Using CANS to Reduce Truancy & Absenteeism

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October 4, 2018

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PRESENTATION OUTLINE

1. SCHOOL ENGAGEMENT PROGRAM (SEP)

- Program Description & Purpose
- Demographics

2. CANS CONTRIBUTIONS

- Identifying CANS Trends to Inform and Facilitate System Changes
- Case Studies

3. FINAL THOUGHTS

- Lessons Learned/Plan for Improvement
- Questions

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PROGRAM DESCRIPTION

- School Engagement Program (SEP) is a partnership between Contra Costa County Truancy Court, Contra Costa County Behavioral Health & Lincoln
- Each family has a team of a Clinician & Community Liaison working with them from Lincoln
- All referrals are from the District Attorney/Truancy Court
- Funded by Contra Costa County Behavioral Health

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CONTRA COSTA COUNTY DEMOGRAPHICS

- 2015 population was 1.1 mil, with 10.2% in poverty
- All SEP participants are below 138% of Poverty Guideline
- 180,000 enrolled in K-12(17/18)
- K-12 truancy rate 38.9%(15/16)
- Ranked 46th out of the 58 counties in California in highest truancy rates(15/16)

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Source: U.S. Census Bureau, Contra Costa County, California Department of Education, Contra Costa Grand Jury

CONTRA COSTA COUNTY DEMOGRAPHICS

Ethnicity	County	Schools	Program
African American	8%	9%	40%
Asian American	15%	17%	0%
Hispanic/Latino American	25%	36%	13%
Native Hawaiian	0.5%	-	0%
Native Indian/Native Alaskan	0.3%	0.3%	0%
Two or More Races	4%	6%	20%
White	46%	31%	27%

Source: U.S. Census Bureau, Contra Costa County, California Department of Education, Contra Costa Grand Jury

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PROGRAM RATIONALE

- Truancy & absenteeism is an enormous problem in CCC
- Being absent from school in the early elementary years frequently leads to academic struggles
- Students who do not learn to read by 3rd Grade are 4 times more likely to drop out of high school
- More than 80% of prison inmates were truant or chronically absent when students
- Financial cost to State education system in 2015 was $36 million

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Source: Contra Costa Grand Jury Report 1615

SCHOOL ENGAGEMENT PROGRAM TREATMENT HYPOTHESES

I. Truancy is invariably a symptom of other challenges happening with the student and family.

II. The families in SEP tend to be isolated from both natural supports and the limited community resources that do exist.

III. The most pressing task at intake is assessment and fulfillment of unmet family needs that impede the student attending school.

IV. Underlying issues cannot be addressed through psychotherapeutic intervention until after family has reached a threshold of basic needs being met and crisis issues becoming stabilized.

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SEP TREATMENT MODEL
(12 - 15 MONTH TREATMENT CYCLE)

Phase I – Family Engagement & Intensive Case Management

Phase II – Intensive Therapeutic Intervention & Community Engagement

Phase III – Transition

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PHASE I

FAMILY ENGAGEMENT & INTENSIVE CASE MANAGEMENT (1-3 MONTHS)

1. Build therapeutic relationship
2. Assess family's needs
3. Stabilize and address immediate needs and issues
4. Ensure school meets youth's needs
5. Connect family to resources
6. Develop support network for family
7. Develop collaborative treatment plan

PHASE II

INTENSIVE THERAPEUTIC INTERVENTIONS & COMMUNITY ENGAGEMENT (7-9 MONTHS)

1. Provide intensive interventions in the home, community and school utilizing family, individual, collateral and group modalities
2. Continue intensive case management
3. Continue school placement stabilization
4. Continue development of support network
5. Address any emerging mental health needs & crises

PHASE III

TRANSITION
(2-3 MONTHS)

1. Solidify gains
2. Healthy goodbye
3. Evaluate progress made
4. Transition to mental health services in school or community
5. Transition to community resources for ongoing caregiver support

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DATA INTRODUCTION

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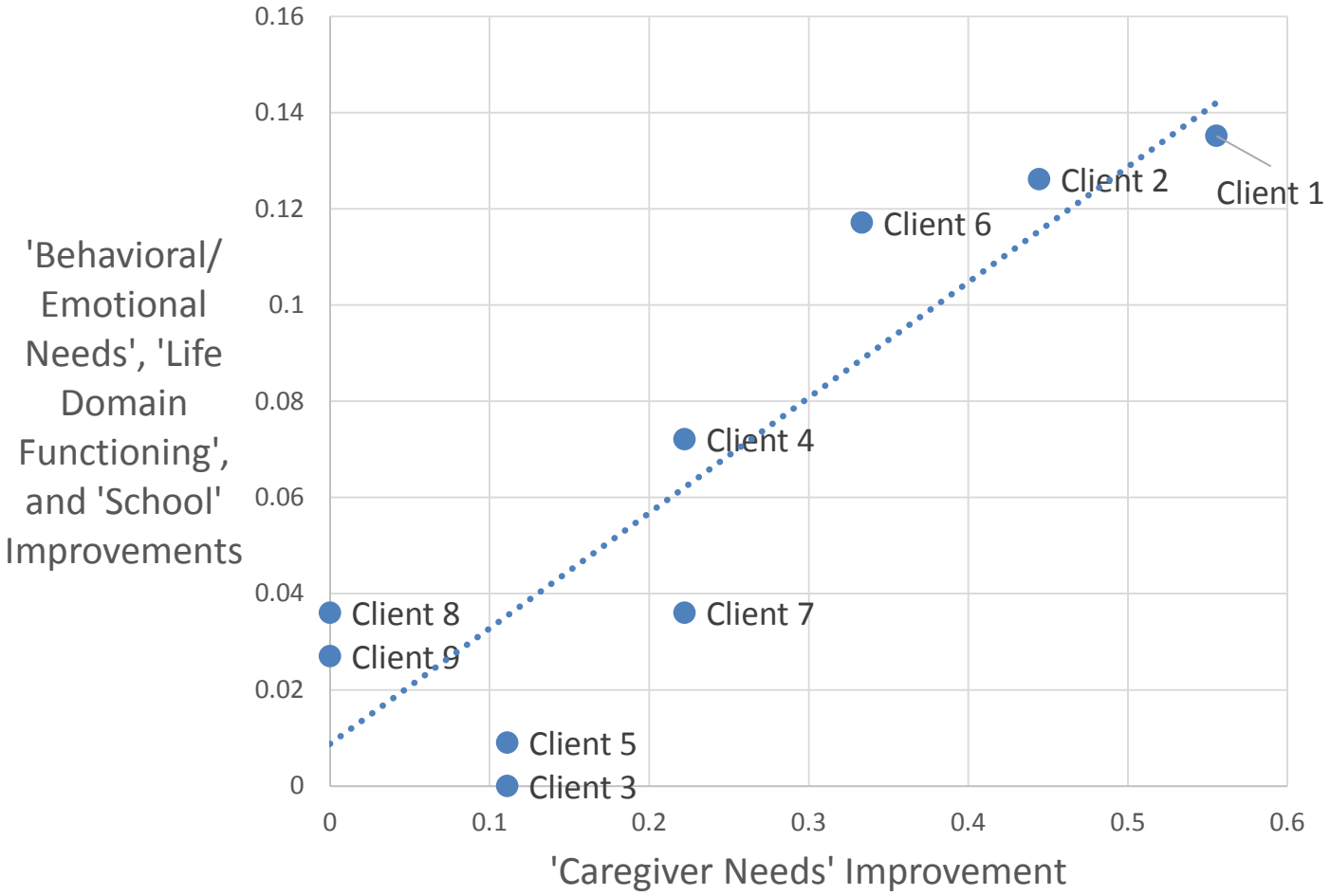
OUTCOME ANALYSIS



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UTILIZING CANS IN TREATMENT PLANNING

- **Comprehensive Assessment** is created including DSM-5 Diagnosis, MSE, Case Conceptualization, CANS Assessment
- **DSM-5 Diagnosis** is reflected in primary goal while the caregiver needs and child/parent relationship is reflected in the family goal
- **Objectives** reflects actionable items associated with the Diagnosis, e.g. anger control, peer relationships, sleep, trauma

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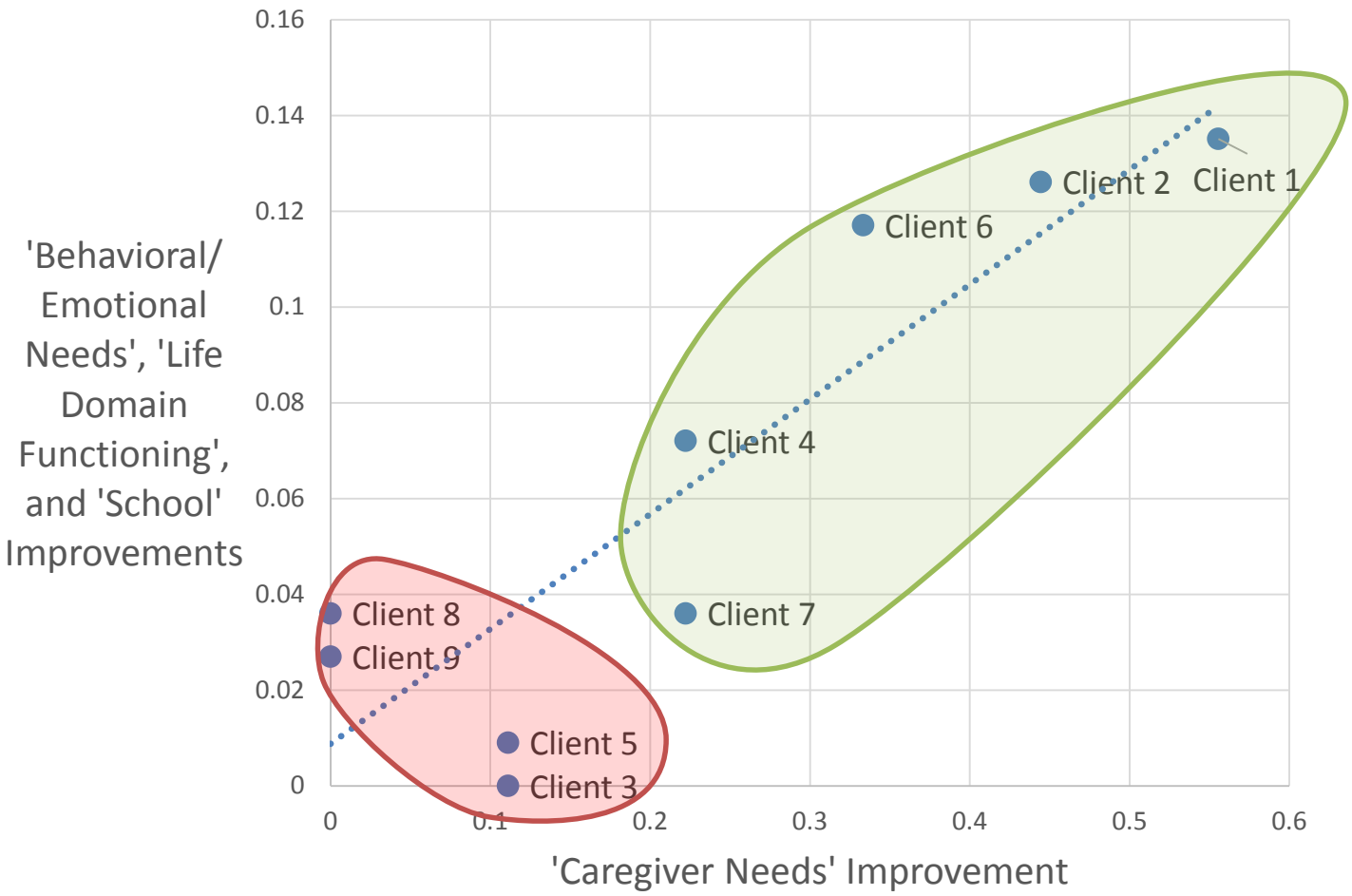
CLIENT COMPOSITE COMPARISON



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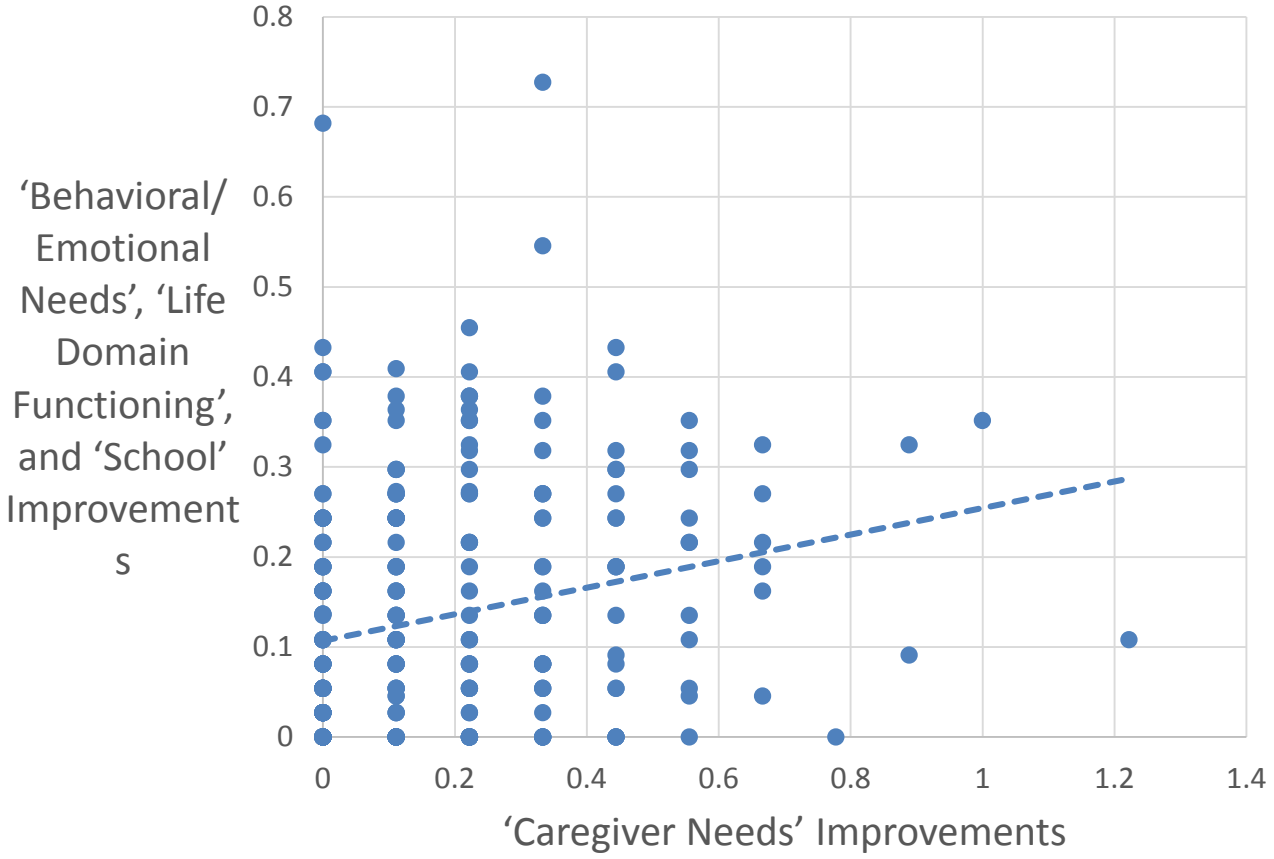
SCHOOL-BASED PROGRAM COMPARISON



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CANS DATA DRIVEN CHANGE

1. Individual (Micro)

Assessment information to develop individualized treatment plans targeting family needs

2. Programmatic (Mezzo)

Outcome data to modify treatment focus and interventions

3. Systemic (Macro)

Data analysis to identify patterns of stressors impacting families to drive advocacy of systemic changes

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