTSS)
- Trauma/ACE-informed schools

**Child Mental Health**
- Quality, evidence-based care
- One-to-one clinician model

**Family Well-Being**
- Family Engagement Specialist
- Community resource mapping
Focus today on:
- Child mental health
- Family well-being
Goal: Improve Child Well-Being & Functioning

1. Fewer students will receive office discipline referrals from PDRP schools.
2. Fewer students will be suspended or expelled from PDRP schools.
3. Students at PDRP schools will have fewer unexcused absences and tardies.
4. Student academic achievement will increase, as measured by GPA.
5. Fewer students will fail to matriculate to the next grade in PDRP schools.
6. Fewer students will be referred to more intensive mental health services (e.g., inpatient setting).
7. Students receiving mental health services will demonstrate symptom improvement, as measured by the Pediatric Symptom Checklist (PSC).
8. Students receiving mental health services will report an increase in resiliency, as measured by the Child and Youth Resilience Measure-12 (CYRM-12).
9. Students receiving mental health services will achieve a majority of their treatment goals by case closure.
10. Students receiving mental health services will demonstrate more positive behaviors at home as indicated by parent report at case closure.
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Measures: Child Well-Being

Pediatric Symptoms Checklist (PSC; Jellinek et al., 1988)

Child Youth and Resiliency Measure (CYRM-12; Liebenberg, Ungar, & LeBlanc, 2013)

Additional items for clinicians to complete at intake/case close:

- **Intake:**
  - Referral source
  - Previous treatment for emotional/behavioral concerns

- **Case Close:**
  - Number of treatment goals established and met
  - Types of EBPs used (e.g., PracticeWise, TF-CBT, psychoeducation, parenting, etc.)
  - Reason for case closure
Outcomes: Child Well-Being

• Goal: Symptoms improved, as measured by the Pediatric Symptom Checklist (PSC). **GOAL MET**
  • Pre-Post Paired sample t-test t(202)=3.7, p<.001, \(d= .27\)
  • Pretreatment Mean: 28.5
  • Posttreatment Mean: 25.2

• Goal: Resiliency increased, as measured by the Child and Youth Resilience Measure-12 (CYRM-12). **GOAL MET**
  • Pre-Post paired sample t-test, t(202)=-4.97, p<.001, \(d= .31\)
  • Pretreatment Mean: 30.4
  • Posttreatment Mean: 31.7
Outcomes: Child Well-Being

- Goal: Students receiving mental health services will achieve a majority of their treatment goals by case closure. **NOT MET**
  - 46 of 262 (17.6%) cases achieved all of their treatment goals
  - 77 of 262 (29.4%) cases achieved at least half of their treatment goals
  - 139 of 262 (53%) cases achieved none of their treatment goals

- Goal: Students receiving mental health services will demonstrate more positive behaviors at home as indicated by parent report at case closure. **GOAL MET**
  - 150 of 207 (72.4%) parents who responded reported improved home behavior at case closure
Clinical Outcomes (Post Hoc)

- Paired sample t-test on selected cases in the "at risk" or above range for general emotional/behavior risk (28 or more total score), on PSC-17
- Students who were at risk at intake showed moderate to large symptom improvement
  - $t(109)= 5.95$, $p<.001$, $d= .75$
  - Pretreatment Mean: 36.8
  - Posttreatment Mean: 29.7
Clinical Outcomes Among At Risk Students (Post Hoc)

- **Large reductions in problems with inattention**
  - $t(105)= 6.85, p<.001, d= .86$
  - Pretreatment Mean: 32.4
  - Posttreatment Mean: 27.3

- **Huge reductions in internalizing problems**
  - $t(42)= 26.83, p<.001, d= 5.44$
  - Pretreatment Mean: 6.56
  - Posttreatment Mean: 0.3

- **Moderate reductions in externalizing problems**
  - $t(108)= 5.76, p<.001, d= .65$
  - Pretreatment Mean: 9.4
  - Posttreatment Mean: 7.5
We [parent and clinician] talked to teachers together. She was at all the IEP meetings. I requested that she be there because she's a part of his life and knows a lot about him.

"Parent Feedback on PDRP Clinician"
He’s very open to come back and discuss like the therapist tells me explain this to your momma, explain that to your mom, and he's very open to talk about it. And he's excited with what he has learned as far as techniques to stay out of trouble as well.

"Parent Feedback on Child’s Experience with SMH"
I think...just that the benefits of having that person on-site and being able to work with the students in a school setting. That kind of takes away from some of the things that would be barriers or would be an issue for the parents.

School Administrator on One-to-One Model
Understanding Lower than Expected Tx Outcomes: Reasons for Case Closure

<table>
<thead>
<tr>
<th>Reason for Case Closure</th>
<th>Number of Cases</th>
<th>Percent of Closures</th>
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<tbody>
<tr>
<td>No longer needs treatment (e.g., symptom, impairment reduction)</td>
<td>34</td>
<td>14.2%</td>
</tr>
<tr>
<td>Promoted to next grade at new school</td>
<td>32</td>
<td>13.3%</td>
</tr>
<tr>
<td>Receiving treatment from community provider</td>
<td>18</td>
<td>7.5%</td>
</tr>
<tr>
<td>Parent no longer consents to treatment</td>
<td>35</td>
<td>14.6%</td>
</tr>
<tr>
<td>Insufficient family engagement in treatment (e.g., appointments missed, unable to contact)</td>
<td>47</td>
<td>19.6%</td>
</tr>
<tr>
<td>Referred to more intensive services (e.g., inpatient care, day program)</td>
<td>5</td>
<td>2.1%</td>
</tr>
<tr>
<td>No longer attending school-related to conduct</td>
<td>3</td>
<td>1.3%</td>
</tr>
<tr>
<td>No longer attending school-related to DSS involvement</td>
<td>20</td>
<td>8.3%</td>
</tr>
<tr>
<td>No longer attending school-family moved</td>
<td>32</td>
<td>13.3%</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>5.8%</td>
</tr>
</tbody>
</table>
Goal: Improve Family Well-Being

1. Students and families will receive assistance accessing community-based services and supports that address issues that impact school functioning and performance, as measured by number of Family Engagement Specialist (FES) referrals.

2. Students and families will receive community-based services and supports, as measured by the number of resource referrals given by the FES and confirmation of supports received at follow-up.

3. For a majority of students and families, the community-based services and supports they receive will adequately meet their needs.

4. Receiving community-based services and supports will reduce stress for a majority of the families referred to the FES.
Measure: FES Database

- Developed on REDCap as an integrated record/data collection system for FES position
  - Allows selective access to designated fields
- Forms for Referral, Intake, Service Provision, Follow-Up
  - Reason for Referral/Referral Source
  - Needs Assessment
  - Resources FES provided
  - Follow-up questions
    - Resources family accessed
    - Parent satisfaction with FES services (e.g., were your needs met, reduced stress)
Outcomes: Family Well-Being

• Goal: Families will receive assistance accessing community-based services and supports. **GOAL MET**
  • There were 363 cases referred to the Family Engagement Specialist.
• Families will receive community-based services and supports. **GOAL PARTIALLY MET**
  • 58 cases (51%) confirmed at follow-up that they had accessed the referred resource.
• Community-based services and supports they receive will adequately meet their needs. **GOAL PARTIALLY MET**
  • 32 cases (29%) reported that the services and supports they received adequately met their needs.
• Receiving community-based services and supports will reduce stress for families **GOAL MET**
  • 53 families (80%) reported a reduction in stress.
At first, I didn’t know about it. And then, once it became available at the school, that’s when I became more interested in it...I didn’t really want him to deal with it for my personal reasons of thinking. But I was wrong, and it was a good choice for him.

“Parent Feedback on FES Services”
We definitely need so much more family training and family support. I would love to see families come in and be involved in an activity. Learning strategies to support their kids at home, like where they’re coming in and they’re having workshops with their kids.
Overall Reflections & Strategies for Success in Your Community
Overall Successes

- Statistically significant increase in student resiliency and reduction in clinical symptoms
- 72% of students receiving services demonstrated more positive behaviors at home, per parent report
- 79% of families who received FES supports indicated that those supports reduced stress for their family
- 94% of individuals attending PDRP training events indicated that they will use what they learned to better provide consistent and quality caregiving
- 81% of individuals attending PDRP training events indicated that they will use what they learned to increase the safety and supportiveness of neighborhoods
Challengetunities We Faced

- Consistent community involvement/incentive
- Family presence in SSTs
- No MOAs/MOUs in place, keeping schools engaged and moving toward MTSS
- Building to sustainability
- Staff turnover
Strategies for Success in Your Community

1. Concentrate, then disseminate
   • Start in one district, one agency
   • Difficult to build a culture of resilience when sites are widely dispersed
   • Challenging for district or agency leadership to consistently support when policies/resources don’t apply to all staff.
2. Clear, consistent expectations: not just for PBIS kids!

- Establish MOU/MOAs with schools
- Clinician contracts should be specific to project expectations
- Create clear, detailed descriptions of tasks, responsibilities, and expected weekly time commitment for project members within team
3. Community members are experts in local needs, resources, and culture...not coalition mechanics.

- Channel good intentions with a structure for creating impact.
- Examples:
  - Practical empowerment evaluation
  - Fetterman 3 step method
  - Getting to Outcomes
  - Empower Action Model
Strategies for Success in Your Community

4. Change takes time: manage expectations & check-in frequently to document and share "small wins"

- This is where qualitative feedback & progress data can be most powerful
- Sustain motivation by being specific about goals – make sure everyone knows how to “win” each step of the way
- Make sure valued actions are reinforced
Strategies for Success in Your Community

1. Turnover happens. Prepare for it.
   - Create a manual with data collection guides & on-boarding materials for project and school-based staff (e.g., data request emails, instructions for data checks)
2. Build in time for data checks and follow-up.
   - Semi-frequent data checks & follow-up to missing data emails help acquire data while it’s still possible
   - Absolutely necessary for close-to-complete data sets!
   - PDRP checked clinician data every 2 months

Project Management Tips:

Clinical Outcome Measures:


Coalition/Empowerment Evaluation Resources:

• https://www.betterevaluation.org/en/plan/approach/empowerment_evaluation

• https://scchildren.org/resources/empower-action/