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Family Peer Support in Texas: An Exploratory Analysis 2017

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Family Peer Support in Texas

Background

The Texas behavioral health system, overseen by the Texas Health and Human Services Commission (HHSC), has increasingly emphasized providing services and supports that increase the resiliency and support the recovery of persons with mental health conditions. A core component of a recovery-oriented system of care is the provision of peer supports. Peer-to-peer support services are delivered by people with lived experience and involve the provision of different types of support to persons experiencing mental health or substance use conditions and/or their families. In Texas, the children’s mental health system has promoted the inclusion of family-to-family peer support services, provided by Family Partners. Family Partners are defined as “a parent or guardian who has lived experience raising a child with mental or emotional challenges and who has learned to successfully navigate the systems of care.”¹ Family Partners receive training and are certified by Via Hope, a non-profit training and technical assistance organization. Community mental health centers across the state contract with or employ Family Partners to provide support services to families of children receiving mental health services.

HHSC requires that contracted community mental health centers provide family partner services and sets performance measures requiring family partner services to at least 10% of families authorized for services in most levels of care (excluding Medication Management and Crisis levels of care).² Despite the contractual support for the provision of family partner services, the services are not currently reimbursable service through the Medicaid state plan. The 1915(c) Medicaid Youth Empowerment Services (YES) Waiver currently reimburses for Family Support services, which is a family-to-family peer support. Family Support is defined as “peer mentoring and encouragement to the primary caregiver(s); engage the family in the treatment process; model self-advocacy skills; provide information, referral and non-clinical skills training; maintain engagement; and assist in the identification of natural/non-traditional and community support systems.”³ Family Support services, through the YES Waiver, are only available to families of youth meeting eligibility, representing less than 5% of the children served in the public mental health system.

Overview of Evaluation Questions

With the investment that the Texas public behavioral health system has made in family support services, there is increased interest in investigating the impact of these services on families and youth. The Texas Institute for Excellence in Mental Health (TIEMH) is initiating a prospective research study to examine the impact of family partner services on caregivers and their children; however, this study is still being developed and results are not yet available. Therefore, this evaluation report will examine evaluation questions that may be answered with existing data available through the state administrative data system. This study focuses on the following evaluation questions:

- Are family partner services more accessible in certain regions of the state or certain levels of care?
- Do families receiving family partner services differ from those not receiving these services in terms of demographics or identified strengths and needs?
- Do caregiver outcomes differ for families receiving family partner services compared to those not receiving services?
- Do youth outcomes differ for families receiving family partner services compared to those not receiving services?
- Does the amount of family partner services received by a caregiver impact the caregiver’s outcomes?

Methodology

State administrative data was reviewed for the period between September 1, 2014 to May 31, 2017, representing almost three years of services. Family partner services were considered to be those primarily provided by a Certified Family Partner, and included Family Partner (Grid Code=2509; all providers) and Parent Support Group (Grid Code=2508) or Engagement/ Continuity of Care (Grid Code=270) when the provider code equaled “K” for peer provider. While Certified Family Partners are allowed to provide Skills Training to parents through the Nurturing Parenting curriculum, this service was not included in the analysis as it is better classified as a parent training program than a peer support service. Additionally, services classified as Family Support under the YES Waiver were not explicitly included in the sample. The existing administrative database did not allow for YES Waiver encounter data to be matched with other administrative data, therefore, the family peer support received by YES Waiver families is underrepresented; however, this limitation is restricted to a small portion of the families.

The primary analyses examine families receiving family peer support in comparison to families that do not receive this service. Families are not randomly assigned to receive or not receive this service; therefore, the two groups cannot be considered equal for research purposes, since individuals who receive family partner services are likely to differ on important criteria, such as intensity of need, willingness to participate, or belief in the value of support. Therefore, analyses comparing the two groups cannot answer questions of causality, such as did the service “cause” reductions in distress. To attempt to control for some of the differences that may occur due to selection processes, researchers identified members of the control sample through propensity matching on key variables. Propensity score matching used the variables service site, baseline caregiver needs, baseline child needs, and child gender to attempt to identify a control sample most similar to the sample receiving family partner services. The resulting sample, however, did demonstrate some significant differences on these variables, suggesting that these or other possible characteristics could impact the findings. Therefore, comparisons are considered exploratory in nature, with more definitive answers about the impact of services restricted to a prospective, randomized controlled trial.

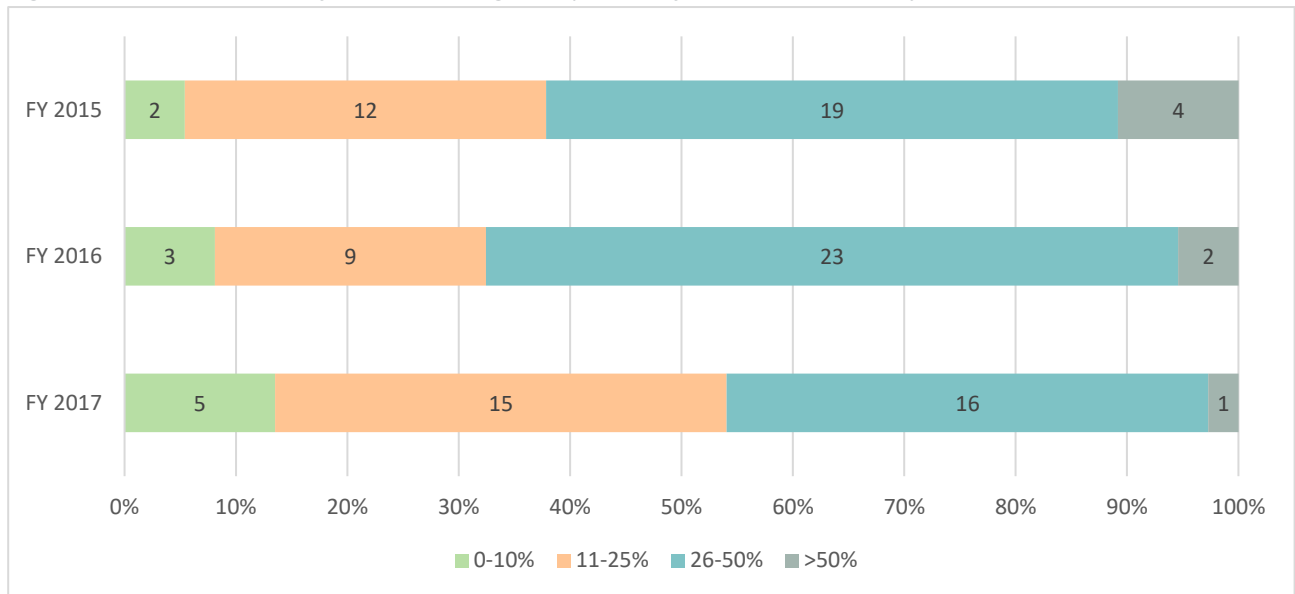
Outcomes within the analysis are explored using the Child and Adolescent Needs and Strengths (CANS) scale. The CANS assessment is completed by mental health providers based on interviews of the youth, caregiver, other knowledgeable individuals, and the knowledge of the provider. Each item is scored between 0 and 3, with larger scores reflective of severity of a need or the absence of a strength. Items can be categorized across five domains, including Child Emotional and Behavioral Needs, Child Risk Behaviors, Child Life Domain Functioning, Child Strengths, and Caregiver Strengths and Needs. Outcomes are presented using the CANS assessment closest to entry into the public mental health system, excluding crisis contacts, and follow-up assessments are selected based on the closest to 90 days, 6 months, and 1 year following baseline. Each scale of the CANS is summarized by identifying the total number of elements identified as needing to be addressed (score of 2 or 3); these are considered “actionable items” needing to be addressed within the service plan. This summary score should be interpreted as the number of identified problem areas within each domain.

Results

Question 1: Are family partner services more accessible in certain regions of the state or certain levels of care?

In the time period between FY2015 – FY2017, all regions have offered family partner services; however, the accessibility of these services varies by Local Mental Health Authority (LMHA) and by year. Figure 1 illustrates the percent of families served by LMHAs in non-crisis levels of care who received family partner services over time. As noted in the figure, the largest number of LMHAs serve between 26% and 50% of families with family partner services. The number of LMHAs serving at least a quarter of families with family partner services seems to be decreasing over time. Consistent with this finding, the overall proportion of families receiving family partner services across all LMHAs has declined from 28.1% in FY2015, to 26.6% in FY2016, to 23.3% in FY2017.

Figure 1. Percent/Number of LMHAs Serving a Proportion of Families with Family Partner Services



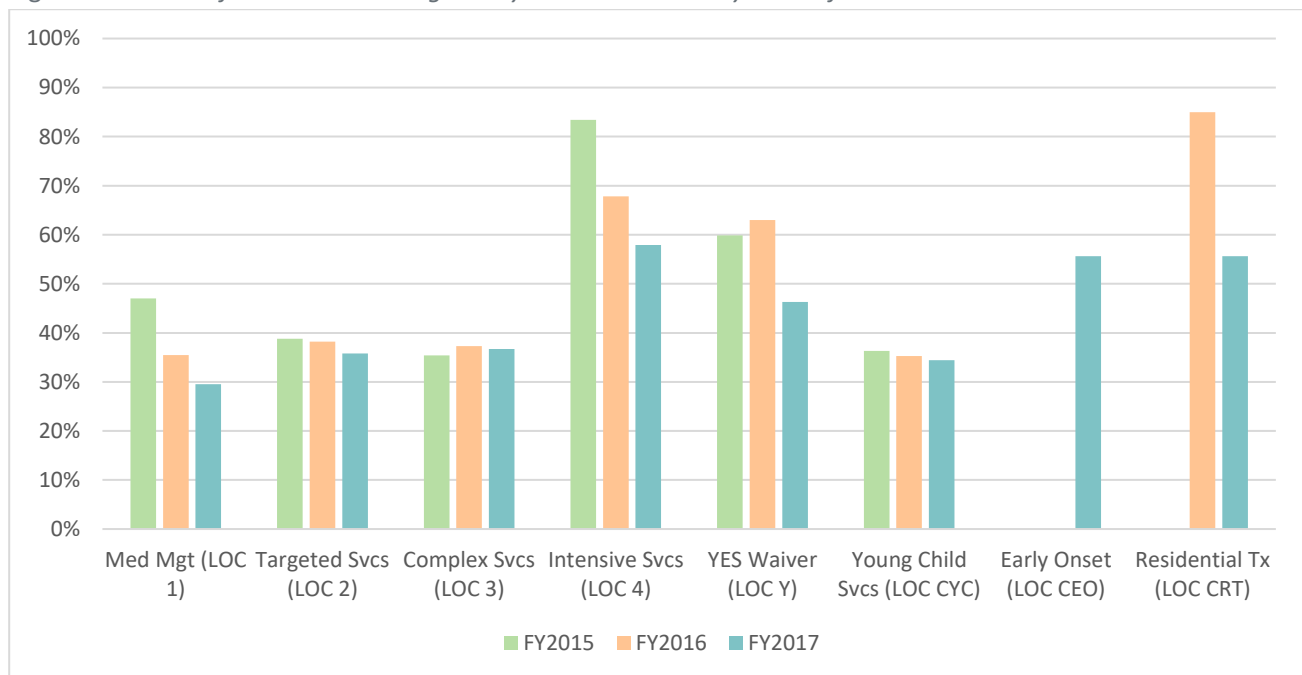
This trend raises several additional questions that might explain why access is decreasing over time. One potential hypothesis is that the number of children and families served by the LMHAs is increasing and that family partner services and/or the family partner workforce are not increasing at the same rate. There is evidence to support this explanation, as there was an increase in the number of families served between FY2015 and FY2016 of 10.1%, and a corresponding increase in the number of families receiving family partner services of only 4.4%. Another potential hypothesis is that the statewide rollout of the Youth Empowerment Services (YES) Waiver resulted in a decrease in the number of family partner services, but that similar services were provided through the YES Waiver Family Support services. This hypothesis is challenging to test definitively with the available data, as LMHAs differ to the extent they utilize the Family Support services and some families receive both family partner and Family Support services. However, FY2016 saw 738 families served by LMHAs through the YES Waiver receiving Family Support services and FY2017 to date saw 931 families served with this service. This accounts for roughly 10% of the families receiving family partner services, and so is likely to be an important factor in trends over time.

Lastly, reductions in access could be due to an increase in the use of Certified Family Partners to provide parent skills training through the Nurturing Parenting curriculum. This activity, while not specifically a parent peer support service, does allow LMHAs to bill Medicaid for the service provided by Certified Family Partners. An examination of the number of Skills Training encounters provided to parents by Certified Family Partners shows that this may also be a factor in reduced access. In FY2015, the provision of skills training by Certified Family

Partners was rare, with 235 encounters provided to 86 families. In FY2016, 599 encounters were provided to 222 families. And in FY2017 to date, 1,004 encounters were provided to 306 families, an increase of 327% from FY2015. While this does suggest a growing tendency for family partners to provide this service, the practice tends to be more limited to select LMHAs and not generalized across the state. Additionally, the data may not fully represent this practice, as Certified Family Partners who also meet criteria as a Qualified Mental Health Practitioner (QMHP) may not reflect the service as provided by a peer provider.

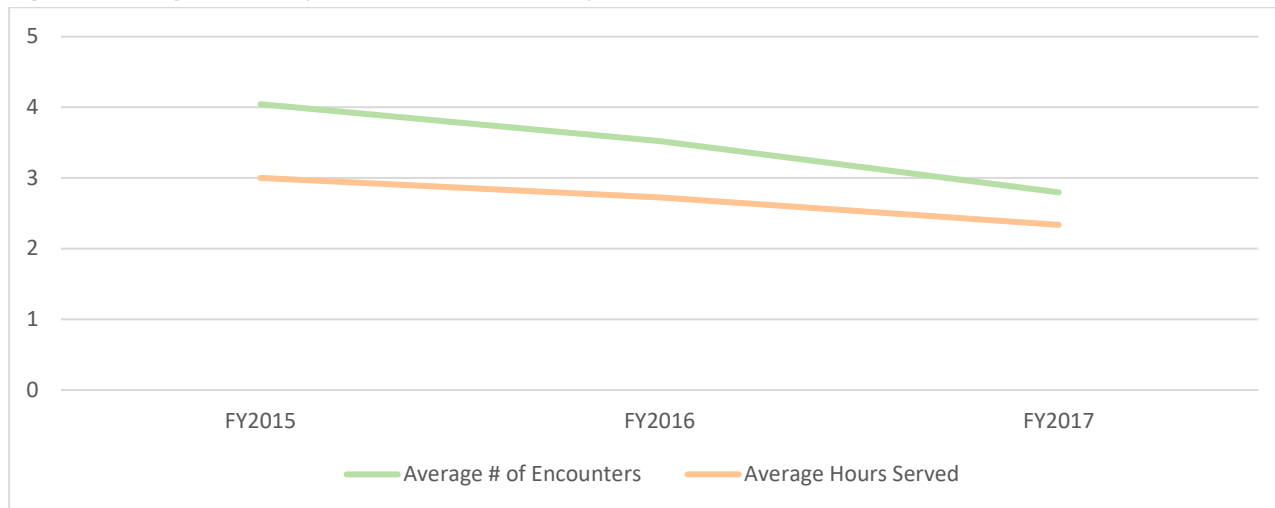
Access to family partner services was also examined across Levels of Care. Figure 2 illustrates the percent of families receiving family partner services in each level of care. As noted previously, data from Level of Care YES does not include Family Support services, and so may under-represent the proportion of families receiving peer support. Access to family partner services was similar across most levels of care, centering around 25 to 40%, but higher rates of service were found in intensive service programs, including Intensive Services/Wraparound (LOC 4), YES Waiver (LOC Y), and newer programs RTC Project (LOC CRT) and Early Onset Psychosis (LOC CEO). A general reduction in the percent of families receiving services is evident in most levels, with the exception of Complex Services (LOC 3), which remained stable over the three years.

Figure 2. Percent of Families Receiving Family Partner Services by Level of Care



Access to family partner services can also be understood by the intensity of the services provided. Increases or reductions in the number of people served may be associated with increased frequency or intensity of services. Analysis of the encounters over the three years suggests that the intensity of family partner services has also decreased over time. In FY2015, families received an average of 4.04 family partner encounters ($SD=5.27$), which decreased to 3.52 encounters ($SD=4.60$) in FY2016 and 2.98 encounters ($SD=3.53$) in FY2017. Figure 3 depicts changes in average encounters and time spent in family partner services over the three years.

Figure 3. Changes in Family Partner Service Intensity over Time



Question 2: Do families receiving family partner services differ from those not receiving these services in terms of demographics or identified strengths and needs?

It might be expected that certain family characteristics may increase the chances of a referral for family partner services. Similarly, family characteristics may impact the family’s interest in participating in family partner services. Table 1 provides a comparison between families receiving family partner services and those never receiving the services. Overall, in part due to the large sample sizes, there are numerous statistically significant differences between the two groups. However, examination of the demographic characteristics of the youth show only small differences between the families that receive family partner services and those that do not, in terms of gender, ethnicity, and age.

Table 1. Comparison between Families Receiving and Not Receiving Family Partner Services

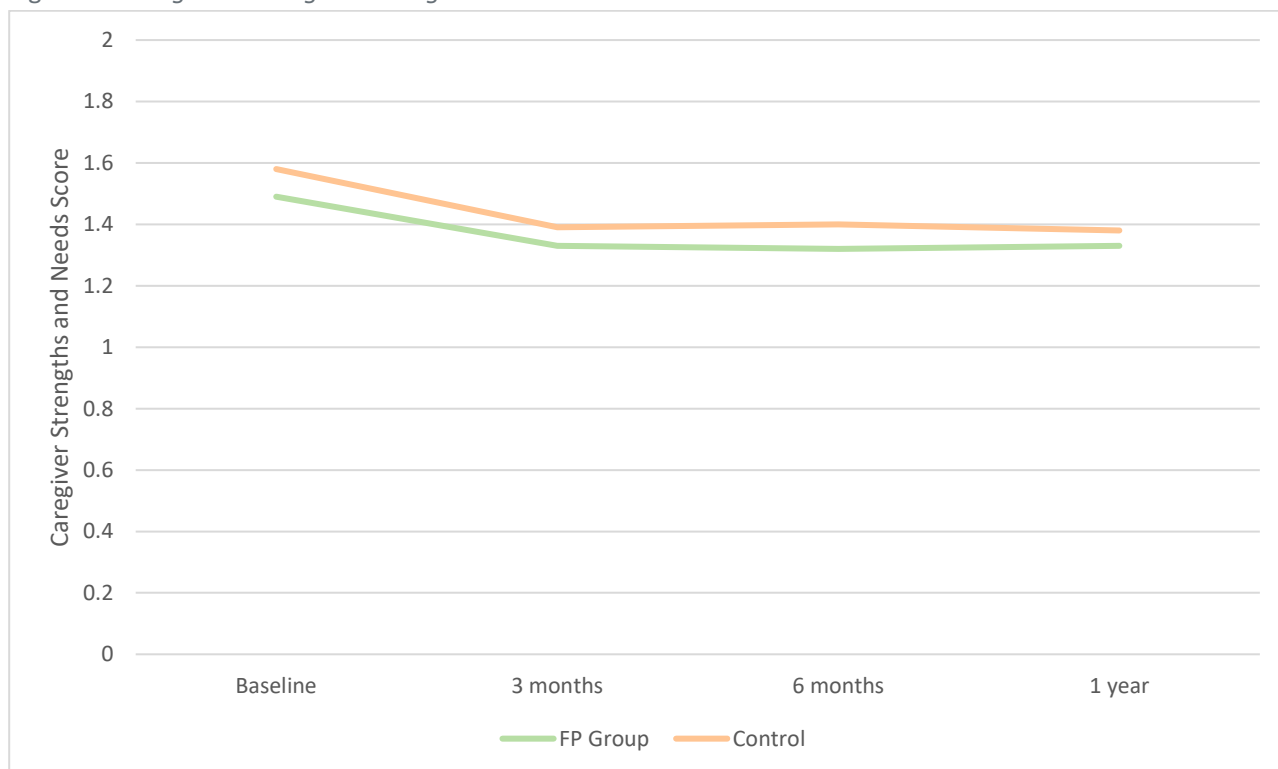
	Families Receiving FP Services (n=18,636)		Families Not Receiving FP Services (n=24,945)		Significance
	N	%	N	%	$\chi^2; p$ value
Male	7,725	41.5%	10,852	43.5%	$\chi^2=18.4; p<.0001$
Female	10,911	58.6%	14,093	56.5%	
Black/African American	3,450	18.6%	4,167	16.8%	$\chi^2=48.5, p<.0001$
Hispanic/Latino	7,406	39.8%	10,427	41.9%	
White/Caucasian	6,487	34.9%	8,857	35.6%	
Other Ethnicity	1,248	6.7%	1,431	5.8%	
	M	SD	M	SD	t test; p value
Age	12.53	3.49	13.16	3.45	$t=-18.86, p<.0001$
CANS Emotional & Behavioral Risk Elevations	2.31	1.53	2.08	1.45	$t=-15.54, p<.0001$
CANS Risk Behavior Elevations	0.60	0.96	0.49	0.85	$t=-12.43, p<.0001$
CANS Life Domain Functioning Elevations	3.45	1.89	3.31	1.83	$t=-7.74, p<.0001$
CANS Strengths Elevations	4.35	3.02	4.63	3.16	$t=9.32, p<.0001$
CANS Caregiver Strengths and Needs	1.49	2.48	1.61	2.83	$t=4.77, p<.0001$

Families show some significant differences in the number of areas of need documented in the CANS assessment. Examination of CANS scores at entry into services show that the children/youth of families receiving family partner services have a greater number of emotional or behavioral health problems, more risk behaviors, and a greater number of functional domains impacted. In contrast, youth of families receiving family partner services had a lower number of undeveloped strengths than other youth and fewer demonstrated needs or undeveloped strengths on the caregiver scale. Overall this seems to suggest that decisions regarding who receives family partner services may be based on criteria other than those measured, such as geographic location or interest in the service.

Question 3: Do caregiver outcomes differ for families receiving family partner services compared to those not receiving services?

The outcomes of caregivers, as measured by items on the CANS, were compared at three months, six months, and one year after service entry. As mentioned previously, the comparison group was a propensity-matched sample of families who did not receive any family partner services. Results are presented in Figure 4 on the overall number of “actionable items” on the Caregiver Strengths and Needs Scale. While both groups demonstrated a small decline from baseline to three months, there were few differences between groups at any point in time. At six months, the family partner group had a slightly greater decline from baseline than the control group ($t=-1.8$, $p=.04$), but this difference was not present at three months or one year.

Figure 4. *Changes on Caregiver Strengths and Needs Elevations over Time*



For individual items on the CANS scale, items scored a “0” or “1” reflect that the item does not currently warrant addressing within the service plan, where items scored a “2” or “3” are considered actionable items. Persons’ change on these individual items can be classified into one of four quadrants, as illustrated in Figure 5. Table 2 illustrates the outcomes of the two groups on specific CANS items measuring the strengths and needs of caregivers. Across both groups, the majority of individuals with a documented need or “actionable item” improved within that domain. There was also a greater percentage of individuals showing improvement over time. Differences between the family partner and control groups were generally small, with the exception of Caregiver Involvement, in which the family partner group showed an additional 11.9% of the group improved at one year, and Caregiver Organization, in which the family partner group showed an additional 10.7% of the group improved.

Figure 5. *Quadrants Illustrating CANS Item Change*

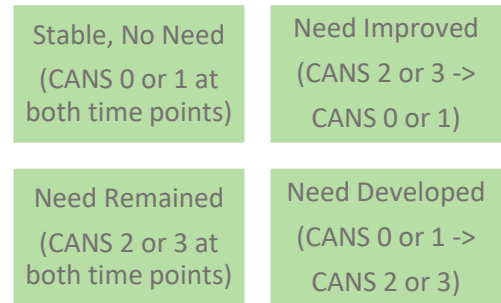


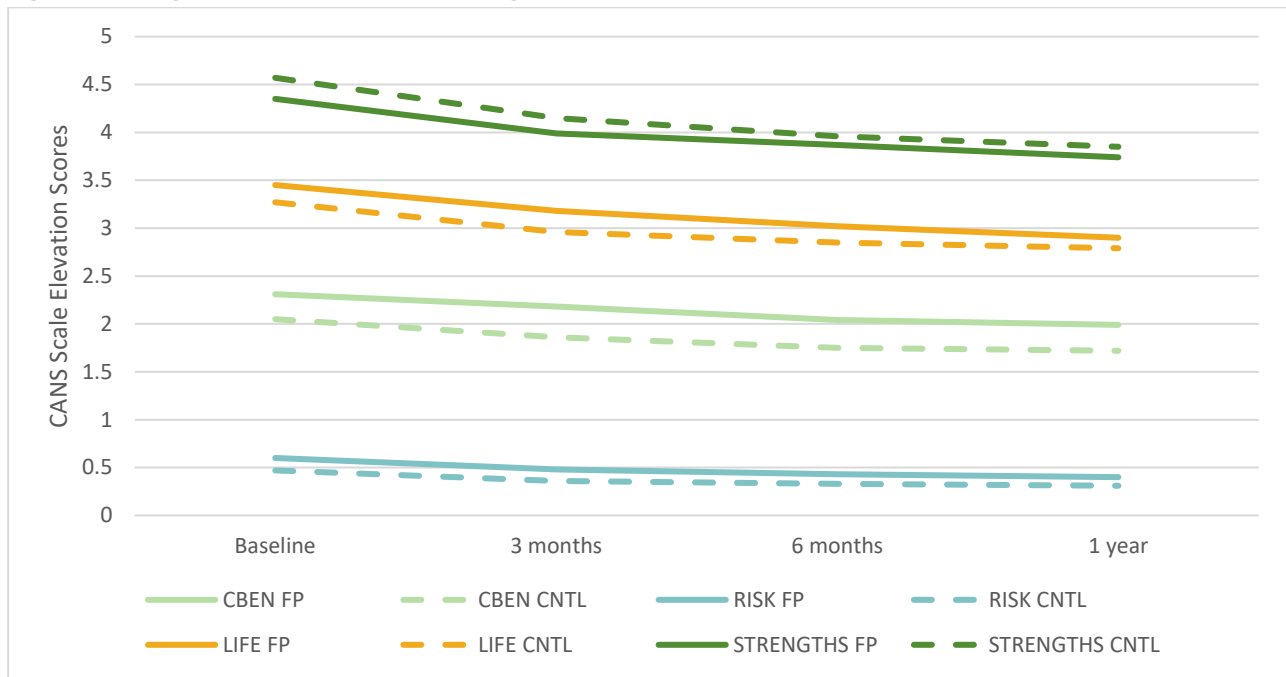
Table 2. *Improvement in CANS Caregiver Items for Families with Need Identified at Baseline*

CANS Item	Families Not Receiving FP Services % with Need Who Improved			Families Receiving FP Services % with Need Who Improved		
	90 Days	6 Months	1 Year	90 Days	6 Months	1 Year
Caregiver Knowledge	52.0%	59.1%	68.0%	50.6%	64.0%	72.1%
Family Stress	53.9%	61.9%	68.5%	49.8%	59.4%	67.8%
Caregiver Supervision	53.6%	59.5%	68.9%	54.0%	65.5%	71.4%
Caregiver Involvement	61.0%	60.9%	68.5%	63.5%	67.6%	80.4%
Caregiver Organization	50.5%	58.3%	61.7%	51.0%	62.7%	72.4%
Social Resources	53.1%	57.5%	66.9%	50.9%	60.9%	67.0%

Question 4: Do youth outcomes differ for families receiving family partner services compared to those not receiving services?

While family partner services are targeted to the caregivers of youth with serious emotional disturbances, the services are intended to enhance the caregiver’s ability to manage the burden and strain of caring for a child with these challenges, empower families to fully engage in treatment opportunities, and assist families in navigating complex systems. These activities are intended to ultimately improve the outcomes of the children and youth in care. Therefore, outcomes of young people are also important in the evaluation of family partner services. Outcomes across the four youth domains over time are shown in Figure 5. The Family Partner group demonstrated more problem areas across all four child domains at baseline, despite efforts to reduce differences through the selection of the control group through propensity matching. Overall, the number of problem areas across each of the four domains decline over time. However, there are no clear differences between groups on the rate of improvement.

Figure 5. Changes on Youth Needs and Strengths Elevations over Time



Note: CBEN=Child Behavioral & Emotional Needs; RISK=Risk Behaviors; LIFE=Life Domain Functioning; STRENGTHS=Child Strengths

Question 5: Does the amount of family partner services received by a caregiver impact the caregiver’s outcomes?

As noted in Question 1, the intensity of family partner services appears to be decreasing over time, with families receiving on average only 2.98 encounters in FY2017. Since family partner services involves developing a peer-to-peer relationship and fostering hope and resiliency, very brief interventions with a Certified Family Partner may be insufficient to lead to change, when aggregated across the full group. Therefore, differences were explored between those families experiencing reductions in Caregiver Strengths and Needs and those either worsening or remaining the same. Forty-three percent (n=8,013) of the family partner group had no identified needs on the Caregiver Strengths and Needs scale at baseline and were removed from the sample as they could not be considered “improved” over time. The remaining sample (n=10,623) was classified into an Improved group (n=3,246; 30.6%) and a Same or Worsened group (n=7,377; 69.4%). A logistic regression analysis was used to examine the predictive nature of total family partner encounters (dosage of the intervention). Results were statistically significant (Wald $\chi^2=149.3, p<.0001$), demonstrating that with each additional 10 encounters, families were 1.5 times more likely to achieve improvement. However, overall prediction was small ($R^2=.022$) and the model correctly classified 53.7%, suggesting that dosage of family partner services may be a small factor in improvement in caregiver scores.

Conclusions

The evaluation indicated that family partner services have been provided across the state over the past three years; however, a small number of LMHAs are providing minimal to no services in the current year. Generally, 28.0% of families received at least one family partner services. However, this rate of access may be misleading as the vast majority of families (77.0%) received five or fewer encounters during their service period and 32.4% received only one encounter. The percentage of families receiving services has been declining over the three years. This seems to be due, in part, to increasing numbers of youth being served without an increase in family partner capacity, the growing use of Certified Family Partners to provide Nurturing Parenting given it provides a

reimbursement opportunity, and growing use of Family Partners to provide Family Support within the YES Waiver. Specific contractual performance requirements targeting the completion of one encounter for a proportion of families are also likely to shape agency procedures and decisions about use of limited providers. Access to family partner services is provided in all levels of care, with access being notably higher in intensive levels of care, including Intensive Services (Wraparound), YES Waiver, Early Onset Psychosis, and Residential Treatment. The intensity of family partner services has also declined over time, resulting in families receiving fewer encounters in the latter years, as well as fewer hours in the service.

Families receiving family partner services differ some from those not receiving these services. Some slight differences existed in the racial and ethnic breakdowns of the two groups, and families receiving family partner services had slightly younger children, in aggregate. Baseline measures of strengths and needs, using the CANS, shows the family partner group has children with more behavioral and emotional needs, more risk behaviors, and more functional impairment needs. However, the family partner group has fewer needs related to Child Strengths (more identified strengths) and fewer problems related to caregiver needs and strengths. This seems to suggest that child severity of issues may make families more likely to be referred to family partner services or more likely to accept them. This difference may be due to the increased access in Intensive Service levels, such as Wraparound and the YES Waiver. It should be noted that identified caregiver needs seems to be either unrelated to referral or lowers the likelihood of referral to family partner services. A significant proportion of families receiving family partner services had no identified caregiver need at baseline (43%). This finding could suggest that LMHAs are not targeting family partner services to families based on need, but rather on other criteria. For example, the agency may offer family partner services to all families and services are based on acceptance of the service. It could also be possible that person-centered planning activities have identified a need that was not well-measured by the CANS Caregiver scale, suggesting it may be an inadequate measure to show both the need and impact of family partner services.

Analyses of the outcomes of families receiving family partner services compared to families receiving no services showed no clear differences in the reduction of caregiver problem areas over time, with both groups demonstrating improvement. Some individual caregiver measures showed a greater proportion of the family partner group improving than the control group, but the difference was not consistent across all measures. There were also no clear differences on youth outcomes between the family partner and control groups. Examination of the predictive impact of family partner dosage (number of encounters) showed a small but significant impact, with every 10 encounters making the family 1.5 times more likely to demonstrate improvement in caregiver needs.

Recommendations

1. TIEMH, in partnership with HHSC, should continue to work towards a more definitive study of the outcome of services, using more sensitive measures of impact. A study that allows for randomization to family partner or treatment-as-usual would allow for the greatest understanding of the impact of the service, as the naturally-occurring groups appear to be different on key measures.
2. HHSC and LMHAs should consider prioritizing family partner resources to those families with identified caregiver needs. At present, the capacity of the workforce is limited and current trends suggest some to most LMHAs are providing limited resources across the greatest number of families. Since family partner services involve the development of close peer-to-peer relationships, limited encounter frequency is likely to hamper the impact of these providers.
3. Consider changes to the performance measure to incentivize appropriate service intensity and staffing. Some possible options include (a) defining a minimal “dosage” of service to be included within the performance measure; (b) basing performance expectation on an appropriate number of encounters

(relative to the population served); (c) setting expectations around number of full time equivalents (FTEs) per population served; and measuring performance on achievement of an outcome, as reported by the caregiver.

4. Consider adding a standardized measure of family partner services, such as the Family Empowerment Scale, to assess caregiver perceptions of key components of a recovery-oriented system.

References

- 1 Via Hope (n.d.). What We Do: Family Partner Training and Certification. Retrieved from <http://www.viahope.org/programs/family-partner-training-and-certification>
- 2 Texas Health and Human Services (July 10, 2017). Information Item C – Service Targets, Outcomes, and Performance Measures. Retrieved from <http://www.dshs.texas.gov/mhcontracts/FY17/InfoItemC.pdf>
- 3 Texas Health and Human Services (June, 2017). YES Waiver Policy and Procedure Manual, p. 112. Retrieved from <https://www.dshs.texas.gov/mhsa/yes/2017updates/Policy-Manual-June-2017.doc>