

Parent Support and Training Service data from research completed by the University of Kansas; KU has developed a PST fidelity tool, PST is considered a Promising Practice, KU is developing a curriculum to use as the required state training for PST statewide in FY 14.

Report of Outcomes:

The children's mental health literature describes effective family support programs as professional-parent partnerships developed through a family-driven approach. This approach encourages processes where goals are assessed in true partnership with families and are grounded in the experience, expertise, hopes, desires, and needs of the children and their families.

- The model emphasizes power sharing among professionals and participants. The services are developed using a family-driven framework, which means families are the primary decision makers in establishing a formal and informal array of services.
- The continuum of roles for families in their children's care as primary decision makers has expanded from involvement to leadership. Family members are collaborating with professionals to function as advisers, service planners, providers, and evaluators.
- One such role, parents as providers, is receiving increased attention due to the positive impact they have on child serving systems.
- Parent to parent support interventions facilitate collaborative relationships between families and service providers.
- In addition, existing studies indicate parent to parent support interventions impact family outcomes by improving parents' ability to cope with family relations, and children's behavior.
- The mutual connections that are recognized in the initial interactions between parent to parent support providers and parents create a foundation on which a therapeutic relationship is built.
- With careful attention to the therapeutic value of self-disclosure, parent providers bring credibility to their work which reinforces the value of the relationship for parents.
- Parents gain hope when they understand how other parents were able to improve their parenting abilities.

Key Findings from CMHC's Study 2007

- **Children Whose Parents Receive Support Have Better Outcomes**

Children whose parents received PST services have better outcomes in terms of residential status, law enforcement contact, academic performance, and school attendance. In addition, children whose parents were receiving PST demonstrated fewer externalizing behaviors than children whose parents were not receiving support.

- **Identification of Most Helpful Functions**

Parent support fulfill a wide range of roles and functions based on what is determined as needed in the individualized treatment planning process. The study identified 24 distinct roles and functions that PST provides. Based on cumulative results, the most helpful functions PST performed on treatment teams included the following: 1) emotional support, 2) peer support, 3) practical crisis coaching, 4) translating all perspectives on the treatment team, and 5) establishing goal-directed or purpose driven services.

- **Services Are Beneficial to Parents and Children**

The majority (98%) of parents agreed that the PST services they receive improve family functioning and child well-being. Furthermore the majority (97%) of parents agreed that PST services helped improve the conditions for which their children were receiving services at the CMHC. Interventions impact children's environments by improving parenting abilities and increasing the efficiency of the community based services.

1) **Improving Parenting Abilities**

Parent Support Specialists provide emotional and peer support which gives parents hope.

2) **Increasing the Efficiency of Community Based Services**

The services PSS provide increase the efficiency of community based services to care for children with an SED in the least restrictive placement that will meet their needs.

- **Characteristics, Life Experience, and Skills of PSS**

Parent Support brings a wide variety of experiences and skills to their work. Over half of the PST survey participants have served as PST for 1 to 2 years and almost one quarter from between 5 and 7 years, with an average longevity of over 3 years. The majority of PST participants were parents of children living with a serious emotional disturbance (SED). Focus group findings indicate that their shared experiences as parents allowed PST to develop close bonds with parents. Thus, effective PST need advanced skills to manage therapeutic relationships with parents. These skills evolve from personal experience (e.g., trial and error), training, and on-the-job learning. Supervision and mentoring relationships with more seasoned PSS peers help PSS to find a personal balance.

- **Integrating the PSS Role Within Treatment Teams**

A team approach helps to integrate the PST role within treatment teams. Parent support roles and tasks must be clearly defined by treatment teams. All members (families, therapists, case manager, etc.) must understand the unique perspective PST bring to treatment teams. In addition, PST must be careful to set limits and engage parents in activities that tie into treatment goals. Regular communication between the treatment team members is most helpful to establish complimentary tasks on the treatment teams.

- **Access to Parent Support Specialists**

The majority of families were already in CMHC services when they were referred to PST services. The majority of PST reported that families were isolated, under stress, experiencing crises, or having difficulty with parenting. In focus groups, administrators conveyed that PST services were reserved for families with the highest needs due to the limited number of PST staff available. Overall, parents said they would have liked to have been referred sooner. Parent support also concluded that **earlier referral would help to prevent crises thereby reducing the intense level of support PST must provide when families have reached a crisis state.**

Study Question 12: Do the Client Status Report Outcomes of Children Whose Parents Receive Parent Support Services Differ From Those Whose Parents Do Not Receive These Services?

12.2 Law Enforcement Contact

Youth whose parents received support had markedly less law enforcement contact than youth whose parents did not receive support (Table 4).

Table 4. Law Enforcement Contact With Parent/Surrogate Parent (n/%) Contacts	Received Parent Support n/%	Did Not Receive Parent Support n/%
No contact (n = 302)	85 (96.6)	217 (88.9)
One contact (n = 17)	1 (1.1)	16 (6.6)
Two contacts (n = 10)	2 (2.3)	8 (3.3)
Three contacts (n = 2)	0 (0)	2 (0.8)
Four contacts (n= 1)	0 (0)	1 (0.4)
Total (n = 332)	88 (100)	244 (100)
Mean number of contacts*	0.06	0.17

*Difference in means .11 or 11% of one contact

12.3 Academic Performance

Children whose families received parent support demonstrated significantly better academic performance than children who did not (Table 5).

Table 5. Academic Performance (n/%) Attribute	Received Parent Support n/%	Did Not Receive Parent Support n/%
Average or above average (n = 266)	79 (91.9)	187 (83.1)
Failing or below average (n = 45)	7 (8.1)	38 (16.9)
Totals (n = 311)	86 (100)	225 (100)
Means*	3.33	3.06

*Based on scale from 1 to 4, with 1 indicative of failing grades, 2 of below average, 3 of average, and 4 of above average (A or B) *Difference between means statistically significant ($p < .02$)

12.4 School Attendance

The school attendance of children whose parents received support was markedly better than those whose parents did not (Table 6).

Table 6. School Attendance (n/%) Attribute	Received Parent Support n/%	Did Not Receive Parent Support n/%
4. Attends regularly (n = 259)	76 (88.4)	183 (80.6)
3. Attends more than not (n = 35)	8 (9.3)	27 (11.9)
2. Attends infrequently (n = 11)	0 (0)	11 (4.8)
1. Not attending (n = 8)	2 (2.3)	6 (2.6)
Totals (n = 313)	86 (100)	227 (100)
Mean Score*	3.84	3.70

*Based on scale from 1 to 4, with 1 indicative of not attending and 4 of regular attendance

*Differences between means not significant

12.5 Child Behavior Check List (CBCL) Scores

Analyses were performed to determine differences in Internalizing and Externalizing CBCL scores from baseline, near the time of intake, to the last quarter of observation for each year of the study. Internalizing scores reflect somatic complaints, withdrawal, anxiety, or depression; and Externalizing scores reflect delinquent or aggressive behavior. The mean baseline, the mean last quarter, and the mean amount of change, on average, are given in Table 7.

Table 7. Internalizing and Externalizing CBCL Scores Change Although increased CBCL scores indicate children are functioning more poorly, when the mean of the last quarter is subtracted from the baseline mean, a minus change indicates scores got worse and a positive change indicates improvement.

Received Parent Support					Did Not Receive Parent Support			
Score	n	Base-line	Last Quarter	Change	n	Base-line	Last Quarter	Change
Mean of Internalizing score (n=323)	87	66.7	63.6	3.1*	236	65.7	62.8	3.1*
Mean of Externalizing score (n=323)	87	71.3	67.1	4.2*	236	69.7	67.3	2.4*

*Statistically significant improvement per paired t-tests ($p < .02$)