The Parent Support and Training (PST) Services Outcome Evaluation and The Construction of a PST Services Evidence-Based Practice Protocol

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Introduction

Kansas provides fertile ground to assess the effectiveness of parent-to-parent support. The professional parent role has been established in the children’s behavioral health system of care since the early 1990s. Parent-to-parent interventions, such as Parent Support and Training (PST), are growing rapidly across the nation. Despite rapid growth, little evidence documents the specific intervention protocols and contributions PST services make toward improved outcomes. This work addresses these gaps in knowledge by examining how Kansas PST services impact relevant outcomes. Phase I of this research, completed in June 2007, utilized a mixed methods approach to describe effective PST practices and provided next steps to sustain the infra-structure of the service. Phase II of this research, completed in June 2008, built on the findings and details extensive collaboration with the PST Statewide network to design and develop the PST services outcome evaluation. This report details the beginning of Phase III of this research, implementation of the PST services outcome evaluation and the construction of a PST Evidence-Based Practice (EBP) service protocol within the practice setting. This protocol is important because it provides the foundation for the development of a PST service fidelity tool. A review of the literature indicates this approach to developing an EBP is not being done anywhere else in the nation. Thus, this work makes a significant contribution to the children’s mental health field and spotlights Kansas’s expertise and long-term commitment to supporting youth and their families.

Purpose

Most broadly the purpose of this research is to maximize Kansas PST stakeholders’ expertise, including families. This is achieved by using community-based participatory research values to achieve results that are relevant to all stakeholders engaged in the process (Davis-Groves et al., 2008).

Specifically, this report is organized in two sections. First, progress on the PST services outcome evaluation is presented. Second, a description on the construction of the PST EBP protocol is offered. Next steps for refining, testing, and implementing the protocol are also reviewed in detail.
1. Parent Support and Training (PST) Services Outcome Evaluation

1.1 Purpose

The PST services outcome evaluation tracks specific children’s mental health outcomes (family empowerment, caregiver strain, and youth behaviors and strengths) that illustrate the impact of the core components of PST intervention over a twelve-month intervention period. These three outcome areas were selected based on the results of previous research and PST stakeholder feedback. In addition, the evaluation seeks further explanation from study participants (families, PST providers, administrators, and treatment team members) to explain how PST services influence treatment within the children’s mental health system of care.

1.2 Theory of Change

A theory of change describes how interventions impact outcomes. Understanding the theory of change for an intervention is important because it drives effective program implementation and evaluation (Burns & Hoagwood, 2002).

The theory of change for the PST intervention is derived from the peer reviewed literature on family support and education (FSE), parent-to-parent interventions, implementation research, and previous research on Kansas PST services. The literature on implementation research for comparable interventions, such as wraparound services, identifies three domains to be considered when articulating the theory of change: 1) impact of the “core components,” 2) impact of the “organizational components,” and 3) impact of the “influence components” (Walker et al., 2007). These three domains will be described on page 19. The theory of change for the core components of PST practice is described in this section.

Family Support and Education (FSE) theory begins with the solution-focused premise that families want to find effective ways to manage behaviors and challenges associated with raising/parenting a child with serious emotional disturbance (SED). Family Support and Education theory suggests that the essence of the intervention lies in the mutual connections between PST providers and parents. These connections, which begin with initial interactions between PST and parents, create a foundation on which a helping alliance is built (Burns and Hoagwood, 2002). With careful attention to the therapeutic value of self-disclosure, PST providers bring credibility to their work, reinforcing the value of the alliance for parents. Ultimately, parents gain hope when they understand how other parents improved their abilities to parent a child with an SED.

Ireys and colleagues (1998) describe five key concepts in FSE that occur in the context of parent-to-parent alliances: 1) social support, 2) ties in social networks, 3) reciprocity, 4) empowerment, and 5) social comparison. The first concept acknowledges the “effects of social support” (Burns & Hoagwood, 2002, p. 155). When people feel they are a part of a community or group, they feel valued and motivated to do well. The Parent PST providers offer a specialized support to newly referred parents because they share the experience of raising a child with an SED. This expertise allows a unique relationship to develop, where new parents may feel truly heard and understood.
The second concept, in FSE theory, illustrates a link between individuals and their communities. “Ties in social networks” are the connections from one person to another that provide valuable information about how the community operates and what it has to offer (Burns and Hoagwood, 2002, p. 155). Ireys et al. (2002) theorized that these “ties” are especially important to parents of children with SED because they feel so isolated from the community. This isolation is the result of the stigma parents feel parenting a child with “socially undesirable behaviors” (Burns and Hoagwood, 2002, p. 161). PST providers help reduce this isolation by serving as a conduit between newly referred parents and community resources.

The third concept of FSE theory, “reciprocity,” considers how individuals respond to being helped. Some studies have shown that in the absence of reciprocity—the opportunity to give something back for help received—some offers for assistance and support are rejected. Reciprocity theory acknowledges that those being helped should have the opportunity to give back (Burns and Hoagwood, 2002, p. 156).

Along with the concept of giving back, “empowerment” theory implies that an individual wants to reciprocate help and will seek out support. This concept acknowledges that in a supportive relationship with a veteran parent, parents make and sustain behavioral changes. They also accept opportunities to effect system change on a broader scale, such as talking to legislators or taking on leadership roles in the services system (Burns and Hoagwood, 2002, p. 157).

Lastly, the supportive relationship parents have with PST providers may serve as a positive “social comparison” (Burns and Hoagwood, 2002, p. 156). This construct proposes that people feel better when they compare themselves favorably to others in similar situations. Social comparison, though valuable, could also have the opposite effect: individuals may feel worse because they do not measure up. To control for this risk, PST providers must openly acknowledge similar experiences while recognizing that each individual develops his or her own way of coping. PST providers prudently share information with parents about ways other parents cope in similar situations, thus instilling hope while encouraging parents to develop a coping strategy that is uniquely theirs.

In summary, the impact of parent support interventions lies in the mutual connections that are established in the course of interactions between PST providers and parents. Early emphasis upon similar shared experiences creates a foundation on which a helping alliance can be built (Burns and Hoagwood, 2002). Over time, this alliance helps newly referred parents of children with SED to increase social ties and build community connections, to mitigate stigma and isolation, and to make positive behavioral and systems changes.

1.3 Specific Aims for the PST Services Outcome Evaluation

No published studies have examined parent and PST alliances within a system of care treatment context. It is unclear at what pace the working alliances between the PST provider and the parent develop. This is important to examine because these alliances seem to have a positive impact on the efficiency of treatment within a children’s mental health system of care. Specifically, parents feel more empowered to participate in treatment and utilize fewer services (Davis-Groves, et al., 2007; National Federation of
Families for Children’s Mental Health, 2008). This evidence could be used to sustain and enhance implementation of waiver services and provide a vehicle to secure other funding for PST services.

Therefore, the primary aim of this portion of the study is to examine the development of the parent and PST alliances over time and in relation to outcomes (children’s behaviors and strengths, caregiver strain, and family empowerment). Specifically the study aims to:

1. Examine the change in the working alliances between PST providers and parents over time (12 months).
2. Examine changes in children’s mental health service usage after parents begin receiving PST services.
3. Examine the relationships between the following outcomes: working alliances, children’s mental health service usage, caregiver strain, family empowerment, and children’s behaviors and strengths.
4. Share summaries of the data collected with study participants to gather their feedback on the changes in working alliances, mental health service usage, and outcomes. For a detailed example of an examination that is shared with caregiver participants, see Appendix A.

1.4 Mixed-Methods Approach

As stated above, Phase II of this research, completed in June 2008, built on the Phase I findings and details extensive collaboration with the PST Statewide network to design and develop the PST services outcome evaluation, reviewed in this report. For details on collaborative design and development see Davis-Groves et al., 2008. Three sites were collaboratively chosen to implement the current study. To date, a total of 19 parents, 8 PST providers, and 10 other treatment team members are involved in this part of the study.

Data Collection and Participants

A mixed-methods approach (standardized surveys and focus groups or interviews) are utilized with parents/caregivers, their PST providers, and at least one other treatment team member designated by the caregivers. Once full consent is obtained, each stakeholder listed above completes a variety of instruments at different points in time.

Parents/caregivers are asked to complete the following surveys within 1 month of referral to PST services, then again at 3, 6, 9, and 12 months:

- Working Alliance Inventory (WAI) (Horvath & Greenberg, 1986; Tracey & Kokotovic, 1989)
- Family Empowerment Scale (FES) (Koren, DeChillo, & Friesen, 1992)
In addition, parents/caregivers are asked to complete the Caregiver Strain Questionnaire (CGSQ) (Brannan, Heflinger, & Bickman, 1997) within 1 month of referral to PST services, at the 6, and 12-month intervals.

These measures were selected because they have sound psychometric properties and they assess key constructs articulated in FSE theory described above. For a detailed explanation of measures, see Appendix B.

The PST providers are asked to fill out the WAI and FES at all data intervals. Another provider on the treatment team who is designated by the parent/caregiver (usually the case manager) is asked to complete the BERS-II at each data interval.

At the 6- and 12-month data intervals, all caregiver research participants are asked to complete an impact survey. The impact survey provides research participants with the opportunity to discuss: 1) how their involvement in the study may have had an impact on them or their family and 2) how satisfied they are with the community-based research process. The impact survey provides feedback to researchers on how the research process is working and what could be improved.

After the 12-month data collection interval with families, a summary of the data is prepared for a final interview. The purpose of the final interview is to share examinations with study participants and seek detailed feedback on how working alliances between PST providers and parents impact CMHC treatment. In addition, this review seeks feedback on the FSE theory of change from families’ perspectives (Appendix A).

1.5 Baseline Results for Caregivers

Working Alliances

The Working Alliance Inventory (WAI) (Horvath, 1981, 1986) measures the quality of the relationship between the recipient of services and the provider of services. The WAI is a 12-item instrument. Responses to items are on a 7-point Likert scale (1 = not at all true, 2 = a little true, 3 = slightly true, 4 = somewhat true, 5 = moderately true, 6 = considerably true, 7 = very true). The WAI consists of a total score and three subscales which assess perceived agreement on the tasks, goals, and the personal attachment (bond) between the PST provider and the parent. These subscales are described in detail in Appendix B. A score of 84 is the highest possible total score, and a score of 28 is the highest possible subtotal on each subscale. Higher scores suggest stronger working alliances.
Table 1 below summarizes baseline scores on the WAI. According to the WAI, all parents are reporting strong working alliances with their PST service providers within one month of receiving the PST service. It is unclear if these averages are consistent with previous research on similar samples as most published findings do not report these descriptive statistics. There is, however, a “robust link between” the service recipients’ perception of the working alliance early on and improved outcomes (Horvarth & Greenberg, 1995 pg 116). Thus, when service recipients experience strong working alliances in early sessions, better outcomes are likely. Most parents are reporting strong working alliances with their PST providers within one month of receiving PST services. This is a promising finding.

It is important to note that researchers expected the baseline WAI findings to be relatively high because the essence of the PST intervention rests in the initial interactions PST and providers have builds a strong helping alliance (Davis-Groves et al. 2007). Researcher expectations, however, were not shared with families prior to data collection. In addition, there are a number of instrumentation strategies utilized to minimize the influence of researcher bias. First, families are invited to fill out surveys in private. In addition, all family participants receive an anonymous ID. Findings are not discussed with parents or service providers and are immediately entered into a database. There are no opportunities for qualitative discussions with parents when they are filling out surveys. After 6 months of participation families have an opportunity to discuss their personal experiences with PST services. This information is gathered separately without any reference to WAI survey responses and is kept confidential as well.

Table 1. Caregiver Baseline Scores on the WAI

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**Family Empowerment**

The Family Empowerment Scale (FES) (Koren, Dechillo, & Friesen, 1992) measures empowerment in families with a youth who has an emotional disability. The FES is particularly useful in agencies whose delivery model features client empowerment as a goal. The FES is a 34-item instrument based on a 2-dimensional definition of empowerment: the level of reported personal empowerment and the way it is expressed. Items are rated on a 5-point Likert scale (1 = not true at all, 2 = mostly not true, 3 = somewhat true, 4 = mostly true, 5 = very true). Higher ratings indicate higher levels of empowerment. Subscales are constructed based on three levels in which empowerment can occur: family, service system, and community/political (see Appendix B).

Table 2 summarizes baseline scores on the FES reported by 19 parents within one month of receiving the PST service. Of the three subscales, average baseline family and service system scores tend to be higher while community/political tend to be lower.

**Table 2: Caregiver Baseline Scores on the FES**

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Caregiver Strain

The Caregiver Strain Questionnaire (CGSQ) (Brannan & Heflinger, 1997) measures the impact on a primary caregiver of caring for a child with emotional and behavioral problems. The respondent caregiver is asked to report the degree to which an event or feeling was a problem due to the child’s problems. The CGSQ includes 21 items that are rated on a 5-point Likert scale (1 = not at all, 2 = a little, 3 = somewhat, 4 = quite a bit, 5 = very much). Higher ratings indicate higher levels of strain. The CGSQ includes three subscales that measure objective caregiver strain, external subjective caregiver strain, and internal subjective caregiver strain (see Appendix B).

Table 3 summarizes baseline scores on the CGSQ reported by 19 parents within one month of receiving the PST service. Of all the scores, average internal subject strain subscales, which measure the types of feelings projected within caregivers, tend to be higher.

Table 3: Caregiver Baseline Scores on the CGSQ

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<td>4.18</td>
<td>4.50</td>
<td>2.25</td>
</tr>
</tbody>
</table>

Range: 2.57–4.67  2.45–4.73  3–5  2–4.5

Average: 3.75  3.74  4.28  2.99
Behaviors and Strengths

The Behavioral and Emotional Rating Scale: A Strength-Based Approach to Assessment-Second Edition (BERS-II) (Epstein, 1998) is a standardized scale used to assess various behavioral and emotional strengths of children, rather than assessing deficits in functioning or pathology. The BERS-II consists of 52 Likert-type scale questions. Responses on the scale range from 0 to 3, and measure to what degree a behavior is or is not present in the child (0 = not at all like, 1 = not much like, 2 = like, 3 = very much like). Within these questions are five subscales that measure Interpersonal Strength, Family Involvement, Intrapersonal Functioning, School Functioning, and Affective Strength (see Appendix B). A score of 161 is the highest possible total strength index score. The highest possible scores for the subscales are as follows: 45 on Interpersonal Strength (IS), 30 on Family Involvement (FI), 33 on Intrapersonal Functioning (IaS), 27 on School Functioning (SF), and 21 on Affective Strength (AS). Higher scores suggest higher strengths in the various areas. Table 4 summarizes baseline scores on the BERS-II.

Table 4 summarizes baseline scores on the BERS-II reported by 19 parents within one month of receiving the PST service. Of all the subscale scores, average FI subscale scores tend to be the highest.

Table 4: Caregiver Baseline Scores on the BERS-II

<table>
<thead>
<tr>
<th>Unique Identifier</th>
<th>Baseline BERS Total</th>
<th>Baseline BERS - IS</th>
<th>Baseline BERS - FI</th>
<th>Baseline BERS - IaS</th>
<th>Baseline BERS – SF</th>
<th>Baseline BERS - AS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1001</td>
<td>109</td>
<td>10</td>
<td>10</td>
<td>13</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>1002</td>
<td>73</td>
<td>3</td>
<td>6</td>
<td>8</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>1003</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1004</td>
<td>47</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>1005</td>
<td>126</td>
<td>12</td>
<td>15</td>
<td>15</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>1006</td>
<td>98</td>
<td>10</td>
<td>9</td>
<td>10</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>1007</td>
<td>82</td>
<td>6</td>
<td>9</td>
<td>4</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>1008</td>
<td>93</td>
<td>7</td>
<td>13</td>
<td>10</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>1009</td>
<td>119</td>
<td>10</td>
<td>12</td>
<td>12</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>1010</td>
<td>104</td>
<td>14</td>
<td>14</td>
<td>10</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>1011</td>
<td>97</td>
<td>9</td>
<td>11</td>
<td>10</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>1012</td>
<td>113</td>
<td>10</td>
<td>12</td>
<td>14</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>1013</td>
<td>105</td>
<td>11</td>
<td>14</td>
<td>9</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>1014</td>
<td>103</td>
<td>6</td>
<td>14</td>
<td>12</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>1015</td>
<td>93</td>
<td>7</td>
<td>14</td>
<td>11</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>1016</td>
<td>88</td>
<td>6</td>
<td>10</td>
<td>8</td>
<td>8</td>
<td>9</td>
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<td>1017</td>
<td>130</td>
<td>10</td>
<td>18</td>
<td>15</td>
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<td>17</td>
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<td>1018</td>
<td>139</td>
<td>14</td>
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<td>17</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>1019</td>
<td>62</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Range</td>
<td>47-139</td>
<td>3-14</td>
<td>2-18</td>
<td>1-11</td>
<td>2-16</td>
<td>2-17</td>
</tr>
<tr>
<td>Average</td>
<td>98.94</td>
<td>8.44</td>
<td>11.28</td>
<td>10.17</td>
<td>8.56</td>
<td>10.89</td>
</tr>
</tbody>
</table>
Final Reviews

Two caregivers have completed data collection. A summary of the data collected was shared with two family study participants. During the review process, caregivers were asked how well the measures capture “what is most important” about PST services. This review process allowed for focused family feedback on how well the selected measures speak to the theory of change for the PST intervention. These interviews were recorded and are being transcribed for analysis. The qualitative findings will be included in the model development analysis described in Section 2 of this report. Caregivers were promised anonymity when they consented to participate; therefore, individual results will not be shared. A sample 12-month data review can be viewed in Appendix A.

1.6 Next Steps

Secure 13 Family Referrals

The goal of the researchers and community partners is to obtain 12 months of data from 30 families. Thirty data sets will provide an opportunity for researchers to analyze statistically significant changes in family and youth outcomes (working alliances, family empowerment, youth strengths, caregivers’ strain, and service utilization) over the 12-month intervention. In addition, relationships between these outcome variables may also be analyzed. This information, accompanied with qualitative explanations from PST providers, parents, and other team members will provide targeted insight into when PST services are most effective to improve youth and family outcomes. Ultimately, this information may be utilized by PST providers, program administrators, and state policy makers to improve the implementation of PST services to families.

Table 5 denotes progress toward the aforementioned goal. Twenty-three referrals have been received; however, three families have dropped out due to relocation, one caregiver has withdrawn, one family has discharged from all services, and three families have chosen not to participate in the study at this time due to other family priorities (these three referrals are not reflected on Table 5). Therefore, the PST Study Team and agency collaborators need to recruit 13 new families into the study. The PST Study Team’s Site Coordinators (Sharah Davis-Groves and Kathy Byrnes) will work closely with PST providers to secure the family referrals.
Table 5: Progress on 30 Family Referrals

<table>
<thead>
<tr>
<th>Unique Identifier</th>
<th>Start Date</th>
<th>Most Recent Data Collection Period</th>
<th>Anticipated Complete Data Set</th>
<th>Important Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1001</td>
<td>4/7/2008</td>
<td>Baseline</td>
<td>n/a</td>
<td>Dropped out due to move.</td>
</tr>
<tr>
<td>1002</td>
<td>4/7/2008</td>
<td>12 months</td>
<td>4/2009</td>
<td>Completed Study</td>
</tr>
<tr>
<td>1003</td>
<td>4/7/2008</td>
<td>12 months</td>
<td>4/2009</td>
<td>Completed Study</td>
</tr>
<tr>
<td>1004</td>
<td>4/14/2008</td>
<td>Baseline</td>
<td>n/a</td>
<td>Caregiver withdrew from study. Youth was placed in SRS custody.</td>
</tr>
<tr>
<td>1005</td>
<td>8/29/2008</td>
<td>6 months</td>
<td>8/2009</td>
<td></td>
</tr>
<tr>
<td>1006</td>
<td>9/12/2008</td>
<td>6 months</td>
<td>9/2009</td>
<td></td>
</tr>
<tr>
<td>1007</td>
<td>9/24/2008</td>
<td>3 months</td>
<td>n/a</td>
<td>Dropped out due to move.</td>
</tr>
<tr>
<td>1008</td>
<td>9/24/2008</td>
<td>6 months</td>
<td>9/2009</td>
<td></td>
</tr>
<tr>
<td>1009</td>
<td>10/20/2008</td>
<td>3 months</td>
<td>10/2009</td>
<td></td>
</tr>
<tr>
<td>1010</td>
<td>11/19/2008</td>
<td>In process–6 months</td>
<td>10/2009</td>
<td></td>
</tr>
<tr>
<td>1011</td>
<td>1/28/09</td>
<td>3 months</td>
<td>1/2010</td>
<td></td>
</tr>
<tr>
<td>1012</td>
<td>1/28/09</td>
<td>3 months</td>
<td>1/2010</td>
<td></td>
</tr>
<tr>
<td>1013</td>
<td>1/30/09</td>
<td>Baseline</td>
<td>1/2010</td>
<td></td>
</tr>
<tr>
<td>1014</td>
<td>3/26/09</td>
<td>Baseline</td>
<td>3/2010</td>
<td></td>
</tr>
<tr>
<td>1015</td>
<td>4/14/09</td>
<td>Baseline</td>
<td>4/2010</td>
<td></td>
</tr>
<tr>
<td>1016</td>
<td>5/5/09</td>
<td>Baseline</td>
<td>5/2010</td>
<td></td>
</tr>
<tr>
<td>1017</td>
<td>4/16/09</td>
<td>Baseline</td>
<td>4/2010</td>
<td></td>
</tr>
<tr>
<td>1018</td>
<td>4/17/09</td>
<td>Baseline</td>
<td>4/2010</td>
<td>Family discharged from all services.</td>
</tr>
<tr>
<td>1019</td>
<td>5/19/09</td>
<td>Baseline</td>
<td>5/2010</td>
<td></td>
</tr>
</tbody>
</table>
Obtain and Organize Service Utilization Data

In addition to the data collected through surveys, focus groups, and interviews, service data are currently being gathered from designated contacts at each of the participating agencies. These data will be utilized to understand frequency and amount of PST services as well as the array of community based services utilized. Themes for how PST services are utilized in conjunction with other community based services will be assessed. Service utilization themes will be presented to participants for review and feedback.

Because each participating agency reports service utilization differently, more time is needed to identify and organize common service utilization variables across the three participating agency sites. In addition, themes in service utilization data will be more observable when the majority of enrolled families have received at least three months of PST services. Researchers anticipate having three months of service utilization data ready for review by January, 2010.

Respond to Stakeholder Feedback—Decrease Volume and Frequency of Data Collection

Peer reviewers and study participants have provided feedback that “this is a lot of measurement tools to be completed so many times.” As an essential component of our community-based participatory research process, we continually solicit feedback from all participants about our methodology and data collection procedures. As a result of this provider dialog we have received consistent feedback from provider participants indicating that the number of measures and frequency of data collection is burdensome. This burden is interfering with participant engagement, deterring providers from referring an adequate number of families to the study, and impacting the reliability of data collected from PST and Non-PST providers, as provider completion of the measures is often sporadic and not consistent with the data collection from the family participants.

The rationale for collecting data on each measurement tool from both caregivers and providers was to increase the reliability of the findings. However, an initial review of the findings indicates that scores for each reporter on the same measure are not illustrating much difference. This fact in addition to the participant burnout we are experiencing indicates a need to review and revise our data collection procedures and it is our judgment that focusing on collecting accurate Caregiver data will be the best use of project resources. So in an effort to maximize our resources, limit our data collection to the most meaningful data, and minimize the strain on participants, our revised plan is to:

- Eliminate collection of the Working Alliance Inventory and Family Empowerment Scale from PST providers at all collection intervals.
- Eliminate collection of the BERS-II from the alternate provider at all collection intervals.
- Caregiver perspective will continue to be studied. The amount of data collected from caregivers will be reduced by collecting BERS-II and third section of Family Empowerment Scale only at baseline, 6, and 12 month intervals. [This change eliminates these data being collected at 3 and 9 month intervals.]
Provider stakeholders will continue to contribute their expertise in the refining, testing, and implementation of the PST model. However, with the proposed changes their engagement will be more targeted and meaningful, thus expediting the referral and data collection process.

1.7 Impact of the Research Process

All research participants were asked to describe how their involvement in the study has impacted them and how satisfied they were with the community-based research process. Caregivers are asked to provide this information after six and twelve months of participation in the study; staff involved in the study at the research sites are asked at the twelve month interval. This feedback helps assess how the research process is working and how it could be improved.

Caregiver Results

Thus far, five caregivers have completed impact surveys on seven occasions (two at both the six and twelve month intervals, and five at the six month intervals). Preliminary results suggested that they were generally satisfied with their involvement in the study (“satisfied” or “very satisfied” 86% of the time) and that participation in the study is having at least some impact or influence on all caregivers. Selected written comments from caregivers follow:

- Gets me motivated to help my child.
- Very encouraged to come to [research meetings] because I was a part of something big.
- Gave me an opportunity to talk to other people during study activities. I feel empowered.
- Helped me to feel more confident in what I am seeking to do with my family.

Caregivers were also asked on the impact survey to comment about what is going well or what can be improved in the research process. Caregiver responses to this question included:

- Seems to be well organized.
- Make a private space for parents to fill out opinions.

PST and Provider Results

Feedback will be solicited from staff (e.g., PST and treatment team members who completed surveys) each time a caregiver participant has completed their involvement in the study. Results will be provided in future reports as only two caregivers have completed the study and feedback is still being gathered from PSTs and other treatment provider participants.
2. Construction of the PST Evidenced-Based Practice Protocol & Fidelity Monitoring Tool

A review of the literature on evidence-based practices (EBPs) in children’s mental health yields few results. Most EBPs are designed for clinicians in traditional outpatient treatment settings. The treatments are difficult to adapt as they are narrowly defined and are not designed to address the developmental needs of children in their broader family and community contexts. While more EBPs exist for adult interventions, for the reasons just mentioned, they are difficult to adapt for children.

As a result, little attention has been paid to the issue of developing evidenced based practice protocols for psychiatric rehabilitation services provided by non-clinically trained professionals. The methods that do exist provide guidance that can be built upon (Walker et al., 2007). Once developed, evidence based practice protocols for non-clinicians must be monitored for fidelity. Kansas is nationally known for work in this area (Marty, Rapp, & McHugo, 2008). Although there is “great diversity in methods to identify and specify fidelity criteria” (Mowbray, Holter, Teagu, & Bybee, 2003, p. 325), the literature does converge on one point: a model must be clearly defined prior to implementing a fidelity monitoring procedure. In the absence of a clearly defined model, there is no “standard” for what is to be studied or evaluated (Mowbray et al., p. 326).

The literature also points to the need to understand and document the impact of psychiatric rehabilitation interventions, such as PST services, in the community (Bond et al., 2000). The community-based research approach outlined in the following model documents the range of impact PST interventions have on communities and other providers. Once fully developed, implemented, and monitored for fidelity, this approach may be replicated and refined to document other models of psychiatric rehabilitation interventions for youth with SED and their families, such as children’s case management.

A Model for Developing PST as an EBP in a System of Care Utilizing a Participatory Action Research Approach (PAR)

A model for developing PST services as an EBP emerged from the following knowledge and understandings:

1. The methods of inquiry must match the broader purpose of the endeavor. The methods must promote benefits to all engaged in the research.

2. The methods of inquiry must also match the approach of PST interventions. By this we mean that the research must be empowering and supportive of research participants. Research efforts should support successful implementation and PST providers’ efforts to improve youth and family outcomes.

3. Kansas stakeholders have a rich history and an established expertise in providing Parent Support and Training Services. Some PST providers, administrators, and collaborative teams have more than a decade of experience implementing the service. This expertise must be clearly documented.
4. The model must be flexible enough to support implementation within a dynamic statewide system. Therefore, experienced stakeholders in multiple dimensions of the system must be involved in order to assure reliability and validity of the end products.

5. The model must also be flexible enough to incorporate the best available evidence on PST services from the peer reviewed literature. Anchoring the model in what is known about effective implementation of PST services provides content validity to the essential components. This knowledge should be applied and relayed to all who have an investment in PST services delivery in Kansas.

A community based participatory research (CBPR) approach is well-suited to address these points (Davis-Groves et al., 2008). A CBPR approach allows stakeholders to collaboratively shape a research agenda that maximizes expertise while empowering and supporting effective PST services provision. For this third phase of work, KU researchers created a model for developing an EBP within a Community Based System of Care (see Figure 1). Each step in the model for developing PST services as an EBP is first generally described followed by a summary of the progress toward that step. Progress on each step is reflected in past tense.

Figure 1: A Model for Developing an EBP within a Community Based System of Care
Step 1: Review and Document Effective Practices

This step includes conducting a literature review to understand the best available evidence for implementing and administrating PST services. Specifically, this step determines an answer to the question, “What evidence exists to understand the theory of change for services similar to PST interventions within children’s mental health systems of care?” Next, the literature review is utilized to conduct an initial investigation within the system of care. The purpose of this investigation is to understand how the evidenced-based components of PST as identified in the review of the literature are being implemented successfully or to understand the barriers to successful implementation. This step was completed in the Phase I study (Davis-Groves et al., 2007).

Step 2: Identify Model Components

Studies on the development and implementation of Wraparound are used as a conceptual guide to identify the model components for PST practice. Wraparound, established in the national children’s mental health system in the 1980s (Blau Chap 1.1 in Bruns & Walker 2008), was a logical “mentor” to this research process. Wraparound is typically included within the service array that comprises children’s community-based mental health services programs. Additionally, research on Wraparound has been conducted extensively for over two decades. The driving principles and value base of wraparound (Bruns et al. Chap. 2.1 in Bruns & Walker 2008) are consistent with those that drive Kansas PST practice (Davis-Groves et al., 2007). Further, unlike other EBPs used within children’s mental health systems of care (e.g., Multi-Systemic Therapy and Functional Family Therapy), Wraparound is not considered a formal clinical approach requiring an advanced degree to implement.

Walker, Koroloff, and Schutte (2003) defined three levels—the team, organizational, and system levels—across which effective implementation of wraparound1 must occur. The team level represents those techniques, behaviors, and procedures carried out by wraparound team members. The organizational level refers to the roles that organizations or agencies play in supporting wraparound at the team level. The system level represents policy and funding decisions that support wraparound at the core and organizational levels. Walker et al. (2007) describe three components of wraparound implementation—core, organizational, and influence—whose roles are similar to the levels described above.

For the Kansas PST model, we adopted the following approach to distinguish the different levels or components that comprise the model. The core components of PST practice refer to the specific techniques, behaviors, and procedures that make up the processes between PST providers and parents that have an influence on family and youth outcomes. The organizational components are broader variables occurring at the agency level, such as agency supervisory, training, and administrative practices that impact successful implementation of the PST intervention. For example, the initial investigation (Davis-Groves et al, 2007) identified specific supervisory practices that characterize effective PST

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1 Walker et al. (2003) use the term Individualized Service/Support Planning—a process that is also referred to as wraparound. The term wraparound is used here because that is the name used within the Kansas children's mental health system of care.
services. Accessible supervisors who provide regular supervision help PST providers understand their role with families and in the agency. Finally, the systems components are variables that impact successful implementation of the PST intervention within state and federal mental health systems. Systems level variables could include funding sources, policy agendas, dissemination efforts, access to technical assistance, and statewide fidelity monitoring procedures.

Qualitative research methods are utilized to gather detailed information from key informants within the system of care. This step builds on effectiveness findings from step 1 and documents the core, organizational, and systems components of PST services. In order to reflect the work completed this fiscal year 2009, the verb tense changes to past tense in this next section. The last paragraph in the section changes tense to summarize future steps for identifying the model components.

Participants

A convenient sample of initial participants was recruited via the PST Services Outcomes Evaluation. In addition all study participants were chosen to participate based on their ability to contribute expert knowledge on the following topics at the core, organizational and systems levels; 1) PST services implementation, 2) PST role on treatment teams, 3) administrative processes that support implementation of PST services, 4) training for PST services, 5) supervisory approach for PST services, and 6) specific population density variables (e.g. frontier, rural, densely settled rural, urban). Initial study participants included 2 Community Based Service Supervisors, 1 Executive Director, 6 Direct Supervisors of PST services, 10 Parent Support Specialists, 1 State Policy Representative, and 5 Case managers, for a total of 25 interviews. In addition, five focus groups were conducted as follows— two at the PST Statewide Network meetings, one with Case managers, one with PST providers, and one with CBS Directors Outcomes Committee. In addition, on two occasions researchers spoke with stakeholders who have expert knowledge of PST services implementation. Stakeholders, were informed of this study and the ensuing, conversations were documented and included within the qualitative analysis. A total of 32 transcripts are included in this initial analysis.

Semi-structured Interviews & Data Collection for Interviews and Focus Groups

Semi-structured interviews were developed based on previous research findings (Davis-Groves, et al, 2007), the current training for PST providers, and relevant literature discussed previously in this report. Qualitative data were gathered via phone interviews with participants by six research team members. A basic interview guide was developed to guide conversations about effective PST services implementation (see Appendix C). When possible, participants received the interview guide prior to the interviews so that they could prepare for interviews. As findings emerged in the interview process, the interviews were changed to reflect emerging themes and additional information was gathered on these themes in subsequent interviews.
Analysis

The first step in the analysis process was to categorize and organize a large volume of detailed information. In order to complete this step, each interview was transcribed and assigned a location in an Atlas.ti qualitative database (Muhr, 1997).

Each transcript was analyzed independently by two research team members using a coding system designed to identify components of PST practice considered essential for effective, high quality PST service delivery. The coding system consisted of categories (see Appendix C) developed from the semi-structured interview questions. New variables that emerged from expert knowledge shared through the interview process were also categorized. Each category was given an initial definition that at least two team members could agree on. The purpose of the category definitions was to provide clear, concise, and objective guidance to outside reviewers about how the qualitative content was organized. This step enhanced the validity and reliability of the qualitative research process.

Once research team members reached consensus on the coding of each transcript, a third research team member reviewed the codes and transcripts and provided feedback, which was then discussed so that consensus was achieved between all three researchers. The third researcher was included in research analysis to further enhance internal validity because of her extensive previous expertise and knowledge as a PST provider. Next, findings were presented to the expert interviewees through a member check process to ensure that the analysis accurately represented the information they shared. Member check feedback was then incorporated into the findings.

The next step in the analysis process involved converting research findings into a practice protocol of essential components of effective, high—quality PST service delivery at the core, organizational, and systems levels. First, the findings were organized according to the level(s) at which they occurred in the model—core, organizational, or systems. For each level, a process of translating the findings into practice language followed. The translating process included reviewing all the assigned content (expert quotations) under each category. In this review, researchers looked for dominant and contrasting themes that indicate effective PST practice. Specifically, researchers looked for actions PST stakeholders took toward achieving desired outcomes or addressing specific challenges in the practice setting. If there were no specific actions identified to address challenges in the initial inquiry, this information was noted under the sub-category definitions. The peer reviewed literature on this topic was then reviewed and integrated into feedback discussions with expert stakeholders in order to identify contextually relevant actions steps (see step 3 below).

Thus, the end result of the translation process was a set of indicators that operationalized the essential components of PST practice into measurable, objective, and observable standards by each of the models three levels. Because PST service delivery was significantly influenced by the CMHC and community in which it occurs, it was critical that the indicators be written broadly enough and with sufficient flexibility so they could be tailored for successful implementation at the individual CMHC level. Each indicator had
corresponding action steps identified by individual CMHCs as the process through which the indicator was demonstrated.

For example, one indicator of the PST referral process (at the core level) was that the family agrees to referral for PST service. The experts generally agreed this indicator was an essential component of the PST practice model. However, the process through which this component occurred varied between CMHCs. For instance, in one CMHC the family agreed to a referral in a formal wraparound meeting, in another CMHC the process occurred more informally through a discussion between a provider and family. Both scenarios were action steps that demonstrated the indicator.

**PST Practice Protocol Guide**

| Level | Core | \| | Organizational | \| | Systems |
|-------|------|\| | Variables at the agency level (e.g., supervisory, training, administrative practices) that influence successful PST service delivery. | \| | Variables at state mental health systems levels that impact successful PST service implementation (e.g., funding sources, policies, fidelity monitoring). |

**Initial Engagement & First Contact with Families**

- **PST emphasizes family comfort during first contacts.**
  - PST meets with the family in a location where they are most comfortable.
  - PST meets the family at a time that works best for them.
  - PST limits how much information is shared during a visit in order to avoid overwhelming the family.
  - PST asks the family to tell in their own words what brought them to services as a way of making them more comfortable.

- **PST takes great care to not be judgmental of families in any way.**
  - PST actively listens to family so they feel they are "being heard."
  - PST educates family that they are not the only ones going through this type of experience.
  - PST shares with caregiver that having a child living with SED does not make them a "bad parent."

Thus far, the translation process has been carried out at the core level of PST practice and a first draft practice protocol has been developed (See Appendix D). This step in the analysis was completed by the project manager and the research team member who has several years experience as a PST provider.

In order to complete identifying the PST model components researchers must finalize the initial coding and defining of the organizational/systems variables from the convenient sample described above. Next these organizational/systems variables need to be translated into indicators and action steps that are congruent with the best available evidence on services implementation and FSE practices. Ultimately,
the developed model will include the theory of change, indicators for each of three levels (core, organizational, and system), their corresponding action steps, and the desired outcomes.

**Step 3: Stakeholders Review Model Components**

This step, stakeholders review, involves taking the developing model for PST services delivery (the theory of change, indicators, actions steps and desired outcomes) back to the experts for review and feedback. All initial study participants will be approached to review the first draft of the PST practice protocol (core level of PST practice).

The first review of the core components in the practice protocol happened at the PST Statewide Network Conference on April, 22, 2009. This focus group was recorded and transcribed for analysis. The findings will be included in the initial analysis and will be incorporated back into the practice protocol.

**Step 4: Refine Model Components**

This step is ongoing throughout the model development process. Specifically, this step involves incorporating all feedback received, assessing with stakeholders’ what perspectives should be included, and assessing the content validity (degree to which a model represents the “range of possible meanings” in a particular context) of the model component parts (Rubbin & Babbie, 2001, p. 194). In this step researchers and community partners are assessing what perspectives may be missing. This refinement step also includes identifying the best available evidence on organizational and systems variables that support implementation of psychiatric rehabilitations services such as PST services.

An initial assessment of missing perspectives suggests family perspectives are missing in the model development sample. Although family perspectives were the foundation of the initial inquiry (see step 1 above), the experiences of caregivers receiving PST services remain under-represented. Therefore, as caregivers reach the 12-month summary review in the PST services outcome evaluation, they will be asked to review and provide feedback on the model component parts. Once incorporated into the PST model, caregiver perspectives will round out the range of perspectives for each indicator and action steps. When this step is complete, model component parts will have foundational level content validity.

A preliminary review of the literature on organizational and systems variable suggests that **fidelity implementation procedures are in fact a variable that impact effective implementation of psychiatric rehabilitation services** such as PST. For example, fidelity tools introduce standards, provide a way to observe improvement, and document the relationship between model adherence and outcomes. Bond et. al. (2000), suggest that fidelity procedures can be beneficial to implement at any stage in program development. Rapp and colleagues (1999) are nationally known as having “one of the most ambitious efforts in measuring program fidelity at a statewide level” for adult psychiatric rehabilitation services (Bond et al., 2000 p. 84). Therefore, as indicators and actions steps for the PST services model are being refined, key stakeholders and researchers will gather information about existing fidelity implementation procedures in Kansas that may be beneficial for the children’s system. The end result will be a template for fidelity implementation procedures that will accompany the core components of the PST services model for review and feedback.
Step 5: Stakeholder Consensus

A method for achieving stakeholder consensus should be developed in order to assure the model and fidelity tool reflect the expertise in Kansas and the empowering and supportive nature of PST services. Since the PST service model and fidelity implementation procedures are intended for statewide application, it is critical that a broad array of stakeholders have a chance to review and provide feedback. There are mutual benefits in this step. First PST stakeholders are receiving an orientation to the PST model and are assessing its applicability to their specific practice settings. In this way, experienced stakeholders have the opportunity to shape a model and fidelity process that will work for them. In turn, this research process—generating a focus on indicators and action steps—could have a positive impact on PST practice (Marty, Rapp, McHugo, Whitley, 2008). Parent Support and Training providers and other program staff will have the best available knowledge to apply in practice.

In order to achieve consensus and obtain relevant feedback in a confidential and efficient manner, a survey will be developed. The survey will detail 1) the core components (indicators and action steps) of the PST services model and 2) all that is known about organizational and systems components. For each indicator, participants will be asked to rate their level of agreement and will be provided a space to write detailed feedback. In addition, participants will see a list of action steps and have an opportunity to give detailed feedback on action steps to achieve the indicator. The survey will be administered online and in-person via focus groups. Consensus will be achieved on indicators when the majority of 50 representative stakeholders agree with the model component parts. Once consensus is achieved, however, the model and fidelity procedures may still be refined to support system changes and unique agency contexts. The end goal is to construct a model that is reliable, yet, flexible enough to support implementation within a dynamic statewide system.

Step 6: Test Model

In this step agency sites will be trained to implement and test the PST services model in collaboration with researchers within the practice setting. Goals in the testing phase are to: 1) assure that protocols suit the needs of PST providers, families, supervisors, and administrators, and 2) provide close supervision and support to assure that new protocols do no harm to anyone they may impact (Hoagwood, Burns, & Weis, 2002). The details in this step can be time-consuming and will rely heavily on what can be worked out between researchers and agency staff. Thus, sites for testing will be recruited for participation and compensation will be considered for the additional time they provide toward achieving goals 1 and 2 described above.

Once researchers and community partners determine that goals 1 and 2 are achieved, the next step is to collaboratively design a quasi-experimental study to test the PST services model. The goal of this step is to determine whether PST services are the cause of improved family and youth outcomes identified in the model. This study will require a control group (services as usual group) and an experimental group (PST model group). If possible, random assignment to the experimental group would increase the reliability of findings. Outcomes for both groups will be tracked for at least 12 months. This step will
need careful consideration, as many Kansas stakeholders will have already been exposed to effective components of PST practice in previous model development steps.

In addition, if researchers become aware that PST treatment produces positive effects on a child’s emotional or behavioral functioning, they must grapple with the ethics of the random assignment of children to a less effective intervention or to no intervention. Collaboration with other states or children’s services systems providing similar FSE services will be sought to avoid this scenario.

**Step 7: Replicate Model**

This step involves identifying other service settings to implement and test the PST services model. Fidelity implementation procedures are crucial in this step to assure that the model adheres to the evidence it was built upon, as well as to assess the model’s “goodness of fit” in other practice settings (Hoagwood, et al., 2002 p. 335). The organizational and systems components of the PST fidelity tool will assist in this endeavor. They will also identify supports needed to sustain PST services in other practice settings.

**Next Steps in Fiscal Year 2010**

In fiscal year 2010, researchers will complete Step 2 (Identifying Model Components) by coding, defining, and translating the organizational and systems indicators for the PST Practice Protocol (September 2009). In addition, researchers will continue with Step 3 (Stakeholder Review) by providing initial study participants with a review of the core components of the PST practice protocol at the 12-month data reviews. Feedback from these reviews will be incorporated, thus Step 4 (Refine Model Components) will begin.

As model components are refined, researchers will gather information about existing fidelity implementation procedures in Kansas. This knowledge will be combined with what is known about effective fidelity implementation procedures from the peer reviewed literature. The end result will be a template for fidelity implementation procedures that will accompany the core components of the PST services model (October 2009).

Once a fidelity template has been developed, Step 5 (Stakeholder Consensus) on the core components of PST practice will be pursued. At this time, a draft of the organizational/systems components (one of which is a fidelity procedure) will be completed and presented to statewide stakeholder groups for review and refinement. The method for achieving stakeholder consensus on model components is described above on page 20. Researchers anticipate Step 5 will be completed by December 2009. Feedback on organizational and systems components will be incorporated into the developing model.

Once all model components have been drafted and reviewed, Step 6 (Test Model), will be pursued (January 2010). Researchers will seek volunteer sites to implement the complete PST practice protocol and fidelity monitoring procedures. In order to do this researchers will: 1) coordinate the development of training materials in collaboration with the Outcomes Committee, SRS, Kansas Health Solutions, the
PST Statewide Network, and the Consumer Liaison, and 2) coordinate site visits with volunteer sites to implement the model and fidelity monitoring procedure.

Summary and Implications for Effective PST Practice

The study process itself has implications for effective practice. First, the best available knowledge regarding PST practices is disseminated within the children’s mental health system of care. Attention is focused on processes and outcomes that contribute to success, which then educates and motivates future behavior of all participants. Second, model development is setting standards for PST practice in Kansas by spotlighting the hard work and dedication of veteran PST providers and their program administrators. The end result is increased motivation to provide effective PST services to families and their children.

"Right now the PST service is probably more productive than it’s ever been and I credit you all. You all have been part of the reenergizing the PST about this work."

Executive Director
REFERENCES


Appendix A: Family Data Review

You have participated for the past year in a study being conducted by the University of Kansas School of Social Welfare on Parent Support services provided at community mental health centers (CMHCs) in Kansas. The purpose of the project is to learn how Parent Support and Training Services impact outcomes for families whose children receive services through a CMHC. The results of the study will be used to help refine state-level policies and practices impacting how Parent Support services are provided throughout the state.

Over the past year, we asked you to fill out surveys about you, your child, and your relationship with your Parent Support and Training Specialist (PST). The information you provided helps us understand: 1) your child’s strengths, 2) how empowered you feel, and 3) your level of caregiver stress. We looked at these areas in particular because families have told us that these are what PST providers help with. We also looked at your relationship with your PST because families said this was also an important part of why the service works.

We looked at this information when you first began receiving Parent Support services and then every three months for a year. We did this to look for changes that may happen as a family receives services.

The following graphs and information are a summary of your survey results. They are not an evaluation of you or your child. They are confidential. We will not share them with anyone in a way that identifies you or your child. We thank you for the all the time and energy you put into this study. We could not complete our work without dedicated parents like you!

- Your ratings of ________’s overall strengths are gradually climbing.
- You feel you are more empowered in issues on all three subscales on empowerment because they increased over a 12-month time period.
- Your feelings of caregiver strain decreased over 12 months across all three subscales (objective strain, internalized subjective strain, and externalized subjective strain).
- You are mostly in agreement with (PST’s name) on tasks you are completing, goals you are working toward, and the personal attachment (bond) between you and (PST Provider) over the last 12 months.

The KU Research Team

Sharah Davis-Groves, Kathy Byrnes, Susan Corrigan, Ashley Hutchison, Sarah Pilgrim, Yinxi Wu, and Megh Chakrabarti
The Working Alliance Inventory (WAI)

This scale measures the relationship between a parent and his/her PST.

*In reviewing these findings it is important to note that this data is from one family and the following graph represents three sub-scales on the Working Alliance Inventory. Since all subscale scores drop, it is possible that the WAI is not measuring three separate constructs within the relationship. In addition, the sudden drop in scores may not be a direct reflection of the PST intervention. For example, in this family data review, two stressful events (marital separation and the death of a grandparent) occurred at the 9 month data interval. The parent was not communicating regularly with her PST provider, not because the PST was not trying, but the parent was occupied with other tasks. If you look at other outcomes you will also notice child functioning (Interpersonal strengths) and family empowerment (services and community involvement) dropped at the nine month interval as well. Despite the drop in scores at 9 months on other outcomes, however, caregiver stress steadily decreased over the 12 month intervention period. The parent was able to discuss in the data review how she recovered from these stressful events and reflected on the impact they had on her family. This feedback will go directly into model development so that the PST intervention can be designed to be sensitive to these stressful events in family life. This feedback also has implications for fidelity monitoring of the PST intervention as well. For instance, if PST observe a sudden drop in WAI scores or parents notice this, they know it is time to assess the need for additional support. This particular data review, however, suggests that this family was able to achieve better outcomes despite the adversity experienced at the 9 month data collection interval. Thus the need for additional support from PST may not be indicated. Rather the PSTs role could be to notice the caregiver’s agency in managing challenging circumstances.
You are mostly in agreement with (PST’s name) on tasks you are completing, goals you are working toward, and the personal attachment (bond) between you and (PST Provider) over the last 12 months.

A score of 28 is the highest score possible on each subscale, and you rated each subscale 25 or higher by the end of 12 months.

Each subscale (red, blue, and green lines) is reviewed individually in the next three graphs.

From previous research, we know that the relationship between the PST and parents is very important. The research you participated in is helping us understand why.

We are not sure these three scales capture what is most important to parents in their relationship with their PST. As we go through these results, we would like you to tell us what you think.

Think about developing a scale to understand an effective relationship between parents and PST, what kinds of statements would be on that scale?
**Task**

This subscale measures the level of agreement between a parent and his/her PST on tasks they are working on.

- ____and I agree about the steps to be taken to improve my family situation.
- What I am doing with my PST gives me new ways of looking at my situation.
- We agree about what is important for me to work on.
- I believe the way we are working on my family situation is correct.

Do these statements get at what is most important about your relationship with (PST’s name)?

For example, how important do you think it is that you and (PST’s name) agree about the steps to be taken to improve your family’s situation?

Please explain.

![Task Graph]

### Task

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<tr>
<th>Subscale Score</th>
<th>Baseline Mar-May ’08</th>
<th>3 Months June-Aug ’08</th>
<th>6 Months Sept-Nov ’08</th>
<th>9 Months Dec ’08- Feb ’09</th>
<th>12 Months Mar-May ’09</th>
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- **Baseline Mar-May ’08**
- **3 Months June-Aug ’08**
- **6 Months Sept-Nov ’08**
- **9 Months Dec ’08- Feb ’09**
- **12 Months Mar-May ’09**
**Bond**

This subscale measures the level of attachment between a parent and his/her PST.

- I believe _____ likes me.
- I am confident in _____’s ability to help my family.
- I feel that _____ appreciates me.
- _____ and I trust one another.

Do these statements get at what is most important about your relationship with (PST’s name)?

For example, how important is it that you are confident in (PST’s name)’s ability to help your family?

Please explain.

---

**Graph: Bond**

- **Y-axis:** Subscale Score
- **X-axis:** Time periods:
  - Baseline: Mar-May ’08
  - 3 Months: June-Aug ’08
  - 6 Months: Sept-Nov ’08
  - 9 Months: Dec ’08- Feb ’09
  - 12 Months: Mar-May ’09

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**Data Points:**

- Baseline: 25
- 3 Months: 27
- 6 Months: 26
- 9 Months: 19
- 12 Months: 28
Goal

This subscale measures the level of agreement between a parent and this/her PST on goals they are working toward achieving.

- ____ does not understand what I am trying to accomplish in treatment.
- ____ and I are working toward mutually agreed upon goals.
- ____ and I have different ideas on what my family situation is.
- We have established a good understanding of the kind of changes that would be good for my family.

Do these statements get at what is most important about your relationship with (PST’s name)?

For example, how important is it that you and (PST’s name) agree on the goals and the types of changes that would be good for your family?

Please explain.

Goal

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<th>Subscale Score</th>
<th>Baseline Mar-May '08</th>
<th>3 Months June-Aug '08</th>
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Goal
Family Empowerment Scale (FES)

This scale measures a parent’s feelings of empowerment. It measures how much the parent feels empowered within his or her own family, the service system, and their communities.
Family

This subscale looks at your levels of empowerment at home and in day-to-day situations. These are the statements from the scale.

- When problems arise with my child, I handle them pretty well.
- I feel confident in my ability to help my child grow and develop.
- I know what to do when problems arise with my child.
- I feel my family life is under control.
- I am able to get information to help me better understand my child.
- I believe I can solve problems with my child when they happen.
- When I need help with problems in my family, I am able to ask others for help.
- I make efforts to learn new ways to help my child grow and develop.
- When I am with my child, I focus on the good things as well as on the problems.
- When faced with a problem involving my child, I decide what to do and then do it.
- I have a good understanding of my child’s disorder.
- I feel I am a good parent.

You feel you are becoming more empowered with immediate family issues. Instead of responding “sometimes,” you more often respond “often” to family empowerment items after 12 months (a score increase from 2.83 to 3.5).
Services

This subscale measures how much a parent feels empowered in working with professionals and the agencies that provide services to a parent’s child.

- I feel that I have a right to approve all services my child receives.
- I know the steps to take when I am concerned my child is receiving poor services.
- I make sure that professionals understand my opinions about what services my child receives.
- I am able to make good decisions about what services my child needs.
- I am able to work with agencies and professionals to decide what services my child needs.
- I make sure I stay in regular contact with professionals who are providing services to my child.
- My opinion is just as important as professionals’ opinions in deciding what services my child needs.
- I tell professionals what I think about services being provided to my child.
- I know what services my child needs.
- When necessary, I take the initiative to look for services for my child and family.
- I have a good understanding of the service system that my child is involved in.
- Professionals should ask what services I want for my child.

You feel you are more empowered in issues with the service system over the 12 month period. On these items, your average score increased from 4 to 4.33.
Community Involvement

This subscale measures a parent’s feelings of empowerment with government groups, policy makers, and the community. These are the statements from the scale.

- I feel I can have a part in improving services for children in my community.
- I can get in touch with my legislators when important bills or issues concerning children are pending.
- I understand how the service system for children is organized.
- I have ideas about the ideal service system for children.
- I help other families get the services they need.
- I believe that other parents and I can have an influence on services for children.
- I tell people in agencies and government how services for children can be improved.
- I know how to get agency administrators or legislators to listen to me.
- I know what the rights of parents and children are under the special education laws.
- I feel that my knowledge and experience as a parent can be used to improve services for children and families.

Community Involvement

Over the 12 months, you feel you became more involved in the community and with policies regarding emotional and behavioral disturbances in children. On earlier surveys, you responded to community involvement questions with “seldom” or “sometimes;” now, you almost always respond “often” (which reflects a score increase from 2.40 to 3.70).
Caregiver Strain Questionnaire (CGSQ)

This scale measures the amount of strain or stress the parent feels as a result of caring for a child with emotional and behavioral problems.

We have learned from previous research that a supportive relationship with someone who has walked in their shoes and/or understands allows parents to quickly learn new skills, make good changes for their families, and take opportunities to use available services and impact change in their communities and states. What are your thoughts on this statement?

Do you think the Family Empowerment scale captures the end result of the work you, your PST, and the team are trying to accomplish?

You reported that your caregiver stress levels decreased over 12 months across all three subscales.

Each subscale (red, blue, and green line) is reviewed individually in the next three graphs.
Objective Caregiver Strain

This subscale looks at negative events resulting from caring for a child with emotional or behavioral problems.

- My personal time is interrupted as a result of my child’s emotional or behavioral problem.
- I miss work or neglect other duties because of my child’s emotional or behavioral problem.
- Family routines are disrupted due to my child’s emotional or behavioral problem.
- One or more family members have to do without things because of my child’s emotional or behavioral problem.
- One or more family members suffer negative mental or physical health effects as a result of my child’s emotional or behavioral problem.
- My child gets into trouble with the neighbors, the school, the community, or law enforcement.
- My family experiences financial strain as a result of my child’s emotional or behavioral problem.
- Less attention is paid to other family members because of my child’s emotional or behavioral problem.
- Family relationships are disrupted or upset due to my child’s emotional or behavioral problem.
- My family’s social activities are disrupted due to my child’s emotional or behavioral problem.
- How isolated did you feel as a result of your child’s emotional or behavioral problem?

![Objective Strain Graph](image-url)
Internal Subjective Strain

This subscale measures how caregivers feel inside (sad, unhappy, worried, guilty, tired, etc.) about their children and their families’ situation.

- How sad or unhappy did you feel as a result of your child’s emotional or behavioral problem?
- How worried did you feel about your child’s future?
- How worried did you feel about your family’s future?
- How guilty did you feel about your child’s emotional or behavioral problem?
- How tired or strained did you feel as a result of your child’s emotional or behavioral problem?
- In general, how much of a toll has your child’s emotional or behavioral problem taken on your family?

![Internal Subjective Strain Graph]

**Internal Subjective Strain**

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- Baseline: Mar-May ‘08
- 6 Months: Sept-Nov ‘08
- 12 Months: Mar-May ‘09
**External Subjective Strain**

This subscale measures the following caregiver experiences.

- How embarrassed did you feel about your child’s emotional or behavioral problem?
- How well did you relate to your child?
- How angry did you feel about your child’s future?
- How resentful did you feel toward your child?

The largest decrease occurred in externalized subjective strain. After 12 months, you felt you experienced this type of caregiver strain “a little,” rather than “somewhat” and “quite a bit.”

We have learned from previous research that parents/caregivers are referred to parent support services when they feel a high level of stress and strain. PSTs assist in finding ways to manage and cope with the stress. What are your thoughts on this statement?

Do you think the caregiver strain questionnaire captures the end result of the work you, the PST, and the team are trying to accomplish?

Please explain.
Behavioral and Emotional Rating Scale, 2nd Edition (BERS-II)

This scale looks at behavioral and emotional strengths of children. It includes 5 subscales that look at specific types of strengths. [Child’s name]’s Strength Index is an overall snapshot of her behaviors and emotions.

Overall Strengths

- [Child’s name]’s overall strength index is gradually climbing.
- The graph below is a more detailed view of her strengths. Each area of strength is reviewed individually in the next five graphs.

Strengths by Area
Interpersonal Strength (IS)

This subscale measures the child’s ability to take control over his or her emotions or behaviors in social settings. These are the statements from the scale that look at IS.

- Uses anger management skills.
- Expresses remorse for behavior that hurts or upsets others.
- Reacts to disappointments in a calm manner.
- Considers consequences of own behavior.
- Accepts criticism.
- Accepts responsibility for own actions.
- Loses a game gracefully.
- Listens to others.
- Admits mistakes.
- Accepts “no” for an answer.
- Respects the rights of others.
- Shares with others.
- Apologizes to others when wrong.
- Is kind toward others.
- Uses appropriate language.

[Child’s name] is stronger in the area of interpersonal strength (increased 3 points).
Family Involvement (FI)

This subscale measures the child’s relationship or involvement with his or her family. The below list are the items on this scale. These are the statements from the scale that look at FI.

- Demonstrates a sense of belonging to family.
- Trusts a significant person with his or her life.
- Participates in community activities.
- Maintains positive family relationships.
- Communicates with parents about behavior at home.
- Interacts positively with parents.
- Participates in religious activities.
- Interacts positively with siblings.
- Participates in family activities.
- Complies with rules at home.

[Child’s name] improved in areas of family involvement (increased 2 points) over the 12-month period.
Intrapersonal Strength (IaS)

This subscale measures how a child views his or her accomplishments and various types of abilities. These are the statements from the scale that look at IaS.

- Is self-confident.
- Demonstrates a sense of humor.
- Demonstrates age-appropriate hygiene skills.
- Requests support from peers and friends.
- Enjoys a hobby.
- Identifies own feelings.
- Identifies personal strengths.
- Is popular with peers.
- Smiles often.
- Is enthusiastic about life.
- Talks about the positive aspects of life.

[Child’s name]’s intrapersonal strength score improved overall by 1 point after 12 months.
School Functioning (SF)

This subscale looks at the child’s strengths in the classroom setting. These are the statements from the scale that look at SF.

- Completes a task on first request.
- Completes school tasks on time.
- Completes homework regularly.
- Pays attention in class.
- Computes math problems at or above grade level.
- Reads at or above grade level.
- Studies for tests.
- Attends school regularly.
- Uses note-taking and listening skills in school.

[Child’s name] improved the most in the area of school functioning (increased 5 points) over the 12-month period.
Affective Strength (AS)

This subscale looks at the child’s ability to accept and express emotions and affection. These are the statements from the scale that look at AS.

- Accepts a hug.
- Acknowledges painful feelings.
- Asks for help.
- Shows concern for the feelings of others.
- Discusses problems with others.
- Accepts the closeness and intimacy of others.
- Expresses affection for others.

[Child’s name] maintained her affective strength score over the 12-month period.

We have learned from previous research that PSTs assist the parents and the treatment teams to see strengths and manage challenging behaviors.

Do you think the BERS questions capture the end result of the work you, the PST, and the team are trying to accomplish?

Please explain.
Appendix B: Standardized Measures

Working Alliance Inventory (WAI)

Author: Adam O. Harvarth

The Working Alliance Inventory (WAI) (Horvath, 1981, 1986) measures the working alliance between the recipient of services and the provider of services. The WAI seeks to measure the quality of the mutuality between the provider and the client as a primary component of effectiveness. The WAI is a 12-item instrument. Responses to items are on a 7-point Likert scale (1 = not at all true, 2 = a little true, 3 = slightly true, 4 = somewhat true, 5 = moderately true, 6 = considerably true, 7 = very true). The WAI consists of three subscales that measure various aspects of the working alliance. These subscales are described in detail below.

The task subscale assesses the extent to which tasks are agreed upon.

- _____ and I agree about the steps to be taken to improve my family situation.
- What I am doing with my PSS gives me new ways of looking at my situation.
- We agree about what is important for me to work on.
- I believe the way in which we are working on my family situation is correct.

The bond subscale measures the level of attachment between the parent and PST provider.

- I believe _____ likes me.
- I am confident in _____’s ability to help my family.
- I feel that _____appreciates me.
- _____ and I trust one another.

The goal subscale measures the level of agreement between the parent and the PST provider on goals they are working toward achieving.

- _____ does not understand what I am trying to accomplish in treatment.
- _____ and I are working toward mutually agreed upon goals.
- _____ and I have different ideas about what my family situation is.
- We have established a good understanding of the kind of changes that would be good for my family.
Family Empowerment Scale (FES)

Authors: Paul E. Koren, Neal DeChillo, and Barbara Friesen

The Family Empowerment Scale (FES) (Koren, Dechillo, & Friesen, 1992) measures empowerment in families with a child who has an emotional disability. The FES is particularly useful in agencies whose delivery model features client empowerment as a goal. The FES is a 34-item instrument based on a two-dimensional definition of empowerment: the level of empowerment and the way it is expressed. Items are rated on a 5-point Likert scale (1 = not true at all, 2 = mostly not true, 3 = somewhat true, 4 = mostly true, 5 = very true). Subscales are constructed based on three levels in which empowerment can occur: family, service system, and community/political.

The family subscale looks at levels of empowerment in the immediate home and in day-to-day situations.

- When problems arise with my child, I handle them pretty well.
- I feel confident in my ability to help my child grow and develop.
- I know what to do when problems arise with my child.
- I feel my family life is under control.
- I am able to get information to help me better understand my child.
- I believe I can solve problems with my child when they happen.
- When I need help with problems in my family, I am able to ask for help from others.
- I make efforts to learn new ways to help my child grow and develop.
- When I am with my child, I focus on the good things as well as on the problems.
- I have a good understanding of my child’s disorder.
- I feel I am a good parent.

The services subscale measures how much the parent feels empowered in dealing with the professionals and agencies that provide services to his or her child.

- I feel that I have a right to approve all services my child receives.
- I know the steps to take when I am concerned my child is receiving poor services.
- I make sure that professionals understand my opinions about what services my child receives.
- I am able to make good decisions about what services my child needs.
- I am able to work with agencies and professionals to decide what services my child needs.
- I make sure I stay in regular contact with professionals who are providing services to my child.
- My opinion is just as important as the professionals’ opinions in deciding what services my child needs.
- I tell professionals what I think about services being provided to my child.
- I know what services my child needs.
- When necessary, I take the initiative in looking for services for my child and family.
• I have a good understanding of the service system that my child is involved in.
• Professionals should ask what services I want for my child.

The community investment subscale measures the parent’s feelings of empowerment with government groups, policy makers, and the community. It pertains to advocacy of children in general, rather than the parent’s individual child.

• I feel I can have a part in improving services for children in my community.
• I can get in touch with my legislators when important bills or issues concerning children are pending.
• I understand how the service system for children is organized.
• I have ideas about the ideal service system for children.
• I help other families get the services they need.
• I believe that other parents and I can have an influence on services for children.
• I tell people in agencies and government how services for children can be improved.
• I know how to get agency administrators or legislators to listen to me.
• I know what the rights of parents and children are under the special education laws.
• I feel that my knowledge and experience as a parent can be used to improve services for children and families.


Behavioral Emotional Rating Scale – 2nd Edition. (BERS-2)

Author: H.M. Epstein

The Behavioral and Emotional Rating Scale: A Strength-Based Approach to Assessment – Second Edition (BERS-II) (Epstein, 1998) is a standardized scale used to assess various behavioral and emotional strengths of children, rather than assessing deficits in functioning or pathology. The BERS-II consists of 52 Likert-type scale questions. Responses on the scale range from 0 to 3, and measure to what degree a behavior is or is not present in the child (0 = not at all like, 1 = not much like, 2 = like, 3 = very much like). Within these questions are five subscales that measure Interpersonal Strength, Family Involvement, Intrapersonal Functioning, School Functioning, and Affective Strength.

The interpersonal strengths (IS) subscale measures the child’s ability to take control over his or her emotions or behaviors in social settings. The following items are on this scale:

• Uses anger management skills.
• Expresses remorse for behavior that hurts or upsets others.
• Reacts to disappointments in a calm manner.
• Considers consequences of own behavior.
• Accepts criticism.
• Accepts responsibility for own actions.
• Loses a game gracefully.
• Listens to others.
• Admits mistakes.
• Accepts “no” for an answer.
• Respects the rights of others.
• Shares with others.
• Apologizes to others when wrong.
• Is kind toward others.
• Uses appropriate language.

The family involvement (FI) subscale measures the child’s relationship or involvement with his or her family. The following items are on this scale:

• Demonstrates a sense of belonging to family.
• Trusts a significant person with his or her life.
• Participates in community activities.
• Maintains positive family relationships.
• Communicates with parents about behavior at home.
• Interacts positively with parents.
• Participates in religious activities.
• Interacts positively with siblings.
• Participates in family activities.
• Complies with rules at home.

The intrapersonal strength (IaS) subscale measures how the child views his or her accomplishments and various types of abilities. The following items are on this scale:

• Is self-confident.
• Demonstrates a sense of humor.
• Demonstrates age-appropriate hygiene skills.
• Requests support from peers and friends.
• Enjoys a hobby.
• Identifies own feelings.
• Identifies personal strengths.
• Is popular with peers.
• Smiles often.
• Is enthusiastic about life.
• Talks about the positive aspects of life.

The school functioning (SF) subscale looks at the child’s strengths in the classroom setting. The following items are on this scale:

• Completes a task on first request.
• Completes school tasks on time.
• Completes homework regularly.
• Pays attention in class.
• Computes math problems at or above grade level.
• Reads at or above grade level.
• Studies for tests.
• Attends school regularly.
• Uses note-taking and listening skills in school.

The affective strength (AS) subscale looks at the child’s ability to accept and express emotions and affection. The following items are on this scale:

• Accepts a hug.
• Acknowledges painful feelings.
• Asks for help.
• Shows concern for the feelings of others.
• Discusses problems with others.
• Accepts the closeness and intimacy of others.
• Expresses affection for others.

Source: Psychological Assessment Resources Incorporated.

Caregiver Strain Questionnaire

Authors: A.M. Brannan and C.A. Heflinger

The Caregiver Strain Questionnaire (CGSQ) (Brannan & Heflinger, 1997) measures the impact on a primary caregiver of caring for a child with emotional and behavioral problems. The respondent caregiver is asked to report the degree to which an event or feeling was a problem due to the child’s problems. The CGSQ includes 21 items that are rated on a 5-point Likert scale (1 = not at all, 2 = a little, 3 = somewhat, 4 = quite a bit, 5 = very much). The CGSQ includes two subscales that measure objective caregiver strain and subjective caregiver strain.

The objective caregiver strain subscale looks at how negative events result from caring for a child with emotional or behavioral problems.
• My personal time is interrupted as a result of my child’s emotional or behavioral problem.
• I miss work or neglect other duties because of my child’s emotional or behavioral problem.
• Family routines are disrupted due to my child’s emotional or behavioral problem.
• One or more family members have to do without things because of my child’s emotional or behavioral problem.
• One or more family members suffer negative mental or physical health effects as a result of my child’s emotional or behavioral problem.
• My child gets into trouble with the neighbors, the school, the community, or law enforcement.
• My family experiences financial strain as a result of my child’s emotional or behavioral problem.
• Less attention is paid to other family members because of my child’s emotional or behavioral problem.
• Family relationships are disrupted or upset due to my child’s emotional or behavioral problem.
• My family’s social activities are disrupted due to my child’s emotional or behavioral problem.
• How isolated did you feel as a result of your child’s emotional or behavioral problem?

The internal subjective strain subscale measures the types of feelings projected within the caregiver.

• How sad or unhappy did you feel as a result of your child’s emotional or behavioral problem?
• How worried did you feel about your child’s future?
• How worried did you feel about your family’s future?
• How guilty did you feel about your child’s emotional or behavioral problem?
• How tired or strained did you feel as a result of your child’s emotional or behavioral problem?
• In general, how much of a toll has your child’s emotional or behavioral problem taken on your family?

The external subjective strain subscale measures the types of feelings projected at the child.

• How embarrassed did you feel about your child’s emotional or behavioral problem?
• How well did you relate to your child?
• How angry did you feel about your child’s future?
• How resentful did you feel toward your child?
Appendix C: Implementation Interview

Information Statement for Model Development Interviews

The Department of Social Welfare at the University of Kansas supports the practice of protection for research participants. The following information is provided for you to decide whether you wish to participate in the present discussion. You should be aware that even if you agree to participate, you are free to withdraw at any time without penalty.

Our purpose today is to interview you regarding the essential aspects of the PST (Parent Support and Training) intervention at the initial engagement phase. By initial engagement, we mean the first PST contacts and activities with newly referred families. This interview is the first step to define the PST intervention protocol within the practice settings. The protocol will provide a foundation for the development of a fidelity tool. From this interview, we hope to learn how PST services are implemented at your agency. We will also be exploring contextual variables (organizational structure, supervisory approach, and any community specific demographics) that are unique to your agency and PST practice.

Your participation is strictly voluntary. We would like to digitally record the current conversation to document the essential components of the PST model. The recording will be transcribed and analyzed. You, your agency, and the information you provide will be kept confidential. Once we have interviewed multiple stakeholders and analyzed the findings on the initial engagement phase, we will bring these findings back to you for your review and comment.

If you would like additional information concerning this study before or after it is completed, please feel free to contact us by phone (785-830-8079) or email (shdavis@ku.edu).

Participation in the discussion indicates your willingness to participate and that you are over the age of eighteen. If you have any additional questions about your rights as a participant, you may call (785) 864-7429 or (785) 864-7385, or contact the Human Subjects Committee Lawrence Campus (HSCL) by writing to University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7563 or emailing dhann@ku.edu or mdenning@ku.edu.

Appendix C: Implementation of the PST Service

These are the objectives for implementation of the PST service taken from PST Training Manual, developed by the Kids Training Team November 2006.

1. Conduct a strengths-based realistic goal for Parent Support and Training Services.
2. Provide objective documentation that construes medical necessity of services.
3. Develop appropriate PST Interventions for Parents and Families.
4. Build a positive working relationship with families with clear expectations.
5. Identify road blocks to parents participating in a parent support group.
6. Explain the importance of incorporating a continuum when dealing with behaviors.

Are there any other objectives you feel are important to address when PST services are being implemented?

PST Intervention Processes & Activities

1. Initial Engagement:
   What is the single most important thing to accomplish during the initial engagement period?

2. Referral Process
   How do you find out about a family?

   What is a typical situation with a referral? What is the step-by-step process?

   What kind of information did you receive about the family and their needs?

   When do you think it is best to refer families to PST services?

3. First Contact with Families
   How many times, on average, do you have contact with families per month?

   What information is provided or received during the first visit?

   Is there anything else you feel should be included in the first contact with families?

4. Family Driven Goals
   What kinds of goals are discussed in the first meeting?

   How are the goals documented or written out and what does this look like?
We are trying to understand the PST service models within various community practice settings. The following questions clarify what factors or variables may influence PST services in your agency and community.

Context Variables

1. **Community**
   - Does the PST at your agency work in different communities?
   - If so, are there any differences between the communities they work in?
   - What are the differences between the communities?
   - Does the type of community affect practice in other ways besides number of visits?
   - Specifically, what skills are needed to provide services in these communities?
   - Would you recommend any specific training for PST in your community to gain these skills?
   - Can you tell us anything about how the community impacts the treatment team?
   - What are some challenges that you think may be unique to your agency and are not apparent in other parts of the state, from a rural/frontier/urban/densely settled rural perspective?

2. **Recruitment & Retention**
   - From our previous conversations, we know that recruitment and maintaining PST staff has been challenging. We hear on the Federation listserv and at national conferences that this is an issue across the nation with this type of service.
   - What contributes to this challenge from your perspective?
   - What are some ways your agency tries to address the challenges?

3. **Organizational Structure**
   - Can you tell me about the organizational structure in each office?
   - Who is responsible for the supervision of PST providers?
   - What are the strengths of your organizational arrangement?
   - Is there anything you would change if you could? If yes, specifically what would be the ideal structure for a PST provider?

4. **CBS Program Mission & Values**
   - From the first study, we know PST services are provided in a statewide system of care that has adopted a philosophy of community-based, strengths-oriented, family-centered service provision that defines the delivery of mental health services to children and families in CBS programs. In this model, the client and family are seen as integral members of a team, actively participating in
the development of goals and objectives and the selection of appropriate services. Taken even further, family members are seen as experts who can offer the insight and experiential details that lead to the identification of strengths and needs, accurate diagnoses, and effective services. This approach to service provision planning is facilitated through a wraparound model whereby parents have the option to invite other family members or caregivers, mental health center staff, significant others, school personnel, and members of the community to participate in the planning process as equal team members directing the provision of services. This individualized process seeks to coordinate mental health services with other community services and resources to develop the most comprehensive and realistic plan possible.

Does this philosophy fit with your Community-Based Services program, mission, and values? Is there anything missing? Please explain?

5. **Access to PST Peers**
   From the first study, we know that PST highly value access to their peers. This peer-to-peer support gives PST the opportunity to share what works in their practice and learn about additional resources to support the families they are working with.

   What is your perspective on PST access to peers?

   **[For Rural/Frontier Respondents ONLY]** While this may not be true in your agency, we've found in the literature that a concern of rural/frontier communities is lack of access to peer support.

   Is this lack of access to peers in rural areas reflective of your agency and/or experience? If so, how have you seen this impact PST? If not, what kinds of peer support are available to PST?

   In addition, the PST providers are considered part of a formalized discipline with a code of ethics and state professional group.

   Are you aware of the PST code of ethics? Are other program staff at your agency aware of the PST code of ethics?

6. **Training**
   We know from the previous study that the appropriate training for PST is important. Specifically, training is needed to address the development of diplomacy skills to manage therapeutic relationships and the delicate balance between PST roles and responsibilities as employees of a CMHC. All groups reported that the training would be more effective if provided by PST who were employees of a CMHC.

   Is there anything else you would like to add regarding training for PST?

7. **Supervision**
   From the first study we conducted, we learned that PST utilize supervision for refining skills to manage the therapeutic relationships with parents. PST are in a unique role because they are
parents and they share their experiences early on in the relationship with the parents they work with, as Norma did.

How is supervision structured for PST at your agency to support PST in managing their relationships with parents?

How often do PST meet with their supervisors?

We also learned from the first study that PST utilize supervision to explore strategies to balance their desire to advocate for families and maintain good working relationships with agency staff.

How is supervision structured for PST at your agency to support PST in finding this balance?

What training do CBS direct staff supervisors receive (i.e., TAG training)?

As an administrator, what training do you think is necessary to provide to supervisors to meet the supervisory needs of PST?

8. Team Approach

From the first study, we learned that a team approach helps to integrate the PST role within treatment teams. Specifically, well-defined roles between PST and other team members are essential. Regular communication and good working relationships on teams are essential to facilitate the team approach. Furthermore, it works best when all team members understand and recognize the unique contribution PST bring to the treatment process. That is, they are experts on the family perspective. Staff may utilize PST as consultants on how to approach sensitive topics with families or to provide a family perspective on a proposed goal/intervention.

Does this fit with your experience of the Team Approach at your agency?

What are some strategies your agency implements to facilitate regular communication on Teams?

Is there anything we need to add to our findings on the Team Approach from your perspective?

Finally, is there anything else you would like to add regarding how PST services are implemented in your agency in the context of your community and program?

Thanks so much for your time!!! We will contact you again in a few months to review the findings with you.

What day and time works best for you? Is this the correct phone number on which to reach you?

Thanks again!
Appendix D: Core Components of PST Services Practice Protocol

Draft of Core Components of Parent Support and Training (PST) Practice

Presented at the Parent Support Specialist Annual Conference on April 22, 2009

PST Practice Protocol Guide

<table>
<thead>
<tr>
<th>Level</th>
<th>Core</th>
<th>Organizational</th>
<th>Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specific techniques, behaviors, and procedures that make up the processes between PST providers and parents that influence family and youth outcomes.</td>
<td>Variables at the agency level (e.g., supervisory, training, administrative practices) that influence successful PST service delivery.</td>
<td>Variables at state mental health systems levels that impact successful PST service implementation (e.g., funding sources, policies, fidelity monitoring).</td>
</tr>
</tbody>
</table>

Initial Engagement & First Contact with Families

- PST emphasizes family comfort during first contacts.
  - PST meets the family in a location where they are most comfortable.
  - PST meets the family at a time that works best for them.
  - PST limits how much information is shared during a visit in order to avoid overwhelming the family.
  - PST asks the family to tell in their own words what brought them to services as a way of making them more comfortable.

- PST takes great care to not be judgmental of families in any way.
  - PST actively listens to family so they feel they are "being heard."
  - PST educates family that they are not the only ones going through this type of experience.
  - PST shares with caregiver that having a child living with SEO does not make them a "bad parent."

About Indicators:
- Operationalize the essential components of PST practice as measurable, objective, and observable standards.
- Written broadly and with enough flexibility so can be tailored for successful implementation at each CMHC through individualized action steps.

About Action Steps:
- Measureable, objective, and observable standards that demonstrate how the indicator is met.
- Identified by each CMHC so are individualized to align with center operation, cultural competence, and community context.
Referral Process/Needs of Families

- CMHC treatment provider considers a referral by talking with a family about what their needs are and considering how the PST service can support those needs.
- CMHC treatment provider considering a referral introduces the PST service to families in a way that supports a successful connection.
- Family agrees to being referred for the PST service.
- CMHC treatment provider notifies PST that (s)he is referring a family for PST services.
- PST obtains information from person making referral and other sources (e.g., staff working with family, records, etc.), as needed, that supports successful initial PST connection with a family, including:
  - What the family’s needs are.
  - Best way to contact the family.
  - Ways to bridge connections for the family between PST and other CMHC staff already working with family.
- PST contacts families to initiate PST service within a few days of receiving referral and information that supports a successful connection.

Initial Engagement & First Contact with Families

- PST emphasizes relationship building for successful connection with families during first contacts.
- PST explores with families what their needs are.
- PST describes how PST service can help address needs identified by families.
- PST emphasizes family comfort during first contacts.
- PST paces interventions in order to avoid overwhelming families.
- PST actively listens to families so they feel they are “being heard.”
- PST takes great care to not be judgmental of families in any way.
- (For PST who are parents or relatives of children with SED/special needs) PST may share part of or all of his/her personal story as a parent/relative of a child with SED/special needs in a way that helps build a relationship and instill hope.
- PST describes how (s)he works with families in a professional role compared to as a friend.
- PST describes to families how the PST service works within a collaborative team approach to treatment services in which the family is engaged.
- PST works with treatment team members to ensure a collaborative approach between the services (s)he provides to families and other services the family receives.
Family Driven Goals

- PST assists families to identify important goals that they want to work on.

PST Role (Interventions)

(Note: Italicized items are taken directly from the KHS service definition which is included at the end of this appendix.)

- PST provides support *that encourages engagement and active participation of the family in the treatment process.*
  - Emotional support: PST is present for the family, listens, and provides an outlet.
  - Informational Support: PST shares information, strategies, and resources.
  - Peer Support: PST may share part of or all of his/her personal story as a parent/relative of a child with SED/special needs in a way that helps instill hope and imparts the wisdom that comes from the lived experience.
  - Instilling Hope

- PST provides training *that encourages engagement and active participation of the family in the treatment process.*
  - Behavioral/Parenting Skills Training
  - Practical Crisis Coaching
  - Coping Skills Training
  - *Training on a child’s medication or diagnoses*
  - *Interpreting choice offered by service providers*
  - *Training on policies, procedures, and regulations that impact a child with SED living in the community:*
    - school
    - working with mental health treatment providers and systems
    - *requirements of the waiver process*
Parent Support and Training Service Definition taken verbatim from page 96 of the Kansas Health Solutions Provider Manual.
http://www.kansashealthsolutions.org/web_docs/Provider_Downloads/Contracting_Documents/KHS%20Provider%20Manual%201-08.pdf

Parent Support and Training designed to benefit the Medicaid eligible consumer experiencing a serious emotional disturbance who, without waiver services, would require state psychiatric hospitalization. This service provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the consumer. For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, grandparents, or foster parents. Services may be provided individually or in a group setting. Services must be recommended by a treatment team, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized plan of care.

Components
This involves:

- assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the consumer in relation to their mental illness and treatment;
- development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the consumer’s symptom/behavior management;
- assisting the family in understanding various requirements of the waiver process, such as the crisis plan and plan of care process;
- training on the child’s medications or diagnoses; interpreting choice offered by service providers; and
- assisting with understanding policies, procedures and regulations that impact the consumer with mental illness while living in the community.