Family Partner Evaluation

Interim Report

Texas Institute for Excellence in Mental Health

Advancing Resilience and Recovery in Systems of Care

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Introduction

Peer support providers, individuals employed in part due to their lived experiences, have been widely used in health care settings for several chronic diseases, such as diabetes, HIV, asthma, and cancer (Lehman & Sanders, 2007; Pearson, Micek, Simoni, Hoff, Matediana, et al., 2007; Swider, 2002; Zuvekas, Nolan, Tumaylle, & Griffin, 1999). Not surprisingly, parent-based peer support also originated in the health care field, with studies in diabetes, asthma, sickle cell anemia, and cystic fibrosis showing decreased parental strain (Ainbinder, Blanchard, Singer, Sullivan, Powers, et al., 1998; Ireys, Chernoff, DeVet, & Kim, 2001; Ireys, Sills, Koldner, & Walsh, 1996; Sullivan-Bolyai, Knafl, Tamborlane, & Grey, 2004; Sullivan-Bolyai, Bova, Leung, Trudeau, Lee, et al., 2010). Research has indicated that when parents with lived experiences are used to provide health-related support to other parents, the parents' mental health and functioning and access to resources improve (Ireys, Chernoff, DeVet, & Kim, 2001; Ireys, Chernoff, DeVet, & Silver, 2001).

Parent peer support began to be viewed as a cornerstone of the public mental health system in the 1980s (Collins & Collins, 1990; DeChillo, 1993; Koroloff, Elliot, Koren, & Friesen, 1994; Pinderhughes, 1982; Hoagwood, 2005). It has been identified as an essential component in service quality (Stroul, 1996) and viewed as a manifestation of the core principle - family-driven care - in system of care movement (Stroul & Friedman, 1986). The use of family peers in the public mental health service delivery system has increased over the last two decades. Parent peer support providers have been defined as parents or primary caregivers who have lived experience caring for children who have struggled with emotional and behavioral disorders (Santelli, Turnbull, Marquis, & Lerner, 1995). This workforce provides support and advocacy for families receiving services and assists them in navigating through service systems. In a review of the emerging literature, Robbins, Johnston, Barnett, Hobstetter, Kutash, et al. (2008) concluded that parent peer support assists families by matching them with others who understand the difficulties and can relate through a shared experience.

Core Components of Parent Peer Support

In 2005, Hoagwood conducted an empirical review of the literature on family support services and concluded that there is no fundamental set of constructs, definitions, or a firm theoretical foundation for the various family support services operating across the country. This lack of clarity has led to the development of many variations in parent peer support programs. In some models, parent support providers work with multi-family groups, primarily encouraging group support and skills development through weekly group meetings. Other models are framed around one-on-one support, focused on psychoeducation, skill development and supportive advocacy to a parent or caregiver of a youth receiving services. And many models may blend these two variations. Similarly, different naming conventions and qualifications for parent peer providers across organizations and communities has led to some difficulty in identifying similar programs.

Over time, a broad consensus has developed around the tasks that should be performed by family support providers (Obrochta, Anthony, Armstrong, Kalil, Hust, & Kernan, 2011; National Federation of Families for Children's Mental Health, 2011), In Hoagwood, Cavaleri, Olin, Burns, Slaton and colleague's (2010) review and synthesis of existing family support programs, the authors identified five core components that span across all types of programs:

1. *Informational/educational support.* This component includes psychoeducation with parents about child development, the course of mental illness and its impact on child development, services and supports, treatment options and other resources.

2. *Skills development.* Parent peer providers teach skills and provide coaching on effective ways to address their youth's mental health needs and manage associated behaviors. This often includes skills toward addressing the caregiver's own well-being.

3. *Emotional support.* Parent peer providers engage families through shared communication (e.g., telling components of their own story), which enhances the engagement of the family, promotes a sense of being understood and affirmed, and instills a sense of hope for their family's future.

4. *Instrumental support.* Concrete services are provided to assist the caregiver in participating in services, meeting family needs, or reducing parental stress. Example services include respite care, flexible funds, child care, and transportation.

5. *Advocacy.* Advocacy includes the provision of information on rights and resources, providing direct advocacy support, or coaching parents on effective strategies to obtain services and navigate systems. This often includes leadership building to help the caregiver develop advocacy skills beyond their own child.

Parent Empowerment Program

One manualized family support program, named the Parent Empowerment Program (PEP), was developed in 2001 through a collaborative workgroup inclusive of experienced parent partners and family advocates. PEP outlines ten core principles of parent support: (1) is individualized, (2) makes connections, (3) is respectful and culturally competent, (4) builds skills, (5) builds knowledge, (6) is engaging, (7) problem solves, (8) focuses on outcomes and success, (9) broadens horizons, and (10) promotes advocacy. In addition, the program identifies five factors that are believed to lead to better outcomes: (a) provide/teach knowledge and skills, (b) address environmental constraints, (c) increase salience (behavior recognition), (d) form new habits and automatic patterns, and (e) address behavioral intentions (e.g., attitudes, expectancies, social norms, self concept, affect, and self-efficacy). Together, these components create the core framework for the model.

To support dissemination of PEP, a 40-hour training curriculum has been developed. A trainer's toolkit supports implementation of the curriculum and includes a trainer's manual, role rehearsals book, parent advocate manual, and parent advocate workbook. In addition, a self-report fidelity checklist has been developed to measure adherence to the principles and active ingredients of PEP.

Training for Parent Peer Support Providers

A survey conducted by the National Association of State Mental Health Directors indicated that three fourths of the respondents were in the process of developing a training curriculum (National Federation of Families for Children's Mental Health, 2008b). The National Federation of Families for Children's Mental Health (FFCMH) has developed guides for families that provide direction for the supervision, support, and training of family peer support (National Federation of Families for Children's Mental Health, 2008a). To help promote standards around competency in the skills of family peer support, the FFCMH has developed the Certification Commission for Family Support (http://certification.ffcmh.org/). The certification process began in 2011 and is a voluntary process targeting individual credentialing (National Federation of Families for Children's Mental Health, n.d.).

Evidence for the Impact of Parent Peer Support

In the adult mental health system, results of randomized controlled trials have provided evidence of benefits associated with peer support services. Some of these benefits include increased engagement with service providers, the promotion of recovery, and lower rates of re-hospitalization (Corrigan, 2006; Dixon, Stewart, Burland, Delahanty, Lucksted & Hoffman, 2001; Sells, Davidson, Jewell, Falzer, & Rowe, 2006; Min, Whitecraft, Rothbard, & Salazar, 2007). The evidence base for family-delivered peer support is significantly more limited (Hoagwood, et al., 2010). Despite the limited nature of the current research literature, some preliminary studies have indicated that family support services have demonstrated improved outcomes for children and families. Some of these improved outcomes include service retention, increased knowledge, and improved family engagement (Hoagwood, 2005).

Robbins, et al. (2008) conducted a review of research studies conducted on parent-to-parent interventions and identified ten studies focused on children with mental health challenges. Six studies were descriptive in nature and provided information on individuals involved in parent-to-parent programs and a description of organizations providing these support services. One such study indicated that parents most value emotional support, information about disability and daily living issues, and group meetings for emotional and education supports (Santelli, et al., 1995). Parents indicate that they would like veteran parents to contact them within 24 hours of a match and that families in early intervention preferred informal, individualized relationships with parent partners. In addition to the descriptive studies, three randomized, controlled trials were identified. These studies suggested that families receiving support services had higher rates of service utilization, greater family empowerment (Elliot, Koroloff, Koren, & Frisen, 1998), higher rates of perceived support (Ireys & Sakwa, 2006; Rhodes, Baillee, Brown, & Madden, 2008), and greater reductions in parental anxiety (Ireys & Sakwa, 2006).

An evaluation of the PEP model found that parent peer support providers reported greater collaborative skills, greater self-efficacy in accessing effective services on behalf of their clients, and greater empowerment over time, following training and supervision in the model (Rodriguez, Olin, Hoagwood, Shen, Burton, Radigan, Jensen, 2011). However, there was no impact on parent report of depression symptoms as a result of working with trained peer providers (Ramos, Burton, McDonald, Rodriguez, Hoagwood, Radigan, et. al., 2009). In a promising recent study, Kutash, Duchnowski, Green and Ferron (2011) conducted a small, randomized controlled trial of a telephone-based family-to-family support intervention for parents of children classified as emotionally disturbed within the school setting. The majority of

parents in the Parent Connector arm of the study were fully engaged in the program and reported high satisfaction with the parent connector. Results of the study showed parents receiving the parent support intervention reported better efficacy of services, greater empowerment, and reduced caregiver strain in comparison to those assigned to no family-to-family support. Youth whose parents were in the intervention group received more mental health services and had greater attendance than youth whose parents were in the control group. Although changes in youth functioning did not differ between the groups for the full sample, when an analysis was conducted for youth of high strain families, youth who parents received support had significantly larger improvements in mental health functioning and academic functioning than comparison youth.

Researchers is beginning to examine the impact of parent support, however there is no research guidance to date on how to best support and promote family-based peer support within organizations or systems (Olin, Kutash, Pollock, Burns, Kuppinger, et al., 2013) and a lack of empirical evidence to determine how best to integrate family support services within the service array. Some evidence does suggest that focusing the intervention on parents with a high amount of strain could be advantageous.

Financing of Parent Peer Support

Many states have incorporated some form of parent peer support into their mental health service system. Medicaid is frequently utilized to support the service, with some states incorporating the service in state plan amendments (SPA), others utilizing Medicaid waivers, and some relying on Medicaid administrative match (Center for Health Care Strategies, Inc., 2012). Currently, the states of Alaska, Arkansas, Arizona, Kentucky, Main and Oklahoma fund family peer support through their SPA. Washington, Georgia, Indiana, Kansas, Maryland, Montana, Texas and South Carolina fund family peer support services through either the 1915(c) Home-and Community-Based Services (HCBS), 1915(c) Severe Emotional Disturbance, and/or the 1915(c) Psychiatric Residential Treatment Facility (PRTF) demonstration waivers.

Some states also elect to provide funding for parent peer support through SAMHSA block grant funds. These funds may be utilized by states to fund necessary services that are not funded through other sources. In 2011, SAMHSA released guidance related to a "good and modern" behavioral health system, and emphasized the importance of financing peer provided services through mechanisms such as federal block grants and Medicaid. Additionally, states may fund family support services through grants, such as the Children's Mental Health Initiative System of Care grants, or state or local discretionary funds.

Fidelity Measurement

A literature review identified two measures intended to assess the extent to which parent peer support is consistent with a manualized or specified model of the services. Developers of the Parent Empowerment Program have developed a self-report adherence checklist completed by parent peer support providers (Rodriguez, et al., 2011). The measure includes six subscales, consisting of (1) emotional support; (2) action planning; (3) information provision; (4) advocacy; and (5) skill development (See Appendix A). A second fidelity instrument, the Parent Partner Fidelity Tool, was developed to measure adherence to the parent partner role within wraparound

(Polinsky, Levine, Pion-Berlin, Torres, & Garibay, 2013). Developed through a consensus process and based on the National Wraparound Initiative model, the 28-item tool was pilot tested with facilitators, parent partners, and parents/caregivers (See Appendix B). The scale has an acceptable level of internal consistency. A factor analysis identified four factors, however many items loaded highly on multiple factors, suggesting a one factor solution may be preferred. This instrument shows some promise as a fidelity measure, but needs additional validation to ensure its utility in assessing adherence and competence of parent peer partners.

Texas Infrastructure for Parent Peer Support

The Department of State Health Services (DSHS) has required local mental health authorities to include parent peer support services within the available service array across the state. Using the term "family partners," these providers work on a one-to-one basis with caregivers to provide the five components of family peer support as identified by Hoagwood (2010). Additionally, in some communities, family partners offer parent support groups.

Training & Certification. Via Hope, a contracted training and technical assistance organization, developed a training program for family partners and offered state-level certification in 2011. A Certified Family Partner (CFP) is defined as a parent or guardian who has lived experience raising a child with mental health needs. Through Via Hope, a CFP is trained to utilize their experience to assist parents of youth who are receiving services through the public mental health system. In order to become a CFP, a parent or guardian must participate and complete a 3 day training course and pass a final certification exam. In order to maintain certification, a CFP must earn a minimum of 12 continuing certification credits each biennium. This process has standardized the core competencies necessary for certification as a family partner within the state. In addition, a training for family partner supervisors has been developed and provided to interested supervisors to further enhance the organizational support for family-based peer support.

Financing. Local mental health authorities have traditionally funded family partner services through federal block grant and discretionary funds. The training and certification program has been supported through grants by DSHS, using block grant funds, and the Hogg Foundation for Mental Health. In 2013, DSHS has added family partners as providers under the SPA. This provider type will be allowed to bill for select Medicaid rehabilitation services, such as skills training. DSHS also funds parent peer support through the Youth Empowerment Services (YES) 1915(c) Medicaid Waiver. In this waiver program, Family Support providers are reimbursed at $4.96 per 15 minutes.

Aims of the Current Study

The proposed evaluation is intended to document the current roles that family partners play within the public mental health system, both within Texas and across the nation. In addition, organizational support for these services and best practices and challenges to optimal implementation will be examined. The current report represents initial findings and recommendations to enhance the impact of family partner services in the state.

In the following year, the impact of two programmatic changes will be examined. Via Hope intends to provide technical assistance to local mental health authorities (LMHAs) to support the use of family partners within these organizations. Also, DSHS has incorporated certified family partners within the Medicaid state plan, allowing some rehabilitation services provided by family partners to be reimbursed through this funding stream. The proposed evaluation will explore the impact of these two efforts.

Methods

The evaluation included a review of the existing literature to identify published conceptual or research papers focused on parent peer support. Interviews were conducted with Via Hope staff and a national expert of parent peer support within the National Wraparound Initiative. Document reviews were conducted, including Via Hope training curriculum, administrative code, Medicaid state plan, and contracts. A survey was developed and conducted with several key stakeholders, including administrators from local authorities, family partner supervisors, and family partners (certified and non-certified). In addition, de-identified administrative data reflecting service encounters by family partners was analyzed to identify current trends in service delivery and the use of family partner providers. The evaluation was submitted to the Institutional Review Boards at DSHS and the University of Texas at Austin.

Results

Survey of Community Mental Health Stakeholders

Characteristics of the Respondents. The survey was completed by 83 respondents, which represents a response rate of 74.1%. Forty-one percent of the sample (n= 34) identified themselves as family partners, 31% as supervisors of family partners (n=26), and 31% as directors or managers of child and adolescent services (n=26). An additional 9% identified another role in the organization, such as a trainer or quality management staff member. Respondents could identify more than one potential role in the organization.

Respondents represented a variety of geographical areas. Sixteen percent (n=13) of the respondents identified they were from large, metropolitan areas and 25% (n=21) indicated they worked in medium-sized metropolitan areas. Twenty percent (n=17) indicated that they worked in small sized metropolitan areas, with 22% (n=18) indicating rural area with a metropolitan area within 100 miles and 8% (n=7) indicating they work in a rural area with no neighboring metropolitan areas. Seven percent of respondents (n=6) chose not to answer this question.

Nature of Family Partner Employment. Administrators or supervisors were asked to provide information about the employment of family partners within their organization. Respondents reported a median of one family partner within the organization and a mean of 1.8 (sd=1.6). These individuals represented an average of 1.3 full time equivalents (sd=1.8). The majority of family partners (75.6%) are reported to be employed directly by the organization. LMHAs contracted with 24.4% of the family partners and less than 1% were employed by an agency that held a contract with the LMHA. No family partners were considered volunteers within the organization. Similar results were reported by family partner respondents, with 84.4% indicating

they are employed directly by the LMHA, 9.4% are contracted providers, and 6.3% are employed by an organization that contracts with the LMHA.

The majority of family partners reported they worked 40 hours per week (56.3%) with a reasonable sample (21.9%) reporting working more than 40 hours per week on average. A small sample reported (12.5%) report working less than 10 hours per week. Fifty-three percent of the family partners indicated that they had productivity requirements in their role. Five (27.8%) indicated that fifty percent or less of their work time is expected to be direct contact hours with families. Six respondents reported productivity expectations between 55% and 90% and four reported that 95% to 100% of all hours were expected to be direct family contact. About forty percent of respondents indicated that their productivity expectations were based on face-to-face contacts.

Employee Benefits. According to agency leadership and supervisors, family partners are generally afforded full employee benefits within their agency. Between 6% and 20% do not have access to a standard benefit, with health insurance for family members the most commonly excluded benefit. Responses from family partners are generally consistent with those of the managers, although about twice as many family partners indicate that they do not receive the identified benefits. This is particularly true for family medical insurance, with 43.8% indicating that they do not have this benefit. This may be the result of more contracted or part-time family partners responding to the survey. The agency may offer these benefits to full-time family partner staff, but individual family partners may not receive them in practice.

Table 1. Employee Benefits by Respondent Type

	Receive Benefit		Don't Receive Benefit		Uncertain about Benefit	
	Managers	Family Partners	Managers	Family Partner	Managers	Family Partners
Employee health insurance	30 (88.2%)	25 (78.1%)	3 (8.8%)	7 (21.9%)	1 (2.9%)	0 (0%)
Family health insurance	24 (72.7%)	18 (56.3%)	6 (18.2%)	14 (43.8%)	3 (9.1%)	0 (0%)
Paid Vacation Leave	30 (88.2%)	27 (81.8%)	4 (11.8%)	6 (18.2%)	0 (0%)	0 (0%)
Paid Sick Leave	30 (88.2%)	25 (78.1%)	3 (8.8%)	7 (21.9%)	1 (2.9%)	1 (3.0%)
Family Medical Leave	29 (85.3%)	26 (81.3%)	2 (5.9%)	6 (18.2%)	3 (8.8%)	1 (3.0%)
Retirement program	30 (88.2%)	28 (84.8%)	3 (8.8%)	5 (15.2%)	1 (2.9%)	0 (0%)

Training and Supervision. Respondents were asked about the nature of the training and supervision provided to family partners within the agency. Managers reported that most family reporters received training through Via Hope and many received additional training through the LMHA. Family partners, on the other hand, were less likely to report receiving training by the LMHA. More than half of the managers reported that some or all of their family partners were

able to shadow more experienced family partners; fewer family partners reported this experience. Given that the many LMHAs only reported having one family partner, shadowing was likely difficult for many programs to organize. Managers report that most family partners in their organizations have been certified through Via Hope and this is supported by the family partner respondents. Over a third of the family report that they intend to seek additional certification in the coming year.

Table 2. Training and Certification of Family Partners

	Managers				Family Partners	
	None	Some	All	Unk/ NA	No	Yes
Training provided by LMHA	5 (11.5%)	17 (39.5%)	21 (48.8%)	0 (0%)	21 (65.6%)	11 (34.4%)
Training provided by Via Hope	4 (9.3%)	7 (16.3%)	31 (72.1%)	1 (2.3%)	1 (3.1%)	31 (96.9%)
Shadowing of experienced family partners	18 (41.9%)	6 (14.0%)	11 (25.6%)	8 (18.6%)	21 (65.6%)	11 (34.4%)
Certification through Via Hope	4 (9.3%)	9 (20.9%)	28 (65.2%)	2 (4.7%)	2 (6.3%)	30 (93.7%)
Certification through Nat. Fed. of Families	25 (59.5%)	4 (9.5%)	2 (4.8%)	11 (26.2%)	28 (100%)	0 (0%)
Plans to Seek Certification	0 (0%)	4 (9.5%)	21 (50.0%)	17 (40.5%)	17 (63.0%)	10 (37.0%)

Supervisors of family partners were asked additional questions regarding training for their role. The majority of family partner supervisors had participated in both the family partner training, as well as the supervisor training offered by Via Hope. However, a significant number (22 to 39%) had not participated in these opportunities. None of the current family partner supervisors had previously held the role of a family partner.

Table 3. Training of Family Partner Supervisors

	Family Partner Supervisors	
	No	Yes
Participated in family partner training	9 (39.1%)	14 (60.9%)
Has been a family partner previously	23 (100%)	0 (0%)
Participating in family partner supervisor training	5 (21.7%)	18 (78.3%)

Most supervisors report that they meet with their supervisees monthly (30.4%) or two to three times per month (34.8%). Twenty-two percent of the supervisors meet with family partners weekly. Nine percent of supervisors reported that they did not meet with their supervisee or did so less than monthly, with one person reporting they met with staff almost daily. Family partners report a similar frequency of supervision sessions, with slightly higher access (15.6%) to daily or

almost daily supervision. The majority of supervisors (65.2%) indicate that they observe family partners providing services as a part of their supervision. This is consistent with the report of family partners, with 51.5% reporting their supervisor observes them providing services.

Supervisors and family partners were asked to indicate the most frequent activities that occurred during supervision sessions. Individual activities were ranked from most frequent to least frequent and are listed in Table 4. Most of the supervision activities tended to focus on discussion of individual families and problem-solving around family issues, with the least amount of time focused on developing skills as a family partner or discussing "fidelity" to the family partner role.

Table 4. Rankings of Supervision Activities

	Supervisors	Family Partners
	Mean Rank (SD)	Mean Rank (SD)
Discuss or review assigned families	1.9 (1.4)	1.9 (1.6)
Problem solve family difficulties	2.8 (1.7)	2.5 (1.5)
Discuss or review case documentation	3.2 (1.3)	3.5 (1.8)
Discuss or review administrative tasks	4.0 (1.7)	4.1 (2.4)
Learn or practice skills	4.7 (1.0)	3.7 (1.8)
Review fidelity information	4.7 (1.4)	3.6 (1.8)

Roles of Family Partners. Survey respondents were asked information about their perceptions on the primary roles of family partners. Respondents ranked a list of fourteen job activities, forcing them to identify importance in comparison to other job duties. Average ratings of importance are presented in Table 5, with 1 representing the most important function and 14 the least. There is a reasonable amount of variability in ratings, reflecting a lack of consensus on the core activities for family partners. There was some general consensus that engaging families in services and inspiring hope are two of the most critical activities. Facilitating team meetings, assisting with the transition out of services and responding to crisis events were generally seen as the least important for a family partner role. Larger discrepancies in ratings were found for responding to crisis events, sharing their personal stories, and gathering information about the child/family. In each case, family partners ranked these activities as more critical than managers did. Additional items that were added to the list included facilitating parent support groups, assisting with interactions with peace officers, and educating families about policy issues affecting their family.

Table 5. Rankings of Most Important Family Partner Activities

	Managers	Family Partners
	Mean Rank (SD)	Mean Rank (SD)
Engaging the family in services	3.9 (3.5)	2.4 (2.1)
Inspiring hope for the future	4.1 (4.3)	3.7 (3.3)
Assisting families in navigating other systems	4.8 (3.7)	5.4 (4.0)
Serving as a role model	5.1 (3.8)	4.2 (3.2)
Teaching advocacy skills to parent	5.4 (3.4)	5.7 (3.8)
Identifying community resources for families	5.6 (3.6)	4.8 (3.2)

Helping families access community resources	5.9 (3.7)	5.0 (3.3)
Gathering information about a child/family	6.4 (4.3)	3.4 (3.6)
Assisting the family in planning services and supports	7.3 (4.4)	7.8 (4.7)
Providing social support	7.9 (4.4)	7.0 (4.3)
Sharing their personal story when appropriate	8.8 (4.1)	5.9 (4.4)
Teaching parenting skills	9.0 (4.6)	7.0 (4.7)
Assisting the family in transitioning out of services	10.2 (4.8)	9.8 (5.6)
Responding to crisis events	11.6 (4.8)	8.7 (6.1)
Facilitating team meetings	12.3 (3.5)	11.1 (5.7)

In addition to the primary roles of the family partner in service provision, family partners were asked about the extent to which they served in other agency roles related to family voice (Table 6). The majority of parents reported that they participate to some degree in the development of programs and services, as well as the selection and training of staff within the agency. Family partners were less likely to report that they participated in oversight boards, evaluation of programs, or engaged other parents in family voice roles within the organization.

Table 6. Additional Roles Undertaken by Family Partners

In my role as a family partner,	**Strongly Disagree/ Disagree**	**Neither Agree or Disagree**	**Strongly Agree/ Agree**
I regularly participate in the development of programs and services.	4 (13.3%)	5 (16.7%)	21 (70.0%)
I regularly participate in the selection and/or training of staff.	6 (20.0%)	6 (20.0%)	18 (60.0%)
I regularly participate in oversight boards or policy committees.	13 (43.3%)	9 (30.0%)	8 (26.7%)
I regularly participate in the evaluation of programs.	18 (60.0%)	5 (16.7%)	7 (23.3%)
I regularly engage other parents to serve as leaders and consultants within our organization.	14 (48.3%)	5 (17.2%)	10 (34.5%)

Administrators and supervisors were asked similar questions regarding the extent to which they believed family partners should serve in these roles within their organization. Table 7 summarizes these responses. Overall, administrators and supervisors were more uncertain about whether family partners should serve in these non-service roles. They reported more agreement with family partners participating in program development and engaging other families for involvement. Managers were less likely to feel comfortable with family partners playing a role in staff selection and training, oversight boards, or evaluation activities.

Table 7. Managers Beliefs about Other Roles for Family Partners

An important role for family partners is	**Strongly Disagree/ Disagree**	**Neither Agree or Disagree**	**Strongly Agree/ Agree**
to participate in the development of programs	3	14	26

and services.	(7.0%)	(32.5%)	(60.5%)
to participate in the selection and/or training of staff.	10 (23.2%)	18 (41.9%)	15 (34.9%)
to participate in oversight boards or policy committees.	11 (25.6%)	21 (48.8%)	11 (25.6%)
to participate in the evaluation of programs.	9 (20.9%)	21 (48.9%)	13 (30.2%)
to engage other parents to serve as leaders and consultants within our organization.	6 (14.0%)	12 (27.9%)	25 (58.1%)

Attitudes Regarding Family Partners within the Organization. Participants were each asked questions about their perceptions of the organizational support for the family partner workforce. Questions were somewhat different for administrator and supervisors versus family partners and are presented in Tables 8 and 9. Most notably, managers reported the most difficulty in their procedures for recruitment of qualified and successful family partners, as well as limited opportunities for career advancement.

Table 8. Administrator or Supervisor Attitudes

	Strongly Disagree or Disagree	**Neither Agree nor Disagree**	**Strongly Agree or Agree**
Our agency has adequate procedures in place to recruit qualified and successful family partners.	14 (33.3%)	10 (23.8%)	18 (42.9%)
Our family partners have adequate training to be competent in their role.	6 (14.6%)	5 (12.2%)	30 (73.2%)
Our family partners receive adequate supervision to be competent in their role.	5 (11.9%)	6 (14.3%)	31 (73.8%)
Our family partners have opportunities for professional development.	2 (5.0%)	9 (22.5%)	29 (72.5%)
Our family partners have opportunities for career advancement.	11 (26.2%)	16 (38.1%)	15 (35.7%)
Family partners have formal opportunities to network with other family partners.	5 (11.9%)	8 (19.0%)	29 (69.1%)
Other staff within the agency understand and value the work that family partners do.	4 (9.5%)	4 (9.5%)	34 (81.0%)
Our family partners understand their role with families and maintain good boundaries.	3 (7.1%)	5 (11.9%)	34 (81.0%)
Agency leadership understands and values the work that family partners do.	5 (11.9%)	3 (7.1%)	34 (81.0%)
Our agency policies are supportive of family partners' responsibilities to their own family members' mental health needs.	4 (9.5%)	3 (7.2%)	35 (83.3%)

Family partners reported the greatest concerns with opportunities for career development and opportunities for professional development. Family partners generally felt they had adequate

training and supervision opportunities. Although most respondents indicated that coworkers and managers understood and valued their work, approximately 30% of family partners could not agree with this statement, suggesting opportunities for organizational changes in some agencies.

Table 9. Family Partner Attitudes

	Strongly Disagree or Disagree	Neither Agree nor Disagree	Strongly Agree or Agree
I have adequate training to be competent in my role as a family partner.	1 (3.3%)	0 (0%)	29 (96.7%)
I have adequate supervision to be competent in my role as a family partner.	2 (6.7%)	3 (10.0%)	25 (83.3%)
I have adequate support from my agency to be successful as a family partner.	4 (13.3%)	4 (13.3%)	22 (73.3%)
I have adequate opportunities for professional development.	9 (30.0%)	2 (6.7%)	19 (63.3%)
I have adequate opportunities for career advancement.	11 (36.7%)	8 (26.6%)	11 (36.7%)
The coworkers in my organization understand and value the work that I do.	6 (20.0%)	3 (10.0%)	21 (70.0%)
Directors or managers within my organization understand and value the work that I do.	5 (17.2%)	4 (13.8%)	20 (69.0%)
Agency policies are supportive of my responsibilities to my family's mental health.	4 (13.3%)	5 (16.7%)	21 (70.0%)

Analysis of Service Encounters

Dataset. DSHS does not have a clear mechanism for identifying individuals who meet the definition of a family partner within the administrative data system. Staff serving in this role may be identified in several different provider types (e.g., non-traditional provider, qualified mental health provider). To identify the best sample of family partner providers, all providers who provided a Family Partner service (service code 2509) or Parent Support services (service code 2508) were identified. Family Partners are the expected provider of these two services. If providers had fewer than 10 family partner service encounters (2508/2509), this was assumed to be error and they were removed from the dataset. After identifying this core set of family partner providers, additional service encounters provided by these staff members were incorporated into the dataset. The dataset was restricted to services provided between April 1, 2010 and March 31, 2013.

Description of Family Partners. There were 110 family partners represented in the dataset with at least one family partner in each local mental health authority. Almost all of the providers (93.6%) were identified as internal to the organization. The majority of family partners were identified as non-traditional providers (60.9%). Thirty-one percent met qualifications of a QMHP, 7.3% were considered paraprofessionals, and 1% was classified as a LVN/CAN. Table 10 describes the workforce capacity for family partners within each LMHA. Capacity ranges from a low of 0.30 providers per 100 youth served to a high of 17.85 providers per 100 youth.

The overall state ration is 1.10 family partners for 100 youth. Since the data does not allow for a determination of the extent to which providers are hired as full-time staff members, the workforce capacity is estimated based on an assumption of full-time providers. Similarly, service targets identified in the performance contract are used in the estimate, and likely under-represent the number of youth actually served. Therefore, the capacity estimates provided are likely to be higher than actual system capacity.

Table 10. Capacity of Existing Family Partner Workforce

Local Mental Health Authority	Number of Family Partner Providers	Service Targets in FY12	Number of Family Partners for 100 Youth
010 Betty Hardwick	1	91	1.10
020 Texas Panhandle	2	239	0.84
030 Austin Travis County Integral Care	3	523	0.57
040 Central Counties	3	191	1.57
050 Center for Health Care Services	9	454	1.98
060 Center for Life Resources	3	44	6.82
070 Central Plains	2	98	2.04
090 Emergence Health	2	588	0.34
100 Gulf Coast	2	194	1.03
110 Gulf Bend	1	124	0.81
130 Tropical Texas	4	399	1.00
140 Spindletop	1	335	0.30
150 Star Care	1	133	0.75
160 Concho Valley	1	64	1.56
170 Permian Basin	1	132	0.76
180 Nueces County	3	212	1.42
190 Andrews	1	142	0.70
200 MHMR of Tarrant	3	544	0.55
220 Heart of Texas	5	147	3.40
230 Helen Farabee	1	269	0.37
240 Community HealthCore	1	330	0.30
250 Brazos Valley	1	83	1.20
260 Burke Center	3	234	1.28
280 Harris County	4	1,873	0.21
290 Texoma MHMR	1	61	1.64
350 Pecan Valley	2	110	1.82
380 Tri-County MHMR	3	223	1.35
400 Denton County MHMR	3	105	2.86
430 Texana Center	2	284	0.70
440 ACCESS	2	126	1.59
450 West Texas Center	5	314	1.59
460 Bluebonnet Trails Community Center	4	228	1.75
470 Hill Country	1	259	0.39
475 Coastal Plains	2	280	0.71

480 Lakes Regional MHMR	6	34	17.65
485 Border Region MHMR	17	261	6.51
490 Camino Real	4	66	6.06
State Total	110	9,904	1.11

Family Partner Services. Most LMHAs primarily utilized their family partners to provide one-on-one family partner services, with a few outlier organizations providing a substantial number of parent support group encounters. Border Region MHMR and Lakes Regional MHMR both provided significantly more parent support group encounters than other LMHAs. Parents of children receiving family partner services received an average of 13.7 (*sd*=18.4; range=1 to 169) encounters while in services. Parents in parent support groups received an average of 3.6 (*sd*=3.8; range=1 to 30) encounters.

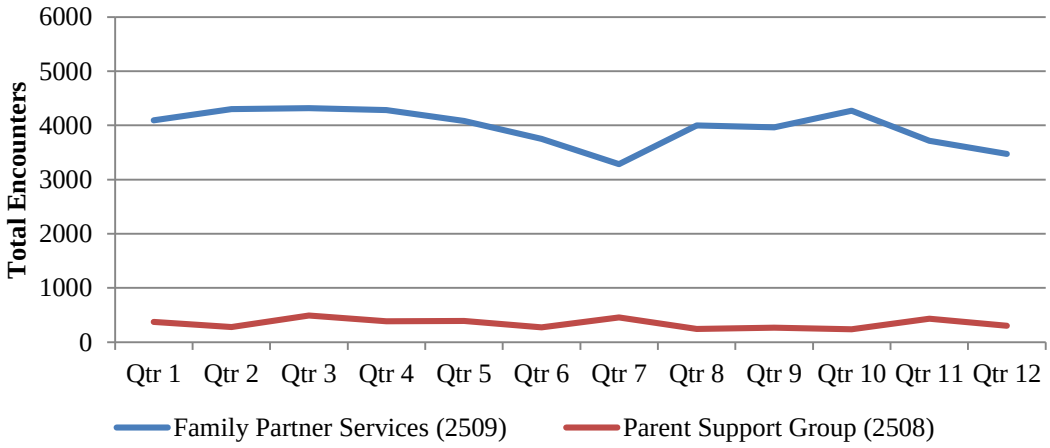
Table 11. Family Partner Encounters Occurring at Each LMHA

Local Mental Health Authority	Number of Family Partner Encounters		Number of Families Receiving Family Support
	Parent Support Group	Family Partner Services	
010 Betty Hardwick	0	1,446	193
020 Texas Panhandle	0	593	214
030 Austin Travis County Integral Care	0	1,435	152
040 Central Counties	0	56	26
050 Center for Health Care Services	0	4,654	615
060 Center for Life Resources	0	77	22
070 Central Plains	0	247	43
090 Emergence Health	0	901	87
100 Gulf Coast	0	534	68
110 Gulf Bend	0	1,473	129
130 Tropical Texas	0	2,368	431
140 Spindletop	64	1,606	289
150 StarCare	0	1,715	90
160 Concho Valley	0	46	13
170 Permian Basin	0	332	26
180 Nueces County	0	942	107
190 Andrews	3	1,834	266
200 MHMR of Tarrant	20	4,251	491
220 Heart of Texas	569	1,773	226
230 Helen Farabee	0	530	97
240 Community HealthCore	52	152	71
250 Brazos Valley	36	773	109
260 Burke Center	0	176	58
280 Harris County	0	8,992	725

290 Texoma MHMR	4	146	53
350 Pecan Valley	16	116	59
380 Tri-County MHMR	0	266	78
400 Denton County MHMR	124	257	95
430 Texana Center	0	3,030	415
440 ACCESS	0	22	12
450 West Texas Center	0	1,828	270
460 Bluebonnet Trails Community Center	309	495	207
470 Hill Country	57	1,107	143
475 Coastal Plains	39	1,180	94
480 Lakes Regional MHMR	155	33	67
485 Border Region MHMR	2,555	801	860
490 Camino Real	117	1,343	309
State Total	4,120	47,530	7,210

Figure 1 depicts the total number of family partner and parent support group encounters provided across the state within each quarter of the three-year time frame. The provision of family partner services has remained relatively stable over the three-year timeframe. There is a potential decreasing trend within the last two quarters that may or may not continue. Parent support groups have also remained relatively stable over the three-year period, with some cyclical trends. Rates of parent support groups appear to decline during the summer months and are elevated in the fall.

Figure 1. Family Partner Encounters
April 2010 to March 2013



Other Child or Parent Services Provided by Family Partners. The data was reviewed to examine other services that providers serving as family partners may provide to families. Table 11 identifies the frequency of the provision of many available services. It is noteworthy that family partners provided slightly more "other services" than they did parent support groups and family partner services. Routine case management was the most common service provided by family partners, with skills training and intensive case management (wraparound) also very common.

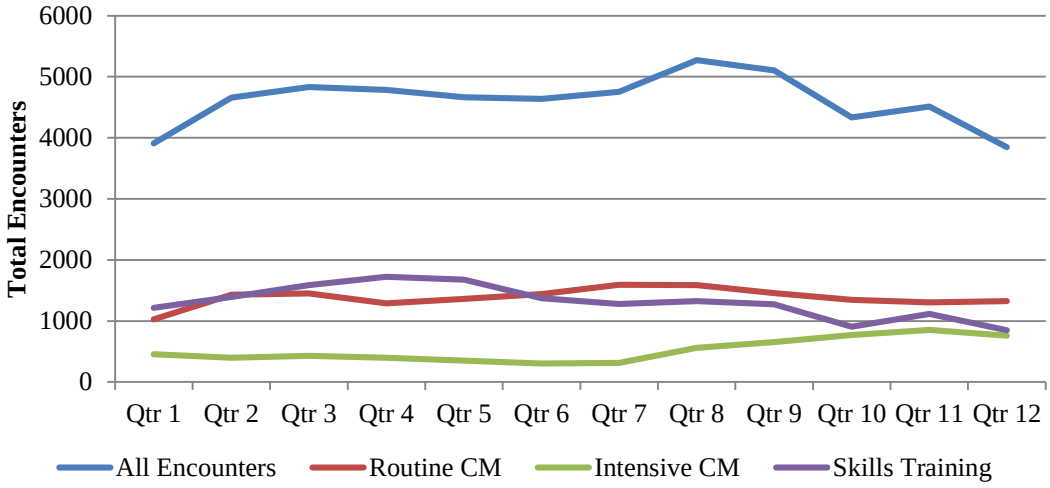
Table 11. Other Child Services Provided by Family Partners

Service Type	Number of Encounters	Number of Families Served
211 Screening	2,473	2,177
222 Assessment	1,192	893
242 Routine Case Management	16,618	2,019
252 Intensive Case Management	6,241	700
260 Benefits Eligibility	295	283
270 Continuity of Service	269	176
280 Family Case Management	212	56
2102 Medication Related Services	2,667	434
2105 Medication Training & Support	3,255	796
2106 Medication Training & Support	2,401	618
2504 Flexible Community Supports	575	20
2505 Crisis Intervention Rehab	2,193	1,025
2506 Skills Training, Individual	15,711	1,561
2507 Skills Training, Group	940	341
2513 Family Training, Individual	260	84
Total	55,302	5,419*

*unique youth served with other child services

Figure 2 depicts the trend in the provision of other services by family partners over time. Overall, it appears there had been a gradual increase in the number of other services provided by family partners over the first two years of the time period, followed by a decline in the third year. There was an increase in the use of family partners to provide skills training in the first year, with a decrease in that trend during the last two years. There was a marked increase in the use of family partners to provide intensive case management between January 2012 and March 2013. This trend did not align with clarifying information provided by DSHS indicating that family partners should not play dual roles (facilitator and family partners) on a family's wraparound team.

Figure 2. Other Child Service Encounters Provided by Family Partners April 2010 to March 2013



Youth Characteristics. The parents of 7,210 unique youth receive either family partner services or parent support group or both. Characteristics of these youth are presented in Table 12. Information on youth whose parent received family partner services either with or without parent support group is described separately from those youth whose parents received support groups alone. Youth were fairly similar across the two groups on their age and gender distribution. The youth whose parents received parent support services were more likely to be White – Hispanic. This is likely due to the significant number of youth served in Border Region MHMR, rather than an increased use of parent support groups with Latino families. Family partner services were most likely to be provided to youth in Level of Care 2 (53.6%), the more intensive service level, although provision in Level of Care 1 (less intensive) was also common (36.9%). In contrast, parent support groups were most likely to be used to reach families in Level of Care 1 (77.1%).

Table 12. Youth Characteristics

	Youth Whose Parents Received Family Partner Services (2509) N=6,017	Youth Whose Parents Received Parent Support Services Without Receiving Family Partner Services N=1,193
Characteristic	**Mean (SD)**	**Mean (SD)**
Youth Age	12.6 (3.7)	11.7 (3.7)
	N (%)	N (%)
Gender		
Female	2,194 (36.5%)	458 (38.4%)
Male	3,823 (63.5%)	735 (61.6%)

Race/Ethnicity		
White – Non-Hispanic	1,973 (32.8%)	214 (17.9%)
White – Hispanic	2,311 (38.4%)	827 (69.3%)
Black – Non-Hispanic	1,403 (23.3%)	117 (9.8%)
Multi-Racial	295 (4.9%)	32 (2.7%)
Other	35 (0.6%)	3 (0.3%)
Level of Care Authorized		
Level 1 (Less intensive)	2,221 (36.9%)	920 (77.1%)
Level 2 (More intensive)	3,226 (53.6%)	155 (13.0%)
Level 4 (Maintenance)	210 (3.5%)	77 (6.5%)
Other	36 (0.6%)	6 (0.5%)
Missing or None	324 (5.4%)	35 (2.9%)

Conclusion

Summary of Findings

The core components of parent peer support services have been identified in the literature. Models vary significantly across the country, although generally in terms of the emphasis of the various components or the use of traditional providers in partnership with veteran parents. Research on parent peer support is limited at this point; however, evidence is beginning to suggest that parent peer support can successfully improve parent engagement in the service system and reduce caregiving stress. Results are mixed regarding whether parent peer supports has a significant impact on child symptoms or functioning. Evidence suggests that parents prefer a more informal, individualized relationship with parent support providers. Early support for telephone-based support is very promising. Two parent peer support fidelity measures have been developed, one focused on the PEP model and the second on parent peer support in wraparound. Both instruments need further study and validation.

Texas is a leader in its use of parent peer support across the state and has developed some strengths in its infrastructure to support family partners in their roles. These include:

- Contractual requirements for family partner services;
- Presence of family partners in all local mental health authorities;
- Statewide family partner training and certification program through Via Hope;
- Statewide training of supervisors;
- Provider definition established in the Medicaid State Plan;
- Financing of services through federal block grant and 1915(c) waiver;
- Growing sense of connectedness between family partners across the state; and a
- General understanding and recognition of the value of peer support in agencies.

Family partners generally felt well-trained and supported in their role as a peer support provider. Most family partners had regular supervision; however supervision tended to focus on problem solving around individual families instead of building generalizable skills in creative problem solving and identification or development of informal community supports. Family partner services were more commonly provided in intensive levels of care, but also being used in lower levels. In some organizations, family partners played several service roles, with the provision of

routine case management, skills training, and intensive case management the most common traditional services provided. Some agencies are utilizing family partners in other agency roles related to family voice, such as participating in program development and staff hiring and training activities.

Despite the significant progress made in supporting family partners across the state, some gaps or weaknesses remain. The issues identified in this initial study include:

- System capacity for providing family partner services varies dramatically across the state;
- Recruitment and retention of family partners remains challenging;
- Professional development and opportunities for professional advancement are sometimes limited;
- Productivity standards vary dramatically and may impact service quality in some agencies;
- Opinions of administrators and supervisors vary about the extent to which family partners should serve in non-service roles representing families;
- Family partners are playing a variety of service roles within some agencies, which may be confusing for the families they serve;
- Financing for family partner services is discretionary outside of the waiver;
- There has been no exploration of the outcomes associated with family partner services, and
- Service quality or fidelity measures have not been incorporated into quality management activities.

Preliminary Recommendations

1. Via Hope and/or DSHS should provide technical assistance and support to local mental health authorities on their role in the recruitment of individuals for the family partner workforce, including opportunities to identify parents within the system who would have an interest in developing the skills to take on this role.
2. Via Hope and TIEMH should work to identify or develop tools to support coaching of family partner skills development, either by a supervisor or external coach.
3. TIEMH, Via Hope, and DSHS should identify or develop and test tools to monitor service quality or "fidelity" to the state's model to enhance the consistency of the service across local mental health authorities and allow for an examination of outcomes associated with family partner services.
4. DSHS should consider revisions to the Medicaid State Plan to incorporate all family partner activities that are potentially reimbursable through this mechanism.
5. Ensure that family partners are considered a critical provider group and family partner services are integral in any benefit package developed for children with SED, whether within managed care integration, health homes, YES Waiver expansion, or other potential system initiatives.

Acknowledgements

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Appendix A: Items from the Family Peer Advocates Checklist

Rodriguez, J., Olin, S. S., Hoagwood, K. E., Shen, S., Burton, G., Radigan, M., & Jensen, P. S. (2011). The development and evaluation of a parent empowerment program for family peer advocates. *Journal of Child and Family Studies*, *20*(4), 397-405.

Emotional support
I spent time listening to the parents' concerns and building relationship with parents (Q2)
I helped this parent identify ways to take care of him/herself (Q18)

Action planning
I clearly stated the purpose of the meeting (Q1)
I spent time setting priorities with the parent (Q3)
I made a list of concerns and prioritized them (Q5)
I made specific recommendations that were clear and realistic (Q6)
I followed up with parent on a previous goal (Q7)

Information provision
I provided information and resources to parents about services they are seeking (Q17)
I provided the parent with information about their child's specific disorder (Q19)
I provided information to parent about how to access mental health services that are best for his/her child (Q24)

Advocacy
I provide parent with information about his/her rights (Q27)
I worked with parent to facilitate a contact with a teacher (Q8)
I accompanied parent to an appointment with a teacher (Q12)
I worked with parent to facilitate a contact with a guidance counselor/school social worker (Q9)
I accompanied parent to an appointment with a guidance counselor/school social worker (Q13)
I accompanied a parent to an IEP meeting (Q25)
I worked with a parent to facilitate a contact with a mental health professional (psychologist) (Q11)
I accompanied a parent to an appointment with a other mental health professional (psychologist) (Q15)
I worked with a parent to facilitate a contact with a medical professional (Q10)
I accompanied a parent to an appointment with a medical professional (psychiatrist) (Q14)

Skill development
I helped parent create a case management book (Q4)
I helped to prepare parent for an appointment with a professional (Q16)
I helped prepare the parent for his/her IEP meeting (Q26)
I role played with parent about talking with a teacher about their child's behavior (Q20)
I role played with parent about talking with a guidance counselor/school social worker about their child's behavior (Q21)
I role played with parent about talking with a medical professional (psychiatrist) about their child's behavior (Q22)
I role played with parent about talking with another mental health professional (psychologist) about their child's behavior (Q23)

Appendix B: Wraparound Parent Partner Fidelity Tool

Polinsky, M. L., Levine, M. H., Pion-Berlin, L., Torres, A., & Garibay, J. (2013). Development and validation of a Wraparound Parent Partner Fidelity Tool. *Social Work Research*, *37*(2), 111-120.

How much did the parent partner:

Engagement phase

1. Explain to the family that they are a parent of child with emotional or behavioral challenges?
2. Explain the role of the parent partner to the family?
3. Effectively share their own story with the family in a way that built connection and confidence?
4. Share their own story with the family in a way that built hope?
6. Explore the family s situation regarding the need for rest and relief?
7. Explore the family's situation regarding the need for safety?

Planning phase

8. Check with child and family team to ensure they understood parent's perspective?
9. Check with child and family team to assure that having differences is acceptable?
10. Assist child and family team in acknowledging family's lived experience and culture?
11. Assist child and family team in acknowledging the family's beliefs to build agreement for a common team vision statement?
12. Actively participate by speaking up to support the family's perspective during the child and family team meeting?
13. Actively participate with the family in the development of the initial child and family team plan?
14. Actively participate with other team members in the development of the initial child and family team plan?

Implementation phase

15. Provide individualized peer-to-peer support to the parents?
16. Develop plans and/or strategies with the family to ensure their concerns were understood by the child and family team?
17. Develop communication strategies with the family to ensure their perspective was being heard by the child and family team?
18. Work with the parents to connect the family with identified community resources?
19. Assist the family in engaging with community resources?
20. Work with the parents and other team members to continue to identify unmet needs that the child and family team agreed to address?

Transition phase

21. Help introduce the transition phase of Wraparound to the child and family team?
22. Help introduce the completion of the Wraparound process to the child and family team?

23. Practice implementation with the family, as identified in the child and family team plan?
24. Rehearse crisis responses with the family, as identified in the child and family team plan?
25. Continue to use the family's culture and beliefs in assisting them to engage in new resources/supports?
26. Continue to use each team member's individual strengths in assisting the family to engage in new resources/supports?
27. Assist the facilitator in preparing the family to transition from Wraparound by ensuring the family's culture and beliefs were evident in the process?
28. Assist the facilitator in preparing the family to transition from Wraparound by ensuring that the family's voice and choice were evident in the process?