Commentary: Collaborative Action on Child Equity: Lessons from the Field

LeRoy E. Reese, PhD[1]; Glenda Wrenn, MD, MSHP[2]; Shemeka Dawson[1]; Sharon Rachel, MA, MPH[1]; Yvonne Kirkland, BS[1]

The Collaborative Action on Child Equity (CACE) pursued child-focused program and policy research through the Morehouse School of Medicine's Transdisciplinary Collaborative Center (TCC). CACE engaged with partners representing 13 states in the United States to implement the Smart and Secure Children Parent Leadership Program (SSC) and to develop local child-focused Policy Action Plans. The objectives of SSC are to support the development of parental agency and leadership in order to achieve positive health and academic readiness among school-aged children. Of the 13 partners, 9 were able to successfully implement SSC, with more than 350 parent-peer learners completing the program. Additionally, several partners were able to successfully develop Policy Action Plans. We discuss our efforts to bring SSC to scale in a national replication effort and to build policy development, implementation and evaluation capacity in organizations serving children and families. We highlight lessons learned in this replication effort and consider their implications for revisions to our training protocols, recruitment and implementation strategies, methods for providing technical assistance and evaluation models. SSC has demonstrated encouraging efficacy results, was developed using community-based participatory research methods and, as such, the lessons learned are critical for how we engage diverse communities to advance positive child development and academic success. *Ethn Dis*.2019;29(Suppl 2):365-370. doi:10.18865/ed.29.S2.365

Keywords: Parenting; Parent Leadership; Child Health; Socioemotional Health; Child Policy; Health Equity

[1] Kennedy-Satcher Center for Mental Health Equity, The Satcher Health Leadership Institute, Morehouse School of Medicine; Atlanta, Georgia

Collaborative Action on Child Equity: Lessons from the Field

Economically disadvantaged and racial/ethnic minority families in the United States often have inconsistent access to quality health care and reasonable educational opportunities for their children as compared with their White counterparts.[1,2] As a result, the children from many of these families experience more challenges in attaining and maintaining positive health status. In instances where these observations are true, there is often an exponential effect on individual and community health, given poverty and environmental disadvantage in the form of quality health care, education, and adequate housing.[3,4] Absent are multi-level interventions and prevention strategies that take these determinants of health and quality of life factors into consideration; often, there may be a generational effect that leaves the most vulnerable in these communities at higher risk for poor educational and health outcomes.

The Collaborative Action on Child Equity (CACE) is a research, policy and practice collaborative modeled after the Institute for Healthcare Improvement's (IHI) Breakthrough Series (BTS) Collaborative.[5] CACE seeks to promote health equity among vulnerable pediatric populations and their families. The approach to the intervention relies on the spread and adaptation of existing, evidence-based, knowledge, skills and abilities across multiple settings to accomplish a common set of aims.[6] In this instance, the CACE collaborative represents a diverse set of partner organizations that serve youth and families across 13 states in the United States. As a collective, they share common goals to promote comprehensive behavioral health strategies and policies to reduce health disparities and improve academic readiness and success among the children of participating parents.

CACE has two primary objectives. The first objective is to replicate a parenting leadership program - Smart and Secure Children Parent Leadership Program (SSC), which promotes parental agency and leadership by improving parent and care-

[2] 180 Health Partners; Department of Psychiatry, Morehouse School of Medicine, Atlanta, Georgia

Address correspondence to LeRoy Reese, PhD, Satcher Health Leadership Institute, Morehouse School of Medicine, 720 Westview Dr. SW, Atlanta, Georgia 30310; lreese@msm.edu

giver understanding of factors that promote child development, positive physical and behavioral health, and parent/caregiver well-being and psychological health. SSC also seeks to develop local cadres of parent leaders who serve as leaders not only in their homes but also in their local schools and communities. The second objective is to identify policy gaps focused on early childhood education and behavioral health. Specifically, members of our collaborative partner with local and state partners to critically examine and inform child health and educational policies that attend to those modifiable determinants of health and portend change in the developmental trajectories in health and education for those children who might otherwise be considered at risk for poor developmental outcomes.

The purpose of this commentary is to highlight several of the lessons learned relative to effective community engagement and place-based investments.[7,8] We provide preliminary descriptive information regarding program impacts to illustrate how the lessons learned can inform future academic-community collaborative engagements; we also offer a case example highlighting program impact.

Intervention Components

Smart and Secure Children Parent Leadership Program (SSC)

This peer-facilitated parent leadership program, originally developed through a community-based participatory research approach, seeks to increase high-quality parenting among parents raising children aged 0-5 years, with a particular focus on parents whose children may have endured adverse childhood experiences. The program focuses on promoting positive behavioral and physical health and academic readiness, as described elsewhere.[9] SSC has undergone multiple single site replications; this study represents a unique opportunity for a multi-site replication of the program across diverse environmental ecologies, eg, rural and urban and ethnicities. Prior replications of the program have been with predominantly African American stakeholders in diverse urban settings. Figure 1 reflects our approach to delivering SSC and support provided to parent leaders who directly implement the program by parent mentors.

Impacting Early Childhood Health Policy

The second aim of CACE encouraged participating collaborative organizations to reflect on, evaluate and propose adaptations to early childhood education and health policies and practices. Through efforts to reach this aim, partners promote a culture of health equity within their home organization and identify opportunities to partner with external local and state partners to improve policies that impact early childhood development and education for children aged 0-5 years.

Participant Engagement Summary

Over the course of this five-year project, more than 350 parent peer learners graduated from the 10 modules of SSC and approximately 40 paraprofessionals and professionals completed a 3-day training to become SSC parent leaders. Of our original 13 partners, 9 successfully implemented SSC. Eleven of thirteen developed Policy Action Plans (PAPs) and seven were able to implement the plans either focused on their internal policies or by engaging with external local and state partners. As policy development and policy implementation often take significant time (ie, years), we are not able to report on outcomes with respect to specific policies that partners were seeking to implement with their external partners.

Lessons Learned

We highlight what we view as instructive lessons from this multi-site project.

Evaluation

There are multiple takeaways with respect to evaluation in this instance; however, two observations stand out. First, while we had nine partners implementing SSC, often conducting multiple implementations of SSC, the program, by its nature, results in small sample sizes that make the utilization of more rigorous inferential statistics difficult. As a result, we are looking at the aggregation of data across multiple implementations and across sites to increase our statistical power. Going forward, we will incorporate a repeated measures design to both allow us to understand the impact/effectiveness of SSC over time and to increase our statistical power, thereby allowing us to do site-specific analyses where

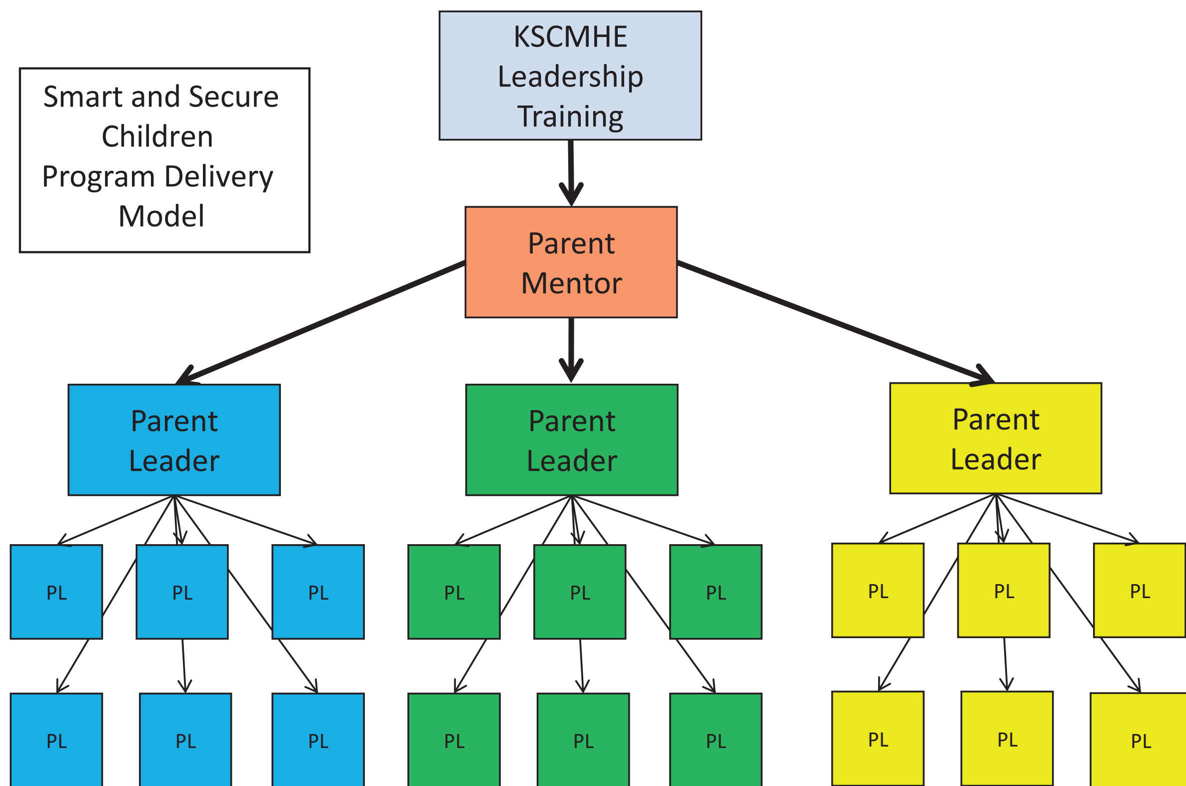

Figure 1. The Smart and Secure Children's Parent Leadership Program (SSC) implementation approach
PL, Parent Peer Learner; KSCMHE, Kennedy-Satcher Center for Mental Health Equity at the Satcher Health Leadership Institute

there can be a more intentional consideration of the role of covariates on impact. Second, capacity is a recurrent theme throughout this project, and it manifested itself in our evaluation efforts. We trained our partners in data collection and management; our experience in this area has allowed us to identify gaps in our training, eg, inadequate assessment of familiarity with data collection and management. Most community-based organizations have limited capacity generally, which is often most apparent in capacity to participate in evaluation activities. Lack of the experience and human resources to understand the intricacies related to data collection was an important learning opportunity in this project. Assessing and understanding organizational capacity in this area is critical, as there were at least two instances in which data collection was compromised ultimately as a function of capacity, thus impacting our evaluation efforts. When these issues were first observed, we took steps to provide more direct technical assistance in the collection and management of data.

Sustainability and Capacity

A key feature and strength of SSC is that it is peer-led and most often these peers come from within the targeted communities. The potential impact is that communities in which the program is implemented can potentially develop their own facilitators (ie, parent leaders and parent mentors) and thereby build their capacity to sustain the program. In this instance, while we were intentional in the training of our parent leaders from our partner organizations, we did not plan for the training of graduates of SSC who could go on to become parent leaders. In our local implementation, we have often recruited program graduates who demonstrated a facility with the intervention content and/or demonstrated group leadership skills to participate in our three-day parent leader training. A unique opportunity exists in a large-scale replication such as this to increase the capacity of partner organizations to sustain SSC-building by developing the human resources to support such an effort. Ultimately, we would like to support communities in building their capacity to sus-

tain the implementation of SSC and providing robust technical assistance. We were able to successfully provide this enhanced form of capacity-building with several of our early-adopter partners (Missouri, Tennessee) by developing a train-the-trainer program for selected graduates of SSC.

Identification of Program Core Components

Because of the multiple ecologies within which this study was implemented, we were afforded the opportunity to learn important lessons in understanding what about SSC works for whom and in what context. This experience also afforded us an opportunity to explicate the core components of the program that generalize across settings while simultaneously allowing us to begin to think through some of the nuances of environment context, geographical locations and ethnicity as we seek to revise program content and training protocols. Our local partners were instrumental in assisting us in identifying areas requiring modification and flexibility regarding implementation. For example, activities that worked in rural Alabama, Kentucky and Mississippi did not work as well in St. Louis or Baltimore and vice versa.

Capacity Assessment

Several of our partners lacked the human and institutional resources to properly implement the SSC program. The lesson learned here centered on the need for project staff to be more intentional in the assessment of implementation capacity in establishing SSC partnerships. To that end, we have been able to identify more concretely what we see as some of the requisite minimal resources for successful implementation in terms of human resources and community assets. Similarly, we have taken note of activities we can encourage to assist interested organizations in developing their capacity for successful implementation and the technical assistance we can provide. For example, some partners had constituents appropriate to participate in SSC but had not secured enough staff to execute the various aspects of the program. In other instances, this was a function of the other responsibilities of staff that made them unavailable to implement SSC. In other cases, there was appropriate staffing but location logistics made it difficult for the program to be offered at times or locations convenient for their constituents.

Policy Engagement Technical Assistance

The development and impact of evidence-based child policy initiatives potentially represent the greatest area of opportunity and identifies the technical assistance needed among our partners. Our partners gave us consistent feedback about their interest in engaging in policy initiatives and their need for on-going training and technical assistance in this area. Specifically, our partners identified needs regarding additional training and guidance in understanding the analysis of child policies to support health and educational equity among children. Additional foci identified included how to engage stakeholders and the development of collaborative partnerships in their policy engagement efforts in order to maximize the impact of their policy efforts. Our partners also acknowledge the value of examining and informing policy at all stages (agenda-setting and development, implementation, and evaluation).

Ms. Yvonne's Story

We conclude with an impact story offered by a graduate of SSC. Ms. Yvonne Kirkland, an early graduate of the program, comments that SSC was powerful and life changing. Since completing SSC, Ms. Yvonne has become a parent leader and parent mentor and continued to champion the importance of parent leadership in the success of children in the Atlanta metropolitan community. Here, she shares reflections on the impact of the program for herself and other parents she engaged during her involvement with SSC.

"As an inaugural SSC parent mentor (parent mentors support the training and development of parent leaders to implement SSC), I was there on the front lines experiencing and supporting SSC to transform the lives of parents and the communities we were working in. Because of my experience as a single mother who struggled to raise my sons on a low-income budget, I was able to relate to many of the SSC parents/grandparents. Their feelings of doubt, low self-esteem, low self-worth, and hopelessness were surreal in one way and very real to me personally. Young and low-income mothers and fathers desire for their children to be healthy and successful in life – just as parents with greater economic resources do. These parents want to support their children's mental, physical,

socio-emotional and academic development so that their children can be the 'best that they can be.' For many of these parents, having someone believe in their potential as good parents and leaders while also valuing the importance of their well-being is critically important. Participating in SSC, a program led by peers from their community, affirmed many parents' importance to their children and validated their potential to be leaders in the lives of their children and community.

Prior to joining SSC, the challenges of my life and the need to take care of my family halted my academic journey for an associate degree in computer science at Atlanta Junior College (now Atlanta Metropolitan State College). Then SSC became a beacon of hope for both me and the community of parents who participated in and completed SSC. My experience has taken me on a path I never thought possible. In 2013, I joined the Satcher Health Leadership Institute (SHLI), under the leadership of Dr. David Satcher. The faculty and staff in SHLI and the nurturing environment in MSM inspired me to continue my academic studies. Since returning to school, I earned my way onto the Dean's list and completed my bachelor's degree in psychology in spring 2017 from Mercer University. Presently, I am in graduate school at Mercer University seeking to become a clinical rehabilitation counselor and to complete my master's degree, with the goal of becoming a licensed professional counselor (LPC). I was also inducted into the Golden Key International Honor Society and accepted into Mercer's highly-competitive 2019 Holland Study Abroad Program. I attribute all these accomplishments and opportunities to the support I received and continue to receive from SSC, Dr. Satcher (mentor), Dr. Kisha Holden, SHLI Interim Director (mentor), and the faculty and staff within SHLI and at Morehouse School of Medicine (MSM). From my initial involvement with SSC, my experiences with parents and caregivers involved with SSC and program staff encouraged my dreams and my potential. I am humbly appreciative of all the support.

SSC has had a transformative impact on my life as well as my family. In my view, it is impossible to quantify the value of SSC as a program that sees possibility in its program participants and seeks to create community cohesion and well-being among parents and caregivers in support of themselves and the children they care for. I am enthusiastic in sharing the good news about SSC when given the opportunity. SSC helped me see the *best* in me as a person, parent and leader."

Conclusions

In reflecting on SSC's objectives and our experience in pursuing them, we have come to understand our efforts as reflecting an emerging paradigm in public health that focuses on person- and place-based investments.[8] As such, what the lessons described herein broadly reflect is the need and role of programmatic tailoring in order to maximize program effectiveness for community-based participatory research programs to take such considerations into account. Unlike the methodological controls afforded in randomly controlled trials/intervention programs, community-engaged programming and research often requires some degree of latitude in the implementation strategies employed. This observation highlights the importance of organizing the evaluation model of such programs around those core components hypothesized to have the great explanatory power statistically in explaining program effectiveness. Also, acknowledging these challenges, it is important to purposely collect process data so that contextual nuances can be captured. As an example, we observed differences in tone and delivery when male parent leaders implemented the program and the experience of male parent peer learners when the parent leader was male. Other differences were observed when the program was implemented in rural vs urban communities. How we understand person- and place-based programmatic efforts should reflect these subtleties.

While the lessons discussed here appear to highlight challenges we encountered, we instead view them as reflecting growth opportunities for SSC and our team. There are a number of evidence-based parenting programs[10] available and we have very encouraging empirical evidence of SSC's efficacy. What is missing in this area are community-engaged parenting programs, which are peer-led, build parenting capacity and agency, develop familial and community leadership in parents, and are designed to be sustainable. This is the unique space that SSC occupies. Taking a community-focused program such as SSC to scale not only builds its empirical evidence but also provides an opportunity to understand how the persons and places where implementation occur are criti-

cal to take into consideration if program effectiveness is to be achieved.

With respect to our efforts in the public policy arena, we would reiterate our prior point regarding the opportunity in this area not only for our partners but especially for the children and families they serve. More than ever, we understand that health policies that reflect the health care and educational needs of our most vulnerable citizens are a key factor in achieving health equity. Too often, policy efforts are driven by entities that are not inclusive of constituencies representing those members of our society most marginalized such as poor children and families and the organizations that serve them. CACE represents an example of what a diverse coalition of organizations pursuing pediatric health and early childhood education through parent leadership and organizational policy engagement can look like. A growth area for our team will be to build our own capacity to work with our partners to understand their organizational and local child-focused policies and provide targeted technical assistance strategies tied to their organizational goals and capacity.

The lessons offered here, as well as the empirical findings from our evaluation efforts, will inform development of program content that can be tailored based on context, the revision of parent leader and parent mentor training models, and focusing our evaluation programs. Additionally, we believe our role going forward will be in providing training and program technical assistance focused on the implementation of SSC and supporting advocacy efforts that encourage evidence-based early education and health policies focused on underserved children and their families. The Transdisciplinary Collaborative Center for Health Disparities Research at Morehouse School of Medicine is well-situated to support us in these efforts through the technical assistance they continue to provide to our team and thus represents an effective and evolving example of what successful academic-community engagement and partnerships can look like and achieve.

Acknowledgments

We are thankful for the enduring efforts of the organizations that comprised our CACE partnership in this project: Alabama Partnership for Children (Alabama); Healthy Start Coalition of Orange County (Florida); Georgia Pathways to Language & Literacy; Berea College Partnership for Education (Kentucky); Access to Wholistic & Productive Living Institute, Inc (Maryland); Minneapolis Urban League (Minnesota); Caffee, Caffee & Associates Public Health Foundation, Inc (Mississippi); City of St. Louis Department of Health (Missouri); Durham Business & Professional Chain (North Carolina); Portland Urban League (Oregon); Healthy Kids & Teens, Inc/Camp Get Fit (Tennessee); Baylor College of Medicine (Texas); and Columbia Urban League (South Carolina).

Funding Support: The project described is supported by the National Institute on Minority Health and Health Disparities (NIMHD) Grant Number U54MD008173. NIMHD is an institute of the National Institutes of Health (NIH). The contents of this article are solely the responsibility of the authors and do not necessarily represent the official views of NIMHD or NIH.

Conflict of Interest

No conflicts of interest to report.

Author Contributions

Research concept and design: Reese, Wrenn; Acquisition of data: Reese, Dawson, Kirkland; Data analysis and interpretation: Reese, Wrenn, Kirkland; Manuscript draft: Reese, Wrenn, Kirkland; Statistical expertise: Reese; Acquisition of funding: Wrenn, Rachel; Administrative: Reese, Wrenn, Rachel; Supervision: Reese, Wrenn, & Rachel

References

1. Shonkoff JP, Garner AS, Committee on Psychosocial Aspects of Child and Family Health, et al. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 2012;129(1):e232-e246. https://doi.org/10.1542/peds.2011-2663 PMID:22201156
2. Okafor M, Sarpong DF, Satcher D. *Improving Social Determinants of Healthy Child Outcomes and Mental Health through Effective Parenting & Leadership*. Presented at the NIH 2012 Summit on Science of Eliminating Health Disparities: Building a Healthier Society, Integrating Science, Policy & Practice; Washington, DC, USA. 17–19 December 2012.
3. Johnson SB, Riley AW, Granger DA, Riis J. The science of early life toxic stress for pediatric practice and advocacy. *Pediatrics*. 2013;131(2):319-327. https://doi.org/10.1542/peds.2012-0469 PMID:23339224
4. Woolf SH, Braveman P. Where health disparities begin: the role of social and economic determinants—and why current policies may make matters worse. *Health Aff (Millwood)*. 2011;30(10):1852-1859. https://doi.org/10.1377/hlthaff.2011.0685 PMID:21976326
5. Eigenbrode SD, O'rourke M, Wulfhorst JD, et al. Employing philosophical dialogue in collaborative science. *Bioscience*. 2007;57(1):55-64. https://doi.org/10.1641/B570109
6. McNamara DA, Rafferty P, Fitzpatrick F. An improvement model to optimise hospital interdisciplinary learning. *Int J Health Care Qual Assur*. 2016;29(5):550-558. https://doi.org/10.1108/IJHCQA-10-2015-0131 PMID:27256777
7. Dupre ME, Moody J, Nelson A, et al. Place-based initiatives to improve health in disadvantaged communities: cross-sector characteristics and networks of local actors in North Carolina. *Am J Public Health*. 2016;106(9):1548-1555. https://doi.org/10.2105/AJPH.2016.303265 PMID:27459443
8. Hussaini A, Pulido CL, Basu S, Ranjit N. Designing place-based interventions for sustainability and replicability: the case of GO! Austin/VAMOS! Austin. *Front Public Health*. 2018;6:88. https://doi.org/10.3389/fpubh.2018.00088 PMID:29623272
9. Okafor M, Sarpong DF, Ferguson A, Satcher D. Improving health outcomes of children through effective parenting: model and methods. *Int J Environ Res Public Health*. 2013;11(1):296-311. https://doi.org/10.3390/ijerph110100296 PMID:24366048
10. Gray GR, Totsika V, Lindsay G. Sustained effectiveness of evidence-based parenting programs after the research trial ends. *Front Psychol*. 2018;9:2035. https://doi.org/10.3389/fpsyg.2018.02035 PMID:30459680