REPORT / CERTIFIED FAMILY PARTNERS

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Outcomes of Services and Supports Provided by the Family Partner Workforce

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Introduction

A Family Partner is a family member of a child with one or more health care concerns who has a strong connection to their community and uses this experience to assist other families in navigating the systems of care in those communities (Osher & Penn, 2010). Models of parent peer support vary on many dimensions, including those that are diagnosis-specific and those with a general purview (Young, McMenamy, & Perrin, 2001). Parents of children with behavioral health concerns experience many barriers when attempting to access treatment for their child, including structural barriers and lack of knowledge and understanding of mental health problems and the health-seeking process (Reardon, Harve, Baranowska, O'Brien, Smith, & Creswell, 2017). Studies have shown that parent peer support can reduce a recipient's feelings of isolation (Slowik, Willson, & Loh, 2004), lower anxiety (Ireys & Sakwa, 2006), increase engagement with other health/mental health services (Koroloff & Friesen, 1991), and improve service quality overall (Stroul, 1996).

As evidence of the efficacy of parent peer support has grown, many states have codified Family Partners as credentialed professionals. In Texas, a Certified Family Partner (CFP) is "a parent or guardian who has lived experience raising a child with mental or emotional challenges" who has attained state certification and is experienced in navigating systems of care (Via Hope, 2018a, para. 1). In Texas, CFPs may be employed to provide mentorship and guidance to other family members of children with similar challenges.

Prior Reports

In 2013, in anticipation of the addition of CFPs as eligible providers for reimbursable services in Texas, researchers at the Texas Institute for Excellence in Mental Health (TIEMH) summarized the literature on support services offered by Family Partners (Lopez, 2013). Researchers conducted a survey of Texas CFPs, supervisors, and program administrators to examine features of CFP employment, including employee benefits, training and supervision, and core functions of CFP employment from the perspective of the respondents (Lopez, 2013). Additionally, researchers examined administrative data, including the number of individuals in CFP services at each Community Mental Health Center (CMHC), volume of service encounters, and changes in the amount of CFP and support group services provided over three years. Results of the survey indicated that CFPs felt that they had received adequate training and were well supported in their employment. However, during supervision CFPs identified that there was little focus on skill development and that much of their supervision was problem-oriented.

To investigate concerns regarding increased turnover and to explore the impact of policy changes allowing CFPs to provide parent-focused skills training, researchers at the TIEMH developed and implemented a new survey of CFPs in 2014 to examine their level of job satisfaction (Lopez et al., 2014). Additionally, state administrative data was re-examined to determine whether the 2014 policy changes had affected the services provided by CFPs. Researchers found evidence that CFP job satisfaction was related to their perception of their impact on the families they serve and percent of time they spent in direct contact with their assigned families. Additionally, researchers found that the intention to maintain employment at their agency was closely related to the CFPs satisfaction with their employment. One recommendation researchers made was for employers to increase the percentage of time CFP employees spend in direct contact with families and to reduce the amount of time they spend completing administrative tasks.

In 2016, researchers and the TIEMH implemented a survey of CFP training and employment outcomes based on findings from the 2013 study of CFP employment (Peterson, Stevens Manser, Lopez, Kaufman, & Granger, 2017). The survey included questions about the following features of their certification and employment:

- Features of CFP training, certification, and continuing education
- Benefits and salary information
- Productivity standards and caseload size
- Opportunities for professional development
- Mechanisms of funding for CFP services
- Content of supervision
- Perceptions of supervisor and coworker supportiveness and understanding of the CFP role
- CFP perceptions of their agency's Organizational Recovery Orientation

In this report, researchers found that the average CFP employment tenure was six years. Caseload sizes and productivity standards were highly variable; this may have indicated that CFPs' roles and job descriptions were increasingly variable. For example, some respondents included individuals employed as CFP supervisors, and other respondents were employed at organizations that did not provide direct care services. Many respondents were unsure about what funding mechanisms were used to pay for the services they provided. Findings suggested that since the 2014 survey, CFPs reported that a nearly equal amount of time in supervision was spent building skills as was problem-oriented (discussing assigned families). Many CFPs reported that they were infrequently able to discuss wellness and self-care during supervision. Respondents rated their supervisors' level of supportiveness as high (8.21/10) and their understanding of the CFP job role (7.84/10) as moderately high. They rated their coworkers' level of understanding (6.40/10) and supportiveness (6.93/10) less highly. Recurrent themes of the survey included discussion of CFPs providing financial support and resources (e.g. food) during group sessions with the families they served, a lack of career advancement opportunities, and the desire for additional trainings, including more information on the topic of trauma informed care.

In 2017, TIEMH researchers conducted a pilot study exploring the accessibility of family peer support across the state and examined differences in demographics and needs between those provided family peer support and those who either chose not to access it or for whom it was unavailable (Lopez & McClung, 2017). The researchers attempted to examine the outcomes of family peer support services using existing measures captured in state administrative data. This study found that most families did not receive family peer support, and that those who do frequently receive fewer than five encounters. The researchers found that family peer support was more likely to be provided within higher levels of care and to children with more significant needs; however access did not appear to be related to an increased rating of family needs. The study found few differences in family or child outcomes based on receipt of family partner services, but did find a small dosage impact, with a greater number of encounters leading to greater improvement on caregiver needs. The authors concluded that any subsequent study should utilize more sensitive measures of child and family needs.

Current Report

The current report aims to conduct a state landscape review of family peer support, focused on financing strategies and rates. The report conducts an analysis of the provision of family peer support within the state.

This report incorporates family peer support provided within traditional public mental health services, as well as the YES Home and Community Based Services Waiver, which provides a primary mechanism for Medicaid funding of these services. The report also conducts a study of the impact of family peer support services, utilizing data available through the Texas System of Care initiative and state administrative data, to provide a more sensitive analysis of the impact of family peer support services on families and youth.

State Landscape of Family Peer Support

A state landscape was conducted, utilizing information from a published review of financing strategies (Schober & Baxter, 2020). Thirty states and the District of Columbia currently provide some Medicaid funding for family-to-family peer support services. Seventeen (54.8%) of these regions provided Medicaid funding through a state plan amendment. Five states, including Texas, provide funding through a 1915c Home and Community-based Services Waiver, which limits access to families of children meeting eligibility for inpatient (or residential in some states) facilities. Three other states provide funding through a 1915i Home and Community-based Services Waiver, limiting access to one or more specific populations. Three states provide Medicaid funding for family peer support through an 1115 Waiver and five through a 1915b Waiver, both of which allow for managed care authority. Table 1 lists the states allowing Medicaid funding for family peer supports and the fee rates for individual (versus group) services. The average rate for individual family peer support was $14.79 per 15 minute interval. Texas' rate through the Youth Empowerment Services (YES) Waiver is $6.25.

Table 1. *State's Funding for Family Peer Support*

State	Method	Rate per 15 minutes	State	Method	Rate per 15 minutes
Alabama	State Plan	$20.30	Michigan	1915c Waiver	PMPM
Alaska	State Plan	$20.17	Minnesota	State Plan	$15.02
Arizona	State Plan	$17.02	Mississippi	State Plan	$7.83
Arkansas	1915i Waiver	PMPM	Missouri	State Plan	$21.97
Colorado	1915b Waiver	Varies by ACO	Nebraska	State Plan	$11.50
District of Columbia	State Plan	$21.97	New Hampshire	1915i Waiver	$20.55
Florida	1115 Waiver	$21.97	New Mexico	State Plan	$12.00
Georgia	State Plan	Varies (m=$19.75)	New York	State Plan	Varies (m=$17.36)
Idaho	1915b Waiver	Varies by MCO	Oklahoma	State Plan	$9.75
Iowa	1915b Waiver	$12.50	Oregon	1115 Waiver	$15.00
Kansas	1915c Waiver	$10.30	Tennessee	State Plan	Varies by MCO
Kentucky	State Plan	$8.61	Texas	1915c Waiver	$6.25
Louisiana	1915c Waiver	$12.91	Virginia	State Plan	$6.50
Maine	State Plan	PMPM	Washington	State Plan	$12.30
Maryland	1915i Waiver	$17.80	Wyoming	1915c Waiver	$14.40
Massachusetts	1115 Waiver	$15.96	All States/DC	-	M=$14.79

Methods

Overview of Evaluation Questions

The evaluation aims to continue to advance the understanding of the implementation and impact of family partner services in the Texas public mental health system. The current study continues to advance previous evaluation questions, examining the impact of service delivery and funding over time by exploring access to services across the state, variability of access across levels of care, and the use of funding strategies to increase access. The current study also aims to increase the state's understanding of the impact of family partner services within existing programs that support enhanced outcomes management and more intensive service delivery. The following evaluation questions are addressed in the report:

1. Are family partner services more accessible in certain regions of the state or certain levels of care?
2. Are LMHAs utilizing Medicaid funding opportunities to support services by family partners?
3. Are families who receive family peer support services more likely to be retained in care compared to those not receiving services?
4. Do family outcomes differ for families receiving family partner services compared to those not receiving services?
5. Do youth outcomes differ for families receiving family partner services compared to those not receiving services?

Data Collection and Analysis

The primary source of data for the current study is the HHSC CMBHS administrative dataset. This dataset houses state information about children served in the public mental health system, including demographic information, authorized service levels, service encounters, and measures of child and family strengths and needs. This data source was supplemented with prospective data collected for children and families participating in Texas System of Care. This four-year initiative provides wraparound services and supports to children and families in four LMHAs, focused on enhancing the current service array and improving care coordination. Individuals served through the Texas System of Care were linked with the state administrative data to provide information on service encounters.

Measures

Caregiver Strain Questionnaire (CSQ): The Caregiver Strain Questionnaire is a 21-item self-report measure assessing strain experienced by caregivers and families of youth with emotional or behavioral health problems. Responses are noted on a 5-point Likert scale from 0 "Not at All" to 4 "Very Much." The CSQ has good convergent validity and correlations have been documented with each of its three subscales with constructs including mental health-related quality of life, maladaptive coping, social support, family functioning, and level of functional impairment/extent of behavioral problems. The internal consistency is also well documented (Khanna, Madhavan, Smith, Tworek, Patrick, & Becker-Cottrill, 2011). The CSQ is completed by a caregiver/parent participating in services at program entry (baseline), every 180 days after enrollment, and at discharge.

Pediatric Symptom Checklist (PSC): The Pediatric Symptom Checklist is a brief screening questionnaire designed for use by pediatric health care providers. The questionnaire contains 35 items that are completed by the child's caregiver or the youth to measure psychosocial problems in children. Each item is rated on a three-point scale (e.g, Never, Sometimes, Often) and includes items such as, "complains of aches or pains," "acts as if driven by a motor," and "feels sad or unhappy." Positive screens are those with scores above 27 for ages 6-18 and scores of 24 and higher for children ages 4 and 5. The PSC-17 demonstrated good construct validity, performing as well as other well-established instruments, including the Child Behavior Checklist (Gardner, Lucas, Kolko, & Campo, 2007). There are two parallel forms: one is completed by caregivers; the other is a youth and young adult self-report. The PSC will be completed by a caregiver/parent and youth (if 11 or older) participating in services at program entry (baseline), every 90 days after enrollment, and at discharge.

Columbia Impairment Scale (CIS): The Columbia Impairment Scale is comprised of 13 items that assess 4 major areas of functioning: interpersonal relationships; broad psychopathology; school or job functioning; and use of leisure time. Items are scored on a scale of 0 to 4 and correspond to ratings of "No problem" to "A Very Big Problem." Results from prior research on this measure show high internal consistency, excellent test-retest reliability, and good validity when correlated with other established measures of global impairment (Bird, Shaffer, Fisher, Gould, et al., 1993). The CIS will be completed by a caregiver/parent and youth (if 11 or older) participating in services at program entry (baseline), every 90 days after enrollment, and at discharge.

Family Empowerment Scale (FES): The Family Empowerment Scale is a 34-item rating scale developed to measure empowerment in families with children who have emotional, behavioral, or mental disorders. Respondents rate each item on a 5-point Likert rating scale. Prior research suggests high factor congruence and published internal consistency estimates of reliability ranged from .78 to .89 for the measure. Such results indicate that the FES has robust psychometric properties and may be useful in assessing the empowerment status of families whose children are served in the mental health system. (Singh, Curtis, Ellis, Nicholson, Villani, & Wechsler, 1995). The FES will be completed by a caregiver/parent participating in services at program entry (baseline), every 90 days after enrollment, and at discharge.

Exploration of Statewide Services

Access to Family Peer Support at LMHA/LBHAs

Access by Region. Access to family peer support services was examined across the 39 Local Mental Health or Behavioral Health Authorities (LMHA/LBHAs) to examine equity of access across the state. Figure 1 illustrates the proportion of families receiving at least one family peer support service during the past year. Table 1 lists the proportion of families receiving family peer services at each LMHA/LBHA. Across all centers, 19% of families had access to at least one family partner or family support service. All centers provided at least one family peer support service, but access to the services varied greatly across the different regions. Six LMHA/LBHAs offered services to fewer than 5% of the families served, including the North Texas Behavioral Health Authority, which serves 23% of all children served in the public mental health system. Another six centers provided peer support to at least 40% of the families. Differences in access do not appear to be due to the rural or urban nature of the region, but rather idiosyncratic to the center.

Figure 1. *Proportion of families in services receiving family peer support*

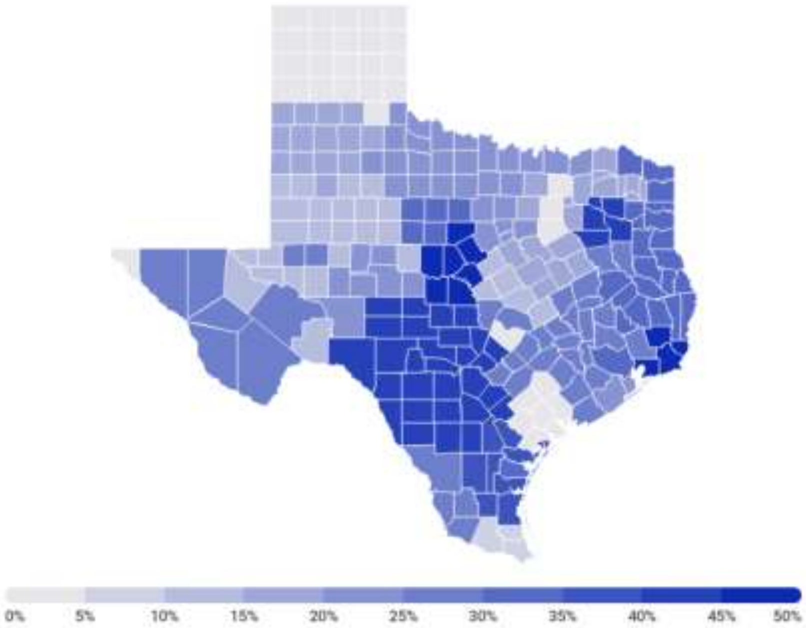


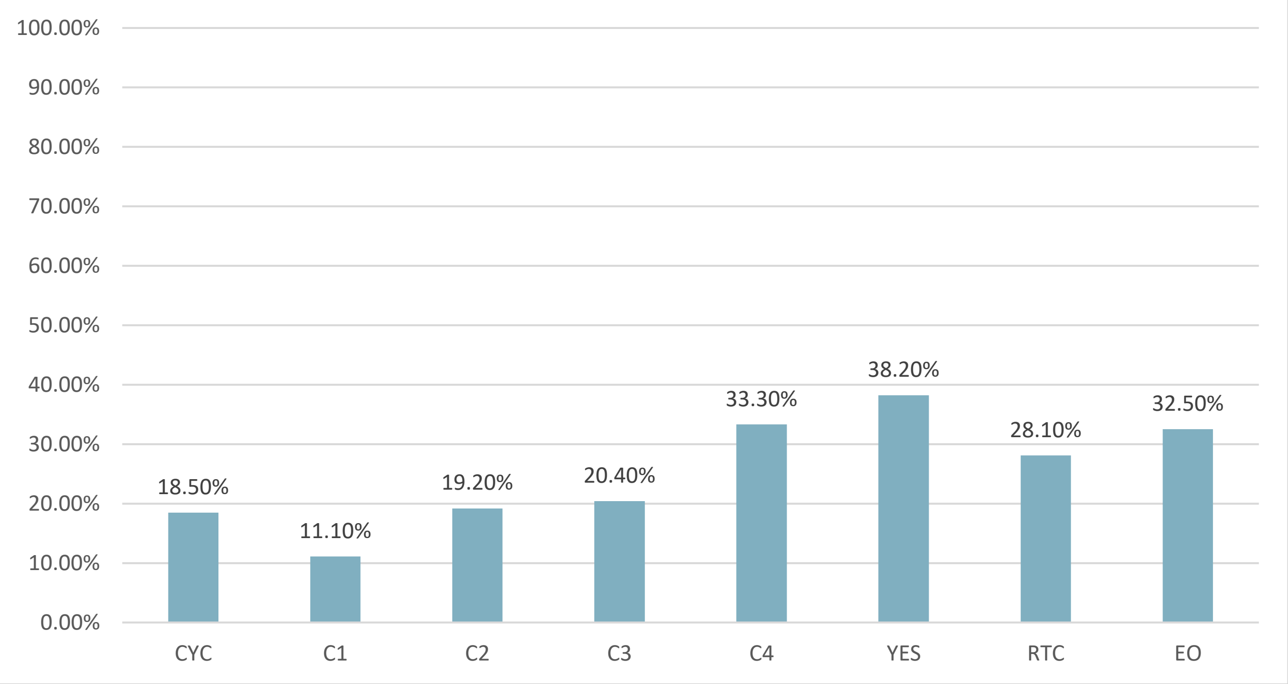
Table 1. *Access to Family Partner Services by Local Mental Health Authority*

LMHA/LBHA	% Receiving Family Partner/Family Support	Total Children Served
All Centers	**19.0%**	**64,338**
Betty Hardwick Center	30.9%	502
Texas Panhandle Centers	1.5%	883
Integral Care	1.9%	2,695
Central Counties Services	10.2%	522
Center for Health Care Services	42.2%	2,587
Center for Life Resources	53.4%	401
Central Plains Center	15.4%	13
North Texas Behavioral Health	0.24%	14,772
Emergence Health Network	4.5%	1,217
Gulf Coast Center	21.8%	541
Gulf Bend Center	0.4%	277

Tropical Texas Behavioral Health	8.3%	6,245
Spindletop Center	49.4%	1,581
Starcare Specialty Health Systems	18.9%	503
MHMR Services for Concho Valley	21.9%	425
PermiaCare	29.7%	414
Nueces Center for Mental Health and Intellectual Disabilities	31.7%	624
Andrews Center Behavioral Healthcare System0.4%4.	43.8%	984
MHMR of Tarrant County	19.6%	2,426
Heart of Texas Region MHMR Center	19.7%	832
Helen Farabee Centers	22.7%	745
Community Healthcore	31.4%	1,698
MHMR Authority of Brazos Valley	28.2%	451
Burke	32.2%	1,520
Harris Center for Mental Health and IDD	31.1%	5,329
Texoma Community Center	23.2%	432
Pecan Valley Centers	21.4%	941
Tri-County Behavioral Healthcare	28.9%	1,770
Denton County MHMR Center	18.4%	598
LifePath Systems	0.3%	1,309
Texana Center	25.5%	1,255
ACCESS	28.0%	425
West Texas Centers	11.9%	754
Bluebonnet Trails Community Services	27.8%	2,161
Hill Country Mental Health Developmental Disabilities Center	40.0%	1,450
Coastal Plains Community Center	39.7%	935
Lakes Regional Community Center	18.5%	211
Border Region Behavioral Health Center	28.6%	2,547
Camino Real Community Services	44.5%	1,363

Access by Level of Care. Family peer support is authorized to be provided across all levels of care within the Texas Recovery and Resiliency system. However, family peer support has been identified as a critical component of intensive services. Family peer providers are important team members within the wraparound approach to care, represented by Levels of Care 4 and Youth Empowerment Services (YES). Family peer support has been identified as a key service within Level of Care Residential Treatment Center (RTC), providing training and support to caregivers as a youth engages in residential services. Family support services help prepare the family for the youth's return to home. Family peer providers are also important team members within the coordinated specialty care services for individuals with early psychosis. Family peer providers provide family education and support to caregivers, striving to reduce stress and discord in families and reduce the burden caregivers may experience. Figure 2 highlights the proportion of families receiving a family partner service by Level of Care. As expected, more families in intensive levels of care received family support services; however, access was still fewer than 40% of families. Access to family peer support seemed particularly low for families in the RTC and Early Psychosis levels of care.

Figure 2. *Percent of Families Receiving any Family Partner or Family Support Services*

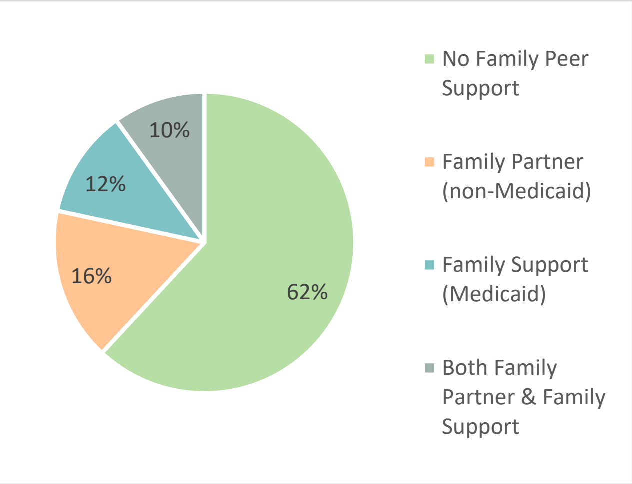


Note: CYC=Young Child; C1=Medication Management; C2=Targeted Services; C3=Complex Services; C4=Intensive Services; YES=Medicaid Waiver; RTC=Residential Treatment; EO=Early Onset Psychosis

Funding for Family Peer Support

Individual and group family peer support services are not currently reimbursable under the Medicaid State Plan. Instead, LMHAs provide most family peer support services with state general revenue or block grant funding, which is not directly allocated for this service. This limited funding makes expansion of family peer supports challenging for LMHAs/LBHAs. LMHAs/LBHAs have two additional mechanisms to fund services by family partners through Medicaid. Family support services are an allowable service for families qualifying for the YES 1915c Medicaid Home and Community-based Waiver. Certified family partners are also one potential provider allowed to provide parent skills training, which is reimbursable by Medicaid through the State Plan.

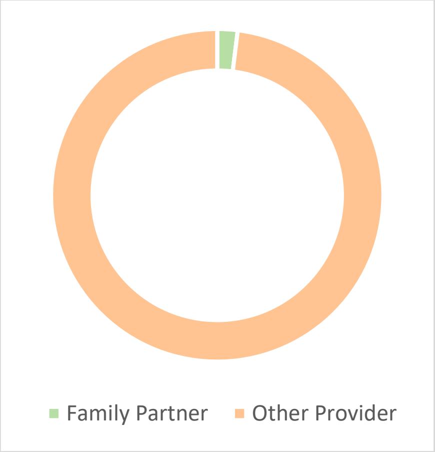
Figure 3. *Proportion of Families Receiving Medicaid-Funded on non-Funded Family Peer Support*



Family Support in YES Waiver. Families who are eligible for the YES Medicaid Waiver program may be eligible and opt to receive family support services. All services within the YES Waiver are eligible for reimbursement by Medicaid, therefore family supports offers an opportunity for LMHAs to be reimbursed for the services provided by family partners to YES family participants. Family supports in YES Waiver are defined as "provides peer mentoring and support to the primary caregivers; engages the family in the treatment process; models self-advocacy skills; provides information, referral and non-clinical skills training; maintains engagement; and assists in the identification of natural / non-traditional and community support systems. Twenty-four of the 39 LMHAs (61.5%) utilized Family Supports (Medicaid) to fund some family peer support services. Eleven LMHAs (28.2%) offered only Family Partner services (non-Medicaid) and did not provide any Family Supports (Medicaid). This may be an opportunity for LMHAs to increase reimbursement opportunities for family peer support, for a small proportion of children and families served. It should be noted, however, that family support services are reimbursed at a rate of $6.25 per 15 minutes, which may not cover the cost of service provision and therefore may be insufficient to increase access to the service.

Parent Skills Training. Some LMHAs/LBHAs may choose to have certified family partners provide behavioral parent training to parents and other caregivers through models such as Nurturing Parenting or Incredible Years. This service may also be provided by Qualified Mental Health Providers (QMHPs) or Licensed Professionals of the Healing Arts (LPHAs). Thirty-two percent of all families served in the last year received parent skills training. As illustrated in Figure 4, only a small proportion of families received (0.67%) received parent skills training by a certified family partner. The majority of the families who received skills training by a family partner also received skills training by a QMHP or LPHA (n=283, 68.2%). Only seven LMHAs/LBHAs clearly had parent skills training provided by certified family partners, with several additional LMHAs/LBHAs having five or fewer families with parent skills training coded as provided by family partners. For this small group, it is possible that this represents inaccuracies in coding rather than a service choice. The majority of LMHAs/LBHAs did not choose to have family partners provide skills training.

Figure 4. *Parent Skills Training*



System of Care Pilot Study

One challenge to measuring the impact of family partner services within the Texas public mental health system is a lack of standardized measures that can illustrate the impact of services on caregivers and their children. As noted in the 2017 Family Peer Support in Texas report, the Child and Adolescent Needs and Strengths (CANS) measure has limited sensitivity to changes in caregiver strengths and needs and caregiver needs on the CANS were unrelated to the provision of family support services. A unique opportunity to examine the impact of family peer support services is provided by the pilot project within Texas System of Care. This initiative provides wraparound care to children and families with significant mental health needs, especially those at risk of out-of-home placement. The initiative provides funding to increase access to family peer support, which may result in both greater access to family partners and increased intensity of peer support services. In addition, the study includes measures of caregiver burden and family empowerment, as well as standardized measures of child symptoms and functioning. This provides an opportunity for an enhanced examination of family peer support, focused on high-need children and their families.

Participants. There are 374 youth who have been served to date in the System of Care initiative across four LMHAs, Burke, LifePath Systems, Harris Center, and Coastal Plains Community Center and 321 had an accurate match to the state administrative data system and received at least one encounter during the time in System of Care.

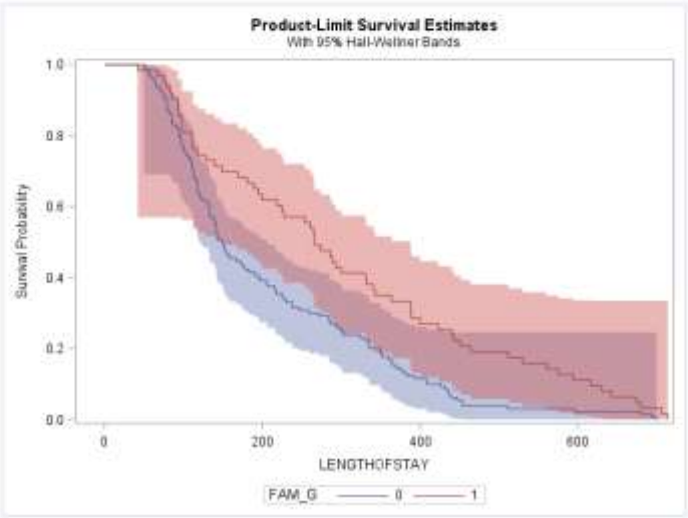
Family Peer Support. The proportion of individuals receiving family peer support through traditional services and/or the YES Waiver are presented in Table 2. Almost 59 percent of families in the sample received family peer support at some time, with the vast majority receiving traditional family partner services. Families who received family supports through the YES Waiver received the service later in their care. The average family received six family peer support visits over their time in care, with those receiving both traditional and YES Waiver services receiving more visits.

Table 2. *Types of Family Peer Support Received by Participants*

Type of Family Peer Support	Total and % Receiving *n*=321	Average Days to First Service *(SD)*	Total Number of Encounters Per Person *(SD)*
Traditional Family Partner Services only	174 (54.2%)	69.4 (74.7)	5.6 (6.2)
YES Waiver Family Support only	5 (1.6%)	159.8 (132.6)	4.2 (2.8)
Both Traditional and YES Waiver	10 (3.1%)	113.5 (57.7)	8.5 (7.0)
Any Family Peer Support	189 (58.9%)	74.1 (77.3)	5.9 (6.2)

Retention in Services. To examine the impact of family peer support services on retention in services, three unique groups were formed. One group (FAM30) consisted of families who had received at least one family peer support services within 30 days during their time in care (*n*=64). The second group (FAM60) consisted of families who had received at least one family peer support service within 60 days during their time in care (*n*=50). The comparison group (CONT) consisted of families who did not receive family support services during their time in System of Care (*n*=132). Another group of families (*n*=75) were dropped from the analyses because they received their first family support services after more than 60 days in care. To ensure that the two groups have an equal opportunity to receive family support services, only those receiving family support within 60 days were included in the analysis.

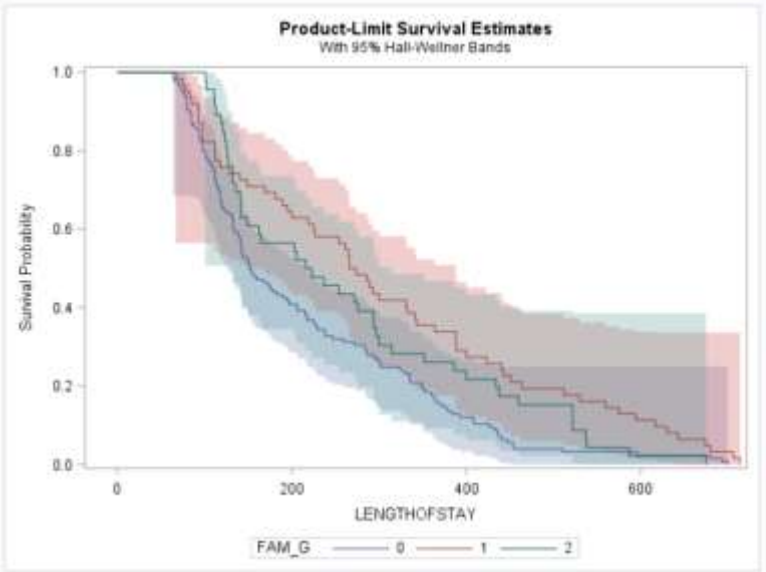
Figure 5. *Survival Analysis of Family Support in 30 Days*



The impact of family support on retention in services was assessed through a survival analysis, which examines the time to a discrete event, in the current analysis the event is treatment withdrawal. The first analysis limited the sample to those retained for 30 days and included an examination of the prediction curves for FAM30 (depicted in red) and CONT groups (depicted in blue). As illustrated in Figure 5, individuals receiving family partner services within the first 30 days were predicted to have a greater probability of being retained in treatment over time. Fifty percent of the CONT group were predicted to drop out of care by 149 days (CI: 133-183 days), while 50 percent of the FAM30 group was predicted to drop out of care by 266 days (CI: 200-302 days). The difference between the two groups was statistically significant (Wilcoxon χ^2=9.30, df=1, *p*=.0023).

A similar analysis was conducted to examine whether receiving family peer support services within the first 60 days of care was equally effecting in reducing the risk of treatment withdrawal. In this analysis, three groups were modeled, the FAM30 and CONT group described in the previous analysis, and a FAM60 group who received their first family support service between 31 and 60 days after enrolling in the program. This analysis limited the sample to those retained in the first 60 days. This analysis adds the FAM60 group, depicted in green. As illustrated in Figure 6, the survival curve of the FAM60 group (green) shows a probability of retention than those receiving no family peer support (blue), but a greater probability of withdrawal than those receiving family peer support within 30 days (red). In this analysis, fifty percent of the CONT group were predicted to drop out of care by 152 days (CI: 139-197 days), while 50 percent of the FAM60 group was predicted to drop out of care by 219.5 days (CI: 142-294 days), and 50 percent of the FAM30 group was predicted to drop out of care by 270 days (CI: 200-341 days). The difference between the three groups was statistically significant (Wilcoxon χ^2=11.28, df=2, *p*=.0039).

Figure 6. *Survival Analysis of Family Support in 60 Days*



Family Outcomes. Family peer support services are intended to reduce the significant caregiver burden that is frequently experienced by caregivers of children with serious emotional challenges. Family outcomes on the Caregiver Strain Scale were explored for families receiving family peer support services within 180 days of program entry (FAM180) and those not receiving family peer support (CONT; see Table 3). The analysis was hampered somewhat by a relatively small sample size for families with no family support. However, the FAM180 group did demonstrate greater improvements on Objective Strain, which includes items like missed work days and financial strain, than the CONT group (*F*(1,71)=-2.44, *p*=.017).

Table 3. *Independent T-tests Comparing Change on Caregiver Strain Measures*

	Family Peer Support in 180 Days (n=56)		No Family Peer Support (n=16)		Statistic	
Scale/Subscale	Baseline *M (SD)*	Follow-up *M (SD)*	Baseline *M (SD)*	Follow-up *M (SD)*	F	*p*
Global Strain	9.7 (2.3)	7.8 (2.6)	8.6 (2.7)	7.9 (2.8)	-1.55	0.124
Externalizing Strain	2.5 (1.1)	2.1 (1.0)	2.2 (1.1)	1.9 (1.2)	-0.34	0.738
Objective Strain	3.5 (1.0)	2.6 (1.0)	2.7 (1.2)	2.6 (1.2)	-2.44	0.017
Internalized Strain	3.7 (0.9)	3.1(1.0)	3.7 (1.0)	3.4 (1.1)	-1.56	0.126

Family peer support is also intended to increase families' perceptions of their capacity to manage challenges caring for their family, enhance their ability to navigate the mental healthcare system, and empower families to help others with similar problems. Table 4 provides a comparison between the FAM180 group and the CONT group on the Family Empowerment Scale. Overall, any improvements on the scales measuring family empowerment were minimal and did not differ significantly between the two groups.

Table 4. *Independent T-tests Comparing Change on Family Empowerment Measures*

	Family Peer Support in 180 Days (*n*=56)		No Family Peer Support (*n*=16)		Statistic	
Scale/Subscale	Baseline *M (SD)*	Follow-up *M (SD)*	Baseline *M (SD)*	Follow-up *M (SD)*	F	*p*
Total Scale	123.4 (15.8)	129.6 (19.3)	125.3 (18.1)	128.3 (20.2)	0.69	0.495
Family Subscale	44.9 (6.9)	47.6 (7.6)	44.2 (9.9)	46.6 (8.5)	0.15	0.883
Services Subscale	50.1 (6.1)	51.4 (6.9)	52.6 (7.9)	52.6 (7.9)	0.75	0.457
Community Subscale	28.4 (6.9)	30.6 (8.8)	28.4 (6.6)	29.1 (8.0)	0.66	0.514

Child Outcomes. Child outcomes on symptom and functioning measures were explored for families receiving family peer support services within 180 days of program entry (FAM180) and those not receiving family peer support (CONT). While family peer support does not directly impact children's mental health, reductions in caregiver stress and improvements in caregiver functioning can support better overall family functioning, and indirectly impact children. The results of independent t-tests comparing the two groups on changes in child measures is presented in Table 5. The FAM180 group showed a larger decrease in total symptom scores on the Pediatric Symptom Checklist at follow-up than the CONT group, resulting in a statistically significant finding. Similarly, the FAM180 group had a greater reduction in functional impairment, as measured by the Columbia Impairment Scale, than shown by the CONT group. This finding also reached statistical significance.

Table 5. *Independent T-tests Comparing Change on Child Symptom and Functioning Measures*

	Family Peer Support in 180 Days (n=89)		No Family Peer Support (n=31)		Statistic	
	Baseline M (SD)	Follow-up M (SD)	Baseline M (SD)	Follow-up M (SD)	F	*p*
Pediatric Symptom Checklist Total	21.6 (6.0)	18.2 (6.9)	20.2 (7.7)	19.3 (6.3)	-2.20	0.030
Columbia Impairment Scale	26.9 (10.7)	21.3 (10.8)	24.3 (11.1)	24.3 (11.3)	-2.32	0.025

Conclusions

The current evaluation study demonstrated that access to family peer support services continues to be provided within most regions of the state, with 19% of families receiving at least one family peer support service in the past year. While all 39 LMHA/LBHAs report providing at least one service, the availability varies greatly across the organization. Differences between the organizations appear to be unrelated to the size of the catchment area or the urban/rural mix of the region. Instead, variation in access seems to depend on the decisions or capacity within organizations, with 6 LMHA/LBHAs offering services to fewer than 5% of the families served and another six centers providing family peer support to at least 40% of the families. Family peer support tended to be offered more commonly within intensive levels of care, including Wraparound, YES Waiver, and Coordinated Specialty Care (early psychosis). While the YES Home and Community Based Services Waiver offers an opportunity for Medicaid reimbursement of family peer support, few organizations used this approach. This may be due, in part, to the low level of reimbursement offered for Family Support, coming in below the rate offered in any other state fee-for-service system.

The proportion of families receiving family peer support was larger in the System of Care sample, yet the total number of encounters continued to remain low, averaging 5.9 encounters across the span of time in care. While most families were engaged by family partners early in care, some were either never engaged or engaged later in care. The current study examined the impact of family peer support by developing samples based on the time to receive family peer support. This methodology allowed the evaluators to control for early treatment drop-outs, which would have reduced a family's ability to access family peer support services. In the first set of analysis, early engagement with family partners (first 30 days) led to reduced risk of treatment dropout over time. Delayed engagement of family peer support (between 31 and 60 days) was superior to no family peer support, but showed less reduction in the risk of dropout.

The impact of engagement in family partner services with 180 days on caregiver outcomes was explored. Families engaging with family peer supports had greater reductions in objective caregiver strain over time than families who did not engage with family partners. Other family outcomes were not statistically different between the groups. Children whose families engaged in family peer support had greater reductions in overall symptomatology and functional impairment than those who did not. Child measures were collected on a more frequent time table than parental measures, and a larger sample size may have led to a greater power to detect change on these measures.

Overall, the current study adds to previous evaluation findings demonstrating several positive impacts of family peer support services, despite relatively low levels of involvement over time. The impact of family peer support on child outcomes may result from an increase in service engagement, with families involved early with family partners staying significantly longer in care. The current study was strengthened by the inclusion of standardized measures of caregiver burden, child symptoms, and child functioning. The small sample sizes, particularly for the non-family partner groups with follow-up data, was a limitation to the current study.

Recommendations

1. Consider studying the adequacy of the YES Waiver family support Medicaid reimbursement rate and adjusting for the current market. The state should encourage YES Waiver provider organizations to utilize the reimbursable service when appropriate and provided to the family of an eligible child. An examination of the rate may require interviews with LMHA/LBHAs to determine the rationale for its lack of use and problem solving to expand this funding opportunity.
2. Consider a state marketing campaign to increase awareness of family members with lived experience as a caregiver of a child with mental health needs about the employment opportunity available as a family partner. The campaign could include PSAs and printed posters that could be made available in mental health and pediatric clinics, as well as schools.
3. Reinstate opportunities for certified family partners to provide family psychoeducation through medication training and supports. This service category was developed to support families in gaining mental health literacy, participating in shared decision-making, monitoring symptoms and side effects with their child, and reinforcing positive coping strategies. Many components of this service could be successfully provided by family partners with minimal practice support.
4. Continue to explore opportunities to study the impact of family peer providers in Texas, including strengthening the measures that reflect relevant outcomes, and supporting an intensity of services based on the demonstrated needs of the family member. Workforce shortages, coupled with minimum service requirements, lead to a minimal frequency of contact across the system.

References

Bird, H. R., Shaffer, D., Fisher, P., & Gould, M. S. (1993). The Columbia Impairment Scale (CIS): Pilot findings on a measure of global impairment for children and adolescents*. International Journal of Methods in Psychiatric Research.*

Collins, B. & Collins, T. (1990). Parent-professional relationships in the treatment of seriously emotionally disturbed children and adolescents. *Social Work, 35*, 522-527.

Gardner, W., Lucas, A., Kolko, D. J., & Campo, J. V. (2007). Comparison of the PSC-17 and alternative mental health screens in an at-risk primary care sample. *Journal of the American Academy of Child & Adolescent Psychiatry, 46(5),* 611-618.

Hoagwood, K. (2005). Family-based services in children's mental health: A research review and synthesis*.* *Journal of Child Psychology and Psychiatry, 46*(7), 690-713.

Ireys, H. T., & Sakwa, D. (2006). Building family-to-family support programs: Rationale, goals, and challenges. *Focal Point, 20*(1), 10-14.

Khanna, R., Madhavan, S. S., Smith, M. J., Patrick, J. H., Tworek, C., & Becker-Cottrill, B. (2011). Assessment of health-related quality of life among primary caregivers of children with autism spectrum disorders. *Journal of Autism and Developmental Disorders, 41(9),* 1214-1227.

Koroloff, N. M., & Friesen, B. J. (1991). Support groups for parents of children with emotional disorders: A comparison of members and non-members. *Community Mental Health Journal, 27*(4), 265-279.

Lopez, M.A. (2013). *Texas family partner evaluation: Interim report*. Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin.

Lopez, M.A., Cohen, D.A., & Szlyk, H. (2014). *Texas family partner evaluation: Addendum*. Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin.

Osher, T. W., & Penn, M. (2010). How family partners contribute to the phases and activities of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative.

Peterson, H. L., Stevens Manser, S., Lopez, M., Kaufman, L., & Granger, B. (2017). *Assessing the Status of the Certified Family Partner Workforce*. Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin.

Reardon, T., Harvey, K., Baranowska, M., O'Brien, D., Smith, L., Creswell, C. (2017). What do parents perceive are the barriers and facilitators to accessing psychological treatment for mental health problems in children and adolescents? A systematic review of qualitative and quantitative studies. *European Child & Adolescent Psychiatry, 26*(6), 623–647.

Robbins, V., Johnston, J., Barnett, H., Hobstetter, W., Kutash, K., Duchnowski, A., & Annis, S. (2008). *Parent to parent: A synthesis of the emerging literature*. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Schober, M. & Baxter, K. (2020). *Medicaid Funding for Family and Youth Peer Support Programs in the United States.* Substance Abuse and Mental Health Services Administration.

Singh, N. N., Curtis, W. J., Ellis, C. R., Nicholson, M. W., Villani, T. M., & Wechsler, H. A. (1995). Psychometric analysis of the family empowerment scale. *Journal of Emotional and Behavioral Disorders, 3(2),* 85-91.

Slowik, M., Willson, S. W., & Loh, E. C. (2004). Developing a parent/carer support group in an inpatient adolescent setting. *Psychiatric Bulletin, 28*, 177-179.

Stroul, B. A. (Ed.). (1996). *Children's mental health: Creating systems of care in a changing society*. Baltimore, MA: P.H. Brookes Publishing.

Stroul, B. A. & Friedman, R. M. (1986). *A system of care for severely emotionally disturbed children and youth*. Washington, D. C.: Georgetown University Child Development Center.

Tondora, J. & Davidson, L. (2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. Retrieved from http://www.ct.gov/dmhas/lib/dmhas/publications/practiceguidelines.pdf

Via Hope. 2018a. *Certified Family Partner Program*. Retrieved from https://www.viahope.org/programs/family-partner-training-and-certification/

Via Hope. 2018b. *Certified Family Partner Advisory Council meeting minutes*. Retrieved from https://www.viahope.org/wp-content/uploads/2018/06/CFP-Council-Minutes-4-13-18.pdf

Young, M. H., McMenamy, J. M., & Perrin, E. C. (2001). Parent advisory groups in pediatric practices: Parents' and professionals' perceptions. *Archives of Pediatric and Adolescent Medicine, 155*, 692-698.