



The University of Texas at Austin

**Texas Institute for Excellence  
in Mental Health**

*School of Social Work*

**Parent Peer Support in Texas:  
A Report of Stakeholder Input**

Texas Institute for Excellence in Mental Health

September 2016

Submitted to the Department of State Health Services and

Health and Human Services Commission

## Background

There has been recent interest in the possible inclusion of peer support services provided to individuals with behavioral health conditions as payable services in the Texas Medicaid program. To inform potential policy decisions, the Texas Institute for Excellence in Mental Health (TIEMH) led a collaborative endeavor to gather public input on existing peer-to-peer services provided to parents of children with mental health challenges and examine opportunities for growth and development in the future. This report is an initial summary of the process and results. A final report will be submitted following completion of all public data gathering and a review of the report by partner organizations.

### Preparation for the Stakeholder Input Activities

The planning committee established for this effort included representatives from the Department of State Health Services (DSHS), TIEMH, Via Hope, Texans Care for Children, and the Texas Family Voice Network. The initial meeting was also attended by a representative of the Health and Human Services Commission (HHSC), Office of Mental Health Coordination, to provide guidance on key issues that would benefit HHSC if staff were directed to create a proposal for Medicaid-payable parent peer support. The planning committee met on several occasions to consider logistics for a public stakeholder meeting, identify a process to facilitate input, and develop the meeting agenda. The group crafted key questions that would be posed to gather input from stakeholders. The planning committee also developed a Meeting Announcement and planned distribution through the children's mental health directors at Local Mental Health Authorities, Certified Family Partners, the System of Care and Texas Family Voice Network email distribution lists, and the Texas Council of Community Centers. In addition, the Hogg Foundation for Mental Health distributed the announcement to individuals invited to a previous meeting held to gather input on adult peer services. Planning documents were shared with staff from the Office of Mental Health Coordination and Medicaid Policy for feedback and were finalized after revision.

### Methodology for Information Gathering

The primary strategy for gathering information was the hosting of a public meeting, held at Any Baby Can in Austin. The meeting agenda included a brief presentation on the purpose of the meeting, an overview of the current parent peer support services in Texas, and an overview of the plan for information gathering. Following the development of ground rules for discussion, participants were separated into four groups for small groups discussions. Participants responded to four question probes within their small groups and reported out their responses to the larger group. Additional discussion and comments were gathered at this phase. To support participation by individuals who were unable to attend the meeting in person, individuals could also join through a web-based meeting portal. Individuals online were able to participate through the chat feature and their responses were also shared during the group reporting period.

To provide an opportunity for participants to provide individual feedback and to support public input from additional respondents, a brief web-based survey was also developed and distributed following the meeting (see Appendix A). The web survey was open from August 26, 2016 through September 15, 2016. A total of thirteen individuals provided input through the survey and results are presented in the report.

The responses of all meeting participants were gathered and used to inform the report. There was no effort to reach consensus on the questions raised, and participants at times disagreed with each other. Therefore, the information shared below should not be considered representative of all meeting participants.

### Respondents

The stakeholder meeting was attended in person by 30 individuals. Participants included parents, youth, Certified Family Partners, representatives from advocacy organizations, and staff from DSHS and the Department of Family and Protective Services (DFPS) who oversee family peer roles within the agency. Two representatives from HHSC also attended. An additional 9 individuals participated through the web-based portal.

The web-based survey was completed by 13 individuals. Respondents reflected on each of the primary roles that they play, with most indicating multiple roles. The majority of respondents were parents or guardians of children with behavioral health challenges and family partners.

- Peer support provider or family partner 76.9%
- Parent/guardian of child with behavioral health challenges 61.5%
- Advocate for behavioral health 30.8%
- Other behavioral health provider 15.4%
- Program administrator 15.4%
- Youth/young adult who has accessed services 7.7%
- Other 15.4%

### Results from Stakeholder Meeting

The key themes discussed in response to each question will be summarized, with all responses included in Appendix B.

#### ***Question 1: What are the core activities within parent peer support services?***

- Parent peer supports include sharing similar lived experiences, being a symbol of hope and a role model to other parents.
- Parent peer support involves engaging families in mental health services, providing information about processes and options, and supporting the family member in shared decision making.
- Parent peer support involves helping families navigate child-serving systems, such as schools, child welfare, and juvenile justice, advocating for families when needed, serving as a neutral witness, serving as a mediator, and informing families about their rights within each system.
- Parent peer providers provide non-clinical parenting skills training, teach organizational skills, such as record keeping, goal setting and model effective parenting practices.
- Parent peer providers coach and support family members in self-care strategies, to support the overall capacity of parents as caregivers for their child.
- Parent peer providers link families to community resources, connect families to other parents, and involve caregivers within their community to build natural supports. Providers also outreach to community members about ways to support caregivers.

- Parent peer providers also provide practical supports when needs are unmet, such as transportation to relevant activities, translation, and child care during appointments, when directly supporting the family's service goals.
- Parent peer support providers are stewards of the principals of "family voice and choice" and "family-driven and youth-guided." Peer providers ensure that caregivers have the support needed to make informed decisions about their family and communicate actively with others to ensure the family's preferences are reflected throughout the process.
- Parent peer support providers focus the parent/caregiver and providers on the child and parent's strengths and reframe behaviors through a strength-based lens. Peer providers motivate, empower, inspire and serve as "cheer leaders" for families.
- Parent peer support includes the provision of support and comfort during child crises, assisting families with coping during times of intense stress, and ensuring they are not alone.
- Parent support providers also assist in system-level activities, serving as staff trainers, meeting conveners, and using their lived experience to inform system change efforts.
- Parent support providers facilitate parent support groups and provide Nurturing Parenting interventions.

***Question 2: What organizations would house providers of this service? What would be the qualifications that should be considered for providers of this service?***

- Respondents felt parent peer support providers should be housed or able to provide services within a wide range of settings, including schools, daycares, community-based providers, local mental health and IDD authorities, early childhood providers, residential treatment centers, public and private psychiatric hospitals, emergency rooms, pediatrician offices and health clinics.
- Participants also felt that parent peer support providers could be housed within health and human services departments, including social security, housing, WIC, food stamps, foster care placing agencies, police and sheriff departments, juvenile courts, and county behavioral health response teams.
- Parent peer support could also be provided in other non-health care settings like churches, family violence shelters, child advocacy centers, YMCAs or recreation centers
- Parent peer support providers should also be represented in appropriate state agencies or organizations, including DARS, DFPS, Medicaid, insurance companies, Texas CASA, mental health associations, and legislative state offices.
- Parent peer support providers should have personal lived experience, preferably in the same system as the family served. Providers should be in a place of "wellness or recovery," although it was noted that this may be difficult to assess.
- Some additional practical qualifications were listed, including a minimum educational background of a high school diploma or GED, and the ability to pass a Medicaid background check. The importance of a diverse workforce was stressed.
- A certification or credential should be required, perhaps eventually being a state license (but not requiring college degree). The parent peer provider should be affiliated with or supervised by someone with a behavioral health or health license. The idea of having parent peer providers affiliated with an organization or serving as an independent contractor were also shared.
- Parent peer providers should complete the Certified Family Partner training or some training with consistent presentation of core concepts. A comment indicated that this training should

happen within the first year in the role. On-going training and CEUs should be offered and all training should be paid for by hiring organizations (not out of the parent peer provider's pocket). Additional training should allow providers to specialize, such as in juvenile justice, military families, or families of children with autism. Training at national conferences would also strengthen the workforce and provide additional motivation to providers.

- A variety of specific training requirements were suggested, including Mental Health First Aid, trauma informed care, Nurturing Parenting program, wraparound and systems of care, and trust-based relational intervention.

***Question 3: What challenges do you foresee to implementing a change to include parent peer support as a Medicaid payable service, if it were to occur?***

- There would be inadequate funding to support parent peer support through Medicaid.
- Wages would be inadequate to support parent peer providers and recruit additional individuals to the role.
- It would be challenging to manage guidelines for the qualification of providers. Policies around background checks (e.g., prior CPS involvement for the aspiring provider) could be a challenge.
- There would need to be opportunities for parent peer providers to advance within the workplace and have a career ladder.
- There would be a shortage in available parent peer providers and difficulty identifying potential providers.
- Training requirements would need to be clear; training would need to ensure that staff had the required competencies. There may not be enough capacity to meet the training needs that could arise.
- Supervisors would need to be well-trained and qualified, with all supervisors receiving training. Supervision model should be "dual," including both a clinical supervisor and an experienced parent peer provider supervisor. Process for monitoring fidelity would be needed.
- Peer providers could be challenged by isolation and need the opportunity to work in teams and have ways to network and get support from other providers in similar roles. Parent peer providers do not have a state professional organization to seek support. There was a suggestion made for a state-level organization staffed with experienced peer providers to provide mentoring to others throughout the state.
- Ensuring that organizations understand and value the role of parent peer providers could be a challenge. There would need to be respect and value for lived experience by degreed staff and organizations would need to embrace the legitimacy of the role. The goal would be for parent peer providers to be fully integrated into teams. Organizations would also need to understand how they could benefit from having parent peer support providers, recognizing "what is in it for them." Organizations also need to understand reasonable caseload sizes and staffing ratios to meet family needs.
- Organizational leaders and managers may have stigma against parent peer providers, fear that they need to be carefully managed, or fear that clinical services will not look professional. In contrast, peer support providers may fear that support services will begin to look clinical.
- There may be practical barriers, such as space to house peer support providers and needs for equipment. Space issues may be greater in rural areas of the state.

- Peer support providers could be challenged by burnout and secondary traumatic stress associated with serving families. They may also experience stress related to caring for their own children, which may add complexity to their role.
- Organizations may not understand why they should offer parent peer support services. They would need to be provided with information and data to support its use. They would need to have demonstrated that it is “billable” to Medicaid and have opportunities (e.g., a listserv) to ask questions. The case would have to be made that the status quo is inadequate and that they should consider the inclusion of what might seem like a “non-traditional” service.
- It may be challenging for parent peer providers to work in their full role, having autonomy and voice within a bureaucratic system, and being able to advocate openly for individual families. Parent peer providers will need some flexibility to make decisions around what would be most helpful for families.
- Shifting some organizations from a medical model to a philosophy of family centered care could be challenging.

***Question 4: What would be the benefits to including parent peer support within Medicaid (e.g. to families, to provider organizations, to payors)?***

- Including parent peer support within Medicaid would ensure services are more cost effective, by improving engagement in care, helping children remain in the community and out of expensive residential settings and hospitals.
- Parent peer support providers may also reduce costs to other systems, by reducing involvement in the education, juvenile justice and child welfare systems. Improving parents’ capacity to care for their children and reducing the stress associated with their caregiver role will also lead to better health for parents and reduced healthcare costs.
- Having parent peer support results in improved outcomes for families, making current treatment more effective. It can also support accountability for family members and support parents in feeling capable of caring for their children at home. Ultimately, good outcomes lead to children growing up to be healthy adults and contributing taxpayers.
- Parent peer support helps improve continuity of care across treatment settings and provides stability when other providers “turn over.” Families would be guided to more effective services that they want, reducing the use of unnecessary services, and opening up those services to other families that may benefit from them.
- Medicaid support would increase the level of respect and legitimacy of the parent peer support role. It would bring additional revenue into agencies and lead to more organizations being willing to hire peer providers, more parents being interested in the positions, and create additional jobs benefiting the state economy.
- Having more family members hired in peer support positions allows these individuals to financially support their families, serve as a successful role model to their own children, and create a generational impact on better employment outcomes.
- Parent peer providers are able to support/enhance services provided by other behavioral health providers (not replace them), partially mitigating the negative impact of the behavioral health workforce shortage in Texas.
- Parent peer provider services would reduce the stress and burnout of other behavioral health providers and the system as a whole, as parent peer providers reduce the frequency of family

crises, provide quick responses to avert crises, and reduce the frustration that parents experience as they try to navigate systems.

- Parent peer support services help “humanize” the system and reduce the blame and shame that some families experience. Peer support is a best practice for individuals who have experienced trauma, helping to support personal choice and empowerment, and build resilience.
- Parent peer support may reduce wait times for individuals accessing services, support better “flow” through the service system, and reduce family confusion in the process.
- Parent peer support helps Texas taxpayers intervene earlier with families, which may prevent youth from needing more intensive and costly services, reducing the school to prison pipeline, and keeping youth on a path to success. There is a better return on investment with early intervention.

## Results from Stakeholder Survey

### *Would you be in support of the inclusion of parent peer support as a payable service in Medicaid?*

The majority of respondents indicated that they support the inclusion of parent peer supports in the Medicaid program (92.3%), with one respondent indicating “maybe” (7.7%).

### *Question 1: What are the core activities within parent peer support services?*

- Parent peer support includes direct family-to-family peer coaching and mentoring focused on the unique needs of the family.
- Providers assist with navigating systems, such as educating parents around working with schools, local mental health authorities, juvenile justice, health care and other agencies, teaching them how to identify services and obtain needed help.
- Parent peer support providers teach parents how to be record keepers so as to document what happened or needs to happen so they are not overwhelmed trying to keep up.
- Providers are present when parents are struggling and in need of encouragement and support, as this is where you often discover what is or is not working.
- Parent peer support includes assistance with accessing community resources, including helping the parent file for disability for the child, SNAP or TANF benefits, or access services to address the behavioral health needs of the parent.
- Services include supporting parents during mental health crises, including providing continuity of care during hospitalization or other treatment placements; be the “calm in the storm.”
- Peer support providers share their own lived experience to help parents understand they are not alone, role model personal wellness and family wellness, and help remove stigma so parents will access and continue in services.
- Parent peer support providers advocate for families and teach them to advocate; they help them have a voice in all aspects of treatment.
- Providers participate in the wraparound process through parent support and partnership with wraparound facilitator.
- Parent partners provide family skills training or nurturing parenting.
- They facilitate parent support groups.
- Parent peer support providers serve as Special Education Support Advocates and attend ARD meetings.

- Parent peer support includes providing psychoeducation and medication education.
- Peer support can include transportation.

***Question 2: What organizations would house providers of this service?***

- Any organizations that serve the needs of families with children struggling with mental health challenges should have parent peer support providers, including family-run organizations advocating for families.
- State-funded agencies should include parent peer support, such as DSHS, TJJD, DADS, DARS, DFPS.
- Parent peer support should be available in behavioral health clinics, primary care clinics, behavioral health hospitals, schools, juvenile probation offices, and child advocacy centers.
- Parent peer support should be available on community crisis response teams.
- Parent peer support should be housed within public assistance programs (Medicaid, food stamp offices, housing authorities).
- Parent peer support providers should be housed in regional service centers,
- Parent peer support should be available in domestic violence or rape crisis centers, as well as homeless shelters.

***What would be the qualifications that should be considered for providers of this service?***

- Parent peer support providers should be parents or caregivers of children/youth or now adults who have experienced an SED or MH diagnosis.
- Providers should be able to pass background check.
- Entry level positions should require minimum of high school diploma (other respondent suggested GED), while advanced level positions should require Associates or Bachelor's Degree.
- Providers should be certified and have competency testing; any state or national certification in family peer support, such as the Via Hope CFP training or the National Federation of Families for Children's Mental Health (NFFCMH) training, should count. There should be reciprocity of other states' training.
- Providers should have ongoing training/continuing education requirements.
- They should be intellectually and emotionally committed to the role of serving the family's needs.
- Parent peer support providers should be familiar with cultural competency.
- Agencies housing parent peer support providers should have training on how to utilize and supervise parent peer support providers.

***Question 3: What challenges do you foresee to implementing a change to include parent peer support as a Medicaid payable service, if it were to occur?***

- Too many regulations could result in not enough flexibility within the service.
- There may not be enough recognition of the value of the work; lawmakers and policymakers may have no personal experience with mental illness and not understand the value of this type of service.
- Adequate funding and shifting funding to the "front end" of the system is a challenge.



- Administration of the certification could be a challenge, but viable through Via Hope.
- It may be difficult to have parent peer support providers accepted by other professional groups.
- There may be an inadequate workforce and struggles to identify enough providers.
- Defining and maintaining the boundaries between the role of parent peer support providers and clinicians could be a challenge.
- It may be challenging to get other organizations unused to providing parent peer support, to employ and house a provider within their agency.
- None.

***Question 4: What would be the benefits to including parent peer support within Medicaid (e.g. to families, to provider organizations, to payors)?***

- Families (including youth) are more likely to achieve lasting recovery, feeling happier more often and having a greater quality of life.
- There may be fewer cycles of acute psychiatric crisis for youth and reduced expenses related to fewer hospitalizations.
- Outcomes will include increased attendance in school and graduation, fewer arrests or detentions, fewer child deaths, and increased engagement in services.
- Families will benefit from greater access and engagement with community and natural supports.
- There will be more family voice and choice in service systems.
- Billing Medicaid would hold staff more accountable.
- A result would be greater inclusion of recovery issues within service systems (more recovery-oriented service plans).
- Parents would have a main support contact who understands their perspective, resulting in less feeling of isolation or being misunderstood.
- Provider organizations would have access to staff with significant experience and skill at navigating systems and addressing barriers.
- There is a benefit to parents serving as peer support providers in being able to support other families, based on the strategies that they have learned, including meaningful employment and continued growth and development.

***Question 5: What should be considered when determining the fiscal impact of adding parent peer support within the Medicaid State Plan? Are there strategies that should be considered to ensure a strong cost-benefit ratio?***

- Rates need to be sufficient to cover the costs of salary, benefits, and travel, which can be significant in rural and frontier areas.
- Policymakers should consider the work that is necessary between face-to-face visits, such as researching resources and drive time, in the setting of rates.
- Policymakers should consider the reductions in the number of psychiatric hospitalizations, which will save money.
- Teaching families to cope and helping them grow has long-lasting impacts that can save taxpayer monies. It's cheaper to provide services that educate and empower families than to provide public assistance with no such supports.

- We may not be able to measure the nuances of relationships, but respect and trust the experience of experts in this field that family peer support works.
- Families will experience fewer cycles of acute psychiatric crisis for youth, which will lead to reduced expenses related to fewer hospitalizations.
- Agencies should explore family outcomes, conduct surveys, and evaluate pilot programs.

## Personal Testimony

Stakeholders responding to the survey were asked to share their personal experiences, as they relate to parent peer support services or the need for such services. The following stories were shared:

“My son was diagnosed at a very young age with early onset schizoaffective and bipolar. He has PTSD and anxiety disorder. When he was first diagnosed I was lost and grief-ridden. Lots of clinicians and doctors surrounded me, but I felt completely and utterly alone. Friends and even family turned away. I didn't have a clue what to do at school, at home, in the community. Nothing. I didn't know how to access services or even what services were available. I really thought I wasn't going to make it because he was so ill, everything was so intense, and I was alone and floundering. Then my family partner was introduced to me. She was the single most valuable person I have ever had in empowering me to manage my son's illness. She had been through it, lived it, and walked the journey ahead of me, and she was willing to share what she had learned with me. She did not enable me, she supported me. She empowered me with information and confidence.”

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“Today I am a Certified Family Partner working in an LMHA. I help bring hope to families so they will not have to endure the pain I have endured. My 21-year-old son completed suicide in 2010. My husband and myself, through much CPS involvement, are caring for our grandchildren who have been removed from our mentally ill daughter. During our dark years there were no family supports. There was no one there to communicate their lived experience. We were alone in our suffering. Our loss is great. Certified Family Parents help parents navigate systems and provide emotional support. Our story could have been different!”

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“I live in a small rural community of 6000 residents in West Texas. I was fortunate to be acquainted in a roundabout way with a child Psychiatrist who I was able to access for our daughter at 14. She was diagnosed with Anxiety Spectrum Disorder and ADHD. Privacy in a small town is rare. The two most integral individuals who gave my daughter the attention she needed in the proper manner were her Psychiatrist and her high school Principal. He took an interest in her as a freshman after he noticed she was the only girl who wore dresses to school. Of course due to her condition she panicked, fearing she was in trouble. That first bit of interest developed into a mentoring relationship between them. He would find reasonable ways and opportunity to speak with her, checking in to see how she was doing. He helped build her confidence and reduce her anxiety. There are so many youths who never realize Principals are caring professionals. Many youths do not see authority figures as helpers. She was able to see this clearly without sacrificing her privacy. This is the result of the principal who chose to let her know he was there as a member of her team and able to give her appropriate encouragement and support. Our daughter is now a High School English Teacher.”

## Summary and Next Steps

All responding stakeholders clearly articulated the multiple roles and benefits of parent peer support providers and were consistent about the value and benefits of those positions. While the challenges to implementing these positions as Medicaid reimbursable services were evident, participants were also quick to identify the overall potential and meaningful, lasting benefits of this change. This report will be provided to the Health and Human Services Commission, disseminated to meeting participants, and posted on the TIEMH website. The planning committee would like to thank the caregivers, youth, providers, and advocates who contributed to the content of this report through participation in the meeting or survey.

## Appendix A

### Parent Peer Support Survey

Some behavioral health providers in Texas offer parent peer support services to the parents or guardians of children with behavioral health diagnoses. In Texas, this is frequently known as "Family Partners" or "Family Supports." These services are not currently reimbursed through the Medicaid State Plan, which defines the services reimbursable to eligible Medicaid recipients. This survey is intended to gather input from interested parties about the potential benefits, challenges, and desirable characteristics of parent peer support services, if a change were to occur to the Medicaid State Plan. There is no assurance that this change will be proposed or occur; however, information gathered from this input process will be shared with the Texas Health and Human Services Commission, the agency responsible for oversight of Medicaid. Thank you for your time to share your thoughts.

Please describe your roles (check all that apply):

- Parent or guardian of child with behavioral health challenges
- Youth or young adult who has accessed services
- Peer support provider or family partner
- Other behavioral health provider
- Program administrator
- Advocate
- Other \_\_\_\_\_

Would you be in support of the inclusion of parent peer support in the Medicaid State Plan?

- Yes
- Maybe
- No

What do you see as the benefits to including parent peer support as a Medicaid-reimbursable service?

What concerns do you have about including parent peer support as a Medicaid-reimbursable service?

Do you have suggestions for the determining the medical necessity of parent peer support for eligible children?

What qualifications should be considered for providers of parent peer support?

What are the core activities within parent peer support in your opinion? What should be included in a definition of the service?

What challenges do you foresee in implementing this change, if it were to occur?

What should be considered when determining the fiscal impact of adding parent peer support within the Medicaid State Plan? Are there strategies that should be considered to ensure a strong cost-benefit ratio?

Please share a personal story, if you would like, related to parent peer support services. Your story may be shared (with no identifiers) with state leaders.

Please share any other comments.

## Appendix B

### Individual Responses from the Stakeholder Meeting

#### *Question 1: What are the core activities within parent peer support services?*

- Sharing lived experiences
- Engagement in MH services
- Help navigate child-serving systems
- Non-clinical parenting skills
- Linkages to community resources
- Steward of family voice and choice
- Connecting families
- Helping with educational and judicial systems
- Being a symbol of hope
- Facilitating support groups
- Educating community members about ways to provide support
- Working with other agencies to facilitate positive changes for families
- Supporting and comforting a parent whose child is in crisis
- Mentoring and empowering the parent of a child in services
- Advocacy in many systems, inc MH, Ed, basic needs and resources, PH, CPS, JJ
- Education in MH, such as teaching, holistic approaches to TX, alternatives to meds, referrals for de-escalation training (e.g. SAMA), informed consent, parent and child rights
- Community linkage, collaboration (across community and agencies)
- Parent mentoring and/or modeling, emotional support, organizational skills (record keeping), empowerment, “go-getter” skills, being a cheerleader, being a hope-giver, sharing lived experience
- We are a trainer, strengths-based, and system of care, wraparound, and sharing lived experience
- Wishes – such as using videos to share a child strengths and humanizing and normalizing the child
- Family support for unmet needs
- Emotional support, shoulder to cry on
- System navigation
- Transportation
- Translation
- Child care
- Self-care coach
- Advocacy
- Parenting role model
- Providing real, authentic truth
- Provide hope
- Partnering to ensure that they are not alone
- Empowerment, inspiration, cheerleader

- Bridge builder, mediator
- Provide knowledge, resources, skill builder
- Lived experience
- See things from a strength based approach, reframing
- Motivator, light shiner, accountability partner,
- Intervene
- Access
- Planning
- Goal setting
- Team member
- Meeting convener
- Re-director
- Dependable
- Knowledgeable family leadership
- Validate family strengths
- Mental awareness in community
- Facilitate nurturing parenting groups
- System navigator from family perspective
- Mutuality
- Making information available
- Advocacy
- Normalizing
- Representing trauma informed care
- System orientation for stakeholders
- Help prioritize needs and be neutral, a witness
- Capacity to do more through YES waiver family supports
- Helping families with making informed decisions
- Family-driven care; youth-guided – national definitions

***Question 2: What organizations would house providers of this service? What would be the qualifications that should be considered for providers of this service?***

- Every school
- Offices like housing, WIC, food stamps
- RTC, boot camps, emergency rooms, psychiatric hospitals
- Juvenile system/courts (adult and juveniles);
- Police and sheriff's departments
- Health and human services departments
- DARS
- YMCAs and Rec Centers
- Legislature and state offices
- Insurance companies/Medicaid
- Churches
- Day care

- Licensing and training for foster families
- CASA
- Shelters like homeless shelters, family violence shelters
- DFPS
- FQHCs
- mental health associations or other non-profits
- Community based providers
- Family partners in the organizations, but also pediatricians' offices
- Family peer providers could have their own independently family-run offices, then they could contract with all of the above organizations.
- Child Advocacy Centers
- ECI (early Childhood Intervention) providers
- Faith-based organizations
- County behavioral response team
- Foster care planning agencies
- Day cares and pre-schools
- WIC
- Universities/Parent to Parent
- RTCs
- State hospitals
- IDD and LMHAS
- Private mental health hospitals
- Social Security Offices

#### Qualifications:

- Personal lived experience
- Mental health training/ Mental Health First Aid
- To go through CFP training
- Trauma informed care training
- Nurturing Parenting Program
- Wraparound and Systems of Care training
- Some type of certification or credential
- Affiliated/supervised by someone who is licensed
- Licensed, but understanding that there's some challenges to that (eventually, but wouldn't require college degree)
- Possibility of having CFPs working with /affiliated with organizations or as an independent contractor
- Training such as TBRI (Trauma based Relational Intervention?)
- Consistency in training with basic core concepts, but with ability have some specializations such as juvenile justice, military autism, foster care
- Minimum would be high school education or GED
- Ongoing training, including out-of-state training would raise the perspective of family partners, giving them validation and motivated by information received



- Diverse workforce is necessary to represent all families in Texas
- Lived experience in that system is preferred, but not necessary
- Ongoing CEUs and training
- Person should be in recovery
- Person should not feel alone (so many are the only family partner in the organization – no tokenism; need support)
- Able to pass a Medicaid background check
- Curriculum, like CFP, within a year of being hired
- Ongoing training paid for by organization, not out of person's pocket
- HS diploma or GED
- Place of wellness or recovery (how to quantify that remains a question)
- Be able to share their lived experience without falling apart

***Question 3: What challenges do you foresee to implementing a change to include parent peer support as a Medicaid payable service, if it were to occur?***

- Funding
- Wages
- Room to advance within the workplace
- Managing providers and their guidelines and qualifications
- Training requirements
- Location; where would they be housed, especially in rural areas
- Buy in from communities and agencies
- Respect and value for lived experience by degreed staff
- Lack of education for providers – CFPs
- Community awareness
- Background checks; i.e. CPS involvement
- Stigma and negative judgement
- Identifying parent or peer providers – not enough, shortage
- Burnout, STS with serving families
- Managing personal parental stress
- Lack of support for providers from other CFPs and supervisors
- Adequate number of providers
- Caseload sizes, organizations understanding the number of FP needed to adequately serve families
- Getting organizations to accept legitimacy
- Training for organizations to see the value – what is in it for us
- Need for team approach, not being on your own
- Not accepting status quo, not just good enough
- Having the right data for the right organization to make the case for FP; showing them in their terms, having agencies tell us what would they need
- Having a place for organizations to ask questions, even later; listserv where they could
- Showing the Medicaid billability
- Open communication and transparency that the data matches the dollars

- Sharing that this is not isolated instances, that some of the challenges can happen to anyone, normalizing
- Creating shared connections with people in the organizations
- Making the case that parent peer support may seem non-traditional, but what is in place now isn't working well
- Showing the simplicity; taking the blinders off, it can be simple
- How can parent peer support help the agency
- Lack of awareness and understanding about existing service
- Training capacity
- Workspace and equipment needs
- Monitoring of fidelity
- Qualified supervision
- Required training for supervisors needed for all
- Valued as a team member
- Using a non-medical model and having philosophy of family centered care
- Stuck systems
- Incentive to change
- Informing the state, legislature, and community on why family partners are important and the role they provide, that there are outcomes, important
- Effectively integrating the workforce, can work to their full capacity, not being asked to do something outside of role, seeing their real value, integrated into the team
- FP have autonomy and voice in a very bureaucratic system
- Allowing FP to have some flexibility in making decisions around what will be most helpful for the families they are working with
- Everyone (most) in workforce comes with their own lived experience, recognizing that, challenge for the system to support each individual with whatever needs may come up as we do this complex work – supporting the BH workforce broadly in their roles without judgement
- Dual supervision – clinical and experienced family partner – need access to both (recent manual released)
- Organization beliefs that parent peer support will need to be “baby sat” versus coming in as strong professionals
- Needs to be a resource center staffed by seasoned parent peer support providers to support local providers; some type of state resource; no professional association for them to turn to currently so have to rely on personal networks and fin for themselves
- Could have listserv which would allow for access to additional resources from other peer support providers (current listservs may not be meeting this fully)
- Fear that clinical services might start to look unprofessional
- Fear that support services might start to look clinical
- Managing in rural and frontier counties from a distance
- Expanding into rural areas will be difficult, lack of resources
- Communication and project management – differences in communication styles between clinical and peer support providers
- Education differences and how people are viewed

- Everyone understands and respects everyone's roles
- Fighting the status quo mentality
- Making sure to train staff with needed competencies

**Question 4: What would be the benefits to including parent peer support within Medicaid (e.g. to families, to provider organizations, to payors)?**

#### General

- Better navigation to help people get benefits
- Minimize cost concerns to help hire peers – neutralize the cost
- More cost effective – helps with engagement
- Helps people stay in community for services, reduces costs
- Coordination of care across treatment settings, such as RTC, outpatient, in patient
- Ability to expand to other settings, such as medical
- Makes current services more effective to achieve better outcomes
- Cost saving due to less hospitalization
- Less RTC placement
- Less use of JJ system
- Less revolving door issues, stay in recovery and out of systems
- Experiences of family partners (FP) would inform the system and professionals
- Potential for children to grow up to be healthy adults and taxpayers as they join workforce
- Less traumatization to systems as FPs help with navigation, less frustration with systems
- Humanize the system
- Reduce the strain on providers because of less cycles of crisis
- Quick response time of FP would help to avert crisis
- Cost savings as families would be guided to best services, less use of unnecessary services
- Help to increase the level of respect and value of FPs
- More of a desire for organizations to integrate FPs
- Creation of more jobs
- Less burnout of staff
- More individuals would be attracted to being FPs
- As we decrease stress in the home and increase resiliency, it impacts health costs as well
- Fills a need due to shortage of other workforce (not to replace, but to build upon/reinforces other professionals)
- Families can get stuck when other providers are cycling through, FP can serve as that continuity
- Reduces the blame and shame that some families may experience
- The net that can catch many families

#### Families

- Increased the number of partners
- More families could use sustainability in the family, becomes generational, see families successful; builds strength in family
- Creates accountability for families

- Strengthens teams, teaching the families to “fish”, strengthens the community because they can pass it on
- Decreases likelihood that unnecessary services are provided
- Empowered parents make better decisions, learn to handle crisis and prevent hospitalization
- Strengthening the family increases likelihood at staying in the home, reductions in out of home placements, JJ, CPS
- Offer other options to families other than RTC, when families are feeling at wits end – preventing unnecessary placements
- Building capacity in the family for feeling able to take on care in the home
- Reducing unnecessary placements opens up those places for those who may need it most
- RTC care may leave the family out of process
- Able to begin process of change when they have more knowledge
- Creates a non-traditional service available

#### Organizations

- Faster flow through creating shorter wait times
- Fluidity and cohesion going through the process
- Fewer interactions between the family and the individual – less headaches – family has the knowledge going in so they know what to expect
- Brings in revenue to the organization
- Brings accolades to the organization as best practice
- Reduces frequent utilization
- Legitimizes family partner workforce
- Helps organizations be able to hire more
- RTCs don’t have an evidence base to support their use

#### Payors

- Return on their investment
- Cutting the fat of other programs
- See the return
- Keeping money away from JJ, prison system; school to prison pipeline – putting it at the front end rather than the back end “insulated pipeline” is the model
- Society – can see the return for the money invested, don’t just see the money going to nothing
- Family partners are the oil that keeps the motor running so that the wheels don’t fall off down the road
- Continuity of care – people not falling through the cracks, keeping the pipeline as narrow as possible
- Prevention rather the reacting – keeping people from re-entry, etc., putting them on path for success