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Youth Crisis and Transition Services (CATS): Incorporating Family Peer Support Specialists to Assist Families During Crisis

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Introduction

The Crisis and Transition Services (CATS) program was developed to serve youth and families seeking urgent mental health care from hospital emergency departments (EDs). In Oregon, statewide shortages of inpatient psychiatric beds, lengthy outpatient provider waitlists, and coverage disparities among payer groups make it difficult for EDs to safely discharge youth back to their homes when inpatient psychiatric treatment is unavailable (Baker and Jetmalani, 2014). These factors contribute to ED boarding, a term that refers to long wait times in the ED because there is not a safe and timely pathway to the next appropriate place for care. ED boarding often has negative impacts on the youth and their families. The CATS program addresses these challenges by providing rapidly accessible home-based crisis stabilization and care coordination during the high-risk period immediately following hospital discharge. It serves as a bridge between ED discharge and established connection with longer-term outpatient support. Placing a high importance on family context and parental involvement in treatment, the program is designed to include direct support services to both the youth and the family.

Program Description

The CATS program is organized as a coordinated specialty care team in which youth and their caregivers gain immediate access to an array of services that includes 24-hour crisis response, therapy, psychiatry, care coordination, and family support. The program is designed to provide these services intensively for a brief period of time, usually 45-90 days. The interdisciplinary CATS team provides care in a manner that reduces or eliminates barriers to accessing services and support, increases help seeking, and builds on youth and family strengths. The CATS team also ensures connections are made to longer-term community-based services and supports that will assist the youth and their families with ongoing needs after the program has ended, thereby increasing the durability of short-term stabilization efforts.

An aspect of CATS that is unique among many clinical interventions for youth is the type of support directed to the parents or caregivers. This support is called *family peer support* and is provided by a Family Support Specialist (FSS). The FSS is a paraprofessional who has personally experienced the complexities of parenting a child with emotional and behavioral health challenges and who has specialty training in providing support to parents and guardians in similar circumstances. While a clinical provider focuses primarily on the needs of the youth, the FSS supports the parent or guardian in developing crisis management and

advocacy skills, gaining knowledge about mental health and systems of care, and addressing their own needs and the needs of other family members.

The clinical portion of the CATS program typically lasts for 30-45 days, while the FSS may continue providing care for an additional 4-6 weeks after clinical care closes, assisting with lingering needs of the parents and facilitating a warm handoff to other community-based services.

Peer Support in Mental Health Care

A study conducted by Kang et al. (2017) identified that parental involvement and support in a child's life significantly decreases suicidal ideation for children who experience high levels of life stress, indicating that parent-family connectedness is a protective factor against suicide. While parent support may help to buffer a youth's relationship between life stress and suicidal ideation, some parents may not have the knowledge or skills to provide that support. Equipping parents with knowledge and providing opportunities to develop new skills both responds to the parent's needs and enables them to better support their child. Providing directed support to the parent also acknowledges the profound impact of a child's mental health struggles on the family and facilitates a more holistic and integrated approach to care.

In Oregon, "peer-delivered services" is a term that refers to an overarching field of work in which supportive services are provided by an individual who has similar experiences as the individual they are supporting. Shared experiences often align around mental health, substance use, suicidality, developmental or intellectual disabilities, and parenting youth with complex needs. Access to peer-delivered services has been shown to be associated with an increase in attendance to health-related appointments (Druss et al., 2010), better adherence to medications (Hoagwood, 2005), a decrease in crisis events that result in ED re-presentation and hospitalizations (Klein et al., 1998), and overall positive improvement in functioning (Greenfield et al., 2008). One type of peer-delivered services, family peer-delivered services, focuses on the parents and other adult caregivers of the youth with identified mental health needs.

The family peer support role is designed to assist parents in clarifying their own needs or concerns, reducing their sense of isolation, stress, or self-blame, and empowering them to take an active role in their children's services (Hoagwood et al., 2010). Wisdom et al. (2014, p. 22) summarized that "growing evidence suggests peer-delivered family

support is associated with important family outcomes, including decreased levels of parental anxiety (Ireys & Sakwa, 2006), improvements in caregiver self-care, empowerment, communication styles (Brister et al., 2012), and engagement in their child's services (Elliott, Koroloff, Koren, & Friesen, 1998; Gyamfi et al., 2010; Hoagwood, 2005)." These outcomes may be directly related to the perceived credibility and trustworthiness of family peer support workers due to the personal experiences they have in common with the family (Wisdom et al., 2014).

Family Peer Support in the CATS Program

Since 2014 inception of the CATS program, peer support directed intentionally to the parents and adult caregivers of the enrolled youth has been considered an integral component of the program. The Family Peer Support Specialist (FSS) was included as an essential member of the CATS team due to the developing body of research that suggests peer-delivered services are associated with the aforementioned positive outcomes.

To be eligible for the position of a CATS FSS, an individual must have experience parenting a child with complex health needs and navigating systems of care, often referred to as *lived experience*. All family support specialists are also required to complete continuing education in peer-delivered services, specifically applying peer support to families. CATS FSS workers are employed by a variety of organizations, including peer-run non-profit organizations, county mental health programs, and community-based clinics. In each of these settings, FSS workers receive clinical supervision and peer supervision from someone who has personal lived experiences, as well as professional experience in the same field of practice. Having both the clinical and the peer supervision ensures adherence to the principles of peer-delivered services. Employers in this field seek to recruit multilingual and multicultural staff to build a diverse workforce that reflects the cultural diversity of families in Oregon communities.

In the CATS program, the FSS assists adult family members with psychoeducation, skills to navigate complex health and education systems, de-escalation practices, and clarifying their own needs for self care and emotional support. The FSS also helps address additional difficulties that parents of youth with complex behavioral health needs often face including: strained communication with clinical providers; limited knowledge of and access to information about suicide risk and safety; and emotional and social stresses of having a child whose symptoms may

display as behaviors that are often judged by others as being the result of poor parenting.

Using a strengths-based approach, the FSS helps the family to re-frame their experiences as health challenges rather than parenting failures, and may help with negative feelings the parents feel due to social stigma and judgments from those who do not understand the complex challenges they are facing.

Goals of this Study

The goals of this study were to identify predictive factors of family engagement with family peer support and determine the strength and helpfulness of their interactions.

The team-based approach of the CATS program aims to provide services and support to both the youth and their caregivers; however, parent engagement with the family peer support provider is optional. Families sometimes opt out of this part of the service without having met the FSS or they may be unresponsive to FSS attempts at engagement.

Family engagement with the FSS may be influenced by variations in how the FSS role is described, timing of when the FSS is introduced, how the FSS approaches the role, cultural needs of the family, and the level of experience the FSS may have in the role. Our study analyzed quantitative data on successful family-peer engagement and qualitative data on parent experience with peer support to gain insight about how to introduce the role to families, to assess whether there is an optimal approach to providing family peer support services, and to help identify professional development opportunities for this workforce.

Methods

Our team, which is part of the child and adolescent psychiatry division at an academic health center in the Pacific Northwest, was contracted by the Oregon Health Authority to conduct a statewide program evaluation of the CATS programs. This project involves monitoring patient clinical and safety outcomes, making recommendations for program improvement, and providing technical assistance to the clinical and family support workers. This project was reviewed and designated as *Not Human Research* by the institution's IRB, waiving continued oversight.

Design

As part of our statewide quality improvement efforts, all CATS programs are required to enter patient data in REDCap, a secure electronic database that is compliant with the Health Insurance Portability and

Accountability Act (HIPAA) and is hosted by our academic health center. Comprehensive data are collected for every youth and family that enters the CATS program. The clinical providers, family peer support providers, as well as our academic health center staff collect data at various junctures of the program: intake, clinical discharge, family support discharge, and two months post-clinical discharge.

At intake, the clinician collects demographic data, referral information and the Crisis Assessment Tool. The Crisis Assessment Tool is a 36-item measure in which the clinician rates a youth and family's functioning over six domains: Child Risk Behaviors, Child Behavioral and Emotional Symptoms, Life Domain Functioning, Juvenile Justice, Child Protection, and Caregiver Strengths and Needs (Buddin Praed Foundation, 2002). At the clinical and family support discharges, the clinician and FSS collect CATS service and family engagement data. Two months after families complete the clinical portion of the CATS program, our team conducts a follow-up survey via phone or emailed link. The survey collects data on youth connectivity to care, general family and youth functioning, clinical outcomes such as re-presentations to EDs or suicide attempts, and parent satisfaction with the program.

Participants

This analysis included retrospective chart data for families that closed clinical care from January 2018 – December 2019. Because some programs did not provide access to an FSS in that period, only families who were referred to family peer support as part of the program were included. Additionally, families must have completed the follow-up survey to be included in the analysis.

Participants were sorted into two groups: "did not engage" with the FSS or "did engage" with the FSS. A participant was placed in the "did not engage" group if the FSS attempted to connect with the family, but the family either explicitly declined or did not return phone or email messages to set up a time to meet. In the case of no engagement, the FSS did not provide any services outside of the initial meeting. To be placed in the "did engage" group, the family must have had at least one meeting outside of the initial team meeting in which the FSS was able to provide support to the family.

Analysis

Data were analyzed using SPSS and NVIVO. Demographic and service data, the Family Strengths and Needs portion of the Crisis Assessment Tool, and parent satisfaction ratings were analyzed in SPSS using chi-

squared for categorical data and t-tests for continuous data, with a significance level of α = 0.05 (IBM Corp., Version 24.0, 2016).

Qualitative family feedback comments were analyzed using NVIVO (QSR International Pty Ltd., 2020), which is an analysis software designed to code qualitative data and analyze themes. First, two research assistants read the raw parent comments in their entirety and independently extracted common themes. Once a consensus of themes was reached, individual sentences of each parent comment were coded into the identified themes. Every comment was able to be coded into at least one of seven themes. After coding the family comments, the data were organized by frequency to evaluate the importance and magnitude of themes that families reported about their experience with peer support.

Results

A total of 147 families met inclusion criteria (see Table 1). Of those families, 60.5% (*n* = 89) engaged with an FSS and 39.5% (*n* = 58) did not. Only one statistically significant difference existed between the two groups. When the FSS attended the first team meeting after intake, parents were more likely to engage with peer support, $\chi 2$ (1, *n* = 147) = 20.60, *p* < .001. There were no other significant demographic or clinical differences between the two groups.

As part of the follow-up survey, parents rated their experience with the FSS on a scale of 1 (completely unsatisfied) to 10 (completely satisfied). Over 70% (*n* = 65) of families rated their experience with the FSS as a 7 or above.

When asked open-ended questions about their experiences, parents provided feedback about their experience with family peer support. Due to the variation in individual responses, comments were sorted into overarching themes to better understand the broad trends in parent feedback (see Figure 1). The most prominent theme that emerged was that parents had generally positive experiences with the FSS (*n* = 44, 49.4%). This theme included parent comments about feeling heard by their FSS or describing the FSS as caring or supportive to their family. One example of the FSS qualities derived from this theme are described by a family that made the following comment:

> [Family Support Specialist] listened to my [youth], listened to what our family needed as a whole, and worked with us to get our needs met.

The most prominent constructive theme was that parents did not understand the role of the FSS or did not feel the FSS would be useful for their family (*n* = 31, 34.8%). This theme was supported by family comments that expressed uncertainty about how FSS services could be utilized in their family's circumstances and that the services offered by the FSS were not necessary. Although all families enrolled in the CATS program are offered services from clinical and FSS providers, some families felt that they needed to prioritize clinical services first. For example, one family reflected on their experience with the team with the following comment:

> [FSS] is not as helpful as [the] clinical team. Wish we used her more, but we didn't really have the time or chance to.

Table 1.
Patient demographics and engagement. Summary of total number (n), percentage, and p-value for all patients.

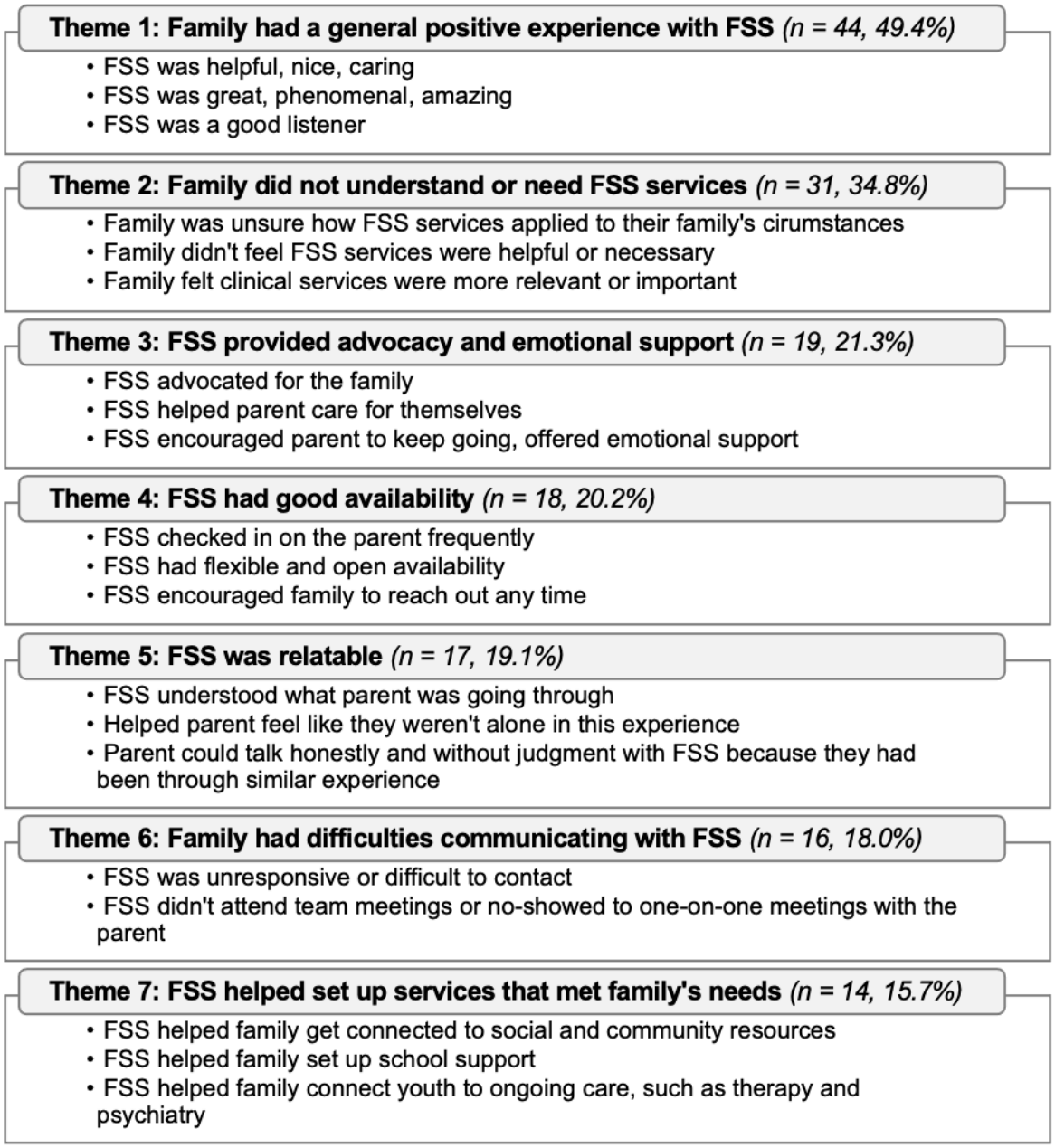
	Total sample		Family support specialist				
			Yes		No		p
	n	%	n	%	n	%	
Total	147	100	89	60.5	58	39.5	
Gender							.155
Male	57	38.8	30	33.7	27	46.6	
Female	83	56.5	53	59.6	30	51.7	
Trans/Non-Binary/Other	7	4.7	6	6.8	1	1.7	
Race*							
American Indian or Alaska Native	6	4.1	5	5.6	1	1.7	.244
Asian	3	2.0	1	1.1	2	3.4	.330
Black or African American	3	2.0	1	1.1	2	3.4	.330
Native Hawaiian or Other Pacific Islander	2	1.4	1	1.1	1	1.7	.759
White	122	83.0	72	80.9	50	86.2	.402
Unknown/Decline to Answer	12	8.2	9	10.1	3	5.2	.285
Ethnicity							.231
Hispanic, Latino, or Spanish	18	12.2	9	10.1	9	15.5	
Not Hispanic, Latino, or Spanish	118	80.3	71	79.8	47	81.0	
Unknown/Decline	11	7.5	9	10.1	2	3.4	
Estimated family							.058

income							
< $24,000	20	13.6	13	14.6	7	12.1	
$25,000 - $49,000	17	11.6	9	10.1	8	13.8	
$50,000 – $74,999	10	6.8	7	7.9	3	5.2	
$75,000 - $99,999	12	8.2	3	3.4	9	15.5	
> $100,000	17	11.6	14	15.7	3	5.2	
Unknown/Decline	71	48.3	43	48.3	28	48.3	
Youth is in foster care	16	10.9	8	9	8	13.8	.361
Youth is involved with juvenile justice system	6	4.1	4	4.5	2	3.4	.754
Youth has trauma history	101	68.7	63	70.8	38	65.5	.501
Presenting referral issue*							
Mental health	140	95.2	86	96.6	54	93.1	.327
Behavioral issue	66	44.9	39	43.8	27	46.6	.745
Developmental disability	9	6.1	5	5.6	4	6.9	.752
Substance use	5	3.4	5	5.6	0	0	.066
Suicidality	94	63.9	59	66.3	35	60.3	.463
Passive suicidal ideation	39	26.5	24	27	15	25.9	.880
Suicide plan and intent	29	19.7	19	21.3	10	17.2	.880
Suicide attempt	26	17.7	16	18.0	10	17.2	.880
FSS attended first team meeting	47	32.0	41	46.1	6	10.3	.000
	$\bar{x}$	SD	$\bar{x}$	SD	$\bar{x}$	SD	p
Age	12.89	2.98	12.84	3.03	12.97	2.92	.808
Caregiver needs and strengths+							
Caregiver health	.58	.98	.61	.98	.53	.99	.647
Supervision	.64	.88	.73	.94	.49	.76	.125
Involvement with care	.62	.98	.65	1.00	.57	.94	.657
Social resources	.96	1.07	.93	1.09	1.02	1.05	.628
Residential stability	.32	.69	.41	.75	.18	.56	.053
Access to childcare	.23	.59	.21	.52	.25	.69	.650
Family stress	1.49	.90	1.48	.93	1.51	.86	.832

**multi-select question; answers are not mutually exclusive, and percentages may add up to over 100%*

+Rated on a 0-3 scale by clinician on the Crisis Assessment Tool; higher number reflects higher need

Figure 1. Themes in parent feedback with example statements



Family comments about their experience with peer support fell within one of seven identified themes. The themes, with the total number and

percentage of parents that endorsed that theme, are presented in Figure 1. Additionally, two to three example comments are provided for each theme.

Discussion

The goals of this study were to identify predictive factors of family engagement with family peer support and determine the strength and helpfulness of their interactions in the context of the CATS program. Two prominent themes emerged: the family's understanding of the FSS role and how it might benefit them and the timing on introducing the FSS.

Articulating the Role of FSS

We found that parents were often unclear about the role or usefulness of the FSS. Currently, there is a lot of variation in how the FSS is described and introduced to a family in the early days of the program. Articulating the role and value of the FSS on the CATS team in a way that is meaningful to families can be a challenge due to its infrequent usage in clinically oriented services. Providing the family with a clear and consistent description of the FSS role and describing the benefits may assist families with meaningful engagement with this service.

In an attempt to improve the articulation of family peer support in CATS, three separate CATS programs that share the same clinical partner on their teams and employ FSS partners from three different organizations were convened to explore the similarities and differences in how they each describe the FSS role in their respective programs. Throughout the process, it was clear that they had more similarities than differences in their approach to care, yet how they *described* their roles differed greatly. Not only did this confuse families, but it also resulted in discrepancies in how the clinical partners viewed and described the FSS role. With the help of the technical assistance team, a document was developed to articulate the CATS FSS role description and activities. The document is geared toward CATS providers and has resulted in clearer understanding of the role on the part of the clinicians; however, the data show this may not be translated to families for improved understanding of the role. More work is needed in this area.

Early Family Introduction to the FSS

Timing for introducing the FSS to the family varies across programs. While the ideal practice is to have both the clinician and FSS at the first in-home meeting after hospital discharge, scheduling and communication challenges often prevent the FSS from attending. Our study shows that

families who engage with peer support were more likely to have met them at the first in-home meeting; conversely, families who did not engage with peer support were more likely to have not met the FSS at the first in-home meeting, requiring them to set up a separate meeting at a later time. We believe that having the FSS present at this meeting could enable the family to hear directly from the FSS about the types of services and support they offer, thereby reducing confusion about the family support role. The face-to-face meeting can also foster the beginning of a trusting relationship between the parent and the FSS, an opportunity which is missed when the FSS is not present at the first meeting and limiting the initial engagement with the family via phone. Additionally, there may be an advantage to starting the program with the full team in attendance, demonstrating a cohesive partnership and setting the tone for a program that supports the needs of the whole family.

Next Steps

This study helps shape the FSS component of the CATS program based on feedback from the families, organizational partners, and the FSS themselves. It highlights the need for a deeper understanding of the positive traits of FSS workers that enable them to be highly effective in helping families in crisis, as well as improved training and support focused on engaging families in a high-acuity crisis program. It also indicates that there may be an unclear focus on the purpose of the family peer role and desired parental support outcomes.

Training and professional development vary widely among the organizations employing those in the FSS workforce. Professional support provided to CATS programs by the state technical assistance team is currently individualized to each team's situational barriers and needs, such as communication, problem solving, and articulating the roles and responsibilities of the various team members. Developing training opportunities to address strategies for positive team-based care delivery, clarifying roles and activities of the team, and arranging workflow and timing of the service may result in increased family engagement with FSS workers, as well as overall function and experiences of the teams.

Gaining an understanding of the most impactful ways that FSS workers provide support to families that enable family resilience and strength in the face of a traumatic experience can yield valuable insight for recruiting, training, and supervising the FSS workforce. Incorporating additional training that highlights the characteristic traits and skills of highly effective family support workers may result in performance improvements

in the CATS program, promote overall workforce advancement, and improve families' outcomes.

Program Impact on Policies and Legislation

In addition to supporting the needs of youth and families transitioning from crisis settings to community-based outpatient care and support, the CATS program and outcomes study have been integral in guiding policy and legislative efforts. In 2015, the program was used as a model of care to guide legislation on safe transitions from EDs to outpatient care for patients experiencing a mental health crisis. In 2017, the state-funded CATS program captured the interest of commercial insurance carriers who are currently working to expand their coverage to include CATS as a service option for their members. And in 2018, reports on the successes and improvement needs of the CATS programs motivated the Oregon Legislature to increase funding investments to expand program availability in more areas of the state.

Family peer support services provided in partnership with clinical treatment for youth holds the potential to improve outcomes for high-risk youth and the wellbeing of their families. Improvements to recruitment, training, and support practices for the family peer workforce, as well as further refinement of the CATS team-based model in regard to integrating family peer support, may help to maximize the benefits of the CATS program.

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