Engaging Families in School-Based Mental Health Services

Karen Mitchell-Oliver

South Carolina Department of Mental Health

Charleston/Dorchester Mental Health Center

February 1, 2020

Table of Contents

	Topic:	Page:
I.	Introduction to SCDMH	3
II.	Problem Statement	3
III.	Data Collection	5
IV.	Data Analysis	6
V.	Implementation Plan	11
VI.	Evaluation Method	14
VII.	Summary and Recommendations	14
VIII.	References	16
Appendix A:	Definition of Acronyms	17
Appendix B:	Service Codes Billed at our Center	18
Appendix C:	Survey Questionnaire	19

Introduction

The mission of the South Carolina Department of Mental Health is to “support the recovery of people with mental illness” (SCDMH website). The South Carolina Department of Mental Health is comprised of 17 community mental health centers, 3 nursing homes and 6 inpatient psychiatric facilities. Our first school-based mental health services was implemented in Simpsonville, SC in 1993 at Bryson Middle School. Over the years, the South Department of Mental Health has been recognized as the leading School Mental Health Services provider within our state. (SCDMH website)

Problem Statement

According to Centers for Disease Control and Preventions 1 in 6 U.S. children, aged 2–8 years (17.4%), had a diagnosed mental, behavioral, or developmental disorder.

Although we have Charleston/Dorchester Mental Health Center clinicians that are stationed at all of the schools (within three school districts), police departments, 911 centers, and hospitals, engaging families into mental health treatment overall remains a challenge.

Our school-based mental health services have full time Masters level clinicians embedded in Charleston County School District, Dorchester District Two and Dorchester District Four school districts. Our center provides a variety of evidence based services intended to be strength-based, trauma-informed, family-driven, and respectful of the culture and preferred language of the youth and families. Some services provided are individual, family, group therapy, crisis intervention and assessments. All of the services provided are documented and billed according to agency protocols.

This year at the Charleston/Dorchester Mental Health Center we have 75 school-based clinicians providing therapy in over 118 schools. The process to receive school-based services starts with a referral. A referral is submitted by a parent, guardian, teacher or other school staff member. Once the referral has been received, our school based counselor reviews the referral information to determine eligibility for services. The parent/guardian will be contacted by the school based clinician to schedule an intake, which includes a comprehensive clinical assessment to determine appropriate course of treatment. Mental health services are provided in a private setting at the assigned school or at the clinic when necessary.

As a former school based clinician, some of the benefits I observed having a counselor stationed at schools included: removal of barriers such as transportation, decreased school suspensions and reduction in the stigma of receiving mental health treatment. Another benefit of having school-based clinicians stationed at schools relates to making it easier to engage family to participate in treatment. However, more families are not participating in their child's mental health treatment.

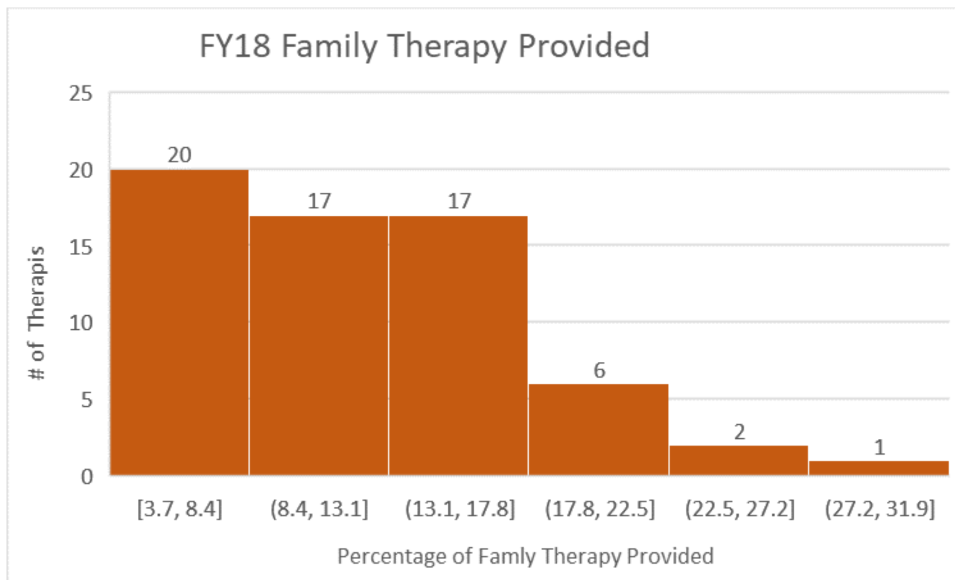
SCDMH believes family participation in treatment is essential to the recovery process. To ensure we support the recovery of people with mental illness, our school-based clinicians are rated on providing 20% of family therapy within their EPMS review period. Providing 20% of family therapy has been difficult to reach with majority of our school-based clinicians over the past couple of years. This project was selected to explore ways to improve family engagement in treatment and determine barriers and strategies to increase family engagement with patients 18 and under.

Data Collection

I obtained data from management information systems Crystal database. The first report is titled Summary of Appointments of Family Therapy scheduled with staff and date prompts. This report highlights school based clinicians' total number of family therapy provided from July 1, 2017 to June 30, 2019. The finding from this report will provide a breakdown of percentage of family therapy provided each fiscal year. This report also shows where family therapy ranked with the other services provided within the center and shows us how we compared to the 20% family therapy goal we have in place. The survey questions provided to school-based team will provide more insight on school based clinician's thought processes and motivation towards family engagement. Refer to Appendix C.

The last data collection method used for this project involved contacting several school based coordinators at other Mental Health Centers to determine how family therapy/engagement is achieved within their center.

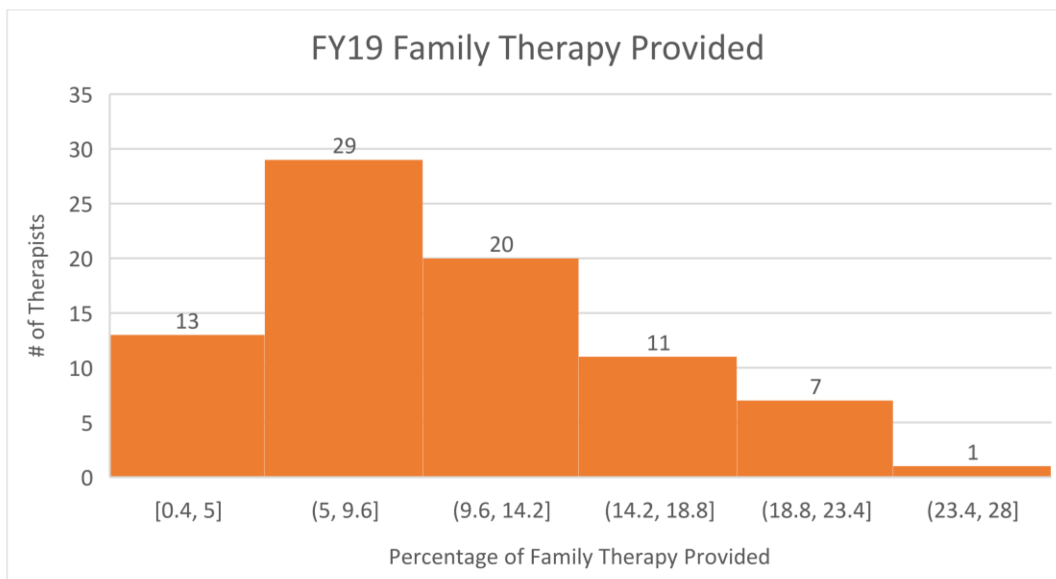
Data Analysis



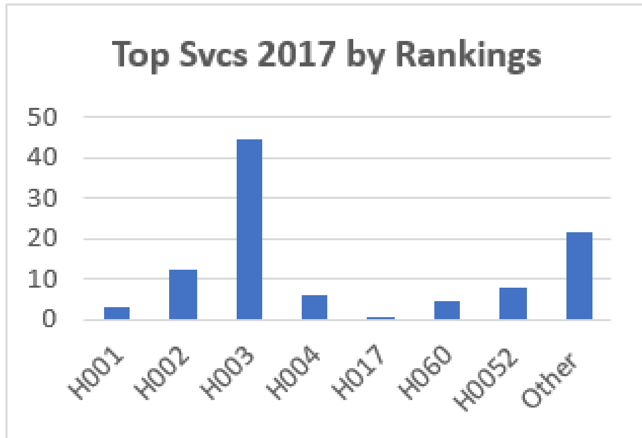
This graph shows a breakdown of family services provided at our center in fiscal year 2018. In FY2018, we had 63 school-based clinicians providing family therapy. This reports shows 32% of clinicians provided a range of 3.7-8.4 percent of family therapy. The second column shows 27% of school based clinicians provided a range of 8.4-13.1 percent of family therapy. Only 9 out of 63 (14%) school based clinicians billing family therapy provided 17.8 percent or higher.

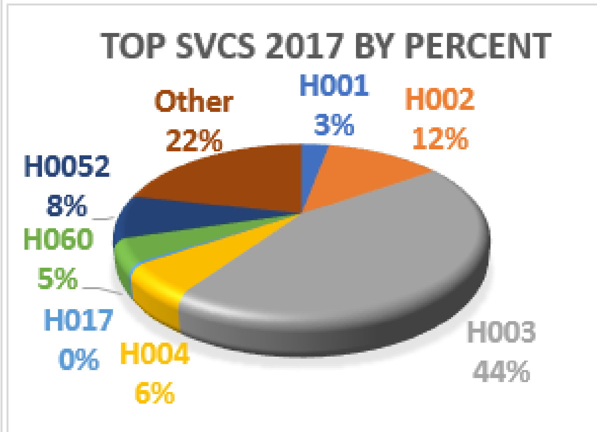
Some of the trends I noticed were that all nine school based clinicians that provided 17.8 % or higher were stationed at elementary schools. The clinician that scored 28.6, served on my school based team for 4 years. She definitely had a great rapport with the school, she was approachable and provided a lot of psychoeducation, empowering and validation to the families and school she served. The clinician that scored 25.3 percent has been a fixture at her school for over 6 years and has a great rapport with her schools and participated in anti- stigma events in the school community. Clinician C that scored 27.2 provides Parent-Child Interaction

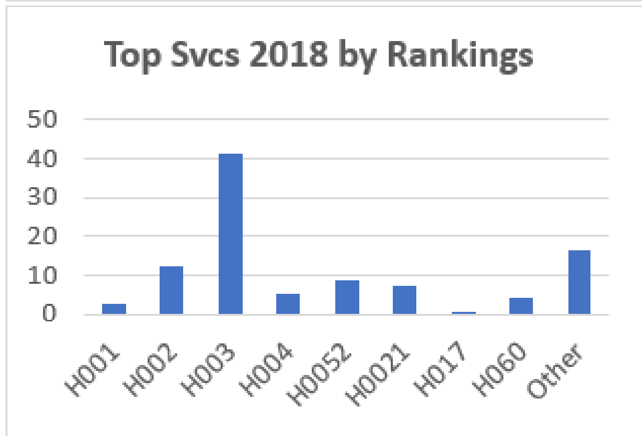
Therapy (PCIT). PCIT is a Parent-Child Interaction Therapy is a proven parent-child treatment program for parents who have children with behavioral problems such as aggression, temper tantrums and defiance. This evidence based practice focuses on promoting positive parent-child relationships and interactions. Clinician C is the only clinician providing this evidence based practice within our center and has proven to be effective with improving and increasing family participation in treatment.

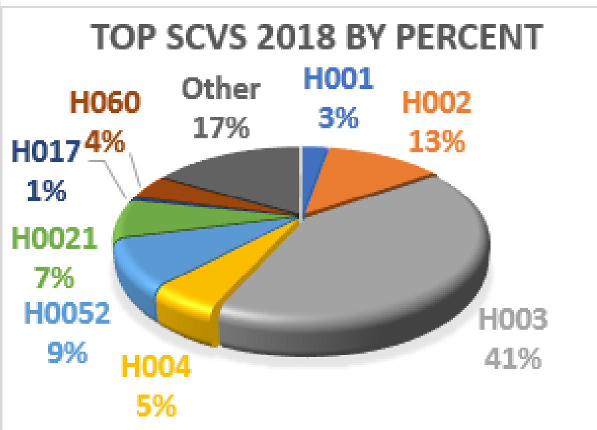


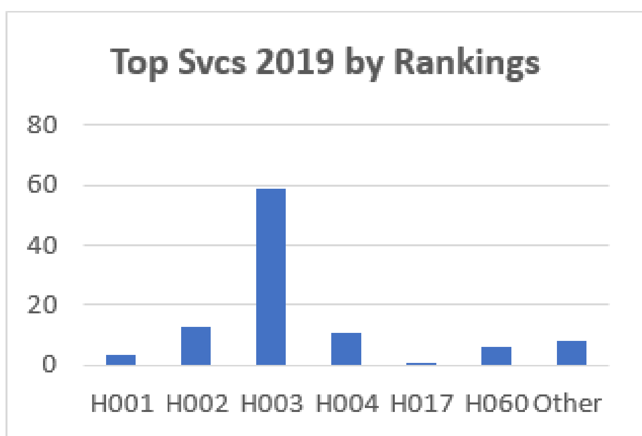
In FY2019, we had a total of 81 clinicians billing family therapy compared to 63 school-based clinicians in FY2018. In FY2019 we expanded our school based services by hiring more school based clinicians to meet the need of the contract. Out of the 81 clinicians only one clinician reached 23.4% out of the required 25% EMPS rating in FY2019. 36% of the clinicians provided 5-9.6% of family therapy and only 9% of therapist provided 18% and above towards family therapy.

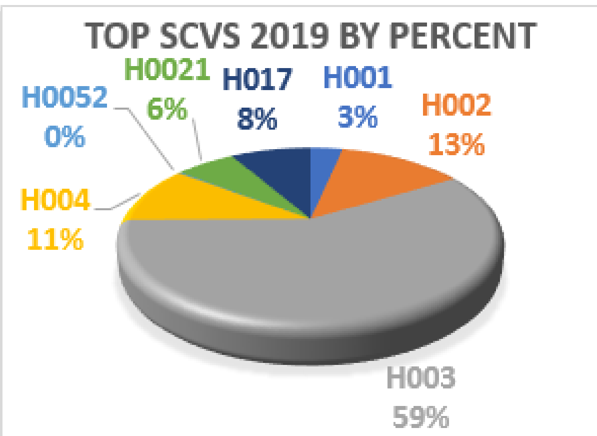












These graphs shows how family therapy (HOO4, see Appendix B) ranked with other services we provide in the center. In FY2018 family therapy ranked number 5 of total services provided. Individual, assessment, PMA and Nursing Services were the top billable services. In FY 2019 out

of 14 billable services provided by our center, family therapy ranked number three. In 2019, we hired more school-based clinicians resulting in more services being provided. Our center increased our school contract to include 4 rural schools, 3 of them are elementary schools.

Interviews/Questionnaire

I distributed questionnaires to 53 school-based clinicians. 41 out of the 53 responded to the questionnaire. According to the surveys, 39 school-based clinicians reported 20% of providing family therapy was not achievable. Some common themes to survey question #3 as it relates to barriers school-based clinicians encounter were:

- For parents who are employed, it is difficult for them to attend sessions during school and work hours therefore I spend several evenings beyond works hours meeting with families.
- I feel like you should work with my kid, he has the issue.
- I have to come to school meetings and meet with you too? This is too much!
- I don't have transportation.
- I'm the grandmother, I shouldn't have to come in.
- If they aren't in trouble, why do we have to meet

According to the survey, some strategies identified to improve family therapy focused on providing more training on engaging, and empowering families to participate in treatment. Families are more likely to keep in touch by phone. Conducting family sessions by phone was a theme throughout the survey. Most clinicians expressed level of stress parents encounter when having one more appointment added to their already hectic lives. According to the survey,

providing more home based therapy should be an option if our center consider working a flex schedule.

Another theme presented throughout the survey was providing a family group once a month for parents struggling with ways to manage behaviors at home. This group will allow parents, who may be experiencing some of the same behavioral issues with their child, to feel supported. This may increase more family involvement in treatment.

I also interviewed four school-based clinicians stationed at an alternative behavioral school and they all agreed families are more likely to seek treatment in times of crisis. One of the clinician shared she received more referrals for treatment after the client has been expelled or recommended for expulsion than any other time.

I contacted several school-based coordinators from other mental health centers to determine how family therapy is achieved within school-based services. The coordinators shared family therapy is not listed on staff EPMS but is monitored closely in supervision when reviewing caseload. I interviewed a Quality Assurance director at another center and she shared in the past they used an engagement specialist to engage families. The engagement specialist contacted and scheduled patients based on information provided by school-based therapist. School-based therapist identified families that needed to be engaged in treatment, engagement specialist contacted the family, identified barriers and scheduled an appointment for the school based clinicians.

Implementation Plan

1) Several clinicians inquired in the survey, whether providing family therapy via telepsychiatry should be an option for families that have technology at home. The tele-psych software has been placed on all our school-based clinicians' laptops and is easily accessible. In order for tele-psych to be effective, we have to equip all of our families with tele psych software on their personal computer at home with internet access. This plan would be unfeasible and expensive. However, Skype could be a potential resource in the future.

2) Our school-based clinicians are fully responsible for all the paperwork at their school, to include all intake paperwork: insurance verifications, signing of all intake documents, etc. Based on the increasing school-based referrals and caseload sizes, I recommend hiring a school-based admin staff to reduce the workload for each individual school based clinician to promote family engagement. Hiring additional support staff will allow school-based clinicians to focus on family engagement and providing therapy. The admin staff will support school-based clinicians with opening cases, verifying insurances, making reminder calls of upcoming family therapy appointments, monitoring transportation services and providing feedback to help ensure the efficiency of the provision of services. Some of the strategies our center has adopted to promote engagement are using reminder letters and phone calls. We have a reminder call system already in place that reminds our patients of upcoming appointments three days in advance. Once approved by key stakeholders, the average salary for an administrative specialist would be around $37,100.00 including fringe. Ideally, the

onboarding and training of admin staff will happen two months before school starts to acclimate them to the school-based environment and protocol. Some obstacles that I may encounter is shifting admin support from being supervised by an administrative coordinator to a clinical supervisor. I spoke with our key stakeholders and they already approved to hire an admin specialist to our center and will look into changing supervision to a clinical team.

3) I also recommend scheduling family therapy appointments in advance during the face to face intake session and on a monthly basis. Most of our clinicians schedule family session on a hit or miss basis. For example, if the parent shows up at the school for a meeting and have time for a family session it gets scheduled. This will eliminate barriers, such as transportation issues, and child care issues. Our center recently partnered with CirYoulation therapeutic transportation services to provide free, safe and reliable transportation to our center for treatment. This transportation service will start in February 2020. The budget set aside for this service is $3,000.00 this fiscal year. Some potential obstacles for using this transportation services are that the funds will be exhausted before the end of the fiscal year. We currently serve 6 schools located in the rural area of St. George. This transportation can be used to take parents to local schools for family sessions. I also anticipate a higher use of this transportation during the summer months. Some methods to overcome this issue will be to monitor on a biweekly basis the usage of this services, assigned to the administrative specialist. Another potential transportation resource our families will benefit from is Logisticare transportation services. Logisticare offers transportation services for families that are

Medicaid approved. The potential obstacles with Logisticare is all appointment have to be made three days in advance. We currently have a manager that serves as our Logisticare liaison. After meeting with our Logisticare liaison, it will be impossible for us to change the three day notice to two day notice because of the agreement with Medicaid. Communication with key holders will be considered in the future. One of the job duties of the new admin staff will be to monitor usage of transportation funds and request for funds as needed to her supervisor.

4) All of our school-based clinicians are trained in Motivational Interviewing (MI) within three months of being hired. Motivational Interviewing is an evidence based technique that helps address barriers to change. Research indicates that "MI skills, when used throughout supervision, can increase compliance with treatment, reduce violations, reduce recidivism and improve outcomes. MI is one of the many tools that can be helpful when working with families who are reluctant to change" (Dowden & Andrews, 2004). In my experience, most parents think the client is the only person that needs to be treated. I have heard many times, "my kid has the problem not me". Moving forward, we need to use the MI trainings we already have and focus these techniques on increasing family engagement. Providing a training focused on family engagement and attending consults to this resource will not cost us anything, just changing the way we do business. Our center has a Staff Training and Development/Zero Suicide Coordinator who specializes in bringing new evidence based trainings to fit the needs of our patients. I met with her and she agreed we can tailor MI techniques to increase family engagement.

Evaluation Method

The provision of family therapy will be tracked by generating monthly family therapy reports to determine if clinicians are tracking towards the annual goal. School-based clinicians will be surveyed at our scheduled quarterly school-based meeting about progress and barriers towards reaching family therapy goals. This information will be shared with our administrative specialist and executive management team for tracking purposes. The success of Motivational Interviewing (MI) technique will be measured by a readiness ruler. This self-evaluation tool assesses individuals' readiness to change towards engaging in treatment.

Summary and Recommendations

Creating a platform to allow staff delivering the services to share their input with this project was essential to understanding the importance of family engagement and barriers. Based on the data, our center is providing an average of 10.5% family therapy. In FY17-18, we provided 5.9% of family therapy services and increased in FY18-FY19 to 10.5%. Overall, this data proved that is not likely that school based-clinicians will be able to achieve the required 20% family engagement goal per current EPMS standards. Based on the survey findings, I recommend decreasing family therapy goal from 20% to 15% to make it more achievable. Future EPMS should reflect the family therapy change from 20% to 15% family therapy immediately.

Despite the challenges school-based clinicians encounter, all of our clinicians have a "whatever it takes" attitude when it comes to engaging family in treatment. It is important to help everyone in our organization and community partners to understand how family engagement impacts our mission statement and provide the necessary tools to increase family engagement.

I received an overwhelming response from the school based surveys to utilize technology as a means to increase family engagement. Most of the school based counselors we hired in the past three years are Millennials, and they live their lives communicating through text, and FaceTime. I strongly recommend our state agencies to adapt to the needs of the new generations and change the way we do business.

References

South Carolina Department of Mental Health Website. www.scdmh.org

Centers for Disease Control and Prevention

Retrieved from https://www.cdc.gov/ncbddd/index.html

Dowden, C. and Andrews, D.A. 2004. *The Importance of Staff Practice in Delivering Effective Correctional Treatment: A Meta-Analytic Review of Core Correctional Practice.* Inter-national Journal of Offender Therapy and Comparative Criminology 48(2):203-214.

Appendix A: Definition of Acronyms

CDMHC- Charleston Dorchester Mental Health Center

SCDMH- South Carolina Department of Mental Health

PCIT-Parent-Child Interaction Therapy

FY-Fiscal Year

Tele-psych- Tele-psychiatry Services

Appendix B: Service Codes School Based Counselors Billed at our Center

H001 Crisis Intervention

H002 Assessment

H003 Individual Therapy

H004 Family Therapy

H017 Service Planning and Development

H021 Nursing Services

H052 Subsequent PMA's with Psychiatrist

H060 Service Planning and Development Interdisciplinary Team

Appendix C

Family Engagement Questionnaire School Based Clinicians

1. Do you think 20% is an achievable number for family therapy?
   YES NO

2. Based on your last EPMS rating, did you meet the 20% family therapy goal?
   YES NO

3. What are some of the barriers you encounter when scheduling family therapy?

4. Overall, what are some strategies we can use to increase family engagement?