Family Service of Rhode Island

FOR BRIGHTER FUTURES

Realities: Ideas That Have Become Successful Collaborations With Schools & Other Stakeholders

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Who We Are

Our Mission: To improve the overall health and well-being of the communities we serve through high impact partnerships and high quality innovative programs.

FSRI is…

- Private non-profit
- Accredited by Council on Accreditation (COA)
- Funding through third party billing, grants and contracts
- Focused on evidence-based practices, strength-based interventions and family involvement
- Services across the lifespan

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Pillars of Service

COMMUNITY

Mobile Intake

Emergency Behavioral Health Services

Solutions Cedar

Providence Children's Initiative

Mount Pleasant Academy

Restorative Practices

AIDS Project Rhode Island

School & Community Behavioral Health Services

HEALTH

Mobile Intake

Emergency Behavioral Health Services

Solutions Cedar

Early Intervention

Healthy Families Rhode Island

Home-based Behavioral Health Services

Behavioral Health Clinics

Psychiatric Services

Children's Treatment and Recovery Center

WELL-BEING

Mobile Intake

Emergency Behavioral Health Services

Solutions Cedar

Treatment Foster Care

Family Coaching & Visitation Center

Trauma Informed Services

Evidence Informed/Based-Practices

Trauma Systems Therapy

Youth Diversion Program

Residential Services

Providence Talks

PARTERNSHIPS

Solutions Cedar

Family Care Community Partnership

Providence Police Go-Team

Victim Advocate Services at RI Parole Board

Partners IN Service

St. Joseph's Hospital

Miriam Hospital

Lucy's Hearth

Together Forever

Services in RED are either based within a school or available onsite to schools.

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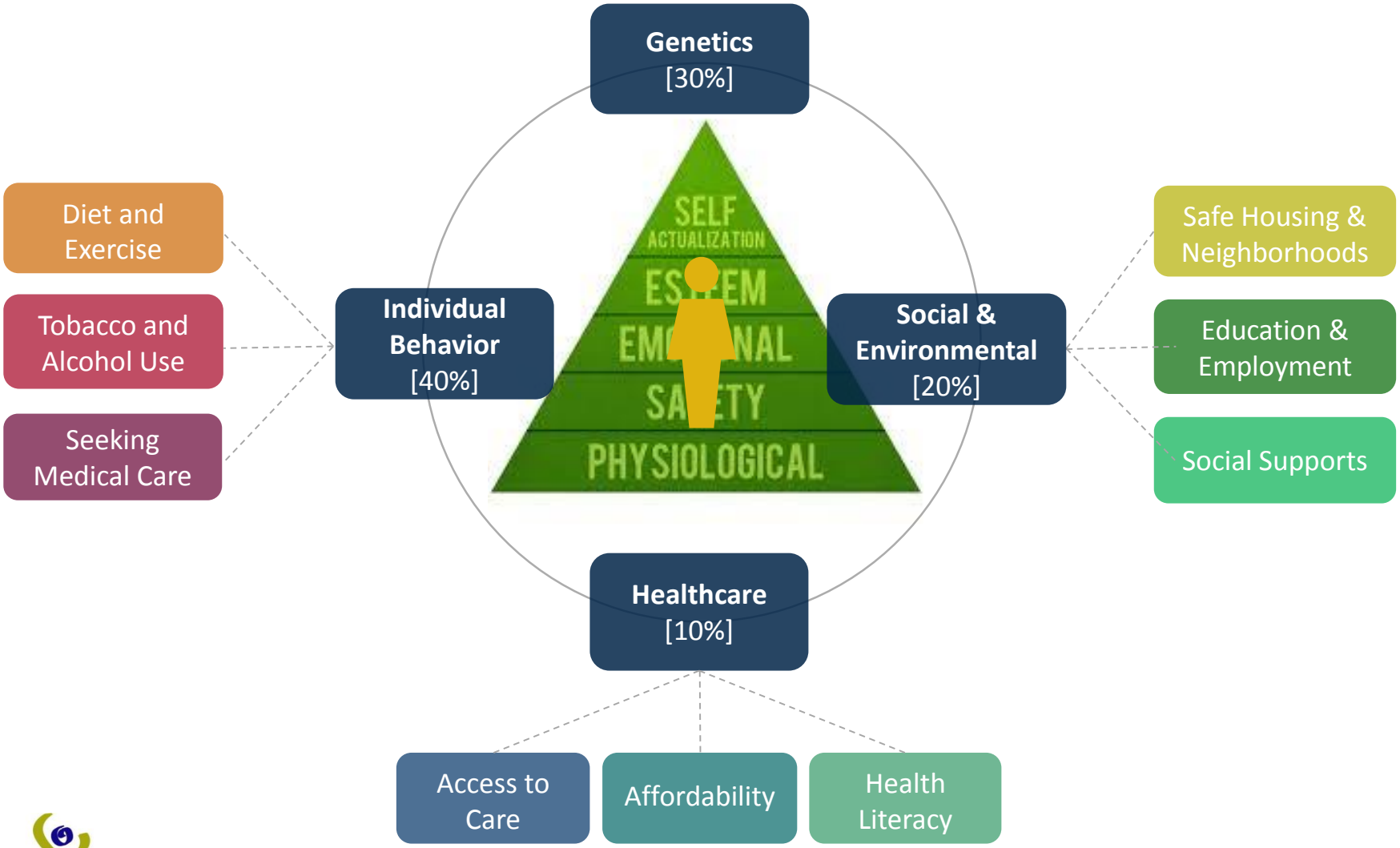
Maslow meets the Determinants



Adapted from Schroeder, SA. (2007).

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Non-Profit Agency - School Pedagogy

FSRI programs acknowledge and responds respectfully to individual school culture as well diverse student populations throughout Rhode Island.

Culturally Responsive Pedagogy:

- **Institutional**: Understanding school specific administration, operational policies and values. Develop a working knowledge of school specific culture.
- **Personnel**: Examine faculty attitudes and beliefs toward themselves, students and families/communities. Assist in staff development when applicable.
- **Student Population**: Acknowledge the diverse student population and sub-populations within each individual school and provide evidence informed services which may be applicable or adaptable as appropriate.

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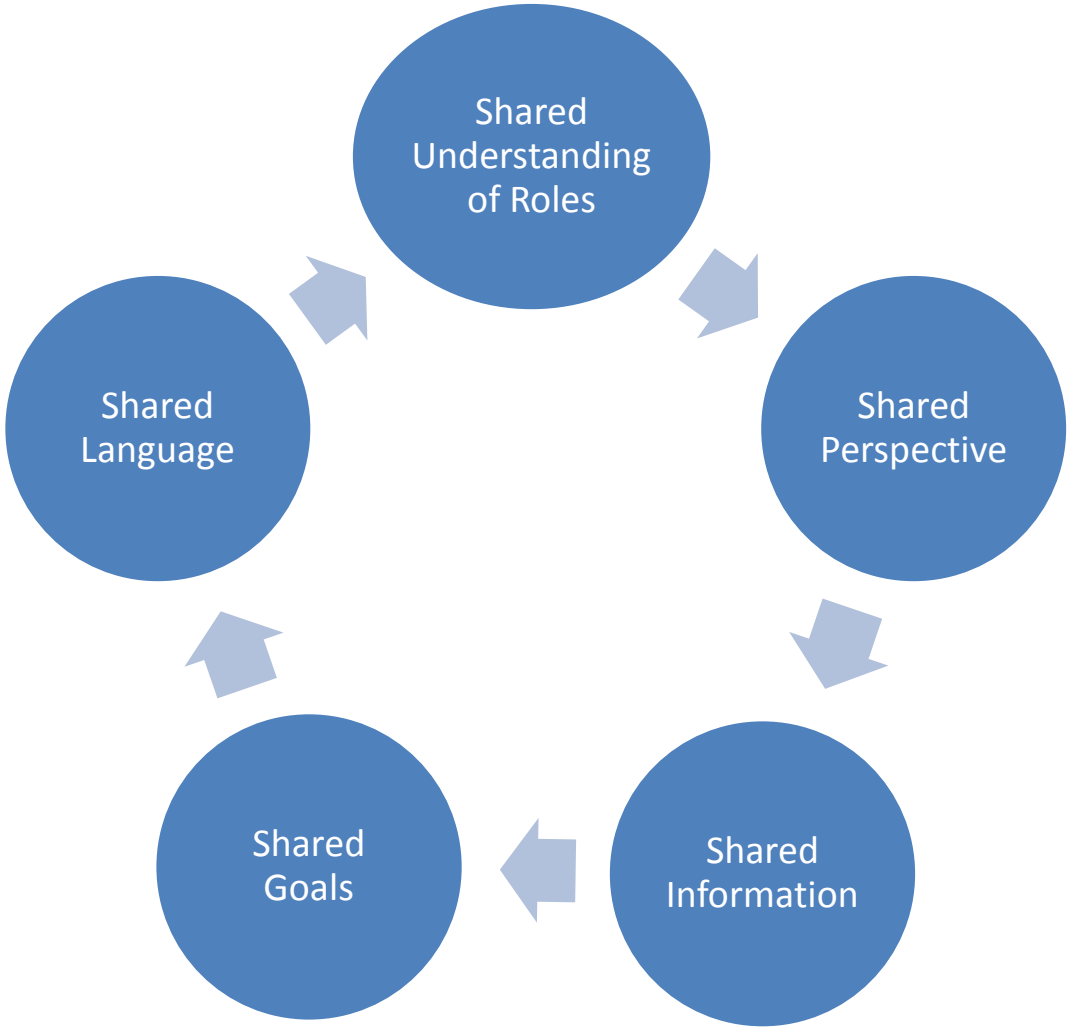
Collaborative Culture

- What it takes to achieve a collaborative culture



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Building Collaborative School Culture & Address Wellbeing

- Consolidate access points and responsible persons.
- Provide trauma informed training to all staff, both agency and school: effects of trauma on the brain, trauma response, trauma reactive behaviors. Create a common language.
- Include Restorative Practices through all interactions both with staff and students. Make it a part of the culture. Create a common language.

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How we combine Restorative, Emergency Service and Trauma Informed Treatment to affect collaborative services.

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Collaborative Services

1. Restorative Practices

2. Emergency Services

3. Trauma Informed Treatment

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Statewide Data

- In RI as of June 30, 2015, 20,800 students in public schools ages six to 21 received special education services (15% of all students).

- In the 2013-2014 school year, 9% of RI student population was suspended from school. Suspension is linked to poor outcomes, including a higher likelihood of dropping out of school. Dropping out is in turn linked to poor lifetime outcomes.

- In 2012-2013, Rhode Island ranked 34th nationally in high school graduation rates (with 1st being the highest rate, and 50th being the lowest rate), and was the lowest ranked State in the Northeast.

- The dropout rate in 2014 was 8% Statewide, but over 14% in the four poorest and largest cities.

- Throughout RI PARCC assessments were first implemented in 2014-2015 school year and revealed the following:
  - 17 schools (6%) were classified as "Commended"
  - 11 schools (4%) were classified as "Focus"
  - 21 schools (8%) schools were classified as "Priority"
  - Schools designated as "Priority" or "Focus" schools were identified for intervention.

1. Restorative Practices

The fundamental hypothesis of **Restorative Practices** is that…

"human beings are happier, more cooperative and productive, and more likely to make positive changes in their behavior when those in positions of authority do things ***with*** them, rather than ***to*** them or ***for*** them"

(McCold, 2014)

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1. Restorative Practices Concepts

Helping Students, Schools, Families, and the Community to:

Build/Connect Relationships

- Builds and encourages prosocial behaviors

Repairing Any Harm Done

- Use of circles to facilitate resolution

Making Things Right Whenever Possible

- Implementing actions to right the wrong

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2. Emergency Response System

- Clinical providers with ability to diagnosis, safety plan and access appropriate level-of-care
- Insurance funded reimbursable service
- Certified state Child Welfare provider
- School and community evaluations
- Urgent (same /next day) and Emergency (within 2 hours)
- Emergency available in-person and onsite within 2 hours (English and Spanish)
- Focused on immediate and ongoing safety concerns
- All cases are provided safety planning
- Able to access all levels of care (including inpatient services)
- Diagnostic ability
- Staff are trained to support schools while addressing dysregulated behaviors

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Statewide Data

- Rhode Islander's age 6-17, one in five (19.0%) children has a diagnosable mental health problem; one in ten (9.8%) has significant functional impairment.

- In 2015, 22% (26,930) of the children under age 19 enrolled in Medicaid/RIte Care had a mental health diagnosis, including but not limited to anxiety, alcohol/drug dependence, psychoses as well as depressive, mood, and personality disorders. Of those children:
  - 29% were ages 6 and under
  - 34% were ages seven to 12
  - 37% were ages 13 to 18

2016 Rhode Island KIDS COUNT Factbook

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Emergency Response System

Statewide Data

- In 2014, RI saw a 53% increase of children hospitalization since 2005, with a primary diagnosis of a mental disorder. Of those children hospitalized in 2014:
  - 74% were ages 13 to 17
  - 50% had Medicaid/Rite Care coverage
  - 47% had commercial coverage.

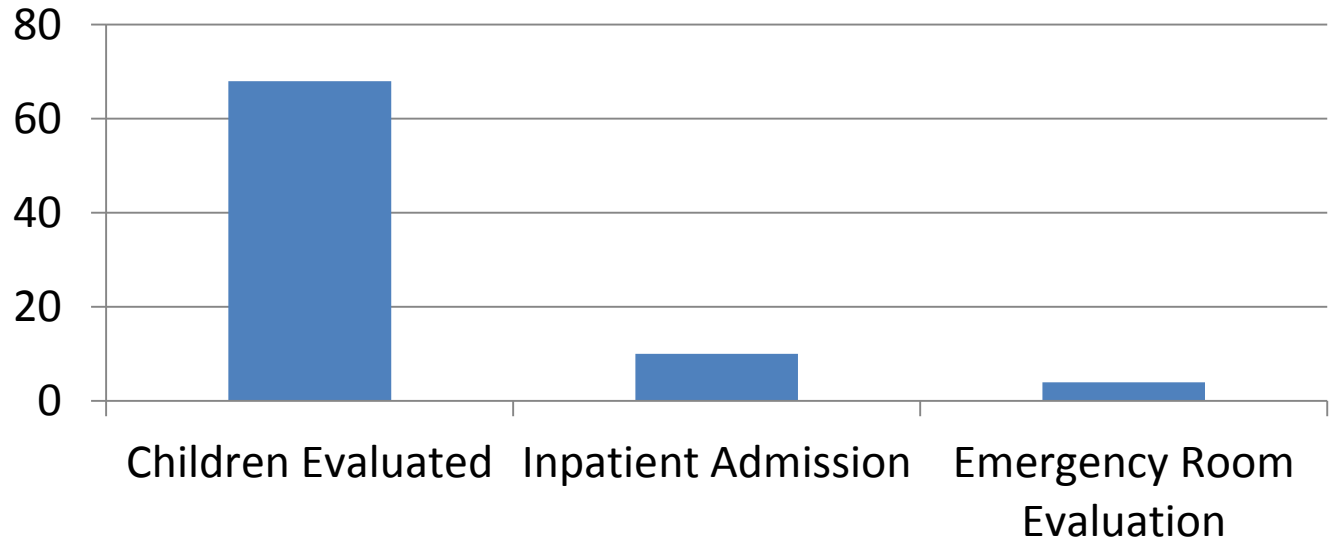
- In 2015, 91% of the mental health related emergency department visits for children under age 19 did not result in a hospitalization.

- In 2015, 11% of Rhode Island high school students reported attempting suicide one or more times during the past year, down from 14% in 2013.

2016 Rhode Island KIDS COUNT Factbook

Emergency Response System Data

- Lower rates of hospitalization according to a leading insurance provider: 1 out of 218 in 2 quarters. This is far below the State benchmark of 60%.
- Of **68** children seen for emergency evaluation in 2013, only **10** were admitted to inpatient level of treatment. (14%). Of the 10 only **4** were seen in an Emergency Department for further evaluation.
- Of the children treated in the TST services over the past year* less than 10% required a higher level of care at discharge.



3. Trauma Informed Treatment

- FSRI partnerships in 30+ RI's school to allow space for school-based counseling.

- Onsite clinical services developed over the past 9 years, with new schools added each year.

- Insurance funded services.

Trauma Systems Therapy (TST)

- New York University, Langone Medical Center
- National Children's Traumatic Stress Network (NCTSN)
- A systemic approach to treating

NCTSN The National Child Traumatic Stress Network

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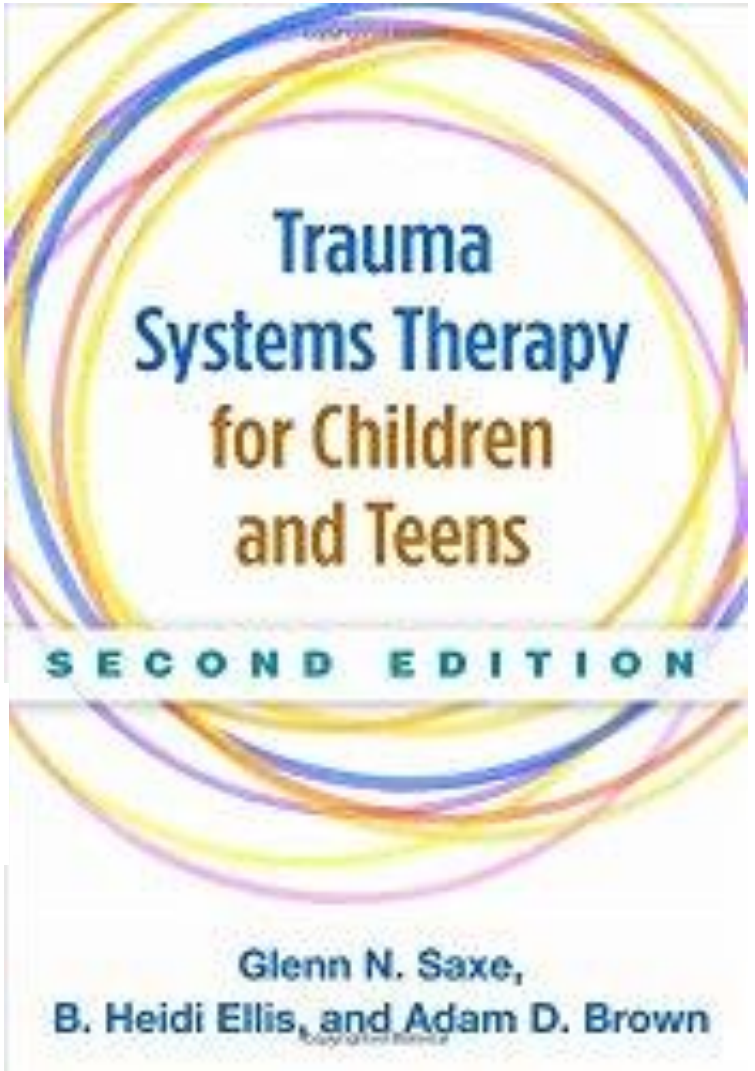

Trauma Systems Therapy

Why it works:

- Turns the conversation language from negative to normative
- Inclusive of the whole child
- Common language
- Ability to work with multiple systems concurrently

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Presented below are the results of a series of repeated measures t-tests conducted on Child Ecology Check-In (CECI) and Child Stress Disorders Checklist (CSDC) scale scores of TST Community Based clients. Our goal was to identify any significant changes in scale scores across time.

Community Based: $T_1 - T_2$ Comparisons

Measure	n	T_1 Mean	T_2 Mean	*p*	Interpretation
Emotion Regulation Score	68	5.60	5.01	**.002***	CECI Emotion Regulation scale scores significantly decreased from Time 1 to Time 2, t (67) = 3.30, *p* = .002.
Behavioral Regulation Score	68	5.34	4.60	**.001***	CECI Behavioral Regulation scale scores significantly decreased from Time 1 to Time 2, t (67) = 3.52, *p* = .001.
Caregiver Score	68	5.53	5.10	.106	CECI Caregiver scale scores did not significantly change from Time 1 to Time 2.
Service System Score	68	4.65	4.26	.089	CECI Service System scale scores did not significantly change from Time 1 to Time 2
CSDC-CV Total Score	22	25.41	22.50	.318	CSDC-CV Total Scores did not significantly change from Time 1 to Time 2.
CSDC-OV Total Score	34	17.26	15.68	.416	CSDC-OV Total Scores did not significantly change from Time 1 to Time 2.

Community Based: $T_2 - T_3$ Comparisons

Measure	n	T_2 Mean	T_3 Mean	*p*	Interpretation
Emotion Regulation Score	35	5.20	4.34	**.001***	CECI Emotion Regulation scale scores significantly decreased from Time 2 to Time 3, t (34) = 3.69, *p* = .001.
Behavioral Regulation Score	35	4.91	4.20	**.037***	CECI Behavioral Regulation scale scores significantly decreased from Time 2 to Time 3, t (34) = 2.169, *p* = .037.
Caregiver Score	35	5.43	4.03	**.005***	CECI Caregiver scale scores significantly decreased from Time 2 to Time 3, t (34) = 3.04, *p* = .005.
Service System Score	35	4.40	3.94	.118	CECI Service System scores did not significantly change from Time 2 to Time 3.
CSDC-CV Total Score	7	18.57	10.00	**.030***	CSDC-CV Total Scores significantly decreased from Time 2 to Time 3, t (6) = 2.84, *p* = .030.
CSDC-OV Total Score	14	13.57	10.43	.299	CSDC-OV Total Scores did not significantly change from Time 2 to Time 3.

Community Based: $T_1 - T_3$ Comparisons

Measure	n	T_1 Mean	T_3 Mean	*p*	Interpretation
Emotion Regulation Score	36	5.69	4.36	<**.001***	CECI Emotion Regulation scores significantly decreased from Time 1 to Time 3, t (35) = 4.93, *p* < .001.
Behavioral Regulation Score	36	5.56	4.22	<**.001***	CECI Behavioral Regulation scores significantly decreased from Time 1 to Time 3, t (35) = 4.29, *p* < .001.
Caregiver Score	36	5.53	3.92	**.005***	CECI Caregiver scores significantly decreased from Time 1 to Time 3, t (35) = 3.03, *p* = .005.
Service System Score	36	5.00	3.92	<**.001***	CECI Service System scores significantly decreased from Time 1 to Time 3, t (35) = 3.99, p < .001.
CSDC-CV Total Score	7	22.57	10.00	**.057***	CSDC-CV Total Scores significantly decreased from Time 1 to Time 3, t (6) = 2.35, *p* = .057.
CSDC-OV Total Score	14	12.93	10.43	.495	CSDC-OV Total Scores did not significantly change from Time 1 to Time 3.

More than just Buzz Words & Lessons Learned

- **Urgent** appointments
- **Immediate** response to referral source
- Same day **outreach** to families
- Available clinicians for **onsite/ in-person crisis evaluation** within 2 hours of request
- 24/7 **Clinical support** to clients and their families
- **Trauma informed** staff at all points of contact
- **Systemic** approach (TST) to trauma treatment. Staff trained in system change.
- **Evidence based/informed** trauma treatment
- Trauma **training** for school staff and community providers
- **Consolidated** point of contact for questions or concerns
- Centralized intake process for **'one stop shopping'**
- **Knowledgeable** staff for support and education
- Ongoing **Care Coordination** available to collaborate efforts across multiple providers

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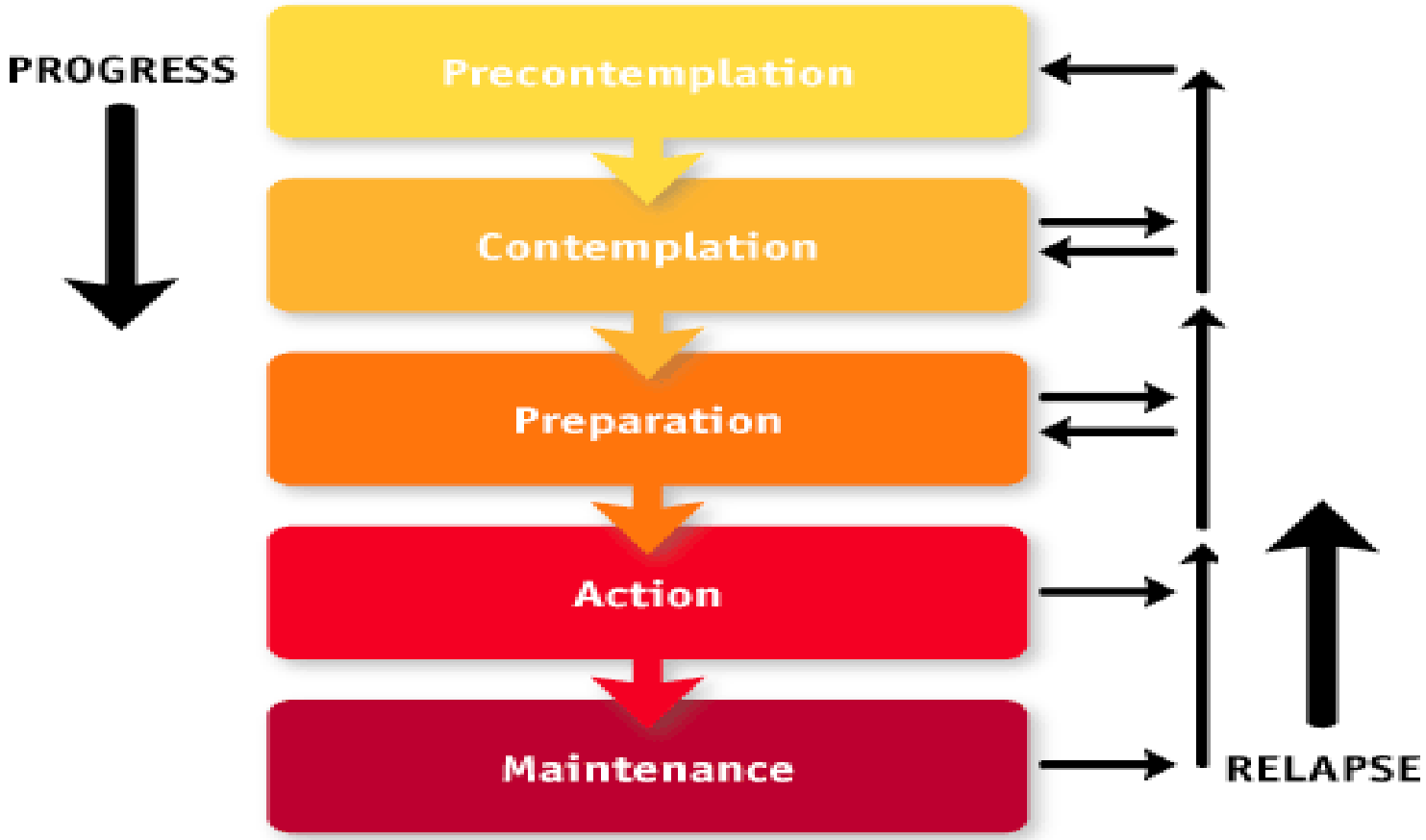
Collaborative Culture.
A commitment to change.



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http://www.addictioninfo.org/articles/11/1/Stages-of-Change-Model/Page1.html

THANK YOU

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