Services to At-Risk Youth (STAR) Research Findings: Final Report

Texas Department of Family and Protective Services

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Acknowledgments

SUMA Social Marketing prepared this report

for

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Executive Summary

The Services to At-Risk Youth (STAR) program provides free counseling to youth and families needing crisis intervention, help in resolving family conflict, improvement in school performance and attendance, and parenting and youth life skills. The program's highest priority is to provide families with the support they need in order for youth to be able to remain in their homes.

The STAR program contracts with 28 local agencies around the state. Its services are available in all 254 Texas counties. The most accessed services are individual counseling and family counseling.

In 2017, SUMA Social Marketing, Inc. (SUMA) conducted qualitative research on behalf of the STAR program at six program sites. The research included focus groups and interviews with healthcare providers, agency directors, counseling staff[1], representatives of referral organizations, parents/caregivers[2] whose families used the services in the past year, and parents whose families could potentially use the services. The following are key findings.

[1] The focus groups with counseling staff primarily consisted of counselors with the exception of two groups, which also included administrative staff members among the participants.
[2] Both parents and other caregivers participated in the parent/caregiver interviews and focus groups. For the sake of brevity, "parents/caregivers" is henceforth shortened to "parents."

Key Findings

- **The program is working.** The vast majority of the 90 parents interviewed reported an improvement in the presenting problem subsequent to their participation in the STAR program. Parents shared heartbreaking stories of family challenges that were addressed by STAR counseling. The services these families received through STAR helped to stabilize them, reduce their conflict, and keep youth in their homes.

  Parents attributed the positive changes they saw in both their children's behaviors and their own parenting skills directly to STAR counseling. Parents said that after receiving services, their children did better in school; exhibited improvements in social behaviors, self-esteem, and communication skills; and practiced anger management and problem solving. Parents cited improvements in their own communication skills, anger management, and patience with their children. Many also said they have spent more quality time with their children since participating in STAR services. They shared specific interventions and strategies that they had learned in STAR counseling and still use in their parenting.

- **There is a tremendous need for STAR services. Do not dilute the mission or the focus in moving forward.** Parents, healthcare providers, and referral sources reported a great need for the types of services offered through STAR in their communities. Based on these findings, the goal should be to expand the current services rather than expand the program by engaging in other, related services.

- **STAR is often the only counseling option available to families.** STAR is a unique program that meets an unmet need. Communities lack access to free and convenient mental healthcare or behavioral counseling for families. In many locations, these services are simply not available, with the exception of STAR. This is particularly true in rural areas.

- **Families struggle with complex issues.** Findings on the challenges that today's children face were uniform across locations and populations. Parents, healthcare providers, referral sources, and STAR counselors consistently reported that divorce, bullying, depression, anxiety, self-harm, grief, abandonment, ADHD, and parental drug use are common and leave children and families vulnerable to behavioral issues, conflict, and destabilization. In fact, these are the very issues affecting the families of the 90 interviewees who received STAR services. Children and families struggling with these issues are in need of, and benefit from, STAR services.

  While families face a number of challenges, the pervasiveness of illicit drug use was a key topic in every community. The scourge of drug use crosses economic, educational, ethnic, and geographic boundaries, and its impact on the family cannot be overstated. In the course of the research, participants recounted stories of children being used to complete drug deals, hospitals releasing newborns to methamphetamine-addicted parents, parents who are incarcerated or incapable of caring for their children because of drug use, and a subsequent rise in the number of grandparents raising children.

- **Parents need and desire help with parenting. However, parents across the board rejected the option of parenting classes as they are currently provided, for a number of reasons.** The research explored parental attitudes toward parenting classes. Many parents did admit they need and desire help with parenting, but said they would prefer to have the information delivered through social media or online rather than in a standard classroom setting. Parents cited time constraints, transportation challenges, and stigma as reasons for which they would not be willing to attend parenting classes.

- **The program name "STAR" is confusing.** When parents and referral partners hear the name "STAR," they think of the State of Texas Assessments of Academic Readiness (commonly referred to by its acronym STAAR), a series of state-mandated standardized tests used in Texas public schools. For some parents, the STAAR tests have a strong negative association, since they are strenuous and cause many children stress. There is also a STAR Medicaid-managed care plan, which creates additional confusion. Furthermore, when many parents learn that the acronym stands for "Services to At-Risk Youth," they conclude that the services it provides must not be for them because they do not see their children as being at risk.

- **STAR needs better measurement tools to accurately reflect the significant positive behavior changes families experience as a result of participating in the program.** The current tools are not being used consistently and do not adequately measure the effectiveness of the program. For example, most counseling staff said they do not think the Protective Factors Survey gathers adequate information or sufficiently includes the child. Interviews with parents and staff indicate that the survey is used differently from site to site, and in some cases a post-survey is not captured. Parents reported that some of the statements presented on the survey are confusing. Counselors rely on the monthly action plan and their own observations to determine client progress.

- **STAR caseloads should be more consistent throughout the year.** Counseling staff consistently reported being overworked with excessive caseloads during the school year and then struggling to find cases during the summer months, when school is not in session. The program relies primarily on the schools as referral sources and meeting sites, and hence it is at capacity during the school year in most regions. However, counselors reported a significant slowdown during the summer and said it is a challenge to meet caseload requirements at that time of year.

- **Counseling staff would benefit from additional training and opportunities to share knowledge and expertise.** Training methods, needs, and practices vary from site to site, but most STAR counselors requested more training. Some requested that topics covered include trauma, specific cultural norms and practices, and ADHD management. Agency directors also requested a mechanism that would allow them to learn from other agencies, such as quarterly information meetings.

- **Many counselors are overwhelmed.** In approximately half of the sites, counseling staff reported having almost unmanageably heavy caseloads. They are stressed and stretched thin, which results in high turnover. Staff in each focus group mentioned that they were unable to care for themselves and their own families adequately because of their heavy caseloads. In addition, some reported paying for outreach activities with their own money, as well as using their personal cell phones to text clients and conduct non-reimbursable telephone counseling.

This is notable, since counselors in most of the sites also mentioned low pay as a concern. Several counselors reported having an ethical dilemma about the compromised quality of the services they provide as a result of their heavy caseloads.

- Parents reported that STAR counselors are professional, capable, dedicated, and regularly go beyond their professional duties to make sure their families are supported. Many parents who reported initial feelings of hopelessness with their children's behavior offered high praise for the STAR counseling staff and could cite significant behavioral changes in their children and in themselves after receiving services. Many also commented that staff often went above and beyond the call of duty to ensure the safety and well-being of their families.

- Community referral sources who were unfamiliar with STAR described the program's core offerings as ideal. They were excited to learn about STAR and said they would refer children and families to the program, saying the services it provides are needed in their communities. Referral sources would like STAR to use a feedback loop and a simple referral process.

- There is room for improvement in outreach. Outreach in the community is most often conducted by STAR counselors. Nevertheless, outreach is not their area of expertise, and they receive minimal outreach training. Furthermore, outreach consists largely of one-off efforts, such as having a booth at a health fair or posting flyers on bulletin boards around town. This scattered approach results in inefficiencies, a weak outreach strategy, and low awareness of STAR in communities, ultimately leaving families and children who could benefit from STAR services in need.

  Currently, the most common way that parents first hear about STAR is when the school contacts them and suggests the family could benefit from counseling. Thus, the knowledge of STAR is limited to parents who are actually contacted, whereas others who could also benefit from STAR services do not know about it. It stands to reason that even though most of the staff from the participating agencies reported full caseloads, they are not meeting the needs of the community. If the program grows, it is important to maintain its strengths (e.g., school-based services for children, professional counseling, easy registration, quick access, and convenient program sites) while adding more flexibility to the available times and locations for meetings with busy parents.

  Further evidence that outreach needs improvement is demonstrated by the mixed levels of awareness of STAR among the participants in the referral partner and healthcare provider focus groups. All were in a position to refer families to STAR, but most had not heard of the program, did not know the name of the local partnering agency, and/or were surprised to learn about the range of services that STAR provides. Many commented that they had been in the community for many years and were surprised that they did not know about it, but said it was a necessary service to which they would make referrals.

- Healthcare providers are untapped referral partners. Focus groups with pediatricians, family physicians, and nurse practitioners confirmed that the families they serve would benefit from STAR services and that they would refer families if they were made aware of STAR through effective outreach.

- **The Help and Hope website is not a viable resource for parents who are searching for counseling services.** Parents had difficulty finding information about STAR on the Help and Hope website because the site is not specific to the program. Parents of older children (ages 7 to 18) said the website did not look like it was for them, but rather for parents of young children. Furthermore, the information about STAR did not engage them, notably because the few descriptors of the population it serves include highly charged terms such as "at-risk" and "in crisis." Many parents whose families could benefit from STAR services do not think of themselves or their children as being in those categories.

- **Rural communities face unique challenges.** All the challenges that parents face in more densely populated areas are magnified in rural communities. In addition, the basic needs of some children residing in rural areas—such as food, clothing and shelter—are not met. The dearth of much-needed mental health services calls for an innovative response in rural communities. STAR is well positioned to help rural families in need by providing more counselors and exploring telemedicine and supplemental telephone counseling in these communities.

Recommendations

Expand the current services. Findings strongly indicate that the STAR program works and that more families could benefit from its services. Stay true to the current mission; do not dilute the program by adding other, related programs under the STAR umbrella.

Cap the caseload numbers per counselor, but expand the number of counselors. This will minimize burnout and turnover.

Rebrand the program. The STAR name is often confused with similar-sounding names of other programs, some of which have negative connotations for potential clients. On all outreach materials, focus promotional language on building strong families. Do not use the term "at risk." Parents do not identify their families or their children as being "at risk," and the term carries some stigma. Therefore, it is a barrier to engaging them in services. Update marketing materials. Tout the aspects of the program that STAR parents said they like: no wait list, quick and easy enrollment, no insurance or Medicaid required, confidentiality, and services provided free of charge.

Adopt a robust evaluation tool to provide data that demonstrate the value of STAR, to support current funding levels and/or justify additional funding. The tool used to evaluate the effectiveness of services should measure the impact of services on identified behaviors addressed by the child's counselor, such as interpersonal relationships, anxiety, depression, anger, low self-worth, and school attendance or performance. The tool should also measure changes in parenting skills, such as a parent's knowledge about and practice of discipline strategies, communication skills, patience levels, anger management, levels of family conflict, and time spent engaged in positive family activities.

Redesign reporting requirements to provide more detail about contractor performance and the program's successes and challenges. Capture stories of family transformation through STAR services for internal and external audiences.

Recommendations

Explore ways to offer STAR services in rural communities so that families can access them anonymously. Confidentiality is paramount in rural communities, and the stigma of being seen going to a counselor's office can be a barrier to accessing services. Find alternative meeting places for STAR counseling sessions, such as schools or libraries, so that families will not have to worry about being seen coming and going.

Promote continuous learning with staff. Create platforms for information sharing across contractors and other partners—for example, a website dedicated to sharing information with staff in the form of training, online forums, and research reports on promising and best practices. Hold quarterly meetings, and include time for sharing successes and challenges.

Revamp the outreach methodology. State staff with expertise in outreach should work with a select number of individuals in each local program who receive ongoing training in effective outreach to enhance their own expertise. The outreach methodology should:

- Engage with state-level partners whose constituents are in a position to make referrals (the Texas Medical Association, nurse associations, etc.), to educate their members about the program and encourage them to make referrals.
- Target local healthcare providers, including FQHCs, pediatricians, family physicians, and nurse practitioners. Providers are trusted sources of information for families, who listen to their doctors' recommendations.

Create a comprehensive school strategy that includes state-level, district-level, and school-level methodologies. A school district must approve STAR before any school staff can begin to recommend it to parents, and even then they cannot do so directly. To overcome these barriers, STAR staff at the state level should work with TEA or TASB to get statewide approval and to explore whether schools can recommend/make direct referrals to the program. STAR representatives should attend and present at conferences for school counselors, principals, and superintendents—and other school staff who should be aware of STAR.

Recommendations

Find effective ways for contractors to use telemedicine, telephone, and cell phone technology. Reimburse contractors for some telephone counseling and encourage confirmation of counseling sessions with a text message.

Create a dedicated STAR website. The website should offer an overview of STAR services and stories of STAR families, and should house a directory of regional programs so that families and providers can easily find information about their local STAR providers. Limit the site to information about STAR. Do not dilute the focus by promoting other programs.

Use social media to promote STAR and to offer parenting tips. Findings indicate that the most popular social media platforms for parents are Facebook and Instagram. Create a targeted advertising campaign using these two social media platforms. When users click on the social media advertisements about parent support, they should be linked to short parenting tips, videos, the STAR website, and more. Design subject-specific parenting videos that address topics such as ADHD, bullying, cell phone use, depression, anger, etc.

Offer training on Facebook ad placement to select staff in local agencies. Facebook advertising is a cost-effective, time-efficient, and simple method for reaching parents where they are and linking them to information about their local STAR agency. This strategy will reduce the time counselors spend currently conducting outreach and it will offer a more effective way to reach parents and promote STAR.

Some directors requested a social media toolkit that provides agencies with plug-in content to promote the program, such as helpful parenting tips they can post on their social media profiles. This will both help standardize STAR messaging across the state and expand local efforts. Offer training on managing Facebook Pages and social media management platforms, such as Hootsuite, to help agencies work more efficiently. (Free tools such as Hootsuite allow users to schedule social media posts ahead of time, essentially giving them the ability to "set it and forget it.")

Disseminate parenting tips via a text message campaign that offers age-appropriate content.

Recommendations

Promote STAR by sponsoring local parenting events on relevant issues. For instance, sponsor the airing of educational films such as *Screenagers*, which addresses parenting in the age of smartphones and social media, or an expert's presentation on parenting children with ADHD.

Promote STAR by sponsoring and creating a series of biannual trainings for local stakeholders on issues affecting the welfare of Texas children. Training topics should be determined by state-level staff. Engaging rural communities should be a priority. Use the opportunity to forge relationships in rural communities.

Establish a feedback loop for community referral sources and ensure that the referral process is simple and efficient for them.

Repeat both the parent interviews and the counseling staff focus groups in one year in order to assess the impact of the new request for application (RFA) and to ascertain whether or not the program remains as beneficial to parents once evidence-based therapies have been added.

Methodology

SUMA Social Marketing, Inc. (SUMA) conducted qualitative research on behalf of the Texas Department of Family and Protective Services Prevention and Early Intervention Program (PEI) with the Services to At-Risk Youth (STAR) program. STAR services are intended to promote protective factors in families and promote positive youth development in order to prevent both child abuse and juvenile delinquency. The purpose of the research was to learn about the needs and challenges of Texas youth and families, which can be addressed through PEI services. This research focused on:

- Understanding which services are most relevant and needed for youth, particularly those ages 6-17, and how to engage clients in those services.
- Understanding the perceptions and relevance of current services offered as well as identifying which services are needed and not offered.
- Determining effective language and key messages when describing services to engage clients.
- Gaining insight into what would compel referral sources, such as parents or schools, to refer to the STAR program.
- Assessing how to encourage community partners to refer to the STAR program's services.
- Gaining insight and feedback into potential names for a re-branding of STAR and understanding current perceptions of the program name "STAR," since multiple programs operate under that name.

The target audience populations for this research include the contracting agencies that provide services affiliated with the STAR program; personnel from referring organizations such as schools, mental health agencies, or law enforcement; past and current participating STAR families; and potential STAR participating families.

SUMA worked in collaboration with DFPS PEI STAR staff to identify six programs as key research sites. The collaboration resulted in the choice of the following programs and corresponding geographic sites.

- SCAN
- STARRY
- DePelchin Children's Center
- Connections
- Texas Panhandle
- Deep East Texas Council of Government

- The research included the following components:

- Background research
- A national review of similar programs
- Director interviews (*N* =6)
- STAR parent interviews (N=90)
- Focus groups with STAR staff (6 groups, *N* = 74)
- Focus groups with potential referral sources (8 groups, *N* = 66)
- Focus groups with potential participating STAR parents (8 groups, *N* = 74)
- Focus groups potential rural potential referral sources (3 groups, *N* = 28)
- Focus groups with rural potential participating STAR parents (3 groups, *N* = 26)
- Focus groups with healthcare providers (3 groups, *N* = 22)
- A review of promising practices for rural communities

Please note that the data gathered for this project is qualitative in nature, meaning that it addresses open-ended questions designed to explore matters of "how, why, and what," rather than "how many." Therefore, findings should be considered directional rather than statistically definitive, as those of a quantitative survey might be.

Trained moderators led all focus groups. The sessions were audio-recorded, and the recordings were transcribed verbatim.

During focus groups, researchers do not take exact counts of how many participants respond in a certain way on each line of inquiry, but rather foster a conversation through which participants can speak candidly. Then, as the transcripts of all focus groups are analyzed, trends emerge and qualifiers such as "few" and "most" are assigned to help the reader understand the prominence of each trend.

Findings: STAR Parent Interviews

Objectives

SUMA conducted in-person and telephone interviews from March 20 to June 6, 2017 with 90 parents/caregivers who have accessed STAR services for three months or more within the past year. Table 1 displays a breakdown of interviewee totals by each participating STAR agency.

Table 1: Participant Totals for STAR Parent Interviews (*N* = 90)

Location	Agency Serving This Location	Total
Laredo	SCAN	15
Plano (*N* = 6) Round Rock (*N* = 9)	STARRY	15
New Braunfels	Connections	15
Houston	DePelchin Children's Center	17
Nacogdoches	DETCOG	14
Amarillo	Texas Panhandle	14

The objectives of the research were as follows:

- Assess the current state of STAR services from the parent/caregiver perspective
- Learn how parents/caregivers first heard about STAR and about their signup experience
- Explore the impact STAR services have on families
- Hear from parents/caregivers how they may be challenged to engage in STAR services

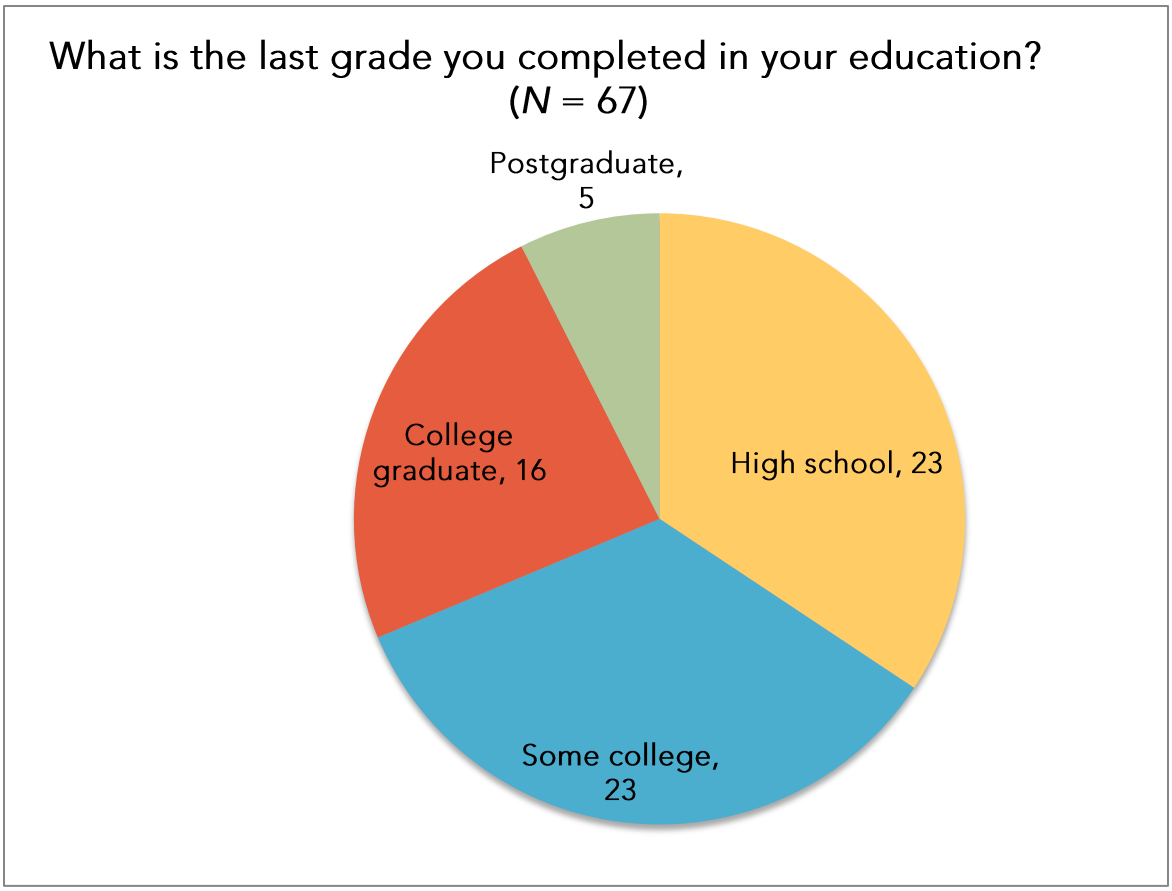
To recruit parents/caregivers for the interviews, SUMA used a list provided by the Texas Department of Family and Protective Services' Prevention and Early Intervention Division. Interviewees represented families that accessed services from agencies serving both urban and rural communities across Texas. The hour-long interviews were conducted either in person or over the phone, and participants were told that their answers were confidential and that no names would be used in final reporting.

Findings

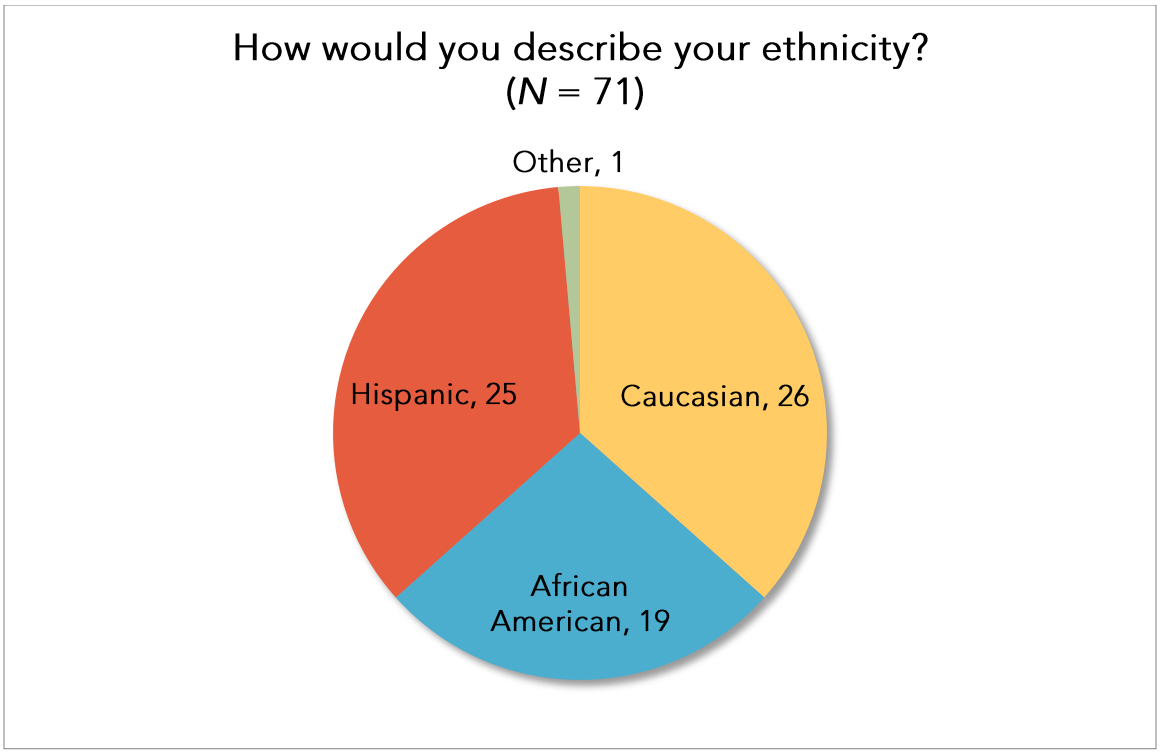
All findings presented in this section refer to the number of parents/caregivers[1] who answered each question, rather than to the entire survey population.

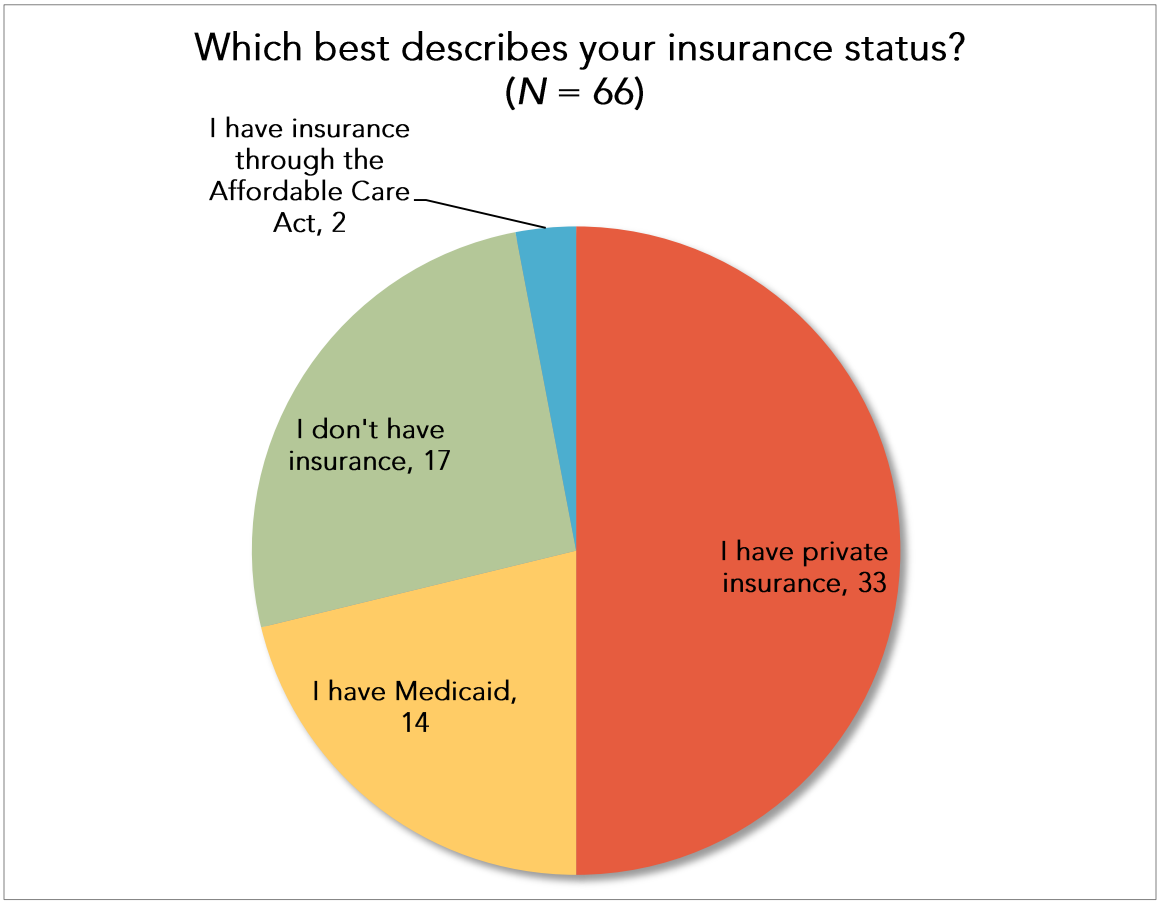
Demographics

Most interviewees had either a high school education or attended some college. About a third of them had graduated from college or a postgraduate program. Interviewees were almost evenly distributed across the Caucasian, Hispanic, and African American ethnic and racial categories. About half said they had private insurance, about a quarter said they did not have any insurance, about a fifth had Medicaid, and a couple had insurance through the Affordable Care Act.



[1] For the sake of readability, in the Findings section the term "parents/caregivers" has been shortened to "parents." However, both parents and other caregivers are represented in the responses and statistical analyses.


How would you describe your ethnicity?
(N = 71)
Other, 1
Hispanic, 25
Caucasian, 26
African American, 19


Which best describes your insurance status?
(N = 66)
I have insurance through the Affordable Care Act, 2
I don't have insurance, 17
I have private insurance, 33
I have Medicaid, 14

STAR's Impact on Child Behaviors

Most of the parents who participated in the interviews reported significant improvement in both their children's behavior and their own parenting skills because of the services they received from the STAR program.

Parents enumerated a wide variety of behaviors and circumstances that led to their families' engaging in STAR services, including divorce, abandonment by parents, and bullying. They described their children as angry, anxious, and/or depressed before beginning the program. A significant number said their children suffered from attention deficit hyperactivity disorder (ADHD), and several of them considered this a complicating factor in other behavioral issues brought on by divorce, abandonment, or bullying. A notable number of children were being raised by their grandparents or other relatives because one or both parents are addicted to drugs or alcohol and can no longer care for the children. A few came into services because of suicidal ideation or a suicide attempt. In a few cases, interviewees brought up health problems with the child or other members of the family, which had adversely impacted the child and resulted in the need for STAR services.

> *He had a lot of issues at a younger age, and there had been some physical abuse and some mental abuse. When I took him to live with me from my daughter, it's been a struggle. It's been a struggle to get him to where he is now.*
>
> *A lot of the reasons we think he needed services was, Dad and I split when he was pretty young. Then Dad joined the army and moved away, so he was stuck with Mom and he wanted Dad. Dad wouldn't communicate with us via phone; he just kind of dropped off. He would see him once in a while, and I think the once-in-a-while versus not at all kind of messed with him.*
>
> *His dad was actually admitted in the hospital for several months. He almost lost his life. We lost our house because he was the sole provider. We ended up living with friends and then finally got him stable enough for us to move down here. Within that year, he went to four schools.*
>
> *He has very severe ADHD, so he's got a lot of emotional issues that go along with that, just being able to control his anger and his outbursts, and just being compliant.*
>
> *She doesn't really fit in with the girls because they're doing girly stuff at middle-school age, and she didn't really fit in with the boys either. She was getting bullied at school, and it was becoming a problem, a daily thing. She'd say, "I don't want to go to school."*

The vast majority of the 90 interviewees described positive changes in their children's behavior, attitude, and school performance after receiving STAR counseling. Several said that they see their children continuing to use coping skills and strategies taught to them by the STAR counselor in their day-to-day lives.

> *Without the services we have now, I don't think we would have been able to accomplish what we have in over a year. I have seen this child come from so angry and so defiant to a child you enjoy being around. It has made such a difference in our life. What is he going to do? Will he throw a tantrum? It has made such a big difference in our lives, ours and his. When* [the STAR counselor] *came to us, we were to the point where we were lost. Every day it was something from school. I hated to answer the phone. I wish I had known about it a long time ago.*

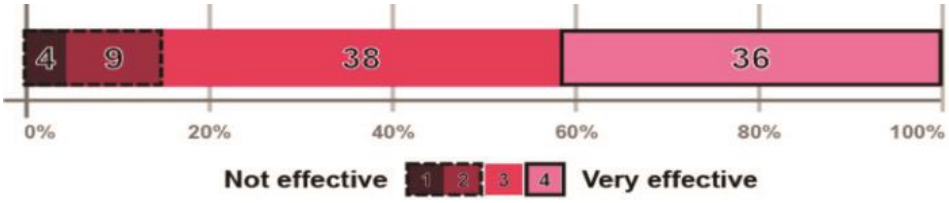
> *At the time ... I think it took for him getting down to the wire and almost having to go to an alternative school and had to get scared about the consequences of his actions. He had a life-altering experience. Being able to talk to someone who wasn't a family member, just an outside person to say whatever he needed to.*

> [The STAR counselor] *taught my nephew a lot of skills, like how to redirect himself when he's unfocused, and skills for me to help him. I am not a parent, and she taught me so much about how to speak with him, why he misbehaves, and how to deal with it. Parents are quick to yell or send them to their room, and she taught us the proper way to handle it, like positive reinforcement, which I didn't know about. The skills she taught me about his ADHD have helped so much, like making a schedule and having a routine, which I never knew about. When you start, it was very gradual. You learn what ADHD is, then you learn more and more, and then you learn more skills.*

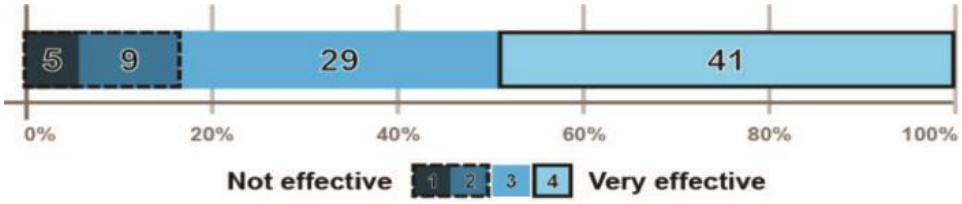
The few participants who felt their children did not receive the services they needed cited poor relationships with the counselor, not being able to work through issues within the six-month time limit, and not having sessions frequently enough due to the counselor's caseload.

> *I think he needed more. I think he was still having quite a bit of trouble at the time. I wish there was more of a special circumstances kind of thing. His counselor left* [and] *he started a new one, so you can either stop and wait six months or start with a new counselor. I wish that six months would have started over with the new counselor. But you're starting all over again. We didn't start that up because I didn't want to start him all over again.*

How effective do you feel the services were for your child? (*N* = 87)



How effective do you feel the services were for your family? (*N* = 84)



Most of the parents rated the services for their children and families as "effective" or "very effective." Several emphasized that the services helped improve communication within their families and that having the counselor act as a third-party mediator was helpful for their families.

> *It gave my husband and me a place where we could talk with a neutral party about our family, what our goals are, how to reach them, and honestly look at the problems. It was something we might not have talked about without prompting.*

> *When we had the family meetings, she would ask me a lot of questions about concerns, and then where he is improving and struggling. I would tell her stories about it and then how I was handling it, and then she would correct me in front of my son, which was helpful for me. And it's like, we're working on me too, not just him.*

Most interviewees said the program helped reduce their family conflict. The few who said it did not had not had family conflict to begin with, but had accessed services for another reason. A few others said their family conflict has continued and could not be solved by STAR counseling alone.

> *It has given our son more of a voice to use words to describe his emotions. By doing that, it has taken some of the emotional energy out so he has the right words to describe how he is feeling. It has given us a little more patience.*

> *There's no reducing the family conflict until my husband is out of jail. The counseling helped, though.*

When asked what changes they have seen in their children's behavior after accessing STAR services, many interviewees reported that their children are calmer and less angry. Several interviewees also mentioned that their children show greater self-esteem and a more positive outlook on life. Several mentioned positive behavioral changes at school as well.

> *My niece has come a long way. I heard her laugh. I didn't know whose laugh that was. I looked around in my house and saw that it was her! I got so excited. It's like hearing a baby laugh for the first time. She had been so angry. I've seen her change her tone of voice and repeat things in a softer tone. You can tell she made a conscious effort to restate things in a softer way. I'm hearing her verbalize things differently.*

> *Better attitude, better grades, better attendance, more self-worth. He now tells me he is going to go to college. He is also getting along better with his brother.*

> *More calm, they take time more, they listen more, they don't jump into stuff like they used to. And they see my perspective. They used to just see me as bad, but now they understand that I'm trying to help.*

Several interviewees said that their counselors went above and beyond the call of duty to accommodate their families' needs, such as by coming to their home at night to talk the child through a crisis. Some parents also attested that the counselor had built a positive relationship with the child and mentioned how important that was to the success of the counseling. This personalized, thoughtful approach made both parents and children feel comfortable engaging in services and gave them another trusted adult outside of the family to turn to for support.

> *He was very excited to see Ms. Jones ... He enjoyed spending time with her. She is a sweet lady. She was so concerned about us, and I know she had other clients, but she was so concerned. I think maybe at that time she was the only one that could make my granddaughter laugh.*
>
> *When we went to the meeting last week, and as soon as he sees her, he ... ran up to her and just gave her a big hug. That makes everything worthwhile.*

STAR's Impact on Parenting Skills

When asked what, if any, changes STAR has made in the way that they parent, most interviewees emphasized improved communication among family members. These interviewees said they had learned to be patient, manage their frustration, and communicate with their children without yelling. Some gave STAR credit for the fact that they now spend more time with their children and give them more individual attention.

> *It resulted in my patience level increasing. I am happier as a parent. Any parent is happy when their child is succeeding. It has given me a lot of joy and peace of mind. I just feel supported. I feel like I am being supported and don't have to pay through the nose for it. It is another part of my journey to say, "Thank you, God" for leading me to the right people.*
>
> *Less yelling and more sitting down to discuss what happened and what you did.* [The STAR counselor] *taught me that it is only human nature to get mad and yell sometimes — and I can actually sit down and talk to him. Stepping back and talking: that I can do now, without being to the point that I was, oh my goodness.*
>
> *I think both my daughter and I had trouble expressing our feelings, and this program taught us to do that. We're closer. I really have learned to be more tolerant, spend more time with them, and give them more attention. We can get so caught up in other things.*

Many parents reported that they continue to use the skills they learned from STAR and described the difference it makes in their relationships with their children. They credited the counselor's calm and friendly demeanor for helping them feel comfortable enough to open up and recognize what they could do better as parents.

> *She helped me control my anger and outbursts towards the kids. To hear them out before we react* [and] *to take the five seconds to just breathe. Especially coming from a family of yellers, to need to hold control on that and change that.*
>
> *She said, "What are your family strengths?" I was like, "I don't know." She said, "First off, you have the mom and dad in the house." And I hadn't thought about that being a strength. That made me feel like, okay, we do have a strength, and I had never thought about it.*

Just the goal setting as far as when we would have those sessions, the questions she asked, and the approach she took stuck with me on how to approach things in a different manner than time-out and things I had been doing. Being able to talk through with him in different terms, smaller words for him. Doing projects together. That being part of the goals, not just rewards like toys, but making it a family event like going to the park. Family interaction rewards. Definitely some good ideas that I've taken with me.

Overall, interviewees said they would advise another parent to try STAR services if they are having issues in their family. Interviewees said they would recommend STAR because the program can help families find solutions and has the major benefit of being free of charge. Several also said they would tell others that signing up and using STAR services is easy, especially when the school is enlisted to help the child. Some said they would tell other parents that the counselors are qualified and dedicated to helping families. In fact, some already had recommended STAR to friends, family members, and coworkers.

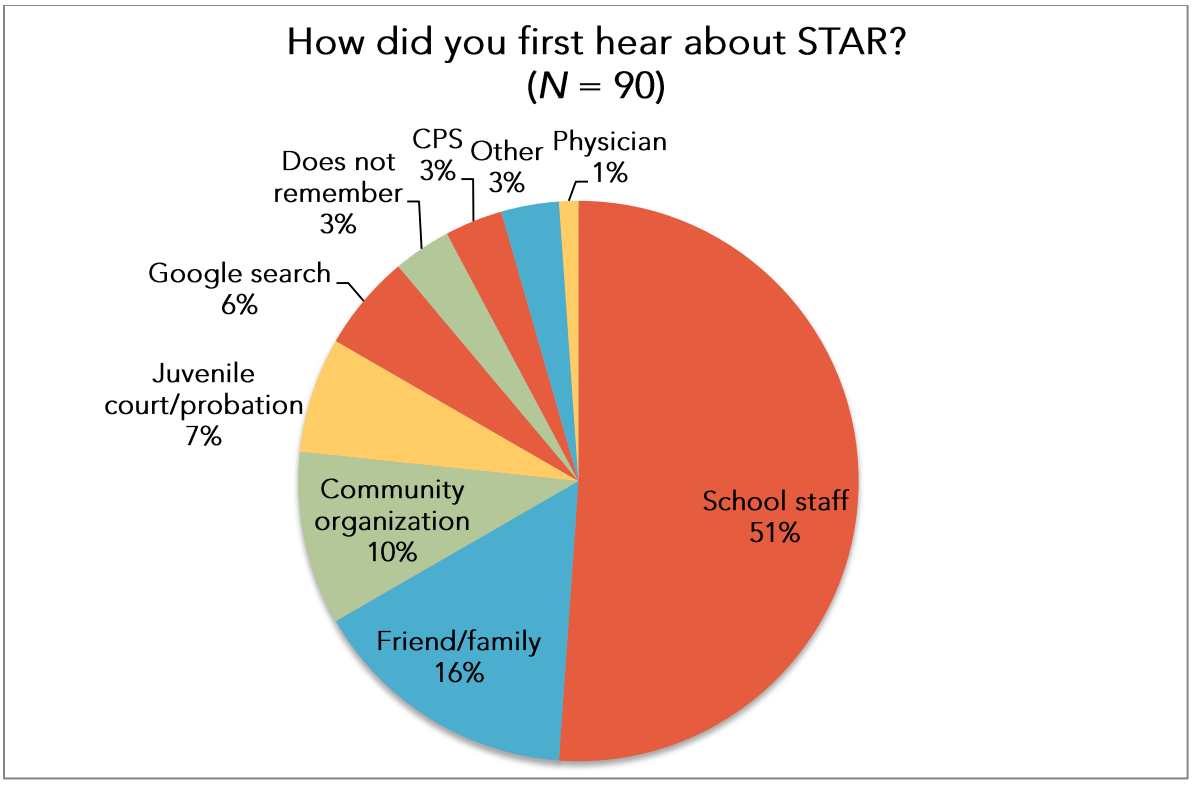
I have recommended it to a woman who was going through a divorce. She was afraid it would give them a record of being problem kids. I told her they are there to help, not to judge. They helped us a lot.

I would tell them if they are having any issues at all, they need to call quickly and get some help. I have given the information to many people, including the middle school principal.

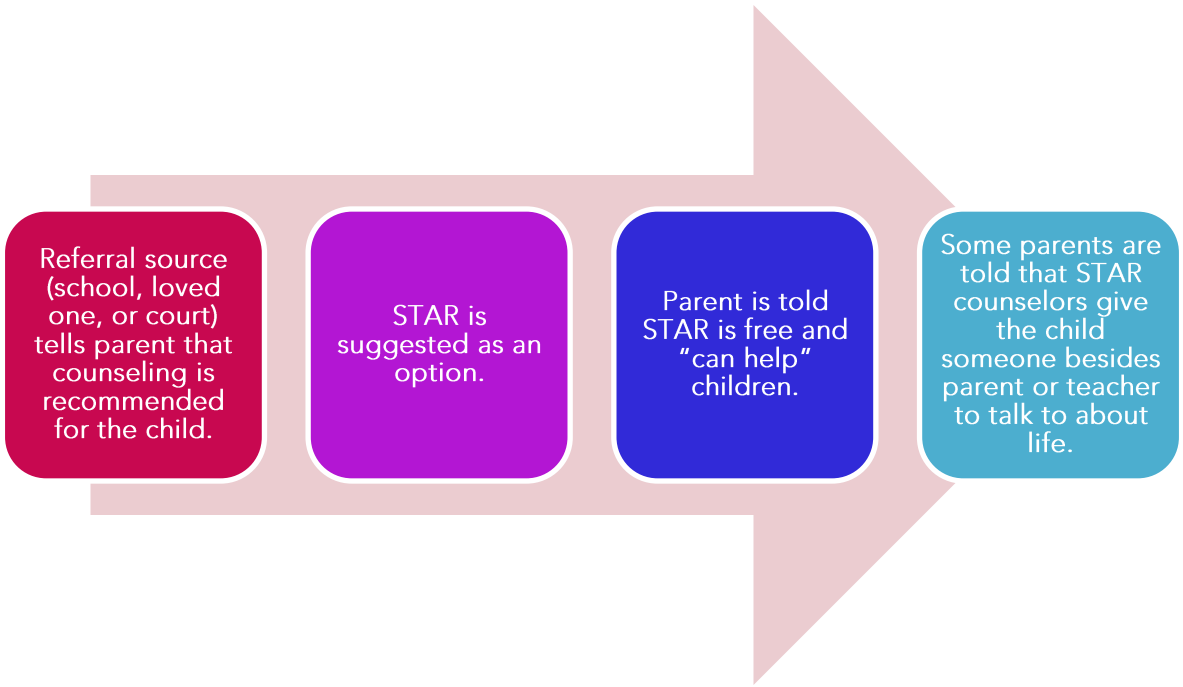
Learning about STAR Services

When asked how they first heard about STAR, more than half of the interviewees said they had heard about the services from school staff, usually the school guidance counselor and sometimes the child's teacher or principal. The second most common referral source was friends and family members who had heard about STAR or used the services themselves.

I was relieved because I wasn't really sure where to go or what to do. I didn't know where to start, so it was nice for the school counselor to say, "Here's what I would suggest, and I can help you get started." Because it's a difficult time in all our lives, and so I am relieved that this program was available to us and the school would assist us in making it happen.



Most commonly, interviewees were told by the referral source that the STAR program "can help" and offers counseling services for children. Frequently, interviewees said they were told that the counseling was free and the counselor would go to the school to provide services to the child. In one common scenario, the referral source (usually someone representing the school or the court) told the interviewee that counseling was necessary for the child and then suggested STAR as an option. Several interviewees were told that STAR would help the child work through issues he or she was facing and that the counselors could provide someone besides parents or teachers for the child to talk to about his or her life. Some heard about STAR services from other family members who had had a positive experience.



> *My friend knew someone who knew about* [the STAR agency]*, so I was talking to him about our issues and he said, "Hey, I know who can help with that." He knew some people who worked there and heard that they helped people out with kids who get in trouble and can't adapt well to a situation that's going on.*

First Impressions and Concerns

Overall, interviewees had a positive first impression when they learned about STAR and said it sounded like a good program. Many also said they were interested in getting help for their children and families and were willing to try anything. Learning that STAR is a free service was crucial to many families' decision to enroll in the program. Many said that their families would have gone without counseling otherwise because they could not afford it. Participants often commented that they were "relieved" or "thrilled" when they learned about STAR, adding that they had not known how to address their family issues and were thankful that there was a program that could help.

> *I didn't expect it. I didn't know anything like that existed. I was happy to hear that the sessions were free ... The counselor going to the school to meet my son was very helpful as far as time goes.*

Only a few interviewees had initial concerns when they learned about the STAR program, mostly revolving around fears that the counseling might be invasive and that someone would get "in their business" and judge them as bad parents. This reaction was more common in small communities. Some said they did not want their "dirty laundry" aired around town, which gave them pause before signing up for STAR counseling.

> *I was kind of apprehensive because I didn't want to open to someone about my business. With* [the STAR agency] *being local, will I see these people in town? Will they judge me? Will they know people I know? The school counselor told me to give it a try. I didn't feel any of this when I connected with the STAR counselor. I got a good vibe when she came to us at our house. I can get a good sense of people, and I could tell she really cared.*

STAR Services Are Often the Only Services Available

Many interviewees reported that having STAR available to them helped them avoid having to seek services from other sources. Many said they would have had no other place to turn to for help, and thus would have gone without any counseling, perhaps to the detriment of their families. Those interviewees cited the prohibitive costs of private therapists, the lack of mental health services in their communities, and the lack of insurance as challenges to accessing the services they needed if not for STAR. A few said they may have gone to MHMR but felt that their issues were not so severe as to require that level of intervention. They also mentioned MHMR's long waiting list as a negative.

> *Without STAR, I would have gone nowhere. I can't afford anything, my husband already sees a counselor, and they're expensive. Even with Medicare paying for the service, you have to pay the co-pay.*
>
> *My husband was our sole income when he was incarcerated, and so I can't pay out of pocket for counseling even though it was helpful. I'm so thankful the school counselor recommended this to us.*
>
> *Maybe not anything, because counseling is expensive and my daughter has special healthcare needs.*
>
> *I don't know. With insurance it gets expensive after a while, and if your child has co-pays with health problems. I honestly don't know what I would have done without* [STAR].

The Name of the Local Agency Can Be a Barrier

Confusion about the mission of STAR's parent agency caused some parents to hesitate to access STAR services. At a couple of sites, the parent agency that administers the STAR program is advertised in local media and is well-known for providing drug and alcohol treatment and/or foster care and adoption services. Parents in these communities were confused about why they were being referred to an organization known for providing drug and alcohol rehabilitation or foster care.

> *In reality, what I knew* [about SCAN] *was what I hear on TV. That they help people with drug addiction and other serious problems. I thought, why would my daughter go there? Then they told me about the other counseling services they offer.*
>
> [My first impression of DePelchin was that they] *catered to troubled children, abused children, some mental issues maybe. That was off what I saw in the commercials, and with my job, I reach out to those types of places.*

A few interviewees suggested using a term other than *counseling* to publicize STAR services. They pointed out that some potential clients may be resistant to access services from which they could benefit because of the stigma around mental health services such as counseling.

> *It's free counseling, anything that's free and has a counselor in it is great …. They consider a psychological evaluation, that they're crazy. If it wasn't called "counseling" — maybe "problem-solving counselors" or something like that — put something in front of the word "counselor."*
>
> *The word "counseling" isn't good. A lot of times, people think, I don't want people in my business. But it's services, it's a helpful tool, and they focus on the behavior or the issue that's bringing you in, not your personal life or personal business. They don't pry. What you go to them for is what they work on.*

Starting STAR Services: Easy Signup Makes a Difference

Most interviewees said they got started with STAR services by a referral from the school, but the actual process varied from location to location. Some said the school counselor wrote a referral and then the STAR counselor called them. Others said they received contact information for STAR from the school counselor and called STAR themselves. Some said they filled out paperwork for the referral in the school counselor's office. Still others called STAR without a formal referral after hearing about the program from family, friends, or online searches.

> *I asked* [the school counselor] *if she would take* [my son] *out, do some counseling with him, and then she mentioned the STAR program. She was saying she can only meet with him a certain amount of time, but she thought that that might be a good resource to utilize ... I was all for it ... I told her that we would go ahead if she could link us up. I got a call from STAR wanting to make sure we were interested in the program, and get paperwork or whatever started. I met with the counselor from STAR at the school. We signed paperwork, and she talked about what was going to be addressed and how she was going to help. I don't think I had any* [challenges with signing up]*. She asked if there was anything else that we needed to address besides anxiety related to school, which he does. Sometimes he has anxious feelings towards going with his dad, because he goes sometimes for long periods of time. Just kind of seeing if there was other problems and addressing them. There wasn't any problems* [with signing up].

The vast majority of interviewees said that the sign-up process was easy and they did not have any challenges. Some pointed out that there was less STAR paperwork than they had expected, especially in comparison with other programs such as Medicaid. One barrier to the sign-up process mentioned by a few parents was that the intake appointment was scheduled during work hours, which meant they had to miss work in order to attend it. For very few, gathering the documentation for intake was a challenge.

> *It was the easiest process. Unlike with Medicaid, where I had to submit a form and show proof I was there and then apply to something. They didn't even use my insurance or her Medicaid at* [the STAR agency]*, and I didn't have to wait two or three weeks to get an appointment.*
>
> *The challenge was just trying to work with my work schedule to get in. It would be better if the hours were more flexible or on a Saturday every once in a while.*

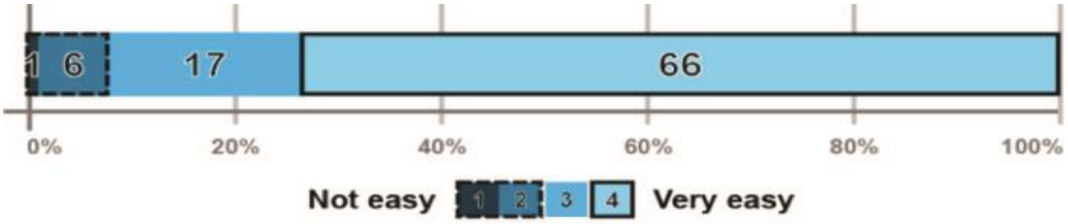
Some participants said it was helpful that the STAR counselor was able to meet at a location and time that was convenient for the family. Several said that having a counselor take the time to explain the program and what the family should expect helped the sign-up process go smoothly. Others said the strong partnerships between the STAR agency and the school made the process easy. Many commented that the counselor made them feel comfortable and listened to them and/or the child during the process.

> *I think there was a lot of communication between school and STAR, and then STAR to me. When we were going to meet, who I was going to meet with. It was real informative about the process and what we needed to do to get started.*
>
> [T]*hey work in conjunction with the school, and that the counselor was able to offer this to me, and I didn't have to go outside looking for something to help with having the financial stress that we have.*

Most interviewees reported that they started services shortly after their first contact with STAR, usually within three days to one week. Others waited for two or three weeks, and a very few waited for a month or longer. A couple of interviewees praised STAR for seeing them quickly when they had a child in crisis and needed to be seen right away.

When asked how easy it was for them to sign up for STAR services, most interviewees rated the process "very easy."

How would you describe the ease of signing up for services? (*N* = 90)



When asked what they think could be done to make the referral or signup process easier for families, most interviewees said they were happy with the experience and had no suggestions for changes. Some responded to this question by suggesting increasing promotion of the program, which is discussed in greater depth in the section *How to Make Accessing STAR Services Easier for Parents.*

When asked what they remembered about the intake appointment, many interviewees said they filled out paperwork and explained their family history and current situation to the counselor. Several commented that the counselor's friendly demeanor made them and their children feel welcome and comfortable. In some cases, the child was in the room throughout the entire appointment. Other interviewees said that the counselor saw the parent and child separately to get their different perspectives on the situation. Many said that the counselor explained the counseling services offered by the STAR program and discussed scheduling. Some said the counselor asked them about their goals as a family and helped them set a goal in the initial meeting.

> [The STAR counselor] *introduced herself. We all got to know each other. She gave me a schedule. We were open to the services, and it was easy. My son was able to talk to the counselor comfortably. We all participated. The counselor said that she wanted him to answer for himself how he feels. She speaks to him in English and to me in Spanish.*

> [The STAR counselor] *was very understanding. She had a way of communicating to make you feel at ease. You don't feel talked down to or alienated by her. You felt she was there to help you. She did not leave until all my questions were answered and reviewed my son's schedule with me. The counselor took time to explain everything.*

Participants' experiences with signing up for services varied by location. Most said that they attended the first STAR meeting with the child and the counselor. Others said they spoke one-on-one with the counselor, and the child did not come to the first meeting. Still others spoke to the counselor along with another parent, and the child may or may not have been present. Interviewees served by one STAR agency said that they had their initial meeting with an intake staff member other than their counselor.

When asked how the initial meeting could be improved, most interviewees said they had no suggestions since they had had such a positive experience. A few did suggest offering a simple document explaining STAR and what types of services are available at the agency. Others thought it would be a good idea to have the counselor speak to the caregiver and the child separately to help the counselor better understand the family situation.

> *I think information is always good, so having more information about the process. The website doesn't have a lot of detail. Something like a one-pager explaining the process and explaining what's available.*

> *I think it might help if the counselor spoke privately to the parents first and then privately with the child. I'd like to make sure the counselor better understood the problem before seeing my child. It was a little rough for my child.*

The Protective Factors Survey

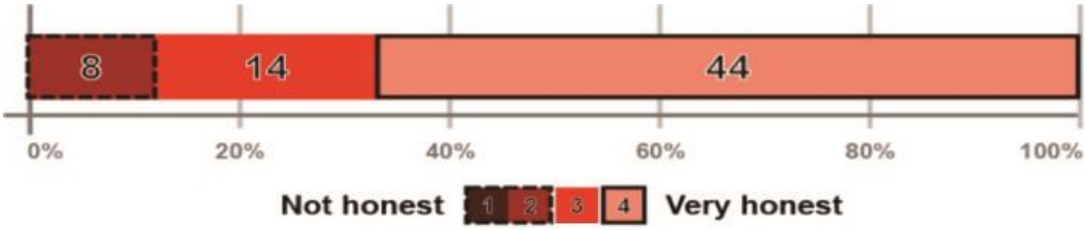
The moderator asked participants to read over the Protective Factors Survey (PFS) to determine (1) if they remembered filling it out and (2) how helpful the survey is for both the parent and the counselor. Most participants said they did remember filling it out at the initial meeting. (See Appendix B for the complete survey.)

Many interviewees said that they were "very honest" when filling out the PFS because they wanted to help their families and felt that if they were dishonest, the counselor might not be able to help them.

> *Ultimately, my daughter is the number-one priority, and I wanted to do anything to help her get help. If you're not honest, it doesn't get you the whole picture of what's going on.*

> *I was extremely honest because I really wanted help. I knew if I lied I wouldn't get the correct help that we needed.*

How honest do you think you were when you first completed the Protective Factors Survey? (*N* = 66)



Most interviewees understood that the purpose of the statements presented in the PFS is to give the counselor a starting point to understand the family's situation and help them identify places to improve through counseling. Some said that the counselor did not explain the purpose of the PFS; several said they did not remember whether the counselor had explained it or not.

> *They want an overall family dynamic, and that depends on how truthful the parent is being, but I feel like if I'm not being truthful, I'm not doing my kids justice. It's helped me reevaluate what we need to work on.*

When asked which, if any, of the statements listed in the PFS were helpful, several interviewees said that considering how well the survey statements represented their situations led them to reflect on their family dynamics. The statement *There are many times I don't know what to do as a parent* was most often cited as the most helpful. Participants seemed to appreciate the statement's recognition that parenting is difficult and parents do not have all the answers.

> *Number 12 is helpful, "There are many times I don't know what to do as a parent." Parenting doesn't come with a book you have to go on. I know I have people relying on me, so I have to keep going.*

According to the interviewees, counselors administered the survey in a variety of ways. In some cases, they reviewed the answers with the parents, and in other cases they did not. Some (but not all) interviewees who had concluded services reported that the counselor had them fill out the survey again, then filed it away with their paperwork without going over the answers with them.

Experience with STAR Services

Duration

Counseling is by far the STAR service most accessed by the interviewees. Most commonly, the child received individual, one-on-one counseling approximately once a week, and the parent and child met with the counselor once a month or so. Of the 90 interviewees, three attended youth skills classes and three others participated in parenting skills classes.

The largest group of interviewees—more than a third—was engaged in STAR services for the entire allotted six-month time period. The next-largest group was in services for three to four months. A few interviewees have been through STAR counseling multiple times over the years, sometimes with the same child and sometimes with different children.

Some interviewees' families were still receiving services, whereas others had finished. When asked why they had stopped receiving STAR services, many said the six-month time limit had run out. Others said they had ended services because the child's behavior improved and they did not need the services anymore. Very few interviewees said they were not happy with the counselor; the reasons they gave for their dissatisfaction related to scheduling conflicts, the counselor's disposition, or the child's refusal to attend. A few ended services because the counselor left the organization or was promoted to another position, and they did not want to start over with a new counselor.

> *Our son is very smart and tough, and we feel that the counselor wouldn't be able to help my son. She was going over the same ground that other counselors had already tried. She wasn't tough enough on my son, because he is very smart and could manipulate her easily.*

Frequency

Most interviewees said their children attended weekly counseling sessions with the STAR counselor. Others said their children were seen every two weeks, very few reported monthly appointments, and one said her child was seen less than monthly.

Most interviewees said that appointments once a week or once every two weeks was best for their children. Some also pointed out that younger children's attention spans are especially short and they may forget what was discussed between sessions if they are too far apart.

> *It was the right frequency. The counselor and my daughter met once a week for a while and then every two weeks. I would then call and ask for a session, and she would schedule us a session and fit us in. She actually still calls and checks in.*

As for the frequency of parent participation in STAR counseling services, the most common response was that they attended about once a month and thought that was an appropriate frequency. Many pointed out that the monthly action plan seemed to pair well with monthly sessions involving the parent, and that a month was enough time to try and apply the skills they had learned to their daily lives and to accomplish goals set in the previous meeting. Of those who were seen other than once a month, several were happy with the frequency because it felt tailored to their unique family needs and schedules. Some interviewees mentioned that with their work schedules, caring for other children, medical appointments, and other responsibilities, they could not have easily fit more frequent sessions into their busy lives.

> [The STAR counselor] *keeps it very on track. She says, "I can't see the girls again until we have our family session." It's good to check in and know what we need to focus on for the next month. We fill out an action plan in those meetings.*

> *I am so busy, so if it had to be more often, then I would not have been able to do it. I am a single mom and I was working a lot of overtime. Single mom with three kids.*

Referrals

Interviewees were asked if the STAR counselor had referred them to other services at discharge, and most said that the counselor had not. Most of those who were referred to private therapists or counseling had not followed up, and many of these interviewees explained that the cost was prohibitive or the child did not wish to start over with a new counselor. Parents who were referred to MHMR and did follow up said the waiting was too long.

> *Because of the six months, we now go to MHMR, and their wait list is ridiculous. Our* [STAR] *counselor told us to get signed up with MHMR a month before we ran out of time because the wait lists are crazy.* [Another mental health organization] *didn't even have a date for when they could start taking someone new. It took a month to get the first MHMR appointment, then another month to see the psychologist, and then another month to get assigned a counselor. I have to take her out of school now to get to appointments. Or I have to miss work. With* [STAR]*, neither of us had to miss.*

> *She did refer us to another counselor, where we have to start all over again. My daughter is good at acting like everything is fine, and I'm not thrilled that I have to start the process over again with someone new. Our* [STAR] *counselor offered to have a meeting with my daughter and the new counselor—even though our services have ended—to help pave the way.*

Where Families Accessed STAR Services

Most interviewees said they were able to receive services in a location that was convenient for them and their families. The few interviewees who said the location was inconvenient explained that they had to travel a far distance or sit in traffic to visit the STAR agency office, which cut into their busy day. In the most typical scenario, the child received individual counseling at school, and the family sessions were held at the agency's office. For most, this model worked well. Parents liked the fact that their children did not have to leave school. A few received services elsewhere, including at a community center, in the parent's own office, and at the child's daycare provider.

> *She came to my house, and sometimes we met at the community center, which is convenient. The counselor told me we could meet anywhere that was convenient. I think it's great not to have to leave my house. I think it also helps them see how you live and interact. The offices are far away for me.*
>
> *Having my daughter seen at her school made it a lot more convenient as a single mom, not having to take time off every week to go take my daughter to counseling. That's a minimum of three hours away from my job. And I'm the manager. I'm needed there.*
>
> *They did not offer to come to my home or go to school. Right now we drive and go to the office. It is hard for me because I have the four-year-old, who has speech and other therapies. I have to be at work at five p.m. So I take them out of school to drive to the office for counseling. We have one car in my family. My youngest was born with a heart issue. He is on lots of medications and therapies. I have a lot of appointments.*

Schools

Interviewees who were seen at school appreciated the convenience of not having to check their children out of school, take off from work, and drive them to the STAR agency office. For the interviewees, minimizing the amount of time children are out of class was a key benefit of having the counselor go to the school. A few also mentioned that they liked the fact that the STAR counselor had a relationship with the school and so could communicate directly with teachers or principals to help the child get the wraparound support that he or she needs.

When asked to identify the challenges of their children's STAR counseling taking place at school, most interviewees said there were none. A few brought up the point that their children felt self-conscious about being pulled out of class for counseling and then being asked about it by curious friends. A few said they would like better communication about when the counselor will see the child in school, rather than having to rely on the child to tell them after the fact.

> *I love that they can be seen at school. So much easier, and it's taken care of by the time I get off work, and most of the time we can be seen together, and her communication with me has been so helpful for me engaging with them at home.*
>
> *The main benefit is that his teacher is there, so if the therapist needs to speak to her, she can. I can talk to the teacher right away too, to tell what we are trying with therapy.*
>
> *The fact that they came to the school to see him, neither of us had to take off work to take him somewhere. We wanted him to get help, but we still need to work to give him a place to live, and my ex had just started a new job, so it was nice to not have to pick him up.*

Home

The few interviewees who were seen at home said they preferred the convenience and privacy of staying at home. Some mentioned that they were glad the counselor could see the child in her or his home environment. A few said they liked being able to do chores or cook meals while the child's counseling session was going on in another room of the house. Others said they would not want the counselor to come to their house because they would not want their neighbors to see.

> *They offered to come to my home, but I didn't want neighbors seeing them coming and I don't want anyone in my business. We live in apartments, and I saw someone peeping at my daughter through the window before.*

> *It's my son's home, so being in his own territory put him more at ease. I think that obviously if you're more comfortable, you're more willing to talk. It was after the workday, and my son had a few hours after school to do homework and relax a bit before counseling—and that made for better conversations.*

STAR Agency Office

Most interviewees who were seen at an office said they liked going there because it felt private and professional. Some said they liked the toys and games for the children to play with in the waiting areas. A few said that they would not want to be seen at home, since some of the issues that brought them into counseling are present in their home space. For these parents, coming to the STAR office allows them to get away from their family conflict and engage more fully in counseling.

Not all interviewees in this study were given the option of receiving services at home or at school; for these parents, the only option was to be seen at the office. A few participants found going to the office a challenge because it was far from their work or home. A couple of interviewees said they had negative experiences in the office concerning the lack of a receptionist as well as a counseling office cluttered with stacks of paperwork.

> *I liked the office because of the setup, with having my son involved in the room. When* [the STAR counselor and I] *were discussing goals, he was also able to play* [with the provided toys] *and not just sit and fiddle. It was a really good setup. Meeting at a coffee shop or something is more distracting and less confidential. I felt safe opening up in the office.*

> *I'm going to say if we had had the home visit, it would have been more uncomfortable. We had subtracted someone from the household and then added someone else. There would not have been privacy to talk in the home. You have another person come in, and then that person may feel like you were attacking them.* [The office was] *like a safe haven. It's a nice and clean building. I can get a free parking spot. Overall you couldn't see people off the street that you know. I never waited over five minutes for her to come get us* [from the waiting room.]

Making Parental Involvement Convenient Is Important

More than half of the interviewees rated their ability to participate in STAR services as "very easy," followed by many who rated it as "easy." Those who said it was easy or very easy to participate in services credited the counselors for offering flexibility in scheduling and locations to accommodate their families. Several participants noted that their counselors made themselves accessible by phone, text, e-mail, or in person, helping even outside of scheduled sessions, which was greatly appreciated.

> *Any time I had a concern with anything, if we needed the family session sooner in the month, I would call her, and she would work it out and it was easy. I could also call her and have a phone session and get her views on a situation that came up before we even had our next appointment.*

How would you describe the ease with which you as a parent were able to participate in services? (*N* = 83)

Those who said it was "somewhat easy" or "not easy" to participate in services attributed their difficulties to restrictive schedules. Of those who said they faced challenges in accessing or receiving services, several said their work schedules conflicted with the available counseling times. Two interviewees said that transportation was a problem, either because they had limited access to a car or because they had difficulty affording gas.

> *It just wasn't easy keeping to that schedule, and it often made me late to pick up my boys. I wanted to do it. It was just hard to keep taking her out of school.*

> *My work schedule was challenging. There are few counselors that can stay later, and that made us have to narrow down our options. If we missed the window, we would have to wait for the next week.*

How to Make Accessing STAR Services Easier for Parents

When asked what would make it easier for parents to participate in STAR services, once again many interviewees said they had no suggestions because their experience with the program had been so positive. In response to this question (as well as to the earlier question about ways to make referral and signup easier), many interviewees said that STAR should do more to make its services known to parents throughout the community. Several said they wished they had known about STAR earlier and speculated that many more families could benefit from its services if only they knew that they exist.

> *The only thing I can think of is to inform parents that there is an opportunity* [to access counseling services]. *I would not even know where to begin to even think about that.*

> *My impression was, I have never heard of this* [and] *there are a lot of kids that could benefit from this. Why isn't it more readily available when there are so many kids who could benefit?*

Some interviewees suggested offering extended hours so that parents do not have to miss work. Some said that having an office closer to their home or having a counselor come to their home would make it easier for them to participate.

> *I was a little nervous about the sessions, and we work too much. I wanted it to be both my husband and I, and that wasn't easy.*

Would Telephone Sessions Make a Difference?

Interviewees were asked if being able to have some sessions over the phone would make a difference in their participating in services. Many replied that they prefer to have these emotionally charged conversations face-to-face and in a private environment where they can connect with the counselor. Several interviewees said that they would like to have supplemental phone calls from the counselor to get updates on their children's progress in addition to their monthly family session; some said they already receive such calls from their counselors and that they appreciate not having to wait a whole month to hear about their children's counseling. A few said that a video call on platforms such as Skype or FaceTime would be preferable to a phone call, so the parent and counselor could see each other. Overall, interviewees did not think phone sessions would be effective for children at all, stating that they would not be able to focus on a call as well as they can in person.

> *Yeah, we did talk on the phone a few times when things would come up. One time, the* [STAR] *intern was up there and was told something by the school staff, so she called me right away, which was awesome and very productive. I thought that was awesome on her behalf. She could alert me to what was happening at the school over the phone, so I didn't have to go down there or wait to schedule an appointment, which was great.*

> *I don't think it would be easier if it replaced the meetings, but if it is phone contact in addition to the meeting, then that would have always been helpful.*

> *I would rather not do it over the phone. I like seeing the kids interact.* [The STAR counselor] *and I talk quite often. She will call me and let me know what happened in the session. She always calls me back. It's been fantastic.*

> *No, it wouldn't. Having the face-to-face interaction was better. If you're having an emotional day, she can give you a hug. It seems impersonal over the phone. Skype or something would be better.*

Parents Want Text Appointment Reminders

Overall, interviewees were enthusiastic about being able to text with the counselor about appointment reminders or scheduling. Many interviewees said they would appreciate reminders since they are busy with other appointments and family activities. Several interviewees had already been communicating with their counselors via text and noted that it is a quick and easy way to confirm appointments or ask questions, especially since it can be a challenge to get through on the phone to counselors who are in sessions all day. A few also mentioned they would like to receive their appointment information in a text so they can easily refer to it on their phones.

> *She would send me a text of an appointment reminder or ask if we needed extra time. That was good because it will always be on my phone and I can go back to it.*

Yeah, just a little reminder that she was going to see the kids at school would have been good. Once we had a doctor's appointment, and I forgot, so [the STAR counselor] *had gone to the school and then the kids weren't there.*

Improving STAR Services

When asked how STAR services could be improved, the most frequent response was to conduct more outreach so that more parents are aware that these services are free and available for them.

I think more advertisement. I didn't even know about it until the school brought it up to me. I didn't even know this was a service available. Find a way to get the program out there more, maybe either commercials on radio, commercials on TV, something just to advertise more. If people actually heard about it more, they may be more willing to [try the program]. *Flyers at doctor's offices. You can put fliers up at doctor's offices or something about it, just something else.*

I think the schools could do a better job of informing parents. Maybe the program could come to parent meetings and talk to everyone.

Several interviewees also wish that instead of a strict six-month cutoff, the counselor and/or family could decide when services should end. Some said they want to see more after-work appointments available for working parents. A few observed that their counselors were not as available or effective as they could have been due to high caseloads.

Really, only the six-month time limit. It took five months for my daughter to even open up to the counselor, and then we were done. I wish we could have stayed instead of having to go to the MHMR and start all over again.

Mainly that the hours—trying to find weekend hours, you don't want to lose your job. Maybe evening programs and maybe going out to the schools. Maybe adjusting the time. You get in there and you get talking and you need a little more time.

From what we experienced, I think the counselors take on too much. I think they need more counselors. I'm sure that they each take on a ton of kids. There are a lot of people in [my town]. *I understand what happened, she took on too much. Not an excuse, but I understand. I know it is hard because it is state-funded, but if there were more, they would not have to take on so much and it would be easier for them to focus on the children they have.*

STAR Parent Quotes

The following quotes from STAR parents in every research location further support the positive impact that the STAR program has on families.

The changes have been our relationship as far as communicating is different. We were missing key points in understanding each other. It's something we have to keep in mind with each other. With their guidance, it helped.

- *Our experience was wonderful. We gained skills so that we communicate better with each other and how to help our grandson communicate better with his family and friends.*
- *It resulted in my patience level increasing. I am happier as a parent. Any parent is happy when their child is succeeding. It has given me a lot of joy and peace of mind. I just feel supported. I feel like I am being supported and don't have to pay through the nose for it. It is another part of my journey to say, "Thank you, God," for leading me to the right people.*
- [S]*he has improved at school and at home. She breathes instead of screaming. She tells us she is angry instead of reacting in a negative way.*
- *You can't change others but you can change how you react. The counselor would listen to my daughter and she would give merit to her words and made her feel like she mattered and that someone was listening, which gave her confidence to voice how she was feeling in a controlled environment.*
- [H]*er confidence is back, but she's still a teen. I like seeing that she's comfortable in her skin again. She's worked out a lot more; she's more self-care focused, taking care of herself more.*
- *Playing those games made me more conscious of stopping and participating with my children. It helped me to learn to enforce our agreements.*
- *He's gotten a lot better—not quite back to how he was—*[but] *not as angry. He was to a point of depression. He hated his life. He would say, "I wish I was never born and he got out of that and he came back into it. But I think the time in the middle was after he got bullied for the first time at school. His behavior overall is getting better.*
- [My child] *understands and is more open to change. She's starting to like herself more, and that started after the counseling.*
- *The changes have been our relationship as far as communicating is different. We were missing key points in understanding each other. It's something we have to keep in mind with each other. With their guidance, it helped.*
- *It just helped me understand* [my child's] *point of view and how she was feeling. I would hear her but never really listen. It did really help with that.*
- *My third child still has his outbursts, but I think he's able to come back and recognize he's gone overboard and will apologize.*
- *My youngest girl just needed to talk about her frustrations about the divorce and conflict with her sister. She always seemed to feel better when she left. The older one always enjoyed going and talking, and I think that's what they needed more than anything—was to talk about what was bottled up inside them.*
- *I try to be a little more patient and understanding. She's my only child diagnosed with so much, so I try to make the effort to spend more time with her.*
- *The STARRY counselor was very good. It was calming* [and] *relaxing …. The room was small and more intimate at STARRY.*

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A brighter tomorrow for children and families in Texas.

We have seen tremendous change in [my son]. Life is getting back to normal.

- [My son] *has gotten better at home. I don't hear a lot of the fighting at home. Things have gotten better for him at school.*
- *She taught* [my nephew] *a lot of skills, like how to redirect himself when he's unfocused, and skills for me to help him. I am not a parent, and she taught me so much about how to speak with him, why he misbehaves, and how to deal with it …. The skills she taught me about his ADHD have helped so much, making a schedule and having a routine, which I never knew about.*
- [My daughter] *did better at school and she wasn't doing well before. She improved a lot. She started getting more socialized with the other kids …. Honestly, I think she did a great job helping us.*
- *We have seen tremendous change in* [my son]. *Life is getting back to normal.*
- *I listen more. How to calm down. How to do breathing exercises. I know I get frustrated and angry, and now I can calm myself down.* [The counselor] *taught us how to breathe and calm down before we react. They are working.*
- *Gave us ways to resolve things without saying, "I am the adult, and you're going to listen."*
- *I take steps instead of blowing it by going to the last state. I try to think and I try positive methods now. It made me change my mindset culturally, morally, about how I think of different things and dealing with my child. I realized that I need to handle her differently because she was a child.*
- *I think both my daughter and I had trouble expressing our feelings, and this program taught us to do that. We're closer. I really have learned to be more tolerant, spend more time with them, and give them more attention. We can get so caught up in other things.*
- *Before counseling,* [my daughter] *was very timid, didn't talk to me about things. Her self-esteem has improved greatly. She used to have anger issues, and she has learned to control that. She is much happier and* [more] *outgoing.*
- *I have seen the change in the kids. He used to explode and he knows how to calm himself. He even tells me so. He has stopped being so negative. My granddaughter had started bullying other kids. She has stopped.*
- *I don't know where we would be without DePelchin. I haven't seen any services like this, and* [with] *the ones out there you have to pay and you have to go through lots of hoops.*
- *My* [grandsons] *would have fits and now he has strategies for controlling himself. The girl* [granddaughter] *was bullying other girls to act out. She tells me now that she doesn't do it anymore, and the teacher congratulates her.*

It works. And they know how to deal with people and different situations and can help find out the best way to help your family.

- *He* [my son] *is more well-behaved and calmer. When he is ready to go or getting impatient and frustrated, he will tap on me or tell me. He did not have those ways to communicate before. He would just start acting up a lot before. He would throw things, jump up and down, scream, etcetera. Now he does not do any of that.*
- [My daughter's] *much better now. Her behavior has changed. She has improved. She still gets in her moods but she has improved.*
- [My son's] *coming to me more and saying he wants to talk to me. He used to go in my room and break my stuff.*
- *It works. And they know how to deal with people and different situations and can help find out the best way to help your family.*
- *Her* [my daughter's] *self-esteem, her grades have come up. Her headaches are going away. Her whole being is changing. She loves to go to church and loves to sing. We are still a work in progress.*
- *It made me a better father.* [The counselor] *helped me understand a lot more. In fact, I've realized that sometimes I might be the problem.*
- *Listening before I talk. Trying to enjoy my children more. I think that was one of the things they showed us in the anger management.*
- *I listen to her* [my daughter] *more. And it's opened my eyes to all the kids who are doing the same stuff, and it may be to get attention, but she's alright …. We haven't gotten in trouble anymore, and I think she thinks about the consequences.*
- *It's been a blessing. I feel like my back was against the wall and I didn't have all the answers. They gave me some ideas on what I could do at home, signs to look for. I thought it was just teens who get withdrawn or shut down, but it was more, and they gave me signs to look for and that really helped.*
- *When my daughter would start drawing on the walls, we would put down old newspaper or something and let her write on that. Don't make it something she has to do, but then she can write on that and not the wall.* [The counselor] *said make it fun to clean up with your son, clap or snap, put on music, and have boxes labeled. For every count, tell him you have 30 seconds, and he loved that. I would count down, and he loves running around like that. I feel more confident, like I can do this. I was 23 when my son was born. I didn't know how to be a parent. Usually you have your mother to help, but I didn't have that. My dad was good, but he's a man and isn't nurturing. I think I let it go on so long because I needed it more than my kids. To have confidence.*
- *Always stay open to let* [my son] *know he can come to us and have someone to talk to. Don't have to bundle everything inside.* [The counselor] *told* [him] *something that really stayed with him about his body and other bodies. He's not a bad kid. He just doesn't know that no means no. We have huggers in our family, but I told him you can't do that to everyone. She taught him a lot about letting people have their own space.*
- *It's changed the way we talk to our kids. I used to yell at them but I learned there is another way to talk to our children. It's OK to be mad but not screaming at them. Look at their eyes and talk firmly.*
- [The program] *changed a lot. We visit more together. I just don't blow off the first thing they* [my children] *say. I try to listen and talk to them.*
- *It opened up my eyes to check on* [my son] *more often, to call the school to check in. How are his grades? And just check on him. He's a senior, so I ask if he is going to graduate.*

> This is a good place. They help kids a lot. It's a good program. I hope they stay like this all the time.

- *With my son, I decided to take him there. We lost my mother-in-law, and he was very close to her. He was depressed. He was 9, and I could see he was depressed and misbehaving. He wasn't himself. He isn't usually like that. He kept a lot of feelings to himself. Now he is a different person. He is happy now and he can talk about his grandmother and not feel sad.*

- [N]*ow* [my son's] *passing all his classes and he's stopped skipping school.*

- *This is a good place. They help kids a lot. It's a good program. I hope they stay like this all the time.*

- *My son has changed. He is achieving his goals.*

- *She* [my daughter] *really needed it because she wouldn't mind me and she was getting in trouble at school and at home. I see that she has changed a lot. She's behaving pretty well. Things changed for me. I didn't hit them, but I used to get very angry and I learned to change that.*

- *We're on the path. Not finished. They are helping everyone. The middle child seems more aware, and my oldest's grades have improved.*

- *I see the change for the positive in her* [my daughter]. *There's not much fighting going on in the house anymore. I see the change.*

- [I]*t helped her* [my daughter] *with whatever problems she was having at the time. She just needed someone else besides me to tell her the same thing she needed to hear.*

- *She* [my daughter] *is more affectionate, more responsible, and there is better communication between us.*

- *My son is still rebellious, but it was very effective for my daughter. My son no longer threatens to kill himself, or* [say] *that he should have never been born. He does not do that anymore. My daughter is much more responsible always with me …. It helped us to learn to talk to each other and listen. We express it correctly. With me, it was about learning to be more firm.*

- *It changed our family dynamic. WE now know how to resolve issues …. My daughter has changed her values. My son is not interested in drugs. They still ask for the SCAN counselor. They liked talking to her.*

- *My son would come home and tell me what they* [the counselor and my son] *discussed, and they put things in ways that he really understood. It made me happy …. They rarely call me from the school about disruptive behavior. It used to be every day.*

CONNECTIONS
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EMPOWERING YOUTH.
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BUILDING FUTURES.

He [my son] takes his nap. He's learning to play. It's a whole community effort. He looks forward to going to Connections and he puts his stuff away. I want to give them credit for that.

- *I am proud and grateful that Connections was there. If they weren't there, it would be rough.*
- *He* [my son] *was going from a one to a ten in his behavior. He didn't know how to calm himself down but now he does.*
- *He* [my son] *has improved attendance, improved grades, and self-worth. They helped us have more understanding of things that the kids need from us …. That made us realize that we need to squeeze in some more time with them.*
- [I'm] *listening more. Trying to be more constructive. What's better for him* [my son], *like get him to sleep earlier and give him consequences. Making him responsible for his actions …. He's not as silly. He acts more mature and responsible and apologetic for his actions.*
- *She* [my daughter] *is more communicative with us about what she is needing and feeling. She is more open about how she is feeling. She also talks more about what she is going through and she used to hide. She will ask now about things that before, she would have just snuck and done it. She also responds to "no" better.*
- *He* [my son] *takes his nap. He's learning to play. It's a whole community effort. He looks forward to going to Connections and he puts his stuff away. I want to give them credit for that.*
- *We have gotten closer because of our plan and the goals we set on the first meeting. We talk to each other more. We spend more time together. We play games, watch movies, and eat dinner.*
- [My niece is] *leveling out in a normal household. She's come a long way. I heard her laugh. I didn't know whose laugh that was. I looked around the house and saw that it was her! I got so excited. It's like hearing a baby laugh for the first time. She had been so angry. I've seen her change her tone of voice and repeat things in a softer tone. You can tell she made a conscious effort to restate things in a softer way. Hearing her verbalize things differently.*
- *My son is using the tools to control his anger. Not only that, but we also want to be more united as a family. I see them* [my children] *be more patient with each other and the family. I think it's helped so much.*
- *The counselor was great at coming up with ways to have my daughter refocus when she feels like she wants to self-harm, like putting an ice cube on your hand or taking a hot bath …. I felt good knowing that I had strategies to help my daughter when she goes to that dark place where she may hurt herself.*
- *She* [the counselor] *helped me control my anger and outbursts towards the kids. To hear them out before we react. To take the five seconds to just breathe. Especially coming from a family of yellers, to need to hold control on that and change that.*
- *She* [the child] *had no parental structure. Her mom took off to San Antonio and left all her kids with a drunk […] She went from failing, not caring about her appearance or hygiene, to today, she is passing all her classes with A's and B's. She's not scared to take a shower anymore, and we don't worry about head lice.*
- *Before I was quick to answer, but now I stop and think about things* [the counselor] *has told me to do, like try to listen to my daughter instead of getting her upset.*

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She [my daughter] is usually more explosive, and since the counseling, she's learning to use her coping skills. It's not a fix-all, but she's definitely working on not going to that instant. She's using coping skills that I think are really beneficial to her.

- [My son] *is more mature in how he deals with his emotions. He can take disappointment now without having a fit. He's just overall happier because of that.*
- *A lot of it is ultimately teaching me how to engage with [my children] when they are—especially my oldest. She has a lot of anger issues. How I need to react to her, and the things that I need to be saying to her. Those things have stuck with me a lot.*
- *It's made it to where I don't just snap at* [my son]. *I'm more, "Okay, what happened?" I'm more able to talk to him more and him actually open up and talk to me instead of trying to lie or hide it. When I don't snap at him, then he's more willing to talk to me. It helped me; I wouldn't say control my anger, but control my emotion when I talk to him. Once you have that third party looking in, the things you do on a daily basis, you don't know you're doing it because you've done it for so long. Then when they point out, "You did this," you're like, "I did? Oh, yeah, I did."*
- *I get to talk to her* [the counselor], *and I don't have to blow up at him* [my son]. *That's what the family counseling is about* …. [I]*t helps me deal with* [him] *because I don't talk to his stepdad. I don't talk to his dad. I don't talk to his grandpa because none of them are going to help with anything.*
- [My son] *still has the anxiousness, but he has tools that he can use. If I see him start to get anxious, then I say, "Remember what your counselor talked about. Where is your safe space?" He can use those; it's just a matter of reminding him to use them.*
- *It's easier now for me to know how my family—each person in my family brings to the table as an individual. It lets me view my son a little bit differently on how I parent. When he feels overwhelmed, he'll just tell me, "Mom, I've got to go run." "Go ahead; go for it." Used to before I'm thinking, "Why are you doing this?" or "Why are you doing that?"*
- *She* [my daughter] *is usually more explosive, and since the counseling, she's learning to use her coping skills. It's not a fix-all, but she's definitely working on not going to that instant. She's using coping skills that I think are really beneficial to her.*
- [The services were very effective] *because of the child that was then and the child that is now. We have a child that we can actually communicate with, a child that makes good choices. He's not angry; he's not defiant …. It's like we have a different grandson.*
- *They gave* [my son] *some real-life examples of how to handle behaviors and situations, and then there's information and things that* [the counselor] *handed out and talked to all of us about as a family, a couple of little booklets. It gave us a starting-off point of looking at where we were at and where we wanted to be and how we wanted this whole thing to look at the end, because, like I said, we had just separated and were going through divorce, so it was helpful.*

Findings: STAR Staff Focus Groups

Background and Objectives

SUMA conducted focus groups with STAR staff from six agencies to better understand their perspectives on community needs, barriers, gaps in service, and trends. In addition, lines of inquiry focused on strengths and unmet needs for the staff members themselves and their operational and measurement procedures, such as the assessment and intake process. As direct service providers with the current contractors, these participants were able to provide frontline insight. All focus group participants provided core STAR services to the priority populations. Table 1 below illustrates how many staff participated from each agency.

Table 1: Participant Totals for STAR Staff Focus Groups (*N* = 74)

Agency	Location	Total
Connections	New Braunfels	16
DETCOG	Nacogdoches	6
DePelchin Children's Center	Houston	6
SCAN	Laredo	7
STARRY	Round Rock	29
Texas Panhandle MHMR	Amarillo	10

Findings

A Day in the Life

Each focus group began with a series of questions to learn about the daily life of a STAR service provider: who they are seeing, what they are seeing them for, where they are being seen, and in which other activities staff are engaged. The clear sense is that staff from all locations view their mission and work as providing an important service to their communities. In several cases, they spoke of being the only resource for families who are low income and in need of psychosocial and counseling support on a myriad of issues. As an opening question, the facilitator asked participants to share what a typical day is like for them. This question led to rich discussions that provided insight into what it is like to be a STAR service provider. For the most part, participants in all locations spoke of days filled to capacity with individual counseling, school-based counseling, travel, outreach, and paperwork.

> *My day, basically: I get to the office, read my emails, go to my calendar, take off to the schools and do my sessions. In the schools, I'm usually there until lunchtime, and then sometimes after lunch, I'll do a little more; I'll go back to some schools that I didn't get to go to. Then I get back to the office and sometimes I'll have family session, and sometimes I'll do my documentation. Basically, that's what my day looks like.*

The ebb and flow of their caseloads is based on the school year, with summer being lighter. All programs indicated that they have fewer cases in the summer and that they have very little, if any, room for additional capacity during the school year.

> *It happens a lot in the summer where the parent—and I guess the youth as well—like, sometimes the parents won't show up. He didn't want to come. He was asleep. He's been asleep all day or he was up all night. I think in the summer is when I have issues engaging everybody.*

> *Right now for counseling, we've been in the 30s* [caseload], *each person. It's hard to treatment plan, do case notes, contact CPS, and then still try to find time to do outreach.*

All agencies have designed their counselors' days to reach as many clients as possible. To that end, staff in multiple locations spoke of having flexibility in their schedule so they could meet with parents either early in the morning or later in the evening.

> *Sometimes we'll come in a little bit later but stay until seven-thirty at night for families who can't make it. We try to make it to where that can't be the only excuse is [sic] "I can't get my kid out of school" or "I can't miss work." We're like, "Okay, we can stay until five-thirty," and they're like, "Oh, yeah, that would be great." We're more flexible on that, where other counseling offices are like, "We work eight to five, so sorry, you have to take off to come in."*

It was during this initial segment of the focus group that staff in most locations first suggested that their daily work load was unmanageable during at least a significant portion of the year. They revisited this theme throughout the entire length of the focus group. For example, when the moderator probed about a way to improve or change a process, staff would offer their ideas and then indicate that it was not feasible with their current caseloads. Participants in half of the locations

spoke of consistently working 10- to 12-hour days. Some staff in multiple locations work on Saturdays conducting outreach, and their ability to be flexible with that time is dependent upon the program and their caseloads.

> *Yesterday was a pretty normal day. I started my day at 7:00 a.m. and left at 7:00 p.m.*
>
> *If you have to be somewhere at eight o'clock just to set up a booth, and by the time it's over at two and you take it down, you're still not getting home to* [sic] *maybe four or five on a Saturday. On a Sunday, you may have a parent texting you or calling you because a kid is acting up at church who didn't want to be at church, or something happened at home, so you really haven't had a weekend.*

Presenting Challenges and Community Needs

Staff are providing services to families facing a variety of challenges. The most common issues, which were mentioned by half or more of the programs, include:

- Grief
- Trauma
- Self-harm
- Bullying
- Truancy
- Attention deficit hyperactivity disorder (ADHD) issues
- Parenting issues
- Drug and alcohol abuse by child or adult
- Coping with divorce

Other issues that were mentioned by fewer than three of the participating programs include:

- Gangs
- Deportation of family members
- Pregnancy
- Sex trafficking
- Anxiety
- Suicidal ideation
- Depression
- Sexual abuse
- Eating disorders
- Incarcerated parents
- Sexual orientation

While the preceding list provides the counseling topics, it does not adequately portray the severity of issues with which some children and families are presenting. Staff spoke of situations where families have no other resource—children are not appropriately parented due to complex family problems; they are experiencing trauma due to bullying and other events; and they are struggling with anxiety, self-harm, and sexual orientation issues. Participants from one program stated that sexual orientation issues can lead to family violence in their community.

> Participant 1: *They will kick them out of the house [for being gay].*
> Participant 2: *They're going to beat that out of them.*
> Moderator: *So, you try to work with the parents on that?*
> Participant 3: *Helping them cope with what the child is going through.*

Counselors spoke of referring families to other programs when services were beyond their capabilities or STAR's mission. However, the threshold for when to refer appears differently between programs. For example, one program indicated that they do not see children who are engaging in self-harm or suicidal ideation, while other agencies do see children presenting with these issues.

> *I've had quite a few make it through the whole six months, but I also feel like my caseload may be a little bit more unusual. I've had a lot of self-harm and suicidal ideation going on with my clients, so the longevity of it looks different versus a behavioral issue. I've had quite a few make the six months.*
>
> Participant 1: *For example, they'll send a child who's made a suicidal threat to us to be evaluated for suicidal ideations, and we don't do that.*
> Participant 2: *Or cutting, self-mutilation.*
> Participant 3: *Cutting, yeah, kids that are cutters, stuff like—these are kids that's beyond what we do.*

Where services are provided varies between locations and even between staff members. Some meet families wherever they need to be met, including parking lots, restaurants, schools, and in their homes. Others focus primarily in the school, and some focus more on office visits. Staff in all but two locations stated that they meet parents wherever needed and reported going to multiple schools to see children.

> *Schools and two separate offices.*
>
> *We have met families at restaurants: McDonald's, Popeye's, anywhere. We have had sessions in our car, even, sometimes.*

According to staff, meeting specific community needs differentiates the STAR program from other counseling and crisis programs. Specifically, the ability to meet with children at schools, or with parents and families in their home or another convenient location, is a community need that STAR provides. Besides disengaged parents, transportation was the most common barrier to service articulated by staff at every participating program. As discussed later in this staff report, parental engagement is a challenge for a variety of reasons, including parents' busy work and personal schedules. The concept of having the counselor go to the child and/or parents through these two options allows families to engage in STAR services.

> *A population that's been really challenging in some communities with high poverty is reaching the clients who are in a poverty situation, because of transportation.*
>
> *This summer we did groups, and the big barrier that a lot of families had in not coming was transportation. We can't transport kids. Then they couldn't get the kids here, so that was kind of a big thing.*
>
> [S]*ometimes we have to do sessions at a park, or at a restaurant, or in their homes. Sometimes the parents don't have transportation and no other counselor [is] going to go to your house to provide the services for you. We drive to their homes. Our schedules are so flexible. Most offices, we close at five and that's it. Too bad if you didn't get out of work. We don't. It's like OK, we'll stay here until six-thirty, seven if we have to. We're working around them.*

Offering services for free is another community need that STAR is meeting. Staff in each participating program stated that there are no other resources available for people who are not able to pay either sliding scale or private practice fees.

> *Our services are free, so a lot of times parents will choose to come to us because of that. They have no other means of getting them this type of service. Even though it's a short-term service, they're okay with that, simply because it's free of charge and we are available. We don't have a wait list, so it does help.*

> [I] *feel like providing a service in Spanish—that it's not easily found for free. I think that's a huge piece.*

Some staff also mentioned other community needs that they are able to meet such as providing parenting classes, being able to treat the child as well as the entire family, and connecting families to resources..

★ Notable Practice

Some staff who work closely with schools stated that they are able to help parents advocate within the school and bridge communication between the teachers and students. They specified that some parents do not know how to discuss their child with a teacher and are unaware of how certain accommodations and special education programs could benefit their child. Staff stated that this was a community need they were able to meet.

> *I would say advocating because a lot of the times people just don't know unless you're talking to them about it. When you're talking with a teacher, and they're like, "Well, they just won't sit still." Sometimes it can be a sensory issue, so you're explaining that they're not doing it behaviorally. They really have a trouble and need something to fidget with. I think advocating is the biggest thing that we do on a daily basis because people just don't know.*

> [S]*ome parents don't know how to approach a teacher and say, "This is what's going on," so kind of talking through that with them, too.*

The conversation around unmet needs varied a bit more than that of met needs. There was less consistency, with no themes emerging during this conversation. Instead, individual programs commented on the unmet needs of their community. However, the need for more Spanish-speaking staff was mentioned in more than one program. In addition, two programs indicated that although they meet the need of some families by providing services in schools, transportation issues remain a challenge and an unmet need for some. Staff in one program, which does not provide service outside of assigned schools and their offices, indicated that people without transportation are not easily able to access service. Other identified unmet needs include a lack of places to refer children who need more than six months of counseling and the inability to help families with basic resources, such as shoes.

Drug and alcohol abuse counseling was mentioned in several groups, either organically or after the moderator specifically asked about it. Staff indicated that drug and alcohol abuse is a prevailing problem in their communities, and that there are few resources for both parents and children who are abusing drugs or alcohol.

> [T]*here aren't that many free services for families to go and get support with that, but then if we see drug and alcohol use, it's not—we can't do too much. We can't do detoxing with them. We're not trained in that, so it's helping them try to find healthier coping skills, but we can only go so far, and then referring them to other places is difficult because most of our families don't have the resources financially for them. I think that's something that I see, at least.*

> *Substance abuse* [...] *Many times, parents are so desperate and they're like well, "Can you please help?" It's like, "No, I'm not specialized in that." There's* [sic] *a lot of substance abuse issues in the school, so they really need it there. We're not able to meet that need.*

Engagement

The prevailing answer to how long youth engage in services is "It depends." Focus group participants were quick to point out that every case is different. Therefore, the length of service varies. However, even with the individualized approach, staff in each location consistently indicated a typical engagement period of approximately three months, with some clients needing the full six months and beyond. Staff appear to be conscious of their caseloads and do not keep clients engaged in service longer than necessary in order to accommodate new clients.

> *I evaluate my kids at the three-month mark because if they're doing really good and my caseload is really high, we need to save those three months because I have more coming in than I have going out. I want to make sure that all my clients feel like they're heard and I can't do that with 35-plus kids.*

> *Everything's different with each family. Sometimes we do reach the six months, and the parents want more. There's some other cases where in two months, they're ready to go and they're doing much better. It's different with each case.*

Parent engagement also varies on a case-by-case basis. Staff in multiple locations reported that some parents are engaged and complying with services and suggested referrals to STAR, while others are not for a variety of reasons.

> *There's* [sic] *some families that are really good, that the entire time they'll be coming in. There's some families that within the first month, they notice that their child is doing improvement* [sic] *and they never show up in our office again.* (Laughter.)

Many parents do not follow up on meetings, which causes staff to close their cases. Two programs indicated that they close a high percentage of cases due to a lack of parent involvement.

> Moderator: *What percentage of your cases do you close because the parent has not participated?*
> Participant: *Half.*

According to staff, there are a variety of reasons for parents not engaging in services, ranging from the fact that they work full time or have complicated and unstable lives, to more psychosocial indicators such as being in denial that their child has an issue or that they may be part of the issues themselves.

> *Again, it varies from case to case. It just depends. There's* [sic] *some families where there's just—there's time constraints. They work. They can't make it in. You try to be flexible with them. They won't show up. You wait until six. For whatever reason, they can't make it. It's always something. It's just life gets in the way, I guess. Then you do have those other parents where they're just complying.*

> *I think parents that don't want to be involved, because a lot of the time* […] *what needs to be fixed is the relationship, but the parent—I've literally had a parent say, "I do not want to come back."*

Participants did not have many suggestions on how to improve parent engagement outside of what they currently do, which is to provide flexible scheduling and practice rapport building from the very first conversation. The overriding sentiment is that parent engagement is complex. There are many factors that impact a parent's involvement, and outside of building rapport and offering flexible scheduling, there is not much that staff members can do to impact it. One group did indicate that parents are asking for Saturday hours, which they do not provide. Another group suggested providing incentives to parents or charging them for missed sessions. Some staff indicated that progress and improvement can still be made with the child even if the parent is not engaged. The counseling could include teaching the child communication strategies with their parents.

> *It's the rapport building at the beginning. It starts with the phone call and then that first session, making them feel heard, making them feel like this is for them, this is about them. I think that most of the time you'll hear them, and over the phone you can tell they're a little not motivated or not really interested, but they have to do it. Once they're in the door, it's just making them feel welcome. We start to see some change.*

> *I don't think it has anything to do with the program itself. Personally, I think it's the parents.*

Barriers were discussed in several of the focus groups. As stated previously in this staff report, transportation was mentioned as a barrier to accessing and receiving services. Other barriers included the (specifically Hispanic) cultural belief of handling problems within the family; the fear that involvement with STAR would somehow be on their child's record; the stigma associated with counseling; and the fear of CPS involvement. Families are scared to open themselves up for help because they are afraid of CPS.

> *Sometimes they're afraid. Like in my case, I know that they're afraid of Child Protective Services. They're afraid that, you know, if somebody gets in the family they're going to find out more, and they're afraid of CPS. A lot of these families, like they said, they're so unstable. They have all this family conflict going on, and they have stuff to hide, that they're afraid is going to come out if the child talks to somebody.*

The idea of having some telephone or telemedicine sessions was discussed in every group, brought up either by the moderator or the staff. Many staff are already informally providing counseling over the phone. They indicated that parents call in and they have conversations with them. However, they are aware that they are not allowed to bill for those sessions. In general, the idea of supplementary

phone sessions was met positively by staff. They also stated that having the option to text families for appointment confirmations and reminders would be helpful. Some staff reported driving long distances and then having people be "no shows." They thought that confirmation text messages would be a useful tool to help with this struggle. However, they did raise the point of needing state-authorized phones. While some staff do use their own personal cell phones, others are not comfortable doing this as their privacy would be limited.

> *There have been a lot of times that we've spent well over a half an hour, 45 minutes with some parents because they don't want to hang up because they're telling us everything that's going on. And even within that conversation, and the end of it, we'll tell them we're going to set up an appointment for this day, whatever* […]

> *That would be another reason why phone appointments would be so much easier for parents that can't get off work, because we could talk to them at lunch or whatever, but driving home after working until six and then you don't get home until eight o'clock, so that's another reason. I try to keep it to two days a week that I work late, and then there's still a whole bunch of other people that I haven't been able to see, which moves onto the other problem,* [which] *is our caseload size is just insane.*

Rural areas face specific barriers associated with families and mental healthcare, primarily the perception that everyone knows everyone else in the town. Participants indicated that they struggle to maintain confidentiality in rural areas. One program indicated that they have parents drive to their main office for services so that people in town do not know they are getting services. The idea of telecounseling was appealing to some staff who work in rural areas as a way to combat the stigma.

> *Yeah, that's definitely an issue with the rural areas—that it's so small that the secretary knows the mom or the mom was married to the teacher. You know? It's such a small town that everybody knows everybody, so now you're seeing the child of so–and-so. Those are definitely issues that come up.*

Intake and Assessment Process

The intake and assessment process is composed of multiple steps to ensure that clients are appropriately enrolled in the program and that counselors have enough information to create an initial action plan and goals for the child and/or family. This process varies between agencies in terms of which staff member is conducting which parts of the process as well as the forms used to gather information. While staff from every participating program suggested improvements or pointed out deficiencies to the process, most indicated that this process provides them with the information they need to begin services with children and families.

> [W]*hen you're done with it, you just feel like you have enough information to start.*

The participating programs structure their processes differently from each other—and in some cases, within their own agency—but all maintain similar components, including:

Referral: Most referrals come from the schools. The majority of counselors do not receive the referral directly but rather are assigned to the family by someone else in the program. Some staff who do receive the form directly suggested a more in-depth referral form or one that is streamlined for their internal processes.

Screening: This process includes determining eligibility and informing parents what paperwork will be needed.

> *The screening, you just want to ask and verify personal information like location, age, and then you want to screen them out.* [I]*f the kid is on probation, then they don't qualify. So if they do qualify all of those, you just write a brief synopsis why they've been referred* […]

Intake and assessment: Includes Form 2075A and is generally conducted in person with a parent and child. This portion of the process is considered to be paperwork-centered. In most cases intake and assessment are conducted in the same session. The Protective Factors Survey (PFS) is used by all participating programs, as it is mandated by STAR. In addition to these two assessment tools, some programs include their own psychosocial documentation to augment the PFS—which received mixed reviews from focus group participants.

> *At the intake, we get to do lots of really fun paperwork and make sure the paperwork is in order, make sure the custody documents are in order.*
>
> *The CANS* [Child and Adolescent Needs and Strengths] *itself, I'm not looking at the different measures that they—I don't—we plug in the information that we got, that we already know, and it does nothing to help us, I think. I don't know. I can only speak for myself.*
>
> *I had taken my child to another STAR program because I couldn't use ours, and the psychosocial was a couple of pages, so it was too long. Ours is good, so I think that's a help. It does give us a lot of information on that client and it allows us that opportunity to start building that rapport.*

Programs have created an assessment and intake process that by and large works well for them, as staff in each location indicated that they generally feel equipped to begin counseling with clients. In some cases when the counselors receive the client information directly from the referral source, they may contact the referrer for additional information if needed. Additionally, in some cases when the counselor is not conducting the PFS, the counselor would prefer to do so themselves so that they have an opportunity to build rapport.

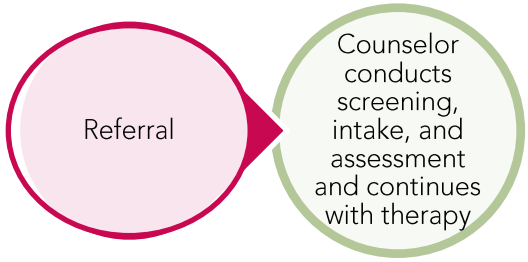
> *I think one of the challenges that we see is that since we are getting referrals—they're assigned to us—sometimes the call's picked up by someone else or they're sent in by the school, so once we have them in session, the referral form only asks certain things. We find out other things for what they might not qualify for our program. It's good because we get to refer them out and work with them, but as far as time and because we carry big caseloads, I spend an hour-and-a-half with a case that wasn't assessed properly over the phone* […]

Two of the participating programs have staff specifically assigned to screen potential referrals for eligibility. The screening includes verification of personal information, determination of CPS involvement or probation, and determination of custody. In all but one participating program, the person who conducts the intake and pre-test for the PFS remains with the family as their counselor. Some programs utilize different processes for staff who operate out of the main office and for those that operate out of satellite or rural locations.

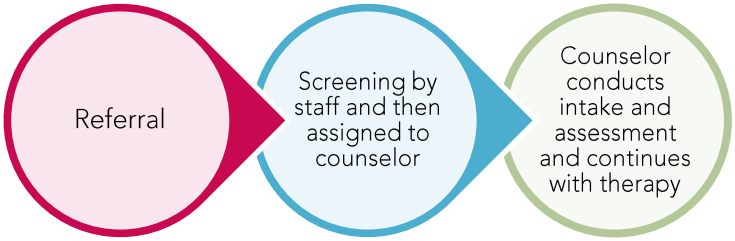
Figure 1 illustrates the three intake and assessment process models shared by participating programs.

Figure 1: Three Models of the Intake and Assessment Process

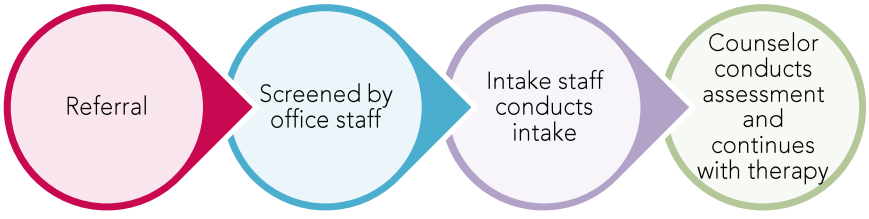
Model I



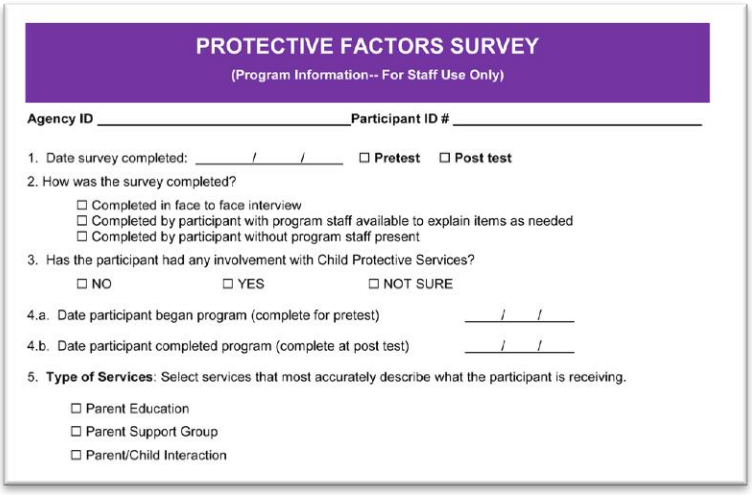
Model II



Model III



Protective Factors Survey



PROTECTIVE FACTORS SURVEY

(Program Information-- For Staff Use Only)

Agency ID _____ **Participant ID #** _____

1. Date survey completed: ____/____/____ ☐ **Pretest** ☐ **Post test**
2. How was the survey completed?
   - ☐ Completed in face to face interview
   - ☐ Completed by participant with program staff available to explain items as needed
   - ☐ Completed by participant without program staff present
3. Has the participant had any involvement with Child Protective Services?
   - ☐ NO ☐ YES ☐ NOT SURE
4. a. Date participant began program (complete for pretest) ____/____/____
4. b. Date participant completed program (complete at post test) ____/____/____
5. **Type of Services**: Select services that most accurately describe what the participant is receiving.
   - ☐ Parent Education
   - ☐ Parent Support Group
   - ☐ Parent/Child Interaction

The first few questions on the Protective Factors Survey. (See Appendix B for the complete survey.)

The PFS is used by all counselors. Staff in every focus group stated that the survey could be improved. Responses were mixed as to whether the PFS informs counseling. Some staff members complete the form out of necessity and do not rely on it to create the action plan. Others indicated that they do use the information to help focus their upcoming session and create an action plan.

> *I don't feel it's valid enough to help guide the way we do counseling.*
>
> *I would say the pretest I don't even generally look at. I just get them to fill it out, and it's totally irrelevant to me.*
>
> *The last part I think I pay a lot of attention to, where it kind of says, "My child and I are close to each other," or "I am happy being with my child." Those questions where it talks about their relationship. I'm able to focus on that, because it tells me a little bit about how they get along and how much support the parent is to the child. That does influence what I'm going to work with.*
>
> *There's a question at the very beginning of the intake that says, "Why are you here?" I use that, and whatever they give me on that, and sometimes since it's at the very beginning—sometimes they're hesitant to say and they're like, "I don't know."*

Staff cited three main issues with the form: the point in the process in which the PFS is conducted; the wording of certain questions; and that the PFS is mostly filled out by the parent with little to no input from the child.

Timing: Staff in all focus groups indicated that parents might not complete the form as honestly as they could because they are concerned that they will be judged as poor parents. Some staff suggested that completing this form at a later session, after the parent and counselor have established a relationship, might yield more accurate results.

> *It's true. I think a lot of parents do minimize their situation. They score higher than they probably are, because once you start working the case, you kind of notice that you don't even have a support system—you don't have any communication. I think pretty most* [sic] *all families will score higher than they really are.*

> *It's a lot of vulnerability at your very first time meeting somebody, with somebody who you might not stay with long term. It's almost like if it was three sessions in. I know you're not getting the first glance, but you'll have some more trust.*

Unclear wording: Staff in all focus groups stated that the wording of multiple questions is unclear to clients. Some explain the questions to parents in an attempt to build rapport and understand the family dynamics. Others are hesitant to provide explanation because they are concerned that it will impact the parent's answers. Some staff who work with low-literacy or Spanish-speaking populations expressed concern about the high literacy level of the document and the poor Spanish translation. The Spanish words may literally be correct but are not phrased appropriately, according to some staff.

> *Sometimes the parents don't fill it out right because they can't read the question right.*

Child involvement: Staff approach child involvement with the PFS differently. Most staff do not involve the child in the completion of this form and stated that it would be beneficial to get the child's thoughts. Some staff read the questions aloud so that the child hears how the parent answered, allowing the child an opportunity to comment. The way in which children are involved in the assessment is also dependent upon the child's age. Staff are cognizant that teenagers may not open up when their parent is in the room.

> *Everybody has a different perception* [of] *what their life really is like, so there should be one provided to the kid to see how it's rated.*

> *I read it out loud to them and they give me the answers, and the kids are there, so many times the kids are like, "No, Mom."*

> [T]*he kid, I think, would be more likely to be truthful because the parent wants you to think that they're a good parent, and things are going good, whereas the kid probably would be more truthful.*

> *It depends on the kid because sometimes I'll go back—with the high schoolers I'll go back and I'll re-ask the psychosocial questions, and they'll be like, "Oh, yeah, I didn't want to say that in front of my parent." So, we'll go back and go over the psychosocial with my high school kids, talk about the suicidal and the self-harming because they don't want to talk about that. Or the drug use, or it asks about the sexuality or what they'd change.*

Measuring Change and Effectiveness

The majority of participating staff indicated that they measure change and effectiveness through their interactions with the clients and the monthly action plan. They do not see the post-test on the PFS as being a valid way to measure effectiveness because either they believe the parents did not fill it out accurately at the beginning or they are scrambling to get parents who are terminating service to complete the form. A couple of programs stated that they administer a satisfaction survey at the end of service. However, some of the counseling staff do not think it is a valid measurement tool.

> *I think we all do the plan of service. I feel like that's what we really use to guide our sessions with our families. We update that every 30 days, so I think that paints a better picture of where the families are and how we're doing altogether. As far as for us as therapists, they complete a satisfaction survey at the end, and that kind of gives us information about how we're doing, but again, I feel like the families have mostly all built really good rapport that they just score us very high.*

The action plan is a valued tool used by all of the counselors. Participants had few negative comments to share about the action plan and no suggestions to improve the document. Staff update the action plan on a monthly basis and use it for both parents and children. A few struggle with the guidelines of how it must be completed, such as using *-ing* words; using the client's words; and framing behavior change positively. However, by and large this is the relied-upon means to measure improvement and reach the objectives and goals.

> *There's a couple of spots on there where we ask on a scale of one to ten how would you say your family is doing. When clients come in, they typically say their family is a three. By the end of their time they're at an eight, and I'm like, "Look at this. Look at how far you've come." I feel like maybe that scale is more of how I rate success within a family. Yeah, that's what I like to use.*

Staff also spoke of measuring change through their own observation. They noted that the child presents better because they have showered, used deodorant, brushed their hair, and are more engaged. In addition, the monthly action plan is used by some therapists as a dynamic document, with data that can be reflected back to the families. It also allows them to track issues the families and children are struggling with and note progress or a lack thereof.

> *I was just talking to somebody about this. Just that it's how the problems change, like maybe they first come in and really the focus was that their child was talking about suicide. Maybe we're three months down and there are still issues, but now it's just the child doesn't want to eat dinner at the table. It's a totally different level of crisis, which I think sometimes to remind the families look how far we've come. Everything isn't flowers blooming and whatever, but this is huge, that this is what we're worried about now and not "are they going to be safe through the night." I think it's with each family, and you can tell them "look how far we've come" and "what's the goal now compared to what it was."*

Staff who work closely with schools stated that they also rely on informal feedback from school personnel. This informal feedback loop is built through relationships with school staffs and counselors. STAR staff stated that there was no formal feedback process with schools.

> *Through demeanor, through conversation, through documentation, report cards, through just different things like that.*

> *Teachers will come to me and say, "Hey, he hasn't come to the office all week. That's an amazing thing for him."*

Suggested Improvements

Staff did provide suggestions on how the intake and assessment process could be improved, but their feedback was varied, and no consistent themes emerged. In fact, some programs practice the suggestions provided by other programs.

Include diagnosis and medication on the intake and assessment forms. Some programs already solicit this information.

Add open-ended question such as, "Is there anything that has happened in your family in the last year that we should know about?"

Create an assessment for the child that can be given as a pre- and post-measurement on their perceived progress.

Add more specific information to the referral form. Programs that do not have staff pre-screening potential clients would like more information on the referral form so they can better determine why the family is coming for services and other presenting issues.

Training

Two types of training were discussed: initial training for new STAR counselors and ongoing training for continued skills and practices. As with other aspects of the STAR program, training methods, needs, and practices differed between the agencies. Staff in most participating agencies are aware of the 16-hour annual requirement and indicated that they complete ethics and multicultural training to meet that requirement.

Initial Training

Most of the staff stated that they were initially trained by shadowing other STAR counselors. The length of time they shadowed varied between agencies. Some agencies shadow for approximately one month. Other practices during this onboarding phase include supervisor training on policies and procedures; watching videos on topics such as ethics, culture, and trauma; and online training.

A couple of notable practices emerged during this discussion and are explained in the remainder of this section.

★ Notable Practices

One agency has the supervisor sit in on the first few client sessions to ensure that the trainee is prepared and follows protocol. This is subsequent to an online training, peer shadowing, and policy and procedures training by the supervisor.

> *We shadow. I guess it's already been six months. We did the training first, right—some online training first, and we do sort of agency procedures with our supervisors. We shadow, so I shadowed a couple of* [the other staff here]*. Not as many, because a lot are Spanish speakers, but I shadowed people. Then I had my first intakes, so my supervisor—our supervisor—they sit in with us for the first however many until they feel like OK, good to go. Then we're done.*

Another agency provides the staff with sample charts and assessments so they can mirror language and view the way in which forms should be completed. Staff stated that this training was detailed, extensive, and helpful. They remarked on using their files as a resource when they are practicing independently.

Ongoing Training

All but two agencies stated that they receive ongoing training. The continued training opportunities differ by program. Some programs have community resources available to them for trainings, such as local experts, community colleges, and universities. Others stated that they have not received any supplemental training in years because their caseloads are high and there is no flexibility in their schedules. Staff in a couple of agencies stated that their supervisors are supportive of training requests and work to find them appropriate training. The quotes below represent two agencies that approach ongoing training differently.

> *Even at our regular meetings, we have—like our supervisors put together mini trainings on whatever it is that we need help on: anger, ADHD, anything that we request. They're pretty good about addressing our needs.*

> *We never do, and I have been here since 2005. I started back in 2005. There has never been a formal training on anything except the action plans.*

In addition to the continued formal training, some programs encourage continued support and collaboration amongst their staff. Participants from two agencies stated that they review cases in staff meetings as a means of collaboration, problem solving, and quality review.

> *That's like once a month you pull a certain percentage of everyone's files. As far as paperwork goes, you pull a percentage of everyone's files and then you look through them to see if there's* [sic] *any corrections that need to be made or anything. We try to get our files to look as uniform as possible across offices, so that's kind of the process we do to make sure that it's being done correctly.*

> *Right. We can definitely lean on each other. There are some of our staff meetings* [when] *we'll discuss a client situation and how we can help.*

Staff in all but one participating program identified additional types of training they would like to receive, including the following varied topics.

- Specific common diagnosis, such as autism and ADHD
- Refugee
- Trauma
- Bullying
- Anger management
- Family counseling
- Gang
- Sex trafficking
- Drug and alcohol abuse and use
- Post-traumatic stress disorder (PTSD)
- Oppositional defiant disorder (ODD)
- Military family dynamics
- Grief

Community Relationships and Referrals

Conversations regarding community relations, outreach, and referrals were robust in all of the focus groups. Participating programs shared common practices and perceptions, as well as a few practices that are program-specific and unique. In general, the participating programs have established referral source organizations with which they maintain relationships. They spoke positively about partnerships with other community organizations. While no other organizations that provide free preventive counseling were identified in any of the focus groups, there are community organizations that conduct counseling and provide specific services that STAR clients may need. For example, staff spoke of grief camps, hospice services, and other mental health services.

Most participating programs stated that their STAR program is well known among referral sources but not necessarily by parents in their community. According to staff, when parents do know about STAR, it is because they pass their agency's building or have heard of it by word of mouth.

> *I think it depends on who you're asking. If you're going to ask a random family on the street, then probably not. Schools are very well aware of us. We all do outreach at the beginning of each school year, and throughout the year we do outreach. The probation officers are very much aware of us. The school student/family advocates are very much aware of us.*

Staff who work in well-established organizations that facilitate more programs than STAR made a distinction between the organization being well known and STAR services being well known. Even if the organization is recognized among parents, STAR services are not.

Most of the programs do not refer to themselves as STAR but by their individual organization name (i.e., DETCOG, STARRY, SCAN, Connections, Texas Panhandle MHMR, and DePelchin). Some staff identified benefits of being known by their organizational name rather than the STAR program, and others identified concerns. Some programs operate other, more well-known programs such as foster care or drug rehabilitation. Staff shared that they sometimes need to mitigate preconceived ideas about the organization while introducing the STAR services they provide to parents. Once staff are able to explain to people that they offer free counseling or support services, families are more receptive to services. However, they noted that this can be a barrier to service.

One of the benefits of being known by the agency name is that the program name "STAR" is complicated and can be confused with other programs. Multiple programs and initiatives in Texas are named STAR; staff spoke specifically of STAAR testing and the STAR Medicaid program. This can be confusing for some parents. Ironically, it should be noted that some children are coming to receive STAR services because of anxiety related to STAAR testing.

> *So that's part of my spiel, "We're funded through the STAR grant, which has nothing to do with the STAAR test." It's like one continuous sentence.*

In addition, staff tended to be reticent to explain what STAR stands for, specifically "At-Risk." They shared the fact that some parents do not see their children as at risk. In addition, staff in multiple programs did state that stigma is a barrier to services. The term "At-Risk" could perpetuate that feeling.

> *When they ask—when anyone asks what STAR means or they see that, Services to At-Risk Youth, it actually scares some people away. "My child isn't at risk. There's nothing wrong with my child."*

When asked about other names they might use to promote the program, the staff generally spoke of strength-based words and phrases, such as "mentor," "support services," and "prevention program."

> *If they changed the name, I would want it to be strengths-based. I could think "what do we do?" We do families in crisis, but I would not love a name that says "families in crisis," because if a family doesn't feel like they're in crisis…*

Outreach

Each agency spends significant time and resources promoting itself in the community through an assortment of outreach practices. Some agencies are more organized and strategic about their outreach than others. For example, staff at one agency work as a team to formulate an outreach plan and then divide the work, mostly geographically, so that they can canvas as many places as possible. Other organizations appear to be less methodical in their outreach. Some organizations conduct more outreach in the summer, when their caseloads are lower. Staff from multiple agencies were quick to point out that they have full caseloads, which limits their ability to conduct outreach.

The way in which agencies approach outreach is fairly consistent, which is to first create relationships with potential referral sources and then supplement that approach with increased community awareness (by attending popular events and health fairs).

Awareness-raising within the community includes a variety of methods, such as placing information on bulletin boards and having tables at health fairs. One agency purchased T-shirts with their organizational name displayed. Others discussed providing referral sources with brochures and their business cards attached or of having packets they distribute with information and stress balls. Another agency distributed a community resource guide, and yet another provided families with magnets with pictures of faces expressing various emotions.

> *I'll go out into the field, I'll do the health fairs,* [and] *walk around talk to people.*

Yeah. I've heard of this counselor that used to go and sit outside of Walmart and pass out information there.

In the summer, I've gone to stores and they have a bulletin where they have houses for rent or stuff that they're selling, so I've put the flyers there for free counseling and stuff, like in stores in town and stuff like that.

Regardless of the strategy or level of planning with which an organization approaches outreach, it does not appear that any staff have been trained to conduct outreach.

I think as a lot of us are trained as counselors, and I didn't take any kind of marketing class in college or grad school, so it's kind of this whole new realm of, "Marketing? I want to counsel. You have to do marketing?" That kind of is the struggle of the outreach.

In general, outreach appears to be mostly unorganized and fractured. For example, all programs speak of the school as their primary referral source, and it is clear that each program expends time and resources creating relationships with schools. However, there appears to be little to no strategy on an organizational level for interfacing with school district leadership (with the exception of one program's strategy, which is described in the "notable practice" section later in this report). In addition, staff describe an array of outreach tasks that appear to be piecemeal.

I've had a teacher who put the referral form in the kids' take-home packet the first day of school, so that kind of passes the word out to parents, and they can fill it out on their own. A lot of times parents also don't really want to do it or want to reach out because they're embarrassed or anything like that, so it's kind of cool that they can actually do it themselves, just turn it in, and teachers can just forward it on.

[We give people] *all our information and we explain the program to them. We touch base a lot with the school counselors, and each* [school] *at least has maybe one or two, three counselors, so it's very difficult to meet with all of them. One counselor might know about us, but the other two don't because they don't share that information. We really try our best to go, leave our pamphlets. At community centers, we post them up on the corkboards that they have for announcements.*

In general, most staff do not speak fondly of performing outreach. Instead, and with very few exceptions, they speak of outreach as something that is keeping them from their core obligations of serving families and completing their required paperwork.

I think the struggle comes with our caseloads when they get so high and having to do all these outreach events. And if they're in the evenings and weekends, some of us have families [and] *limited resources* [for] *ourselves being able to attend. That can be the challenge, I think, or the obstacle.*

★ Notable Practice

One program stated that their supervisor conducts all of the outreach. This person goes to the community fairs, reaches out to the schools, and generally manages the outreach process. Focus group participants shared very little about the outreach details because they are not aware of them. They instead focus their time and attention on counseling and the associated responsibilities.

> *No. I think for her it's more important that we're attending to our families here, because if we went to fairs, that's a lot of driving out, that's a lot of time spent away, and that's a lot of driving back. That's maybe a whole day or half a day where we could have helped some families and we can't anymore. I think she really wants us to just focus on doing that, and she's willing to go out and do these fairs that take up her day so that we're not sacrificing spending time with our families.*

The moderator brought up the idea of having a designated outreach worker as part of the STAR staff. In general, most staff in all of the other participating programs liked the idea. A couple of staff indicated that they liked conducting the outreach or thought it would reduce their knowledge of what was happening in their own community.

> *I'm not in an area that has a lot of outreach, so I would like to have somebody find the stuff for me because I don't have that in my area.*

> *I think having a designated outreach staff member would definitely help. While we all do outreach, our caseloads can get large. We have file responsibilities—just client care. It can be a lot on top of everything else to be like, "Oh, don't forget you have this thing on Saturday from eight to five." I think that would help the offices in general, someone who it's their job to go out and do outreach.*

Referral Sources

Most programs shared a similar list of potential referral sources, which include the sources listed in Table 2.

Table 2: Potential Referral Sources			
	Schools: Communities in Schools, counselors, principals, teachers, and other administrators		Boys & Girls Clubs
	Community Resource Coordination Groups' (CRCG) meetings		Local mental health agencies
	Juvenile courts		CPS

I would say that now that we're taking CPS cases, we have a lot of CPS cases. They refer to us a lot now, so I think that's kind of—navigating the system and figuring out, like working with the case worker because that's something that we make sure that they're aware of. We will contact your caseworker. You have to sign a release for them so that we can follow up with them and kind of know what their case is about, so that we're aware of what the goals are for CPS too, so the reunification or whatever it's going to be.

A couple of the programs mentioned doctors, hospitals, and churches as referral sources. However, they noted that they receive only a couple or few referrals from these sources. When the moderator specifically asked about pediatric and family practice referrals, staff stated that more referrals from those sources would be a good idea.

The following conversation not only highlights the idea of pediatric referral sources but also the lack of strategic outreach vision, full caseloads, and shortage of training.

Moderator:	[H]*ave you guys have a concerted effort with pediatricians or family practice doctors?*
Participant 1:	*No.*
Participant 2:	*I didn't even think about it. We probably should.*
Participant 3:	*Just for me, it was a good place. I don't know any doctors in town. I know one doctor, or maybe two, so I didn't want to be a strange person walking in and going, "Here."*
Participant 2:	*I have small kids. I can go and take a brochure. I know I hear a lot of parents* [say], *"Well, I'm going to take my kid to the pediatrician to get medication for sadness."*
Participant 3:	*I do want to say we do get a lot of referrals.*

Schools

By far the most common and time-intensive referral and outreach source is the schools. Staff indicated that the schools are the primary referral source for children and families. This is primarily why caseloads decrease in the summer: staff are not able to see children in the schools. In some schools, the staff maintain relationships with the principals, while at others they maintain relationships with the counselors and teachers.

> *If we didn't have the schools, I don't think we would have all the referrals.*

Relationships with schools vary depending on the school. In most cases, staff work with multiple schools, which can encompass a broad geographic region. In one program, staff are assigned to a school and visit it the same day each week for the entire school year. According to the staff, this schedule allows them a closer relationship with their assigned school, a fixed location to conduct their counseling, and a consistent schedule.

STAR staff in all participating locations work hard to maintain relationships with school staff and seek additional opportunities to collaborate with local schools. Staff indicated that their relationship with the schools is important in order to meet the appropriate caseload numbers. Participants in one location spoke of spending their own money on small thank-you gifts for office personnel and counselors so that the school staff continues referring to STAR, thereby helping the agency's staff meet their required numbers.

Staff indicated that some schools allow them to come and work with the children whenever needed. Other schools only let them come in during certain times of the day, and still others do not allow STAR staff to come to their school to counsel children at all.

Challenges were identified specific to working with schools. The most commonly articulated barrier is that most schools designate specific times of the day when the children may be seen by STAR counselors so that their core academic classes are not compromised. Staff identified having multiple children at different schools that must be seen during the same window of time as a challenge resulting from these time constraints. The issue is more prevalent in rural—rather than more densely populated—locations.

> *Even that gets kind of difficult because they want us to go a certain time, so that messes up our schedules. You have all this caseload and you're trying to organize. I can only see this kid this time but I can only also see this kid at that same time. That's where it gets the issues* [sic] *because the PE time in a state for certain kids are at the same time at every school and you're like, OK, I can't be there at eight o'clock to see everybody.*

Their ability to provide meaningful counseling also varies depending on the school. Some counselors see children in closets, cafeterias, and break rooms, while others are assigned specific rooms and are even allowed to see children before and after school hours.

> *I've been put in a copier room, where people come in and out.*

Additional Supports

Before ending the focus group, the moderator asked each participant to answer the question: what do you need to be able to provide better services in your community? Responses focused on the main themes of mental health support, financial compensation, caseloads, and employee appreciation.

Participants expressed the need for mental health support for STAR counselors. Staff in some programs expressed this need more drastically than others. However, the need was stated in every focus group and by multiple staff in each program. For some staff members, the need for mental health support is framed around being able to discuss their difficult cases and workload with other staff members. For others, the self-described constant pressure of keeping up with everything causes stress. Some staff also spoke about the negative impact on their families.

> *There are nights that I don't sleep because I'm freaking out about what I have to do the next day, and if I don't sleep, it's hard for me to function. Twelve cups of coffee doesn't do it. Then having to see twelve clients back to back to back, and then you have until 7:00 p.m. to meet with three other[s]… It doesn't work. The process is draining and […] it not only affects us personally but it affects our loved ones too.*

> *We need more mental health days because doing this work is exhausting. It is extremely exhausting, and we go home and have to be mentally stable for our children and our family. Honestly, that is hard. That is super hard. We have to be there for everyone else, and I think as providers we forget that people need to be there for us.*

> [T]*he thing is that usually if we do try and just talk to each other, usually it's frowned upon. It's "You're not using time wisely. You're wasting time."*

Financial compensation was also a need that was discussed in most of the focus groups. Staff state that they work hard and long hours; they are well-educated; they have to pay for their expenses and continuing education; and they are neither well nor competitively compensated for their work. They indicated that these factors can also lead to burnout and high turnover. Counselors in a couple of locations spoke about not being paid overtime. Instead, they are provided with flextime, which some stated they are unable to take because of their high caseloads. Participants in one agency stated that their pay is reduced if they do not meet their individual numbers.

> *I feel like even going the other way, the quality of service that we provide and the amount of numbers that we do bring in do not reflect the salary that we receive.*

> *In April and May, when it gets really crazy, I feel like sometimes we're just zombies, kind of, walking around. I still feel very confident that we do a good job for our clients, but I think that in those really rough months, we could probably do better if we weren't as overworked. Especially for the salaries that we make.*

STAR staff in most locations asked for support around their caseload numbers. They stated that their caseloads are excessive and may impact the quality of care they are able to provide to families. Paperwork was noted to be high, and a decrease in caseload would positively impact the amount of paperwork they are required to complete. Nevertheless, the main objection to heavy caseloads was compromising quality of care.

> *I think sometimes we're so overworked that preparing for sessions, something has to go. I'm not even having time to plan my next activity with people because* […] *I've got to go back to back to back. Then I have to do notes and all the paperwork, and now I have to sleep.*

Staff in multiple focus groups spoke about needing and wanting to be recognized and appreciated for the work that they do. Some staff spoke of being rewarded with something tangible, and others spoke more about the need for verbal appreciation.

> *Some motivational component, something to motivate counselors—to appreciate counselors—because we don't see any of that. I think just acknowledgment of the fact that even if you weren't able to get your families to come in, you tried.*

There were a couple of ideas that were only mentioned by staff in one agency but are notable either because of the potential impact on other agencies or because they are unique to agencies that serve rural areas. Staff in one group spoke about the need for additional support for their program's crisis hotline. However, staff in other focus groups mentioned the burden of the crisis hotline. When it is their turn to staff the crisis hotline, counselors can receive phone calls throughout the night and are then expected to be at work in the morning for a regular day. Others spoke of receiving crisis calls while in session with other families and having to ask those families to wait.

> *I would say back to what she said earlier, taking away the crisis phone* [and] *creating a hotline for everybody in the state. They all call one number.*

Staff who serve rural areas spoke about the need to be compensated for driving as well as the desire to have telephone counseling. While they are reimbursed for their mileage, they do not believe this takes into account the wear and tear on their cars when driving long distances regularly. They also would like to have the option of conducting telephone counseling sessions so that they can meet occasionally with families over the phone instead of driving those long distances.

> *Yes, mileage is nice. We get reimbursed [for] that, but it's putting wear and tear on our vehicles. When there's one, two cars to use, it's really hard when there's six of us traveling.*

> *If they can start letting us bill some of the phone conversations and things like that, or get—what is that* [thing] *with the TV screen if you're in a private room?*

Recommendations

The findings suggest the following strategic recommendations.

Create a training library on current topics so that all STAR staff, regardless of which program they are in, are trained consistently.

Conduct program-wide surveys on training needs and respond with courses on identified topics.

Allow telephone calls for certain appointments.

Encourage text messaging for appointment reminders.

Consider organizational changes in order to centralize the outreach function to one staff member per agency. Outreach is a burden to most of the STAR staff. They are not appropriately trained to conduct outreach and prefer to spend their time counseling families. Suggestions include piloting this concept to measure the difference in outreach numbers and staff performance or incentivizing programs that restructure their outreach.

Conduct outreach training for staff and directors for a cohesive and strategic approach in the community.

Modify the intake and assessment process so that the child's voice is heard.

Field-test any materials (in English and Spanish) that are for parents, such as a new intake and assessment form. This will ensure that parents understand the materials. It is also important to field-test any form(s) that the staff will be using internally to ensure that they understand the form(s) and determine if anything is missing or confusing.

Incentivize programs that provide mental health support for their staff.

Use a different tool to establish a baseline for services. The tool should allow for measurement at the conclusion of services.

Findings: STAR Agency Director Interviews

Objectives

SUMA conducted telephone interviews with six STAR agency directors between February 7-15, 2017.

The objectives of the research were to:

- Assess the current state of STAR services in each region from the directors' perspectives.
- Learn about STAR staff training.
- Explore the relationships among STAR agencies, referral sources, families, and the greater community.
- Hear from directors why they think families are challenged to engage in STAR services.
- Explore lines of inquiry for future qualitative research with parents, staff, referral sources, and parents who could potentially access STAR services.

Note that this report will use the singular "they" and "their" to refer to directors in order to protect their identities.

Findings

Services and Population Served

Directors said that they provide STAR services for an ethnically and racially diverse client base, which is reflective of the increasingly international population of Texas. Multiple agencies are located in popular immigrant and refugee resettlement areas. With their large coverage areas, every agency delivers STAR services to a number of communities with different needs. For example, one agency serves both an urban center and a remote rural area with mostly Spanish-speaking monolingual, low-income families. Half of the directors said their agencies serve both rural and urban populations, and the other half serve mostly rural and suburban populations. While some said they serve a wide range of socioeconomic levels, most directors said they have a client base that is in the middle- to low-income bracket and lacks health insurance, or is unable to afford their co-pay.

Barriers to Service

Many directors said the first barrier that came to mind was transportation, which prevents families from participating in STAR services. While they try to address this barrier by seeing youth while they are in school and by making home visits, the lack of public transportation in some areas and the cost associated with transportation are still issues.

Cultural differences are considered a barrier by some directors. For example, they said Asian families are less likely to start services, and Hispanic mothers are typically the caregiver who participates in services but often are not the decision maker in their house.

Stigma around mental health services was also mentioned by some directors. One stated that parents can get defensive about having their child referred to STAR because they feel like they are being told they are bad parents. A couple of directors said they wished they had more funding and time to market their STAR services in order to address a lack of awareness in their community.

Directors spoke of the specific challenges associated with providing services in rural areas. Their providers must drive long distances to provide services to families who struggle with basic needs and transportation.

Presenting Issues and Unmet Needs

Many directors said that "family conflict" is typically the reason families enroll in STAR services, especially related to communication between children and parents. Issues like depression, anxiety, self-harm, suicidal ideation, gender and sexual identity, grief related to death or divorce, trauma, and substance abuse contribute to family conflict among STAR clients. Several directors said they are seeing more blended families and grandparents as primary caregivers than they have in the past. The second most prevalent reason, according to the directors, is issues at school, including disruptive behavior and academic and attendance problems.

Schools, youth with incarcerated parents, and frontier/rural regions are among their most underserved areas, according to a few directors. With lack of funding for schools to hire counselors, STAR counselors are the only ones able to try to fill that gap as best they can. With their parents in prison, children are faced with trauma, anxiety, and economic hardship in their fractured families. For rural families in need, limited providers and access to transportation prevent them from seeking or engaging in services.

All directors said that individual youth counseling was their most accessed service, followed by family counseling. Most said that—aside from respite, which is never or very rarely used—the youth and parenting skills classes were their least accessed service. Tactics to overcome their historically low attendance include providing dinner, scheduling classes during after-work hours, and changing the name of the classes from "parenting skills to "conversations," but these have proven to be unsuccessful in attracting more parents. Some directors said they believe some parents conflate attending a parenting class with admitting they are unfit parents, and that the stigma attached to being a bad parent keeps them from attending. One director said their agency provides parenting classes that some CPS parents are required to attend, and that the STAR parents who are there voluntarily do not like being in classes with parents who have been court-ordered to attend.

When asked what services they do not currently provide but wish they did, a couple directors pointed to the need for addressing issues that parents are experiencing that in turn affect the child and family. One director explained that even if they have identified that the parents' marital problems are the cause of the child's trauma, there is not much the STAR counselors can do to address the root problem with the parents. With more blended families, grandparents as primary caregivers, and parents suffering from mental health issues and substance abuse accessing their STAR services, these directors wished they could do more to address the caregivers' needs, which would then help the child and the family. One director said that being able to only bill for sessions with primary or secondary caregivers limits the agency's ability to also help step-parents or grandparents who are not one of the two recognized caregivers but are a big part of the child's life nevertheless.

Several directors wished they could do more to address substance abuse. Substance abuse among primary caregivers was noted as a growing problem within their STAR clientele. They said that there is a lack of resources in their communities to help families deal with substance abuse and that they have difficulty finding treatment facilities to which they can refer parents that are affordable, have open beds, and are in their area. Because of the lack of resources, STAR counselors often provide the only form of substance abuse therapy that these parents will receive, according to the directors. Opioids and alcohol were the problem substances most mentioned by directors.

There is also a shortage of mental health providers and services in many agencies' coverage areas. A director said that in one of the counties covered by their agency, there is only one mental health provider for every 3,000 people. Because of this lack of providers, directors said it is difficult to find a place to which they can refer clients if they need more in-depth mental health treatment than STAR can offer. Thus, as with the substance abuse clients, STAR counseling services are sometimes the only mental health treatment a client will receive, regardless of need or severity of condition. Another director noted that the "beauty" of the STAR program is the program's flexibility to jump in and plug the gaps in services as well as its ability to help families while they are waiting for scarce mental health services to become available.

Changes in the New RFA

State STAR staff were praised by several directors for the changes that have been made to the new RFA to increase flexibility in how they deliver services to the community. The end of the 180-days rule was particularly popular among directors, as well as the $150 in ancillary funds available to help a family at the agency's discretion. Several directors said they were glad to see STAR lift the rule on having to close out a case at 180 days. They found the rule to be arbitrary, and its rigidity, regardless of circumstance, meant that in the past they had had to stop seeing clients who still needed services just because of that rule. Directors were also happy that they will be able to see families who are in the CPS system and provide services to that population.

The perceived high cost and strict regulations of evidence-based programs is an area of concern for many directors. One noted that they have enough qualified staff to offer more sophisticated interventions than the agency currently offers due to the prohibitively high cost of licensing those programs. According to the director, they did the math and they would have to get rid of a dozen counselors in order to afford one of the higher-level evidence-based counseling programs that they were considering. Another director said that it is challenging to deliver an evidence-based program with high fidelity when STAR services are voluntary. For example, one parent only attended eight out of the required 12 sessions for a parenting program. The director said if parents decided to quit, the agency has no recourse to keep them involved, and if it only takes eight sessions for them to get the tools they need for the goal they set, they may not want to complete those other sessions. Another director wished that they could get involved in more cutting-edge practices and help build the evidence base of new interventions, but worried that being required to deliver evidence-based programs would undercut their ability to do so.

Assessment and Intake Process

Most STAR clients come from referrals made by other organizations in the community including schools, according to directors. Once a family is referred to STAR, the agency contacts the family to get more information in order to determine eligibility and schedule an initial intake appointment. Some families call for STAR services by themselves without a referral, and they are then scheduled for an intake appointment after they have been found eligible for services.

Most directors said the initial intake appointment takes from one-and-a-half to two-and-a-half hours to complete. They said the process involves the STAR counselor hearing from the parent, and preferably also the youth, about the issues that caused them to seek STAR services. It also includes filling out paperwork, including a psychosocial assessment, Protective Factors Survey (PFS), and STAR treatment plan. These directors said this process works well because the client experiences continuity by working with the same counselor from the first appointment on, and that the clients often reveal a lot of information in that first appointment that would help the counselor understand the family's situation.

A couple of agencies do intake differently. One agency does not have the counselor conduct the intake appointment, but rather has an intake department that receives the initial call, takes down the family information, determines eligibility, and then schedules and conducts the intake appointment with the family, after which a supervisor assigns the family to a counselor. This director said this model helps cut down on the amount of paperwork the counselors have to deal with, thus freeing them up to spend their time on delivering services. Another director said their agency has bachelor's-level, office-based intake specialists that screen phone calls, schedule the first appointments, and manage the files and data entry to take those tasks off the counselors. They are also responsible for the follow-up calls with the clients.

A couple of directors spoke to the importance of setting a positive, collaborative tone with the families from the first intake appointment. One director said the agency strives to help parents understand they are an integral part in the process during the intake appointment. He said the counselors explain to parents that they will be working on the issues that the parents deem to be important, and that the counselors will not just be telling them what to do. Another director said the agency strives to commend parents for engaging in services in the first place, recognizing the courage that is required to ask for help in tough situations.

Measurements

A couple of directors said they do not gather any outcome measures other than what STAR requires. They periodically review the PFS's pre- and post-results to see what percentage of families are achieving positive outcomes. The PFS is not considered to be a useful tool by some directors. These directors explained that they wish to measure more parenting outcomes and resiliency, which is not covered by the PFS. One director said they have found ways to make the survey more useful to their agency, namely assigning one employee the task of examining the results of all the pre- and post-surveys and reporting them to the director.

However, they stated that the monthly progress notes are a useful tool for the counselors to measure individual progress for each family. They noted that this tool also has a numerical measurement component that allows them to compare months and note client progress.

Many agencies are collecting outcome measures that are not currently required by STAR. Many agencies conduct client satisfaction surveys, the results of which they review to improve services. Another director said their agency issues a client satisfaction survey at discharge, as well as a yearly community satisfaction survey, which is distributed to referral sources and community partners.

Some directors said their agencies are using the CANS assessment to measure outcomes for their STAR clients. One agency conducts the assessment agency-wide for all programs, including STAR. Another agency is piloting the CANS assessment at one counseling site but does not have the funding for a dedicated in-house person to own that task, which would be required.

One director expressed frustration with being unable to pull reports on their own from the state database to which they submit their STAR client information. This director said that since requesting reports from the state can take several weeks, the agency does double data entry so they can more easily access information by maintaining their own client database and also fulfilling the requirements of entering information into the STAR database.

When asked what benefits they see from the children and families who graduate from STAR services, some directors pointed to increased family stability and skills. One director explained that helping parents be in a position to support their child and advocate for them at school is a family-stabilizing benefit of STAR services. Another director said they see youth develop decision-making skills through STAR, thinking through the potential consequences of their actions before they make a decision.

Some directors say they capture the benefits of STAR services by asking families directly about their experience. One agency selects families at random each month to contact and ask about their experience with STAR services. That information is reviewed by the director, who then relays what they have learned to the staff. Another agency receives calls from former clients, updating them on the family's progress, and word-of-mouth referrals from families who have benefited from STAR services.

Training

When asked how they stay up to date on best practices and interventions, many directors said they attend conferences such as the Partner in Prevention (PIP) Conference, Texas Network of Youth Services (TNOYS) Conference, and Texas Counseling Association (TCA) Conference. One director said that their agency holds their own conference on trauma-informed services each year. Many directors said they attend the required PEI conference each year but note that they did not find it to be very innovative or valuable.

Several directors cited lack of funding for why they do not attend as many conferences as they would like. One director said that a barrier to being able to keep up to date on new interventions is the contractual stipulation that does not allow using funds to send staff to national conferences. For example, the director wishes that they or a staff member could attend the National Council on Behavioral Health conference to learn about innovative practices such as "concurrent documentation," in which a therapist can be more efficient with their time by getting the client involved in documentation, but because they cannot use their STAR funding for national conferences, they are unable to afford it. Another director wishes they could attend the Trauma Informed Care conference in California but cannot due to the cost.

Directors also said they and their staff are trained through organizations such as National Safe Place, the SAMHSA website, TNOYS, and by requesting training on particular topics from organizations or colleges in their area. One director said that the Strengthening Relationships/Strengthening Families training held in San Marcos is the best training the agency attends every year. One director noted that their graduate student interns bring the new practices they are learning about in school to the agency, which helps STAR counselors stay current with new interventions.

Another way directors are informed about new practices is by maintaining licensing and accreditations. One director said that keeping the agency's COA accreditation every four years helps them maintain best practices across a wide spectrum, including documentation and supervising staff. Another director said that writing and researching for new grants helps them stay up to date. In addition, one director said that the counselors need Continuing Education Units (CEUs) to meet licensing requirements, so they learn new practices that way.

At one agency, the director has implemented bimonthly meetings, during which all STAR staff come together to brainstorm approaches for certain cases, share lessons learned, and vent frustrations to each other. The director said that this collaborative meeting is valued by the staff.

A director shared that agencies in one Texas region have been meeting for lunch twice a year to share experiences, vent, and learn. Since having these meetings, the director said they realized that STAR providers face many common, similar issues and can help each other find solutions. For example, in these informal meetings, the STAR providers share training opportunities with each other and can tell others which trainings they found to be a valuable investment of time and resources. This director said they did not think the state would want the providers to talk to each other since the RFA process is competitive, so they have not told the state about their off-the-books regional meetings even though they find them valuable. Another director indicated that STAR and other PEI program providers are not encouraged to share and build off each other's successes. The director said that they do not know where all the PEI-sponsored services are in their region and wishes there could be more collaboration among providers.

Referrals and Marketing

Several directors said that there are no other agencies in their area that provide the same services as STAR. A couple said there were agencies that overlapped on some services—such as Catholic Charities, Communities in Schools, and Any Baby Can—but for free or low-cost counseling services in particular, STAR is the only provider in their area.

Several directors said they are able to engage families most effectively by having good relationships with referral sources in their communities, such as schools, CPS, sheriff's departments, Head Start programs, and Community Resource Coordination Groups (CRCGs). Some said they and their staff also go to community events and give presentations about the services they offer. These directors noted that their outreach efforts require a significant investment of time, and some of their staff do not like to conduct outreach.

Some directors noted that there are challenges when working with schools. Directors said that it is convenient to see children for counseling sessions while they are in school, but counselors have to work around the strict guidelines set up by the schools regarding when they can take children out of class for counseling.

A couple of directors said their agency has developed a one-page informational sheet that they use at community events and with families to explain the services they offer.

Several directors said their agencies use the name "STAR" with families and referral sources when referring to STAR-funded services and use the brochures provided by PEI, but they acknowledged that many of their clients and referral sources would know the agency's name over "STAR." One agency only uses their name—and not "STAR"—to refer to STAR-funded services. One director said that there are too many programs in Texas named "STAR" or some variation thereof, and pointed out that families do not respond well to the "at-risk" part of the acronym; these families do not want to see themselves as being "at-risk," and the phrase can potentially cause a family to not engage in services because of the perceived stigma.

Overall, directors noted that since they are the only agency or one of a few agencies that provide these much-needed services in their community, they are consistently receiving new referrals, making the time and effort required to market their STAR services to the public seem superfluous.

Future Lines of Inquiry

These interviews helped inform future lines of inquiry, which will include the following:

- Population demographics
- Challenges faced by STAR staff
- Barriers to service
- Rural challenges
- Presenting issues
- Met and unmet community needs in relation to STAR
- Training
- Intake and assessment processes
- Stigma
- Outreach
- Referrals

Findings: Potential Parent Focus Groups

Background and Objectives

SUMA conducted eight focus groups with parents/caregivers[1] from seven communities to better understand their perspectives on community needs, barriers, gaps in service, and trends. The focus groups were comprised of mothers and fathers of different racial and ethnic backgrounds at various levels of education. As parents of a child between the ages of 7 and 18 who has not received counseling services from school, a private therapist, or another organization, these participants were able to provide insight into the mindset of parents who could potentially access STAR services. All focus group participants said that at least one of the following statements applied to their family, indicating a potential need for counseling services such as STAR:

- I have a child between 7 and 18 who has had trouble adjusting to changes to our family, such as divorce or the death of a loved one.
- I have a child between 7 and 18 who has experienced troubles at school related to their behavior, attendance, or grades.
- I have a child between 7 and 18 who struggles with their identity.
- I have a child between 7 and 18 who has experienced trauma.
- I have a child between 7 and 18 who could benefit from having a counselor to talk to about issues in their life.
- Our family would benefit from support such as counseling, parenting classes, and anger management for teens.

Table 1 on the following page illustrates how many participants attended each focus group. Tables 2 and 3 break down the race/ethnicity and education level of participants.

[1] Both parents and other caregivers participated in the potential parent focus groups. For the sake of brevity, "parents/caregivers" is henceforth shortened to "parents."

Table 1: Participant Totals for Potential Parents Focus Groups (*N* = 74)

Location	Agency Serving Location	Total
Amarillo	Texas Panhandle	9
Houston (Group 1)	DePelchin Children's Center	9
Houston (Group 2)*	DePelchin Children's Center	10
Laredo*	SCAN	12
Nacogdoches	DETCOG	9
New Braunfels	Connections	7
Plano	STARRY	9
Round Rock	STARRY	9

**Asterisk indicates focus groups conducted in Spanish.*

Table 2: Race/Ethnicity for Potential Parents Focus Groups (*N* = 73)

Race/Ethnicity	Total
Hispanic	33
Caucasian	23
African American	10
Other	5
Asian	2

Table 3: Education Level for Potential Parents Focus Groups (*N* = 74)

Education Level	Total
High school	23
College graduate	19
Some college	13
GED	7
Postgraduate	5
Some high school	5

The objectives of this research were to:

- Learn about parental challenges and concerns.
- Learn about existing resources available to families.
- Learn about perceptions of stigma and mental health counseling.
- Assess parents' perspectives on family counseling.
- Explore how STAR services could become better known and utilized by families.

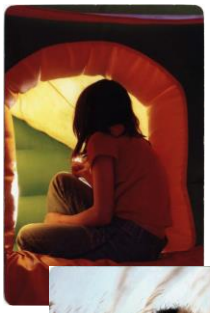
Findings

Parenting Children in 2017

Each focus group began with participants introducing themselves and sharing a little about their children. The moderator then laid out a deck of Visual Explorer™ cards depicting images of a wide variety of people, places, and situations. Participants were asked to browse through the cards and select the one image that best illustrated what it is like raising their oldest child between ages 7 and 18. Participants chose photographs that illustrated their feelings, which generally fell into two categories:

- Reflecting on the joy of being a parent
- Admitting to feeling overwhelmed and stressed by parenting their children

Participants in both categories expressed a desire to see their children succeed, to protect them from harm, and to be good, supportive parents. Several parents chose photographs that reminded them of fun activities and playing with their child. Several parents of teenagers brought up feeling challenged by their children's moodiness as they go through puberty.



I chose this one because I'm seeing it that way, like it's me because sometimes I feel that way. I feel isolated, alone. Because I did not have the support of my children's father, and neither did my children; that's why they are like this. Because my son, the 17-year-old, did not want to grow up with his dad. Since he was three months in my belly, we separated; he left me. And it did affect him.

— Laredo

I was that age, but being the age I am now looking back I realize that I don't really know a whole lot about how they think. This is kind of like not only is there the gender gap because she's a female, there's also just this age gap, and it seems really large sometimes. I feel like I'm sitting back with binoculars just kind of watching, like who is this child that I created? You know what I mean? That's what that said to me.

—Round Rock

When asked what the best parts of raising their children are, many parents said "unconditional love." Many also said the pride they feel in their children's growth and accomplishments is the best part of having children. Several participants said they liked teaching their children about the world and helping them succeed. Others listed taking part in fun activities, holidays, and vacations as a family. Some participants said they liked when they could see aspects of themselves in their children.

> [P]*ersonalities. I get a big kick out of them exhibiting my traits or my spouse's traits.*
>
> —New Braunfels

> [To] *see them grow and help them in their education, too. And guide them, advise them, more than anything because it is not easy for one to raise children alone.*
>
> —Laredo

Parenting Challenges

Participants were asked to share their parenting challenges, which included maintaining open communication with their children, appropriately disciplining them, having patience with them, navigating social media and smartphone usage, keeping them safe, and addressing school issues.

An overarching concern of participants is whether they are doing the right thing. Throughout this discussion, parents had doubts as to whether or not they knew the correct way to handle the challenges they identified. Several parents stated that they have to do the best they can and hope that they are doing right by their children.

> [T]*hat you are fully responsible for this other human being and you're going to have the greatest impact on them … and you're not going to know if you did a good job until they're older. It's one of those things that you just do the best you can.*
>
> —Round Rock

Communication: When asked what the most challenging aspects of raising their children are, a chief concern was communication. Parents overall want to keep the lines of communication open between them and their children, and several worry that their child might be experiencing something painful or difficult and are not telling them about it. These parents spoke of wanting to build trust with their children so that they can stay aware of what is happening in their lives. Several participants also spoke of wanting to have more quality time with their family so that there are more opportunities for conversation.

> *Quality communication. Not so much over the phone and things like that, but being present with them* [my children]. *Meeting their friends. Talking to them. Having conversations, quality conversations with them …. Doing things with family. Having the family together … because that can help, depending on—we all work, and maybe your child will spend all day at school, so being able to eat together once a day. Everyone eating at the table. "How did your day go?" Knowing what's happening in your children's lives. Trust. Having trust.*
>
> —Houston

> *It would be better if they* [my children] *were to talk a lot more with us in the family, so that—maybe with us, the support from us could be more together if we talked more, or we put the phone to the side when we are eating or something, and hang out together as a family.*
>
> —Laredo

Patience: Another top-of-mind parenting challenge among participants was patience. Some said they felt challenged to be patient with their children when they disobeyed or had a bad attitude. For other participants, having patience was hard in terms of trying to understand issues from their children's perspective. In general, participants related having patience to keeping their cool when interacting with their children under stressful conditions.

> *Patience and understanding …. You have to understand where their* [the child's] *mindset is, where they're coming from more so than just reacting directly to them or to the situation.*
>
> —New Braunfels

Discipline: Several participants, especially fathers, listed discipline as a challenge. Many of these parents were unsure if they were appropriately disciplining their children and had questions about how best to correct a child's behavior without using punishments that go too far. These parents want to know which types of punishments are constructive and which are harmful to children. In one rural community, multiple participants spoke about using physical punishment to correct their children's behavior.

Participant: *I know after my daughter ran away from the Boys & Girls Club with another boy to Walmart after she stole $40. I tore that little girl's tail end up and I put her in her room for a week. But after that week, I took her out, just me and her, and I explained to her why I did those things. That right there I felt like—because if she doesn't understand why, all she saw was violence and all this. I had to come back and tell her, this right here is why I did this, and if you do it again, same thing is going to happen, but I hope you learned your lesson.*
Moderator: *What gave you the idea to go back and talk to her about it?*
Participant: *Just me feeling bad. I was like this here is a relationship. I just thought about it a lot, and I was like I've got to make her understand what really happened here. It just wasn't me being angry with her or whatever. It was just you don't steal $40 and run off to Walmart with somebody.*

—Nacogdoches

Moderator: *Anyone else that you reached out to in that challenging time? Or anything that you wish that you had had in that challenging time?*
Participant 1: *A belt.* [Laughter]
Participant 2: *I had plenty of them and it just didn't work.*
Participant 1: *Just in reach to just pick up.*
Moderator: *When they get older—*
Participant 2: *They don't get too old for no whooping, though.*
Participant 3: *Yeah, but you probably hurt them more like taking stuff. You just take the phone. For a boy, take the games. Something to get their attention. I know when I was younger, I think I would rather have a whooping. Just don't take my phone. I can't live without it.*

—Nacogdoches

Smartphones and Social Media: An area of concern across all groups was parenting in the age of smartphones and social media. Many parents feel ill equipped to determine the appropriate boundaries for their children's smartphone use, especially since this is a new issue that parents did not experience when they were children. Many participants said they felt like their child's nearly incessant smartphone use has become problematic at home and at school. These parents feel like their child's smartphone has created a gulf between them, making it more difficult to connect and communicate openly.

I really feel like I've lost my son to social media. It's just amazing, losing your son to a non-human. What do I do? He's always with the phone and totally zones you out.

—Plano

[T]*hey're losing the social aspect. They don't have a whole lot of face-to-face, like you just mentioned. They can't talk about difficult concepts face-to-face like we can. They need to text it. I've noticed the same thing with my daughter. I got her a phone and after that, it was a completely different relationship, just like you mentioned, that really hit home. That's definitely a big concern is [sic] you wonder, are they going to develop the kind of social skills they need to talk to people in the real world when they're adults or not?*

—Round Rock

Many parents are concerned about online bullying and feel helpless to prevent or combat it. A few participants said they were worried about the permanence of social media posts and are at a loss as to how to help their child manage what is posted online; as one mother said, "Once it's out there, it's out there." Some parents said they worry about their children sending inappropriate pictures or messages to their boyfriends or girlfriends.

Participant 1: *I have a major issue. Social media. My daughter—one of the things that we're going through is because of social media. She had a little boyfriend, got caught in the stands kissing, and then somebody put a picture of her, put it on Facebook saying something sexual is going on. She comes and tells me, and like he said, you can't fix everything. She's like, "Change my* [class] *schedule." We've got two more months of school left at that time. I can't do anything. I'm sorry. She comes home crying.*
Participant 2: *Yeah, social media will destroy.*
Participant 3: *That's why I say think twice before they put it on social media.*

—Nacogdoches

Social media is the biggest problem. We give them phones for security purposes, but then they're gone. You don't see them when they go to their room and so forth and so on. Then next thing you know, you're checking, and there are nude pictures and private pictures and this and that. I have a daughter, and I'm a guy. I know. "Dad, you don't know what you're talking about." I know.

—Plano

Safety: Many participants feel challenged to keep their children safe while they are out in the world. Several parents said they worried about keeping their children from harm because they cannot be with them at all times. These participants were concerned about their children getting involved with drugs and gangs, with some noting that they worry their children may fall in with the wrong crowd and adopt bad behaviors. Some participants brought up teen drivers as a safety concern.

Bullying: Many participants worry about their children being bullied at school. Some said they were concerned about children getting into physical fights; specifically, while these parents do not want their children to fight back, they are worried about how their children can stay safe and out of trouble around aggressive children who instigate physical altercations. These parents struggle with whether to tell their children to defend themselves physically or never fight back. A few parents said they had tried going to school staff with their concerns, but this did not make much of an impact on the bullying.

Another issue, as far as what she's saying, like teaching your kids' stuff? I teach my kids not to fight. If you're teaching your kids not to fight, and then someone is coming up to hit them or whatever, I've already taught them not to fight so it's like, "Okay, do I defend myself or do I not fight?"

—Nacogdoches

Participant 1: *Bullying …. It's happening with my kid right now. The fact that like the last three days the teacher has been saying that he's been caught hitting folks. I was going to discipline, but he said, "They hit me first, Mom." I was told don't hit nobody, but if they keep picking with you after you done tell the teacher so many times, hit them back.*
Participant 2: *Hit them back. I tell them that, too.*
Participant 1: *I asked the teacher, and she was like, "They are hitting him back, hitting him first. He is defending himself."*

—Nacogdoches

School Pressures: Many participants said they are challenged to make sure their children have good attendance and that they are performing well in school. Some parents said they worry about the stress their children experience related to standardized testing, homework, and planning for college. A few participants brought up concerns about whether the school can provide the support the child needs to succeed in the classroom, such as assistance with learning disabilities and individualized attention from the teacher in large classes.

Other concerns and issues include:

- Raising children with Attention Deficit Hyperactivity Disorder (ADHD)
- Raising children to be responsible
- Instilling good values and manners in their children
- Preparing children to face life's challenges
- Sibling rivalry
- Being single parents
- Raising a child of a gender different from the parent
- Dating and pregnancy
- Addressing puberty and sexuality with adolescents
- Having enough time to spend with their children
- Raising sons without fathers

Participants were asked to share some of the challenges they believe their children face daily. Parents reiterated many of the same concerns that they themselves worry about. This list also mirrors concerns brought up by STAR staff and parents who participated in STAR, indicating that these issues are widespread and common. Challenges and issues include:

- School pressures
- ADHD
- Divorce
- Dating and relationships
- Wanting to fit in with certain social groups
- Grief (deaths of family members/abandonment)
- Self-harm (e.g., cutting)
- Alcohol and drug abuse
- Behavior issues
- Bullying
- Depression
- Anger management
- Anxiety
- Suicidal ideation
- Truancy

How Parents Help Their Children Navigate Challenges

When asked how they try to help their child deal with these issues, parents' first response in most groups was to talk to their children about their problems. Many participants spoke of wanting to create an open environment at home where the child feels comfortable asking questions and sharing their experiences with a parent.

> *Transparency. Basically, nothing is off the table. If you can't talk to your kids, someone will. If they have questions, they will find answers, and it's better for them to be as informed as possible based off of either your experience, no matter how dark it is. Transparency has done wonders in our household …. It's judgment free.*
>
> —Amarillo

Though several parents strive toward that ideal of fostering openness and sharing in their homes, overall they feel like their children sometimes tell them what is on their minds—but not all the time. Parents feel like they only get part of the story from their children. Several expressed concern that their children may be holding in issues or emotions and not sharing them with adults who can help the children deal with them.

> *I just lost my mom at the end of January, so they* [my children] *were trying to be strong for me, then they had to turn around and be strong for their dad these past two weeks ago. It's like, "I don't want you to try to be strong for us. You're kids." That's hard. I lost my two grandparents when I was grown, and it's hard then. I can't imagine being that age. For me, I worry about if they're holding something in and they're not telling me and they need to talk. You know what I'm saying?*
>
> —Houston

The moderator probed to see what participants would do if they felt their children were not sharing with them; parents said they would encourage their children to talk to another family member, close friend, church members, or school counselor. The most common reply among participants was that they have their children talk to another member of the family if they do not want to talk to their parents.

> *I have a god-sister. We play back and forth. We let each set of children know that if they don't feel comfortable talking to me about something, they can go to her. If her daughter doesn't feel comfortable going to her, she can come to me, or they can find somebody else that's close, that they may have a strong relationship with and then kind of go back and forth with each other—the grownups—and say, "Let such-and-such know, or you talk to their child." … to bounce it back on them, because I feel more comfortable talking to my aunt than I did my mother.*
>
> —Houston

> *The church actually helped me with my son. He was being a little rebel. Nobody could tell him. Dad couldn't tell him. I couldn't tell him. Grandma couldn't tell him. He ended up talking to the pastor. They're real active with the church, and he helped him a lot in his life.*
>
> —Amarillo

> *I have additional support. I go to the school. I involve the school. I'm also the mother that will walk with him from class to class and will sit with him in class if he's acting out. Involving the counselor at school and getting to have just a really good relationship with the teachers is another way that I get school support.*
>
> —Houston

When asked what resources they wish were available to them to deal with these issues, several participants said counseling and parenting classes or support groups. It is important to note that while they said they would ideally like to receive parenting education in a class setting, later in the focus group most recognized that, in reality, they would lack the time to follow through and actually attend such a class. Several parents said they wished they had more support from their child's other parent, especially in situations where the parents do not live in the same house. One parent expressed the desire for mentoring from people who can relate to her family culturally and ethnically.

> *For me, I wish there were more mentorship programs. We're originally from the south side of Chicago. We've been here about six years now. The thing I love about here is the fact that it's very family-friendly. There are a lot of programs available. They love the kids here, but I have to honestly say I haven't encountered—church and volunteering and stuff, but it's not a whole bunch of men that look like us. I struggle. Our reality is different.*
>
> —Plano

> *I wish I had more support from their dad because every boy needs a dad. He's there, but he's there when he wants to be. I need you there all the time. When he gets in trouble, it'll be—I'm fine getting on to him when he gets in trouble, but … I think he'd understand it better if it was his dad. You know what I'm saying? I don't want to be the one that's always getting on to him, and then when he goes with you, he's having fun. When he gets in trouble, you get on to him, too.*
>
> —Nacogdoches

Desired Resources
Parenting classes
Parenting support groups
Communication classes that involve children and parents
Counseling
Mentoring
Parenting assistance via home visiting

Parents' Perceptions of Counseling

Participants were asked what they thought of when they heard the word "counseling"; parents were split between regarding counseling as positive and helpful, or thinking that it could potentially do more harm than good.

Figure 1 lists representative top-of-mind reactions to "counseling" from participants.

Figure 1: Parents' Positive and Negative Perceptions of Counseling

Positive Perceptions

- *A person that makes you open up more.*
- *Gives you advice.*
- *Helps you solve the problem.*
- *Sometimes just them listening to what you have to say and filtering out.*
- *Somebody [children] can open up to. Sometimes they don't open up to us.*
- *Trying to get an understanding of what's going on, like why are you doing this or why are you doing that? What caused this to happen or what caused that to happen?*
- *They are other tips that one does not know and they give you more advice than you already have and you learn more.*
- *They give you another opinion*

Negative Perceptions

- *Problems. Family Problems that you have.*
- *Counseling, when somebody says it, it just makes you seem like you have a psychiatric problem.*
- *It depends. You have to know who the counselor is.*
- *Honestly, failure … You only need counseling when you need help or something's broken. You don't go for fun.*
- *"Why do you need to go to a therapist? Are you nuts?" That's personally—I've thought that myself before.*

When asked how long they think counseling should last, participants generally said they thought hour-long sessions for as long as was needed would be appropriate. Participants in one group said they would want counseling sessions twice a week. Participants in another group said they would like the option to have some sessions in their home. Most participants liked the idea of having counseling sessions available to their children at school and were not overly concerned about them being taken out of classes to access counseling.

Resistance to Counseling

Some participants were resistant to the idea of letting their children access counseling services. These parents felt that they could not trust a stranger with their family issues, for fear of their children being taken away or another unforeseen negative consequence.

Some parents worry that a history of accessing counseling services could follow their children in life and negatively impact their ability to get jobs or be accepted into colleges.

> *Just the grandparents is basically support. My parents and my husband's parents—they're always onto them. If it wasn't us, it was the grandparents. We let them* [our children] *spend lots of time with their grandparents because they were old school. They would just talk to them. You can talk to counselors, but to me it's not the same because they don't know you, but your parent knows you, and your grandparents know you.*
>
> —Amarillo

Some parents said that stigma exists around accessing counseling services. These parents hypothesized that the stigma is due to people feeling too embarrassed to ask for help, which may signal to the outside world that they are not good parents. A few worried that other parents would not want their children to interact with children who are in counseling, which would have a negative impact on their social life. Some parents brought up that their children may be resistant to participate in counseling because they do not want to be picked on by their peers.

> *Bullying—I want to say that I dealt with it in a different way. On one hand, I wanted to be involved and talk to the counselor, but he* [my son] *didn't want that. Then he said, "No, you will not because then everybody will say I'm a snitch." That's one problem, peer pressure, because I know when he's being bullied, and he's mentioned it to me. I want to open a dialogue.*
>
> —Plano

> *The school also referred me to counseling and they* [my children] *did not want to go. Neither of them wanted to go to counseling because they said they were not crazy, and they said, "We do not need any of that."*
>
> —Laredo

Concerns about Counseling
Accessing counseling may indicate serious mental health issues
Having their children stigmatized in their schools and communities
Having their children taken away
Having the content of counseling sessions made public
Negatively impacting their children's future job/college prospects
Being viewed as bad parents
Getting an unskilled counselor
Getting a counselor that does not have experience raising their own children
Counselors do not know the whole family/situation

Pro-Counseling Parents

Several participants in each group said that they viewed accessing counseling services as positive for families. Many parents say they want to do whatever it takes to help their children and would be willing to give counseling a try. A few parents pointed out that not everyone grows up in a household with adults that model good parenting skills and thus, counseling or parenting classes can help parents learn.

> *I feel like if it'll help my kid, then OK. I feel like if I'm paying all this money, and it's not helping, then I'm not going to keep wasting money. But if I'm paying, and it's helping, I'm all for it. Anything to help my kids.*
>
> —Nacogdoches

> *For me, it's good. It's a good thing because there are times that we come from a family where we were never taught many things. They're like a guide to be better parents … so that you improve* [and] *be a better parent* [and] *person.*
>
> —Houston

Most of the participants who exhibited resistance to the idea of taking their child to a counselor did not report ever having gone to a counselor or therapist themselves. By contrast, parents who had participated in some form of counseling or therapy regarded counseling positively. These parents found value in their experience and were open to enrolling their children in services. Only a few parents had tried counseling and felt it was ineffective for their families.

> *I think it's not bad to ask for counseling or a counselor. It helps me. I like it, in fact.*
>
> —Houston

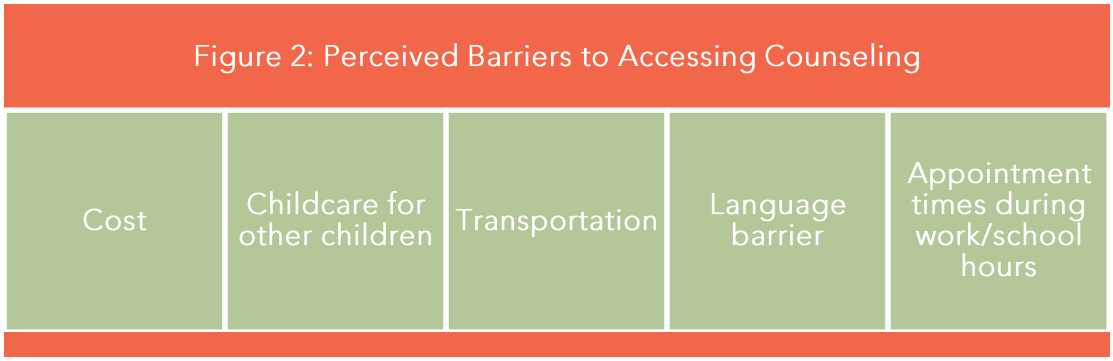
> *To me, "counseling" means growth potential—reaching goals. The reason I say that is because after the divorce, I put my kid in counseling because it was—long story short, it helped them grow and it helped them understand why the divorce happened and that they have a relationship with their dad and then they have a relationship with me, but it's not intertwined. You can love both of us without feeling guilty and stuff.*
>
> —New Braunfels

One father brought up without prompting that his family was considering going to counseling at the local STAR agency because they wanted reassurance that they are not alone in their issues. They also wanted to learn about new or more effective parenting methods.

> *I think the negative powers out there that are in place—if you think about good and evil or whatever—they whisper in your ear and tell you, "You're the only one with this problem. You're the only one." I think if there was a network that we could get together with other families and say, "We're trying the best we can." If we minimize their interaction with video games and phones and such …. There's a group here called Connections that we're talking about going and visiting with. It's a family therapy.*
>
> —New Braunfels

Perceived Barriers to Accessing Counseling

Participants were asked what barriers would prevent them from accessing counseling services for their children. Their answers are listed in Figure 1.



> *Transportation. The majority do not have a car, or have the husband's or wife's car, have a single car … Since I do not drive, I am always looking to see who can give me a ride.*
>
> —Laredo

> *Time might be depending on because their offices close at five, and some people get off at five. It's like you're having to take off work, so that might be an issue.*
>
> —Nacogdoches

Participants from the Spanish-dominant group in Laredo brought up that even though many people in their community speak Spanish, there are many instances where school officials use English, which can be confusing. Participants said they would prefer to have counseling in Spanish to better understand what is being said.

Parenting Classes

Most parents had not taken any parenting classes. The few participants who had previously accessed parenting classes had a positive opinion and found them to be helpful. Some of those who had not attended parenting classes hypothesized that they would feel judged as being unfit parents if they went. Several participants expressed interest in the concept of parenting classes, but as the conversation continued, they admitted they would be unlikely to attend due to barriers such as time and money.

> Participant 1: *I'd feel bad. Like, they don't know how to raise their kids. They have to ask someone else. I would feel embarrassed. They're going to say I don't know anything—that I'm not a good dad.*
> Participant 2: *It would also be the money. We know that all parents have a limited budget. If we take a class, of course they're going to charge us, and nothing's going to be free. If you go above your budget—so, money, embarrassment, time.*
> Participant 3: *As a single mom I work five, six days a week. For me it would time.*
>
> —Houston

> *That's what I took first was the parenting class, before I did the counseling. I did the parenting class. Then I saw kind of—I bought into it a little bit. Then I thought, "OK, this is something—I've learned something from this class." Then that's what made me think, "OK, let me take the next step."*
>
> —Plano

Alternative Terminology

Some parents said they would be more likely to access parenting classes if they were called something other than "parenting classes." Some liked "mediation," but others associated that term with divorce. Some liked "support" but others still thought this word invoked an idea that something that's broken needs extra support, like a broken beam in a house. "Life lessons" and "parenting tips" were also suggested.

The "Tipping Point" for Accessing Services

When asked what would have to happen for parents to consider accessing counseling services for their children, participants said a major event such as an arrest or suicide attempt, or being told by a trusted party (such as a teacher or school counselor) that their child needed counseling would influence them to seek services. Parents said the "tipping point" would be different for each family, but that it would come when they felt like they did not know what to do to help their child. However, in order for parents to take that step, they would have to know that there are services available to them and where they can reach out for help.

In regards to counseling, most participants were generally receptive to the idea of trying it if a teacher or school counselor says needed for their child.

Moderator:	*If you heard from somebody at school—a teacher or maybe the counselor there—that "I think that your child could benefit from receiving counseling," what would your reaction to that be?*
Participant 1:	*I'm all ears. I'm not a parent that's going to disagree with that. Why do you feel this way?*
Participant 2:	*"What type of counseling?"*
Participant 3:	*There's got to be a strong reason why they're saying that. They're not just making it up.*

—New Braunfels

Ideal Program

When asked to describe the ideal program to help families such as themselves, parents said it would be:

- Staffed with qualified professionals
- Flexible with appointment times
- In a relaxing space
- Able to provide childcare
- Easy to get to
- Affordable/free
- Offered in several languages
- Able to host fun activities for children
- Advertised in the community

Several parents said they would want the program to help raise children's self-esteem. Some parents said they would want either individualized or age-appropriate programming for their children so that they can get the help they need and not be lumped into a larger group. Several parents noted that their ideal program would be run by trustworthy professionals to which they felt comfortable sending their children.

> *If you have young ones, a lot of us are going through issues with our older ones and we have younger ones that we kind of pull along for the ride. One of the reasons going to classes would be difficult is because, especially if you do it as a family, who is going to watch the younger ones? It'd be nice to have a place to drop them off.*
>
> —Round Rock

> *It would have to be something saying what kind of people they're around. I don't want to just send my child to some group or activity that I don't know what kind of people they are. I don't know, not necessarily credentially but you've got to know how they* [are].
>
> —Amarillo

Materials Testing

State STAR Brochure

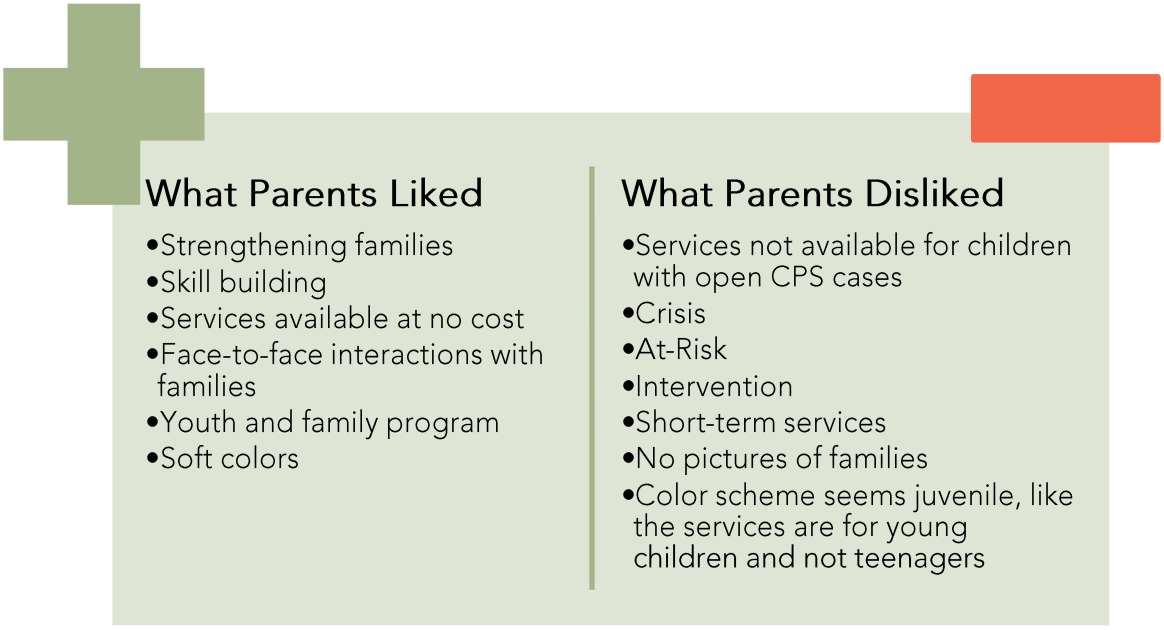
Participants liked the statewide STAR brochure (See Appendix B), noting that it provides a good overview of what STAR can offer families. Participants were asked to circle the parts of the brochure they liked and write an "X" over parts they disliked.

Figures 3 and 4 are word clouds representing the words that parents circled and crossed out on the brochure.

Figure 3: Words Most Circled on STAR brochure

Figure 4: Words Most Crossed Out on STAR brochure

Figure 5: What Parents Liked and Disliked on STAR Brochure



Parents liked the parts of the brochure that focused on positive improvement for families. They disliked parts that they said felt more extreme, such as referring to a child as "at-risk" or a family situation as a "crisis." Several parents disliked the services being classified as "short-term," seeing that as limiting—that perhaps their family could not be helped if their issues take longer to work through.

> *I don't like the word "crisis intervention," even though that's what it is. Maybe a difficult situation would be better, because you don't want to think you're in a crisis, even though you probably are, if you're looking out for help. That hit me. I crossed that out a couple of times.*
>
> —Plano

> *I think that "short-term services" makes me feel like, why am I going to waste my time?*
>
> —Round Rock

Parents in every group noticed the clause about children with open CPS cases being ineligible for STAR services, and each parent who brought it up reacted negatively to it. They explained that it seems like children with CPS cases need the most support, and they did not like that those children were excluded from a free community program. Several parents noticed that "STAR" is an acronym on the brochure and they wanted to know what it stood for. When they were told, "Services to At-Risk Youth," most parents did not like the term "at-risk," saying that no one wants to think of themselves or their child as "at-risk." There was also confusion around the name "STAR," with several parents asking if the named was related to the State of Texas Assessments of Academic Readiness (STAAR) test, which has a negative, stressful association for many families.

> Participant 1: *I think kind of that STAR thing needs to go away. It kind of scares people.*
> Participant 2: *It's like the STAAR test. It is.*
> Participant 3: *Well, yeah, when I saw STAR I was like, "I hate that test already. Don't bring me more."*
>
> —Amarillo

Agency-Specific Brochures

The moderator then passed out other brochures created by individual STAR agencies around the state. While there were elements of each brochure that parents liked and disliked, they preferred the Connections brochure overall. Parents liked the bright colors and cheery photographs of the children on the brochure as well as the hopeful language around strengthening families, such as "for a brighter future."

The front of each brochure that was tested in the parent focus groups. From left: Connections, Texas Panhandle MHMR, DePelchin Children's Center, and Serving Children and Adults in Need (SCAN).

Parents liked that the SCAN flyer had "free counseling" in large font across the top but disliked that there were no pictures of families or other interesting graphics. They also liked that there were names and contact information for specific counselors listed.

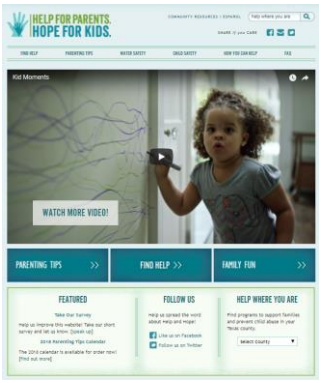
With the DePelchin flyer, parents liked the large font and pictures at the top, but they thought the text on the bottom half was too small and light to be legible.

Parents did not like seeing "mental retardation" on the Texas Panhandle MHMR flyer and said that the design seemed sterile and governmental. They liked that there was a section in Spanish, noting that not everyone reads English in their communities.

HelpandHope.org

The moderator passed out tablets for parents to look at the *HelpandHope.org* home page. Most parents said it looked like a general parenting website for parents of young children because of the video of the toddler in the center of the page. Several participants said that this website did not look like a resource for them, as parents of older children and teens (ages 7 to 18). They were then instructed to find their county under the "Help Where You Are" section and look at the listed services. Several parents said they would not have known to go to that section to find services without being instructed to do so. Many parents expressed surprise that there were programs they had never heard of before in their area. Many also said they disliked the "at-risk" part of the STAR program name, since it is listed on the website as "Services to At-Risk Youth (STAR)."

Overall, parents said the website did not give them enough of a description of what STAR offered in order to influence them to call their local agency to learn more. They also said that seeing "At-Risk" in the program name made them think that that program was not intended for their family, since they do not see themselves as "At-Risk".



In one community, participants clicked on the link to the local agency's website and were confused as to whether the building pictured was in their town or in a neighboring town. They said that the agency's website made it less clear where STAR services were offered in their area.

> *"Child abuse prevention, parenting tips, family fun." It's just a generic parenting website to me. That's what it seems like …. If the whole purpose* [of the website] *is for the services that were on that Connections* [brochure]*, I might stop. That brochure would be nice to see right in front.*
>
> —Round Rock

> Participant 1: *Number one, it talks only about at-risk youth. My child's not at risk, in my opinion, at this point in time. It doesn't mean I can't benefit from other classes that they may have. If I look directly at this, it just doesn't speak to me.*
>
> Participant 2: *I like the slogan on the bottom of the teal* [Connections] *flier. "Providing youths, families, communities, opportunities for a brighter future." That should pretty much be on anything. I don't feel like my child is in crisis.*
>
> —New Braunfels

> Participant 1: *I've never seen this building.*
> Participant 2: *It looks like the jailhouse, girl …*
> Participant 1: *Yeah. I don't think this in Nacogdoches.*
> Participant 3: *No. I think it says it's in Jasper.*
> Participant 4: *No. This doesn't look familiar at all.*
>
> —Nacogdoches

Promoting STAR in Their Communities

Parents overall felt positively about STAR when the program was explained to them, and the most frequent reaction to learning about the program was to ask why they had never heard of it before. Several parents said they liked the idea of their child having another adult in their lives to talk to and ask for advice. Most parents viewed the program as valuable to their communities and wanted to see it promoted through schools, local organizations like churches and YMCAs, and online via Facebook. Several parents also suggested having a community event with free food and family activities to help get the word out about STAR services.

> *Send this home with the kids at school. I get so many flyers. I'm curious as to why I haven't gotten this flyer along with all the other billions of flyers I get.*
>
> —New Braunfels

> *Having an event at different places around town—even the river. There's tons of people that go there, and having any type of event down there and inviting people …. What we used to do at the church is, sit out there and give out free hotdogs and hamburgers just to be a community.*
>
> —New Braunfels

Recommendations

The findings suggest the following strategic recommendations.

Utilize previous STAR clients as ambassadors that speak to the community about the benefits of STAR counseling. Let potential parents hear from real families about how STAR helped them get out of crisis.

Focus promotional language around building strong families.

Do not use the term "At-Risk" in promotional materials geared towards parents.

Advertise STAR services on Facebook to spread awareness among parents.

Create a website specific to the STAR program that appeals to parents of children ages 7-18.

Rather than general parenting classes, hold classes on specific topics such as parenting a child with ADHD or navigating social media and smartphone use with teens.

Findings: Rural Potential Parent Focus Groups

Background and Objectives

SUMA conducted three focus groups with 26 parents/caregivers[1] in rural communities to better understand their perspectives on community needs, barriers, gaps in service, and trends. Focus groups were composed of mothers and fathers of different racial and ethnic backgrounds and various education levels.

The screening criteria for the rural parents mirrored that of the general population groups, which indicated a potential need for counseling services like STAR.

Table 1: Participant Totals for STAR Rural Potential Parent Focus Groups (*N* = 26)

Location	Agency Serving This Location	Total
Carrizo Springs	SCAN	7
Gainesville	STARRY/CCD Counseling	11
Dumas	Texas Panhandle	8

The objectives of the research were to:

- Learn about parental concerns in rural communities.
- Learn about existing resources available to rural families.
- Learn about perceptions of stigma and mental health counseling in rural communities.
- Assess rural parents' perspectives on family counseling.
- Explore how STAR's services could become better known and utilized by rural families.

Findings

Many of the following findings mirrored what was heard in the general population focus groups. Two concerns unique to the rural groups are pervasive worries about confidentiality and a lack of resources to engage children (e.g., movie theaters, arcades, and bowling alleys).

Parental Concerns and Challenges

Each focus group began with participants introducing themselves and sharing a little about their children. The moderator then laid out a deck of Visual Explorer™ cards depicting images of a wide variety of people, places, and situations. Participants were asked to browse through the cards and select the one image that best illustrated what it is like raising their oldest child between ages 7 and 18.

[1] Both parents and other caregivers participated in the potential parent focus groups. For the sake of brevity, "parents/caregivers" is henceforth shortened to "parents."

Participants chose photographs that illustrated their feelings, which echoed the same themes and concerns that were heard in the general population groups and generally fell into two categories:

- Reflecting on the joy of being a parent
- Admitting to feeling overwhelmed and stressed by parenting their children

Parents in rural areas shared many of the same concerns around parenting as their counterparts from the general population. Parent's concerns include bullying, illicit drug and alcohol use, gangs, social media and smartphone use, depression, anxiety, and their children's success in school.

> *I have to still monitor my 16-year-old's phone. This is what the world is coming to. If you don't know it, you will be left behind. In school, you learn from a computer. If you don't have one at home, they're going to learn at school. I do agree you have to monitor* [children's social media use]*, but my daughter helps me out. I have all this Amazon Fire Stick, Roku. I don't know how to work all this, she has to teach me.*
>
> —Gainesville

Discipline: Appropriate discipline is a concern with which several parents said they struggle. They have questions about how to appropriately discipline their children while maintaining boundaries and teaching responsibility—and without going too far and being too harsh. In contrast to the general population parents, rural parents spoke openly about using corporeal punishment on their children. Some parents, especially fathers, explained that using physical punishments such as spanking or hitting was an effective way to correct their child's behavior; others said they were conflicted over whether spankings were appropriate. While the occurrences of grandparents raising grandchildren were not limited to rural areas, more grandparents were represented in the participant makeup of the rural focus groups. They spoke about the difficulty of switching from the role of "grandparent spoiling grandchild" to the "primary caregiver disciplining grandchild."

> *The big problem is, really, what they were talking about earlier about discipline. Since they started changing the rules about, now you can't even spank your kid because your kid's going to go crying to a cop. "He hit me over here! He hit me over there," when really, you hit him on his butt, but the cop's not going to believe you … They would say, "Oh, no. You're abusing your kid, too.*
>
> —Carrizo Springs

> *It's very difficult, the discipline. When you're the grandmother and Grandma is supposed to spoil the child, and then suddenly the grandmother has to be the parent. It's been really difficult because she's—when you used to say yes to her. That, and now you're telling me, "No." Setting rules. It's been tough. Discipline has been a major.*
>
> —Carrizo Springs

Family structures: Rural parents shared that their children's family structures include incarcerated parents, absent or dead parents, large extended families with stepchildren, and grandparents acting as primary caregivers. Several participants said that the children's parents were absent due to illicit drug use, particularly methamphetamine. Some mentioned the challenge of co-parenting their child when the mother and father do not live together or endure other complicating factors in their relationship.

> *I went through a moment where it's still kind of up to* [my son's] *mom whether I'm going to see my son. It's just being honest with him of my actions. I tell him … if it's money or whatever it is, or if it's the legal situation between me and his mother. I just keep it honest with him."*
>
> —Gainesville

Lack of safe places for children: Unique to rural parents are their concerns about the lack of places where youth can socialize and the overall dearth of activities for teens. Parents stated that without spots (such as movie theaters, arcades, and skating rinks) where they can gather, teens are more likely to get into trouble and use illicit drugs and alcohol. In Carrizo Springs, a couple of parents spoke about sending their children to activities at a church of a denomination different from their own because it offered something constructive for the children to do.

> *I was going to say that we're all from the same town, and we know how easy it is to get drugs here in town. We have a lot of gangs. Drugs are easily accessible. There's nothing to do in our community, other than maybe church activities—maybe school activities. There's nothing for our children. A small community library. We were just talking about our kids being addicted to all these devices. There's nowhere—not a movie theater, not a bowling alley. Kids tend to get into trouble because there's nothing.*
>
> —Carrizo Springs

> *Yeah, I grew up here in Dumas, too. There's a spot called Winnie's over there, and you can just walk in there. And people who are partying and drinking there, you can just go and get their beer without them noticing. You've got to keep a good eye on your kids with them growing up and you letting them out, because I was doing that at 13. That's like seventh grade …*
>
> —Dumas

In all three sites, parents reported that methamphetamine use is a problem among both children and parents. Other illicit drugs used in their communities include cocaine, prescription pills (such as opioids), heroin, and marijuana, according to parents.

Resources and Stigma

Community support: Rural parents said that they turned to their family members and church communities during challenging times when parenting their child. Rural parents knew of few counselors in their communities, and several mentioned that they felt unaware of what resources for families might exist in their area. For the resources of which parents were aware, cost and/or lack of insurance were identified as barriers to accessing them.

Participant 1: *Like support, a support team, a good strong support team. If it's coming from the church, if it's coming from a counselor. In situations like that you're going to need somebody. You can talk to your heavenly father, but you know you're going to have to have somebody down here on Earth to get through all that as well.*

Participant 2: *I think there's a lot of programs out there but it's kind of like are the kids willing to go? If their friends are not going to that event, then they don't want to go because all the cool kids are not there. They have different events in the community, but are the kids willing to go?*

Participant 3: *Who? Nobody really just shares that. I had my first child* [when I was] *older. I don't know, and I've been in Denton born and raised all my life. When my 15-year-old son tells me he's going to be a dad, where do you go to? Who do you go to for that support if you don't know? Make the resources available.*

—Gainesville

Confidentiality: Many rural parents described confidentiality as a concern in their communities. These parents worry about counselors breaching confidentiality and sharing intimate details from their sessions with friends and neighbors in their small town. Fears about what their neighbors would discover about their family if they opened up to a local counselor were shared in all three focus groups.

> *Maybe if there was more outside counseling. Working for the school district, I can tell you a lot of stuff. What's said there doesn't always stay there. It doesn't stay there. I'm sorry, but that's just the way it is. It's hard because you go tell the counselor and you feel like they should keep it to them*[self], *unless* [the child says] *that they're going to commit suicide. Of course, they have to take it further. They already know that whatever they tell that counselor, they're going to tell—this is a very small community. It's a small community.*
>
> —Carrizo Springs

Parenting classes: Rural parents were aware of some parenting classes in their communities, though these classes were often prenatal-focused. Participants said that the few classes focused on general parenting skills are not well attended by the parents who really need to build their skills. Several parents in these focus groups brought up the lack of parental involvement as an issue for families in their community.

> *If they would make it to where we could actually benefit from it because a lot of the time they just focus on newborn and pregnancy. Yeah, I've got small kids, but I need to know how to handle my oldest one. Maybe if they planned it out a little better … I don't want to sit through a conversation about something that doesn't pertain to me. I just feel like it's a waste of time.*
>
> —Dumas

> [Parents are] *not supportive, either. When I worked at the school, we had PTO* [parent-teacher organization] *meetings. The same three or four parents over and over. You have these Family Framework* [parenting class] *events. Those are really neat, great prizes, a lot of incentives. Kids get to wear jeans. They get 100 in every class. Same five, six parents. That's it. Where's the support? We're complaining that our kids are doing drugs, doing this out there, they're on their phone, but we're not supporting them.*
>
> —Carrizo Springs

Bullying: Many rural parents had concerns about teachers being able to handle their large classrooms of 30-plus children, especially when it comes to preventing bullying. Several parents also said that sometimes the parents of the bully do not care to engage with school staff or other parents about the problems their child is causing, so nothing changes, even when bullying is reported. Several participants said that in their experience, the schools did not do enough to address bullying. Thus, sometimes they directed their children to fight back to protect themselves rather than ask for help from an adult at school. The pervasiveness of bullying as a concern for parents was echoed in the general population focus groups as well.

> *I had a situation last year when my daughter was getting picked on, but I didn't feel the need to go up to the school, because sometimes we just make it worse for them. They talk to them, and then, "Oh, look at her. She's a snitch." That just causes more pickings from other students. I think the classrooms are a lot bigger than they used to be. Maybe it's a lack of faculty. They don't have enough people to pay attention to the students, to where that's not going on … They're like 24 or 25.*
>
> —Dumas

Bullying. My kid's a nice kid, right? He's going to play first before fighting comes out, but once he's mad there's no—if you hit him, you trigger something. I don't know. I didn't raise him to, say, knock this kid's head off. Teaching him not to do that sometimes is like, I don't want to tell him something against himself because he's an individual. He knows, probably to the point where he felt threatened. I can't say that for him, but maybe to just recognize that level in him … I tell mine, "If they hit you, go tell the teacher. If the teacher don't do nothing, come to me."

—Gainesville

[Bullying] *happened to my daughter and she got pushed, and her front teeth came off completely … She got pushed off in the playground from way up there and she smashed the front of her teeth on the floor. The first tooth came out then and there, and the second one was poking out a little bit and then it came out last week. It's sad. Whenever she told me that I was just like, wow. These kids are really going through these things.*

—Carrizo Springs

Dumas: The shift work schedule in the nearby factories and oil derricks (the primary employers in the area) prevent many parents from accessing services that are only available during regular work hours. High school students in Dumas sometimes work at the factories to help supplement family incomes. Some of those students end up dropping out of school because they can make good money at their factory jobs without a high school diploma.

Perceptions of Counseling

Experience with counseling: Similar to general population parents, rural parents with firsthand counseling experience tend to have a positive outlook on counseling. They were likely to describe counseling as a way to get feedback on situations from a third party, work on oneself, get support in a troubled time, and strengthen relationships. A few of those who had engaged in counseling or put their child into counseling had done so at the recommendation of a trusted professional, such as a doctor.

When I first went to counseling, I was kind of afraid they were going to judge me. I've gone to counseling two or three times. The first time, that man judged me and he twisted my whole thing. We were trying to go to marriage counseling, and I was a good one and he was a bad one. He turned around the story and the counselor made me feel like I did something wrong. Then the next one, the lady, she was awesome … She let me feel like I released a lot of my troubles. It was very awesome.

—Carrizo Springs

Stigma: Most parents said that there was a stigma around counseling for other parents in their communities. Some hypothesized that other children would wonder what was wrong with a child who went to counseling, and that attending counseling could result in more bullying. Some parents also wondered if other parents would judge them for accessing family counseling, but none shared experiences of such a scenario that actually happened to them.

Yes, definitely. The stigma with me was like, what's wrong with her? What's wrong with that child? They're going to a counselor. To me, counseling would be a relief, but it's a stigma.

—Carrizo Springs

[Counseling is] *just having someone to talk to, listen to you. A lot of people are scared of that. When they hear the word "counseling," it's kind of like they're kind of scared. They don't want nobody to know they're receiving counseling.*

—Gainesville

Telemedicine: Three rural parents said that they have had telemedicine appointments and did not enjoy the experience. One parent took their child for telemedicine appointments with a psychiatrist to receive some counseling and a prescription for medication. This parent thought the appointments felt rushed and concluded that they were more about acquiring a prescription than getting quality counseling. Another parent who experienced telemedicine went in for a sore throat and, while she said the experience was strange for a physical diagnosis, thought that perhaps counseling would be better suited for the telemedicine format. The third parent received a counseling session via telemedicine. However, since it was the first and last time she met with that counselor, she did not trust the counselor and did not have an opportunity to build the necessary trust with her.

> *I don't know if this lady was actually listening to me or not. I don't know if she was sitting there drawing instead of taking notes or anything. She could be anywhere, and I'm sitting here talking to a screen."*
>
> —Gainesville

Ideal Program

When asked to describe the ideal program to help families like themselves, rural parents said it would be:

- Confidential
- Comfortable
- Affordable/free
- Staffed with qualified professionals
- Offered in several languages
- Able to provide childcare
- Have a recreation area for children to hang out in a safe environment
- Advertised in the community

They also wanted it to be located in a building with other various services, so that people could not see their car in the parking lot and know that they were accessing counseling. A few participants said the program offering these services should be mobile and perhaps have a van to connect with families around the community at places such as parks or public events.

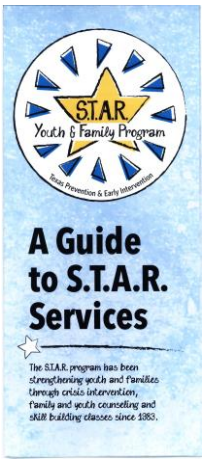
> Participant 1: *It would be awesome if it was a giant—like the community building. If you had an office for counseling if you needed it, a crisis center, an activity center back here for the kids, that'd be cool … Because if it was just the counseling building, I wouldn't go. Honestly, I wouldn't.*
> Participant 2: *Then they say, "I drove by and I seen your car there. What's going on?"*
> Participant 2: *Small town.*
>
> —Dumas

When asked what they wished they had in order to help them parent their children, rural parents said they wanted more support from their communities; aid for single parents, including money for utility bills and food; and affordable childcare.

> *Single-parenting support. That means in everything, like if you're having a troubled teen, any type of utilities, daycare, the mom café, the activity centers. My kids are already big, but when they were little, yeah, sometimes you couldn't go nowhere because you couldn't afford to pay double childcare for work and for this. Stuff like that. Crisis facility. Say you're going through some type of crisis; you could go over there and just talk. If we would have a group to say, "Oh, you know, I have this problem." Just some type of stuff like that.*
>
> —Dumas

Materials Testing

The State STAR brochure was disseminated to the parents for review. The findings reiterated what general population parents said about the brochure. One group liked the "crisis"-focused services, such as the crisis hotline and runaway shelter; the other group said that including the temporary shelter information may signal to children that it is acceptable to run away from home. In contrast, parents who had experience in unsafe homes welcomed this information.



> *I like the one that you can read on the other side where it says, "Free crisis hotline available 24/7." The emergency short-term shelter used for runaways. When I used to run away, I was down into a car and sleep in the car or something like that. Back then, they didn't have no places like this. That's what I liked on there.*
>
> —Carrizo Springs

Parents liked the positive words and phrases, such as "strengthening families," "confidential," and "skill building."

Parents did not like the term "at-risk" because they felt that it indicates an extreme case and would not necessarily apply to their child. Several parents noticed the "STAR" acronym on the cover of the brochure and asked what it stood for.

> Participant 1: *I'd have trouble trusting them if I don't know what STAR stands for. And it's real big, so you should explain it … And because you can have issues with your child but if you see "at-risk," you'd be like "I'm not there yet, at risk." We're over here, so I would be thinking maybe that's not for me.*
>
> Participant 2: *Sometimes it can be a loss of a family member that you need counseling, and that doesn't fit.*
>
> Participant 3: *"At-risk" seems like the kid's just bad as hell.*
>
> —Gainesville

Participants in all groups said that they did not like the disclaimer about program ineligibility for those with open CPS cases, as children in that situation probably need the most help. Some participants indicated that either they or someone they knew had been previously involved with CPS. They were sympathetic to those with open cases.

> *I have something I did not like, that it's not open to CPS investigations. I know people that have help, and that messes with people more than anything when they feel wrongly accused of things and they need to talk to people. I have friends that have been through that…An open case is not a guilty case."*
>
> —Gainesville

Promoting STAR Services

Parents said they trust information and recommendations that they receive from school staff, such as teachers, school counselors, and principals. They said STAR should send information home with their children to raise awareness of the program. Several parents suggested holding community meetings at the school, local fairs, or family events to raise parent awareness of these free services. Parents also said they would expect to find information about programs such as STAR at their children's doctor's offices and WIC clinics.

Local football coaches were identified as a potential referral resource. They suggested that STAR counselors work with these coaches to educate them on how to make referrals to STAR when a child is in need of counseling.

Rural parents said that STAR should advertise on Facebook to raise awareness of the program among parents.

Findings: Potential Referral Source Focus Groups

Background and Objectives

SUMA conducted eight focus groups with community members working for organizations who could potentially refer children and families to the STAR program. The goal of the focus groups was to better understand their perspective on community needs and resources. In addition, lines of inquiry focused on identifying unmet community needs, barriers to service, the ideal referral program and its traits, perceptions of the STAR program, and communication dissemination. All participants worked directly with children and were in a position that allowed them to suggest counseling or other similar services to families. SUMA conducted these focus groups in the same geographic regions as those of the STAR agency staff and potential parent focus groups.

Table 1 below illustrates how many participants attended each focus group.

Table 1: Participant Totals for Potential Referral Source Focus Groups (*N* = 66)

Location	Agency Serving This Location	Total
Amarillo	Texas Panhandle	9
Houston (Group 1)	DePelchin Children's Center	7
Houston (Group 2)	DePelchin Children's Center	9
Laredo	SCAN	9
Nacogdoches	DETCOG	11
New Braunfels	Connections	3
Plano	STARRY	8
Round Rock	STARRY	10

Findings

Serving Families in the Community

At the beginning of each focus group, the moderator led an introductory exercise to learn more about the participants and how they worked with families in their communities. They were asked to share some information about their organizations. The focus groups were filled with an array of professionals who worked directly with children and families. The types of organizations invited to participate in the groups were informed by staff from the Texas Department of Family and Protective Services' Prevention and Early Intervention Division and findings from the STAR agency staff focus groups.

Participants represented the following professions, among others:

- Teachers
- School counselors
- Ministers
- Pediatric nurses
- Nurse practitioners
- Community health clinic nurses
- Childcare providers
- Directors of nonprofit organizations

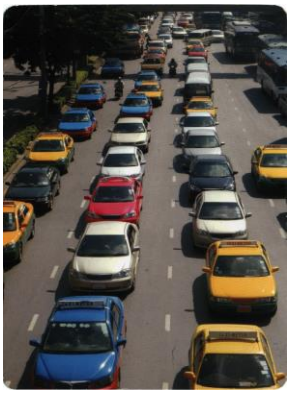
The moderator then laid out a deck of Visual Explorer™ cards depicting images of a wide variety of people, places, and situations. Participants were asked to browse through the cards and select the one image that best illustrated what it is like to refer the families they work with to services.

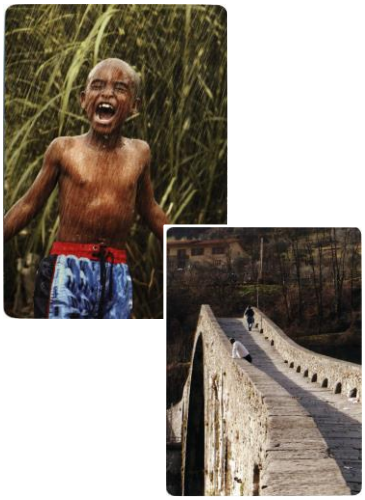
Participants chose photographs that illustrated their experiences and alluded to themes that would remain central throughout each focus group:

- Difficulty in finding appropriate services
- Barriers resulting from insurance and financial constraints
- Challenges of working with some parents
- The hope that their work provides comfort and relief for struggling families

… I feel that we refer out to the community so many kids, these would represent the children, and only one out of all of them get the necessary help. It's really upsetting. We refer out, […] *try to fit them in where they could help them, and they don't get the help they need.* [T]*heir appointments are like a month later, so it's really difficult, so that's why I chose this one.*

I picked "traffic jam" because most of the kids I see, you've already sent them to me. Then parents are like, "I need services." For example, for autism it takes six months to a year to get seen. For counseling, it takes months and months to get seen. Insurance doesn't want to cover for most of them, so it always feels like I'm putting you on the list, but then the next time I see you a month later, "Did they call you already?" "No, they haven't called me." "OK, I'll call them." Then a month later, "Oh, they called me, but they told me they can see me six months from now." It always feels like it's not moving anywhere. Most of the services that I need are like this. I tell them, "Go to your church, go to school, go to different places." Everywhere is inundated by people trying to get services, so everything moves very slowly.





It's this precious little boy standing in the rain, and his mouth is open. You can't really tell if he's screaming in anger and violence or if he's screaming in happiness, shouting out for joy, which for me, when April held it up, I went, "Oh, that's exactly what it's like." […] *At our school* […] *when we feel that it's time to approach a parent about anything as far as services, speech, academic delay, physical delay, you get this. You're not sure if it's going to be screaming in anger, shock, or joy that someone agrees with them.*

I picked a bridge because it's not easy to see, but sometimes it's nice to know that there's an end to the bridge and that you're not alone on your own little island. When you can connect them to other places, then they see that they're not the only ones out there with that situation.

When asked what it was like to serve families in their communities, participants echoed some of what STAR agency staff shared in their focus groups, including the need for services, the belief that the work they do is important and fulfilling, as well as some of the more challenging aspects of providing services. They spoke of families having basic unmet needs, such as food and money for prescription medications.

> *They need to provide basic resources, like if the parent is struggling to provide food for their family. That causes a lot of stress,* [which] *results in all these other problems, so just basic things for them.*

> *I know there are some other practices out there where you do wait months, and sometimes up to a year trying to get these services for these kids, because I've called places and there's like a six months to a year wait just to see somebody. I'm like, OK, nope. Hold on, next one. It's also our job to try to help these families as well, whether it be making that extra phone call or trying to book that extra appointment and things like that.*

Participants shared some of their challenges when working with families. They spoke of trying to work with parents to accept that their child may need additional help. Part of the challenge is parents who are in denial that anything is wrong with their child. These professionals are strategic in how they discuss their programs with parents, as well as how they approach parents. Some spoke of working to build relationships with parents so that if and when they need to refer a child for mental health services, the parents are more receptive.

> *Then I've got parents that are just—they're just in denial. It's like, "We'll be fine. There's nothing wrong. They'll be fine."*

> *I feel like having a relationship with the parents is very helpful, because then when it comes time to tell them,* […] *it's more like talking to a friend. I think they listen a lot better than if you just barely know them or have barely talked to them.*

Challenges to Care

Participants are aware of several challenges that parents and families face when working to link their children with needed services. STAR agency staff also articulated many of these challenges in their focus groups, such as stigma, transportation, working with families who have complicated lives, and disengaged parents.

Disengaged parents: Participants offered a more nuanced view as to why they, like STAR agency staff, struggle with disengaged parents. They reported that some parents are overwhelmed with work and childcare and lack the education to navigate a complicated system as well as advocate for their children. They do not have the flexibility to leave work to attend meetings and doctor's appointments. These parents have difficulty or are unable to find the appropriate services for their children because understanding which ones are needed, which ones are available, and where to find them is complicated and daunting. Focus group participants also spoke of how parents may give up on finding the appropriate services because they have tried unsuccessfully in the past.

> *There's times when the parents just give up. They're not going to do it anymore. They've gone to so many offices and agencies. They've knocked on so many doors that they give up.*
>
> *I also think that even when they do go out there, and they try to file for the services, and they get turned down so many times, that they give up.*

Stigma: Professionals in multiple groups pointed to stigma as a barrier to care. Stigma was also identified as a reality that influences a family's decision to place their child into care. The subject was first brought up when participants discussed challenges to care and revisited when they specifically discussed parenting classes. In general, participants indicated that there is a stigma associated with parenting classes and obtaining mental health care. One participant runs a program that has classes for young women. She calls them "empowerment" classes to reduce any negative connotations. Some use terms such as "life skills" and other phrases to normalize the care.

> *I was just going to say, the one thing that I would think a lot of parents wouldn't go to the parent classes, if they could, would be pride and embarrassment that somebody in the class is going to know them and think bad* [sic] *of them. That's what I would think here in this town.*
>
> [To break down the stigma] *I say, "You'd be surprised how common this is. The majority of kids or people on the earth have this issue," and I'll raise statistics and so on but make them feel safe.*

Transportation: For many low-income families who either do not have a car or the money for gas, transportation is a barrier. It is also an impediment for those who live in rural communities. If one does not have a car, there are limited options for alternative transportation. Some participants shared stories they hear from families about the complication of using Medicaid's Medical Transportation Program. They spoke of families having to wait hours for rides and not being able to bring all of their children, which results in difficulties with childcare.

> *Transportation for in* [sic] *rural communities …. We have a lot of land and a lot of rural communities that don't have access to many of the things that are afforded in these counties.*

Participants in rural locations recounted experiences with families who did not want other people knowing their business. This also included parents who were worried about people learning that their child is receiving services because they see where their car is parked.

> *Nobody wants to see your car outside you-know-who's office because that means your child has something wrong with him, and it's right there on the loop by the high school, and everybody will see you taking your child in that person's office…*

Culture: Another barrier to care participants identified is cultural norms. Professionals in a couple of locations shared a challenge that was also articulated by STAR agency staff, which is the need to care for cultures with which they are unfamiliar. Beyond Texas' significant Hispanic population, there are large immigrant and refugee populations from East Asia, Africa, and the Middle East. These professionals do not know the cultural norms and beliefs as they relate to mental health and are not proficient in how to approach families. Language is another barrier and is sometimes not mitigated by translation services.

> *A lot of dialects. Even though they may be from Africa or Somali, but there's a lot of cultural dialects that we're seeing in Amarillo, like Dinka. There's just lots of dialects of tribal language that are in each one of those cultures.*

In multiple focus groups, participants who serve areas with high Hispanic populations spoke about the cultural belief of not seeking outside help because it is better to solve problems within the family. This was also brought up by parents who have participated in STAR and were interviewed by SUMA researchers.

> *I think maybe it also has to do with our culture, Hispanics, that it's not that "Oh my god, let me see what kind of help you need."*

Moderator:	*What is the stigma?*
Participant 1:	*That they're not doing a good job. They're not parenting well, so people might think, "Oh they're going to the class because…"*
Participant 2:	*They're a failure as parents.*
Participant 3:	*Our families don't do that. There's a famous saying that—it's in Spanish, I wouldn't remember how to translate it. [Respondent speaks in Spanish.] "The dirty clothes you wash at home."*

Lack of services: The complexity in finding services is a challenge both for the professionals trying to refer patients to care and for families seeking mental health services. There is a lack of services in many locations, especially more rural areas. Participants spoke of extremely long waiting lists because there are so few services and programs that must support many people.

> *We try our very best to make it the medical home, and try to coordinate their care, and get them the services, the referrals, the counselors, the mental health. That's been a difficult thing for us because there's not a lot of mental health here* […] *and MHMR, I think, pretty swamped, and every time we try to do a referral, it's like a waiting list* […]

Lack of low-cost options: In addition to the dearth of available services, there is also a perceived lack of affordable mental healthcare. Participants in multiple focus groups stated that finding affordable services and programs is challenging for them when they attempt to refer a family to care. The search is also arduous for families. In addition, participants spoke of the challenge associated with findings programs that accept Medicaid or a family's particular insurance.

> *Even if you have insurance, well, this specialist won't take this insurance or this specialist won't take this insurance, so then you're left having to pay out of the pocket anyway, even though you're paying a crazy amount of money for the insurance that you have, but it's not any good. If you need a specialist, there's none around here that you can go to. You have to take a couple of days off and go far. That's also another thing, not just Medicaid. It's the insurance, too.*

Family and Community Issues

Participants listed an array of issues that children and families in their communities are facing; STAR agency staff also mentioned all of the same issues. Parenting concerns were mentioned in multiple groups. Some spoke of a lack of education when specifically referring to teenage moms. Others discussed a lack of parental engagement; lack of understanding of developmental milestones; stressed parents who are working multiple jobs; and single parents who are overwhelmed. Other concerns and issues include:

- Divorce
- Grief
- Self-harm (e.g., cutting)
- Behavior issues
- Bullying
- Depression
- Anger management
- Substance abuse
- Attention Deficit Hyperactivity Disorder (ADHD)
- Anxiety
- Suicidal ideation
- Truancy
- Alcohol and drug abuse
- School pressures

According to focus group participants, they see parents coping with their children's issues in a variety of ways. Some parents are engaged and determined to get their children the help they need. However, other parents are in denial and do not engage when issues and concerns are brought to their attention. Some participants recalled instances of parents overmedicating their children. Still others had previously tried to access services but either found themselves on a long waitlist or were overwhelmed by the enrollment process/barriers and gave up.

There was a sense in multiple groups that parents are overwhelmed, confused, and unsure of where to turn for help.

> *Other times, they just want to medicate the child. "Is there something that you can give? Can you give them something? I'm tired of the school calling. I'm tired of having to go to the school. I'm about to lose my job because I have to go," and it's just like, what can you give them? What can I do? A lot of times they really just—they give up. They really just want to push the child on somebody else to kind of ease their burden.*

When asked what supports parents need in order to be better equipped to address the issues they are dealing with, participants had few suggestions beyond additional counseling services and programs. However, the concept of a centralized database that clearly lists the services provided—so that parents could easily find resources—was mentioned in multiple groups.

> *We have found in the age of technology now that parents are finding if they can just go to one place like a clearinghouse, an information resource portal that lets them know if it's this you're needing for your child or this* […] *Here's where you can go versus there's so many amazing resources that we all recognize, but everything is in their own silos. For those who are seeking those, what and how and what might it look like? We have found in talking to our parents and guardians that that would be a great starting point.*

> *It would be nice to have a website, so you could type in, "I need this type of service," and it would say, "Where do you live?" "I'm located here."*

Referrals

Current Resources

The organizations represented in the focus groups approach referrals differently. Some do not generally refer families to outside organizations for care, and others work closely with trusted resources. Several participants voiced a sense of not knowing all of the available resources within their communities, either directly or indirectly.

> *Ideal to me would be that somebody with the state—someone would send us an updated list with what services are available, and it's something that they do once a year or twice a year, and we know where we can refer to. I'm lost. I don't know. I'm sure there's a lot of places we could refer out to, but I don't know where or what organizations are available to us. Like the church, because we don't know. As medical providers, we don't know what church offers what and where we can refer. We don't know any of that.*

> *My facility is limited on what we know* [about] *where to send kids.*

Some of the smaller grassroots organizations do not refer families to outside services as a regular practice. They did not appear to know of available community services. If they notice an issue with the child, they try to work it out within the family. Some of the programs spoke of not wanting to betray the child's trust by alerting the parents. Staff will consult with internal leadership first and try to work directly with the child.

> *We try to handle a lot of stuff in-house. We sometimes see parents not getting along and it's affecting children, or children having interviews, and we easily will say, "Can you all stay tomorrow after practice?" We have a group of staff that have been with us for a long time and dealt with a lot of different things. We'll just sit at a picnic table and hash it out. I assume a lot of times there are suggestions made, like maybe you should talk to somebody or take them to do this. I'm not sure that we give anything specific* […]
>
> *I don't believe we have a referral program, but maybe we'll have them come in and talk and maybe just kind of discuss what's going on, not like a licensed therapy, but in-house be able to talk.*

Participants who do refer out stated that they suggest a number of community organizations to parents, such as the local health authorities, which they refer to as "MHMR" (mental health and mental retardation); Federally Qualified Health Centers (FQHCs); grief programs; hospices; Big Brothers Big Sisters; Alcoholics Anonymous; YMCA; food pantries; and United Way.

> *It* [the FQHC] *is a full-fledged clinic, but it has therapists, counselors, psychiatrists. It has a little bit of everything. Nutritionists, education on nutrition. It has a little bit of everything, so it helps. It has not only children counseling, but parenting counseling and family counseling.*

As discussed previously in this report, a perceived lack of available or affordable resources was a theme throughout the focus groups. Participants spoke again of a lack of affordable mental healthcare when discussing where they currently refer families and children.

> *The single hardest service that I've found that I need urgently for my families is actually counseling. This child, bereavement, or they're having behavior problems, or they're having anger issues, or their parents are going through a divorce. I get that a lot. Parents are incarcerated, parents are deported, parents are living in Mexico. They haven't seen them in years. The kid is lashing out, and you don't have anywhere to send them—anyone to send them that they can afford.*

They generally refer families out for service when the need is beyond their capabilities or mission. For example, school counselors refer families to mental health services when the child is presenting with issues that cannot be treated in a few meetings or has complex psychosocial problems, including self-harm or suicidal ideation. Pediatric offices refer clients when the parent requests information or they notice anxiety or other mental health issues they cannot treat.

> *The anxiety, especially this time of year with all of the tests and the pressure. We don't prescribe those kind* [sic] *of medications at our office and we send—it's amazing the amount of kids that our parents are calling saying my nine-year-old is having such bad anxiety, they need Xanax. OK, well, we're not going to give you Xanax, and you might want to go a different route with a nine-year-old.*
>
> *It's a hard conversation to have. I'm not a licensed practice counselor. I'm just a school counselor and I can refer out, and a lot of them don't trust out, so that's where the struggle comes in. I can't do therapy. That's not my job.*

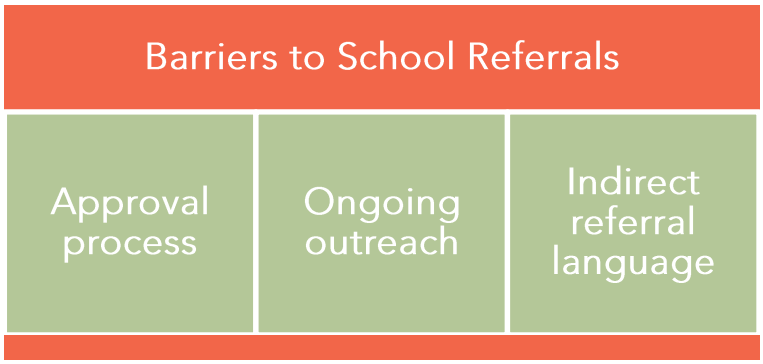
The sense shared in all focus groups is that very few, if any, referrals work in partnership. For the most part, these professionals refer families to organizations and they neither receive formal notification of how the family is doing nor how to coordinate care. Participants in multiple focus groups stated that they would like to have communication with the organization that is now treating the child/family. Instead, they follow up directly with the parent. Some participants in multiple groups believe that lack of agency communication is due to HIPAA laws. One participant stated that HIPAA allows sharing of certain information, which was more detailed than most are receiving, back to the referring agency.

Participant 1: *I actually get that from the parent, not the organization. I usually check in with the parent.*
Participant 2: *It would be kind of nice to get it from the organization, you know?*
Participant 3: *I guess that would probably fall under HIPAA in our situation.*
Participant 4: *Yeah.*

Generally, as a courtesy, even with the HIPAA law, HIPAA law provides that you can release information, protected information; if I refer the patient to you, you can send that information back. It's not a violation of the HIPAA law. A lot of people think that it's a violation but it's not.

A note about schools: SUMA included school professionals in all of the focus groups with potential referral sources because schools are such an important referral source for the STAR program. In fact, half of the STAR parents interviewed by SUMA said that they were referred to STAR by school staff, such as teachers or counselors. STAR agency staff stated that they invest a lot of time, energy, and resources into building and maintaining good relationships with local schools. Three key findings, which are illustrated in Figure 1, corroborate the challenges STAR agency staff shared about why some schools do not participate in the program.

Figure 1



There is a distinct district-level approval process for all organizations. School professionals shared that there is a process that must be adhered to before they can pass the organization name on to parents. In short, the organization must be approved by the school district before any teacher or counselor can share their name. These professionals spoke of a list containing district-approved resources they were allowed to share with parents. If a program is not on this list, neither the counselor nor the teacher is allowed to refer people to it.

> *Lots and lots of campuses, so things go to the main building, but they really look at that. If you look at the director of guidance and counseling, she really will look at it and she's good. She says, "I heard about this," and she sends it out to us or the PR department, whatever. [It] has to be approved and you get stamped and sent out. That's kind of the way we—I see it and I think well, somebody thought that this was legit.*

School participants stated that they must provide the parents with three viable and approved resources. However, they can and do emphasize the ones they prefer during these conversations.

> *I know what their needs are, so I go, "What I like about this one is it has family, and you need the family aspect, or you need the sliding scale, or you need the whatever." We can't say this one or that, but I can certainly point out the good things…*

Ongoing school-level outreach is needed. When discussing STAR specifically, some of the participants knew of their local agency but had "forgotten" about it until the focus group discussion. As STAR agency staff indicated, this lack of familiarity seemingly points to the need for continued outreach with counselors. Participants in these groups said there was no need for a referral source to meet with them if they have not yet been approved by the school district. However, once approved, school professionals stated that it is a good practice for sources to visit them and make presentations about STAR. Referral sources could attend a regularly scheduled district-wide counselor meeting, for example. They also suggested coming to parent nights as a means to educate parents about the program.

> *… They're already on one of our lists. I think it's just the awareness. We're not as aware of them as we are with [other counseling providers] because we work with a lot of those counselors and we're more in communication with them. Like I said, I've heard of them* [STAR] *briefly, but I've never had any dealings with them, so they're not in the forefront.*

Some teachers and counselors are trained to not directly suggest that children need counseling. The school professionals who mentioned this directive said that they were told this shortly after starting their job. The reason cited was the belief that the school district could then be held responsible for paying for the child's treatment.

> *This is my second year with the district. The very first thing they told me—the counselors—is to make sure that you do not refer them to any counselors. You can suggest but do not recommend, because then the parents will expect the district to pay, and not only that,* [but also] *liability. If a student is in crisis and wanting to commit suicide and they go out and commit suicide, parents can always come back and say, "Why didn't you refer my kid to the counselor?" or, "Why did you?"*

Ideal Program

Participants' ideal program looks a great deal like the existing STAR program. As a focus group exercise, participants were asked to describe an ideal program to service the mental health and psychosocial needs of children and families in their communities. This exercise was done before the moderator explained the STAR program in detail to the professionals, so they generated suggestions for a STAR-like program without being aware that such a program already exists. Most of the focus groups listed the following components (See Table 2) of an ideal program.

Table 2 : How the Ideal Program Looks

 Quick entry into service (one week or less)	 Provide life skills training to parents and children
 Sliding scale payment options	 Provide feedback to the person who referred the family
 Free services	 High quality of care
 Provide help with basic resources, such as food and clothing	 Provide transportation
 Flexible locations (in the home, school, or a central location)	 Childcare for other children
 Flexible hours to include weekends and evenings	 Provided in the schools

In addition to the items in the list above, participants also expressed the need for continued outreach and communication. They would like for the referral partner to conduct outreach and be a presence in their organization. These professionals are busy and want to know that there is a reliable referral source with which they can easily connect their families.

> […B]*asically the good, in my opinion, referral partner is somebody who is willing to say, "Let's work together. We'll do all the work you need," because most of the time I really don't have the time to do the additional work needed. I love helping and I love connecting, but I just have so much already. A good referral partner to me is somebody that's going to come in and just really use their expertise and tell the community what they're about.*

Several participants stated the need for good communication. As mentioned previously, participants ideally want to know the status of clients they have referred out. They want to know that when they trust another entity to care for the family, this entity is following through.

STAR and Dissemination

Most of the professionals had neither heard of STAR nor the local agency name. Participants in one group thought they had heard of the program, but further conversation revealed that they were speaking of the STAR Medicaid Managed Care Program. Several participants were surprised when the moderator described what this STAR program offered and informed them that it has been in their communities for a number of years.

> *They need to come out and promote because, obviously, they're not out in the community for all of us to see. Here's a whole bunch of different people here that's in different areas, and we're all like, "Oh, really, they do this?" Because they haven't got out and advertised.*

STAR was not top-of-mind for the few people that did remember hearing about the program and had worked with it in the past. Some said that they had forgotten about it. Others associated the program with another service they provide, such as foster care or drug and alcohol counseling.

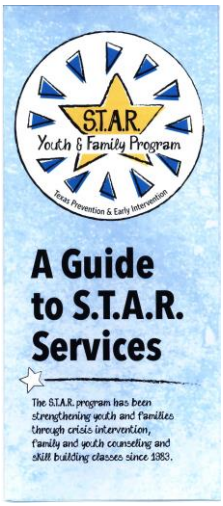
> *I forgot about* [local STAR agency]. *They did [work with] some of our children and they did really good.*

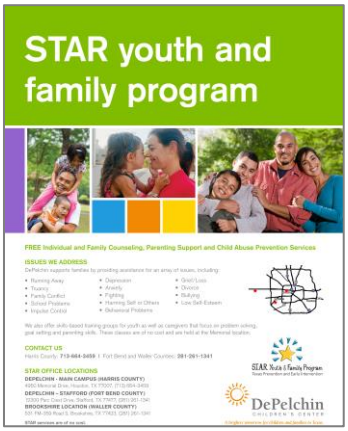
Notably, when participants did hear about STAR, they stated that they were open and willing to refer parents to the organization. They were generally pleased to learn about another resource in their community and especially pleased to learn that services were free. Some participants were surprised that they did not know about the program, and one person thought it was too good to be true.

> *I like what you say, what they're doing there, that they're going to help or guide the family through what is it that it applies to be a parent, how they can help the kids.*

Current STAR Materials

SUMA conducted a brief review of five STAR pamphlets currently disseminated by Texas DFPS and select agencies that offer the STAR program in their communities.





In general, the likes and dislikes from these participants mirrored those of the parents who are not being served by the program (but could be). Table 3 highlights what participants liked about the pamphlets tested as well as areas for improvement.

Table 3: Likes and Improvement Areas

Likes	Improvement Areas
Simple	Words (At-Risk)
Detailed, bullet-pointed list of services	Photographs: more realistic, less happy
Question-like format gets people to think	Photographs: more diversity needed

Participant suggested a few dissemination tools. First and foremost, participants suggested that STAR build a relationship through outreach and by becoming a presence at their organization.

In terms of communicating and spreading the word about STAR services, they suggested placing information on household bills (such as an electric bill) and launching a social media advertising campaign.

Conclusion and Recommendations

The findings suggest the following strategic recommendations.

Create a referral strategy with schools at the district and school level. The strategy should include language to help counselors inform parents that the program is free, with an easy enrollment process, and does not have a waiting list so counseling can be accessed quickly. Consider working with the Texas Education Agency (TEA) to create a strategy for statewide approval. Continue ongoing outreach with local schools in a strategic and organized manner.

Connect with local businesses to create parent-friendly worksites that allow parenting classes. Focus on employers with large numbers of minimum-wage employees. This concept alleviates the stigma associated with parenting classes and brings services to individuals who are unable to leave their work. Use the Texas Mother-Friendly Worksite Program as a model.

Consider adding a portion to the intake and assessment process to establish informational feedback to original referring sources. This addition should include education on what information is allowed by HIPAA to be released so that there is a feedback loop.

Findings: Rural Potential Referral Source Focus Groups

Background and Objectives

SUMA conducted three focus groups with potential referral sources in rural communities to better understand the unique challenges they face. The participant makeup for the groups included school staff, church staff, and members of community organizations. The lines of inquiry focused on identifying unmet community needs, barriers to service, the ideal referral program and its traits, perceptions of the STAR program, and communication dissemination.

The screening criteria for the rural referral sources mirrored that of the general population focus groups.

Table 1: Participant Totals for STAR Rural Referral Focus Groups (*N* = 28)

Location	Agency Serving This Location	Total
Carrizo Springs	SCAN	11
Gainesville	STARRY/CCD Counseling	11
Dumas	Texas Panhandle MHMR	6

The objectives of the research were to:

- Assess rural referral sources' perspectives on family counseling in their community.
- Learn about existing resources available to rural families.
- Explore how STAR services could become better known and utilized by rural families.
- Hear from referral sources why they may be challenged to refer families to STAR services.

Findings

Serving Families in the Community

At the beginning of each focus group, the moderator led an introductory exercise to learn more about the participants and how they worked with families in their communities. They were asked to share some information about their organizations. The focus groups were filled with an array of professionals who worked directly with children and families. The types of organizations invited to participate in the groups were informed by staff from the Texas Department of Family and Protective Services' Prevention and Early Intervention Division and findings from the STAR agency staff focus groups.

Participants represented the various professions, which are illustrated in Table 2.

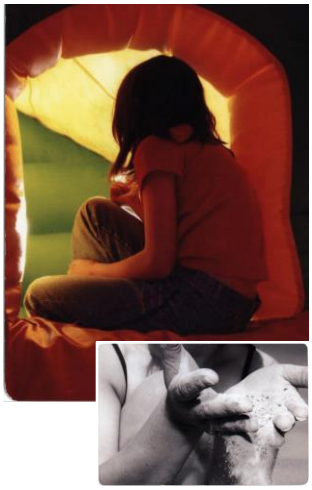
Table 2: Participant Makeup		
Teacher	School counselor (K-12)	Minister
Local nonprofit staff	Home health nurse	Hospital nurse
Truancy case manager	Juvenile probation officer	Crisis pregnancy center director

The moderator then laid out a deck of Visual Explorer™ cards depicting images of a wide variety of people, places, and situations. Participants were asked to browse through the cards and select the one image that best illustrated what it is like to refer the families they work with to services.

Participants chose photographs that illustrated their experiences and alluded to themes that would remain central throughout each focus group, such as:

- Working hard to protect high-risk, neglected children
- Difficulty in finding appropriate services
- Barriers resulting from insurance and financial constraints
- Challenges of working with some parents
- The hope that their work provides comfort and relief for struggling families

In contrast to the general-population referral focus groups, the rural referral sources emphasized that the children they serve are often neglected by their families; lack basics such as food, clothing, and shelter; and have turbulent home lives.



It's a student in what looks like a bouncy house sitting there by herself. There's light in front of her, but it's kind of dark behind her. The reason I chose this is because it kind of illustrates a lot of the students I deal with. Not a very strong support system at home. They're taking care of themselves. She doesn't look to be very clean, well kept. That's kind of what we deal with on a daily basis.

—Gainesville

I specifically chose this photo because the individual carrying sand in her hands is similar to the resources in the rural communities, and as the sand is pouring out of her hands, it's as if sometimes those limited resources are not enough.

—Carrizo Springs

I picked the [guy] *jumping off because we don't have a lot of things for family counseling and for kids that are in need, like psychiatric and stuff. Our district gives us a list of people to refer, and I give that list to the parents. A lot of them are in Amarillo, and they're like, "How much does it cost?" and I'm like, "I have no idea." Insurance is kind of a big thing, because a lot of them don't have insurance. As a school counselor, they think I can fix it. I'm free. "You can fix it."*

—Dumas

I chose this photo, which is [a] *broken-down home, because the kids that I work with—I notice that when their basic needs aren't getting met at home, they can't succeed, whether it's out in the community or at school …. They don't have light at home, electricity, limited food, basic needs like that.*

—Carrizo Springs

Referral source engagement: Compared to the general population groups, rural referral sources described a higher level of engagement with the families they serve. They routinely go above and beyond their professional purview to help families in need, often because there is no one else these families can turn to for help. Because of the general lack of resources as well as the complexity of the problems families face, these referral sources feel obligated to do what they can to help families in crisis, even if it is outside their job responsibilities.

> *My biggest fear is that the child—these children, because it's a big family, when they don't show up for school, I always think the worst. I find myself knocking at the door in the mornings. "Where are they?" "Well, we overslept." Not because that's part of my job, because a truancy officer is the one that's supposed to go out and look for them, but because I have such a fear with this family.*
>
> —Carrizo Springs

Participant 1: *I used to have to go get kids out of the cars because they wouldn't come in for their parent. They said, "Would you come out here and bring my child in?" I'm like, "Are you kidding? OK. Whatever. I'll do anything to get your child in school. But when I get them you better leave. Don't stand and watch. You make it worse.*

Participant 2: *They will call you from home and say, "Will you please come get my child out of bed?" I had a parent call me and ask me that.*

—Gainesville

Challenges to Care

Lack of services: Participants said they felt challenged to connect families to resources since they are limited in their communities and difficult to access, particularly for low-income families. While participants from the general population also said that they lack adequate resources to which they can refer their families, their rural counterparts said they have virtually nowhere to send families in need. The rural referral sources also noted that the limited number of organizations that can serve their area are overburdened by high demand.

> *I feel like you have people that are just stretched. I just feel like I don't want to be here but I need to be here. "Oh, wait, I better be over here." It's limited. There's only so much one can do, that we just don't have enough support, and we're all just trundling along, but it's just sometimes not enough. I feel like we need more.*
>
> —Gainesville

We've got a lot of kids that the parents are doing everything that they can just to keep afloat, and a lot of the kids are self-sustained in the afternoon. Don't get a lot of homework support—little, if any. We've got some good, strong, hardworking Hispanic families. We probably have quite a few illegal families. Very supportive amongst one another, but it's hard to help them when we don't have the resources to help them.

—Gainesville

Parent engagement: Rural referral sources noted how difficult it can be to get families to follow through and actually access the services to which they have been referred. Participants pointed to parents being stretched thin with work, parenting, and their own lives.

Six years of mental health working not only with children and with parents, and then our crisis— a lot of times when we get our people …. They feel like there's no light and no help. They're lost. First we have to get them to trust us and then we have to try and get other people to help us, so that if we're not there, somebody else is there, not—they just don't go right back to nothing where they started. We're trying to build them up and not drop them, but at the beginning, we all feel like this. Not only them, but us too. Sometimes we feel like there's nothing else there for us.

—Carrizo Springs

Overextended CPS: Many referral sources in two communities shared stories about how overburdened CPS is in their community, including high turnover of caseworkers and a lack of resources to care for all the families who need assistance. In the third community, participants mentioned referring children who are hungry or have neglectful parents to CPS. However, the moderator did not probe about the agency's capacity specifically in that group. Some referral sources are required to call CPS when certain behaviors are observed. They perceive that CPS lets their families fall through the cracks because there are not enough caseworkers to check on every family. These participants felt disappointed that they cannot do more for their families in need. While CPS was consistently said to be overwhelmed by the rural referral sources, the general population participants did not raise this as an issue in their communities.

I think that has to do with caseload. In Denton we have a lot of possible referrals, but because there are so many referrals and the staff is limited too—they will probably just take the most severe cases. I know I have filed a number of CPS reports and nothing happens, and then the bad part about that is once you turn it in and the CPS caseworker takes over, you don't find out any follow-up information. You don't get it, so all you know is that I filed this report and CPS took the case, and that's it. This kid is coming back to school. There's some symptoms that are bad in his home that's causing him to still struggle in school. All of those kinds of things impact learning.

—Gainesville

The first thing you've heard about that is that by law, we have to use CPS. We have to call this particular agency for whatever reason we need them regarding a child, and they're the ones not holding up to their end of the bargain. I can't point out individually. There are a lot of good CPS caseworkers but as an agency, I think they're lacking as far as keeping things going, as far as making sure that the follow-ups are being done, and the right decisions are being made by their caseworkers. You see a lot of caseworkers that will close a case or end a case when nothing is really done. The kid, or whoever it is—I deal with a lot of adults too—[is] *still in the same position that they were* [in] *when I made the phone call, but according to the CPS or APS caseworker, "Oh, no, this is fine."*

—Carrizo Springs

Rural Community Involvement

Rural referral sources emphasized how their communities come together to help local families. In one community, participants use Facebook to coordinate fundraisers and donations for families in need. In the face of limited resources, these tight-knit communities do what they can to fill in the gaps.

> *You'd be amazed in a small town or small area like this. It just takes one person to get the ball rolling, and then you have everybody—I don't want to say everybody, but you know a lot of people jumping on board. "I know this person. Maybe I can make this phone call." It's really crazy and it's amazing to see it happen. I've seen a woman do it with, recently, a case where we had one of our high school students and athletes. Their home burned down. She got the ball rolling, and then all of a sudden, you have the American Red Cross, you have the Baptist church, you have hotels giving discounts, people donating clothing* [and] *money—and it's just within a matter of a few hours.*
>
> —Dumas

As was discussed in the rural potential parent focus groups, churches offer support in rural communities. In one community, local churches buy school uniforms for children in need, assist those who need help paying utility bills, and send a van to pick up children who need dinner during the week.

> *At my school, we are predominantly Hispanic, and our Hispanic families are very supportive of one another. They're active in their local church congregations. They've got resources amongst that culture. I see that as very much a positive. I think in Sherman, we've got a lot of churches and organizations that have figured out that we need help. We have a weekend snack program by a volunteer organization that provides snacks for kids on the weekends. We have organizations that are willing to help during the holidays.*
>
> —Gainesville

Family and Community Issues

Illicit drug use and addiction: Many referral sources said that illicit drug use among parents is a major problem in their community. While drug use is also seen in the children, parents' use was a bigger concern among participants, as it often negatively impacts their ability to feed, clothe, and care for their children. In one community, participants spoke about children being used to run drugs such as meth since they would be less conspicuous than an adult. While the general-population referral sources did mention drug use and addiction among parents as an issue in their communities, the extent to which it has become endemic in rural communities was emphasized as a challenge by their rural counterparts.

> Participant 1: *I'm seeing that we have quite a few children in our schools—that the norm is to have addicted parent*[s] *…. When you have children that will come in and talk about that they were running through the woods to deliver a package. They are on the front lines of—*
>
> Participant 2: *Or they bring a syringe to school and say, "Look what I found in our kitchen."*
>
> Participant 1: *There's a huge meth problem in North Texas and southern Oklahoma. Because many of our cities are rural, the final profit transaction may be taking place in school hallways, but where it's being made might be in the woods* […] *the kid will look less suspicious if they're going in the alley over—that was quite eye-opening.*
>
> —Gainesville

We've seen an increase in Child Protective [Services] *cases coming through our doors, or the cases, but also a lot of drug use. We're seeing these parents of these children that are being reported that they're at a younger age and we're seeing a lot of grandparents having to raise their grandkids …. The parents of these—they're teen parents. Drug use is a major factor.*

—Carrizo Springs

Food Insecurity: Food insecurity was a frequently cited issue in rural communities —much more so than in the general population referral focus groups. Participants often encounter hungry children, and some mentioned keeping snacks in their purses to give out to children. In one community, participants theorized that truancy is not a big issue for them since children get a meal at school, and with more than 75% of their children on free or reduced school lunches, it may be the only reliable source of food for that child. A few referral sources mentioned children going hungry at home because of parents selling their SNAP food benefits for drugs.

I think for a lot of our high school kids, school is a safe place for them to come. They're going to get food, and they're going to have a warm, dry place to be …. Seventy-eight percent of the students, I think, are on free or reduced lunches in our district.

—Dumas

You see it in the mornings with the kids when they're hungry, especially the ones that come in late. Those are the ones that there's no food at home, so they come in late and they're coming in at nine o'clock. Breakfast is over, so as a teacher, you know this child is going to be hungry until eleven o'clock. He's probably even hungry all night, and he probably didn't get dinner last night, and he didn't get breakfast this morning, so he's not going to get lunch. I mean, barely. When he gets to lunch, you don't know if he's going to go home and get dinner, and then mom takes forever to get to school. There goes another meal, no breakfast. It's constant—and you identify which child is in need, and then you start looking at—you go into teacher mode and you bring in that box of Cheerios or those little extra bag[s] *of chips. Don't throw it away.*

—Carrizo Springs

Untreated mental health issues: Mental health issues, especially children diagnosed with ADHD, are frequently seen by referral sources. Depression, grief, and anxiety are also prominent in their communities with both parents and children. The lack of resources in their rural communities was cited by participants as one reason why parents and children do not receive treatment for these issues.

Participant 1: *What we're saying is mental health is in a total crisis. I can say that after 25 years because we cannot help enough people, and it's heartbreaking. It's just heart-wrenching and heartbreaking. That's all I can say. To deal with it daily, when you try to be up and all that, but it just brings you down.*

Participant 2: *It brings the kids down. That's my thing. When the child cannot help the issues that they have, and you see how are they are trying, how it affects them* [and] *their self-esteem. They give up. They don't want to try. Why try?*

—Gainesville

I hear parents come in and tell me concerns they have with their children, and it's actually concerns they have about themselves. I'm like, "You seem like you're exhibiting anxiety, but you're telling me your child has anxiety," and they're like, "Yeah, I didn't know what it was." They're thinking something is wrong, and they're not understanding how to deal with it, so they come in and tell me their kid is having it, and it's them.

—Dumas

Lack of communication skills: Many referral sources said families need to improve their communication skills. Participants said that disengaged parents especially need to learn how to better talk with their children and check in with them. Some referral sources discussed the need to teach new ways of parenting to those who grew up in households that dealt with issues through yelling and physical punishments. A few participants were aware of some parenting classes in their communities but said that they were not well attended or advertised.

Community-specific Issues

Rural communities had nuanced differences from the general population referral sources as well as specific issues that were mentioned in only one community. These unique issues are detailed by city.

Dumas

Human trafficking: Participants said human trafficking is an issue among their refugee and immigrant populations. These referral sources reported that families were selling their daughters or arranging marriages for them to gain money or status.

Participant 1:	I think there may be some sex trafficking within the cultures. Mom selling daughter out to make money.
Participant 2:	Dad selling daughter so that someone can become legal, and then upset because daughter is married and has a baby.
Participant 3:	At 15.
Participant 4:	Since we're talking, our daughter is adopted. She's three years old, and her birth mother was sold and didn't know—we still don't know who the father is. Her mother sold her, from the time she was around nine until—you know—and sold her when she was an adult to a guy in Kentucky. It was just—and it was normal, like…

Teen pregnancy: Teen pregnancy was said to be a pervasive issue, with referral sources sharing that it is not uncommon for young women to have multiple children by the time they are 18. Some participants said that pregnant teens face many challenges when dealing with disapproving families.

> *I see a lot of that with teen pregnancy. If she's pregnant and the parents are pissed and they get kicked out, then she's staying at this house or that house or that house. To get a hold of her, you have to call her friends because she doesn't have a phone anymore, or anything else.*

Factory work: The local industry is centered on large factories and oil derricks. Participants noted that since many parents work shifts at these employers, they are unable to access services during normal business hours. This also leaves children unsupervised before or after school hours.

Carrizo Springs

Oil industry: A recent "oil boom" and subsequent "bust" has left many families struggling to find work. In the "boom" years, new homes and hotels were erected, cost of living rose, and oil industry jobs were lucrative and abundant. According to participants, once the price of oil bottomed out, families lost their homes and vehicles, and the resulting financial strain broke up many families.

Gainesville

Drug use: As previously mentioned in this report, referral sources stated that drug use is prevalent in their rural communities. In contrast to the other two communities, Gainesville participant's shared more extreme anecdotes of children being used to transport drugs and being in proximity to adults using drugs. Participants said that the primary drug that is abused in Gainesville is meth, followed by heroin.

Barriers

Transportation: With limited local resources, parents are often left with no other option but to drive at least an hour to a larger nearby city to see providers. Participants noted that not every family has access to a car; childcare for their other children is expensive; and for many, it is not possible to take the day off from work to travel several hours for care.

> *How to get there, from point A to point B. Panhandle Community Services has a bus that runs, and you have to make arrangements 24 hours before you take it …. If you have an emergency and you have to be in Amarillo for a doctor's appointment but you couldn't make the call because you were at work or whatever, they can't get from point A to point B. Not having any kind of transportation for some people, I see a lot of.* [They do not have cars] *or don't know how to drive, period.*
>
> —Dumas

Grandparents as primary caregivers: Many referral sources said that they see children being raised by family members other than their parents, usually grandparents or great-grandparents. This can present problems when the grandparent has health or mobility issues and cannot bring the child to services. Some participants also said that grandparents tend to want to spoil their grandchildren, especially considering the trauma many of them have endured, and are not the firm disciplinarians that some children need.

> *I have an 80-year-old raising two children that are in elementary, second and third grade …. CPS came and dumped them on her doorstep and said, "Your daughter no longer has custody. She lost custody." She'll call me or she'll say, "I can't get him out of bed. I don't know what to do," but these are children who are suffering from depression, because of the loss of the mother, so it's—but the parents, a lot of them are not addressing the problems."*
>
> —Carrizo Springs

Lack of low-cost options: Long waiting lists and income requirements are barriers to families accessing care in their communities. Participants said that families in crisis cannot afford to wait for care. Some families make just enough money to be ineligible for some discounted services but cannot afford the full out-of-pocket cost.

> *We have some parents that want to, but like I said, they make the effort, but then they hit walls when they get to some of our agencies here because of income. They barely make it in that level where they don't qualify for most of what we have. Another one is there's a waiting list for a lot of people to be seen. Some parents do make the effort, and especially when they have a crisis, then they come and they want the help, but then they hit those walls, and that's what makes them give up.*
>
> —Carrizo Springs

Referrals

Available resources: Referral sources reported that there are counseling resources available, but many have long waits. (One clinic had a 30-45 day waitlist). Typically there are a couple of sites in the community that can offer psychiatric services to families, such as diagnosing children for ADHD or depression so that they can be prescribed medications. For more extreme cases, families must travel over an hour to a neighboring large city to access services at hospitals or outpatient facilities. While there are programs that offer counseling in their communities, those resources and staff are strained by the high demand. A few rural referral sources had heard of their local STAR agency and listed it as a resource.

> *We've got an appointment, but like she was saying, once the appointment is made and they have their intake, it may be several weeks before they see a counselor. Then, if testing is needed, it may be a two- to three- to four-month wait. After that's done, then you've got a wait time of getting the report back. If they need medication in the Sherman/Denison area, few of our doctors in town accept Medicaid any longer, so then you've got—right now one of the closest doctors is in McKinney.*
>
> —Gainesville

> *Basically, the services are available, but the people that are qualified* [and] *provide those services are stretched too far thin. There's only a handful from what it sounds like. It sounds like there's a handful of counselors for 500, 600 kids.*
>
> —Carrizo Springs

Telemedicine: One community has counseling at multiple sites via telemedicine, which was initially met with skepticism by families and plagued by technical difficulties. Although some of those issues have been fixed, the referral sources insisted that their community would be better served by in-person counseling, especially in situations where the issues are complex and the counselor cannot take the temperature of the room over video chat.

> *I'm hoping that this goes back to whomever you're going to give this information, that in the rural area, or in our rural area, we need psychiatrists face-to-face to be able to better serve the needs of our community. I know that in big communities in San Antonio areas, you go to them and they're there face-to-face, so I think that's another barrier that we have here in our area in the mental health aspect of it.*
>
> —Carrizo Springs

Rapport with families: Referral sources said that building rapport is very important when working with families. Similarly, they said that rapport and communication from a referral partner is important for them when building their local network.

> *I like the rapport that we have.* [We] *have a real good rapport. If you can build a rapport with someone in the agency, we're all in the same boat. We're all trying to help the same kids, but I like to have a rapport with someone.*
>
> —Carrizo Springs

Finding resources: Participants did not report having a formalized system for learning about potential referral programs or new services in their area. Instead they rely on word of mouth and connecting with friends and neighbors to learn about programs to which they could potentially refer

families. Often there are well-connected people that serve as "hubs" in the community that participants could go to in order to find stakeholders and services. Participants wish for increased collaboration and connection among community organizations.

Challenges to Making Referrals

School protocol: One challenge noted by several school staff referral sources is that they are not allowed to recommend one service over another. While participants understand why in theory the school has this policy, they reported that in practice it means parents are handed an unranked list of resources, which can be intimidating. Parents are also expected to then make all the calls and appointments necessary to receive services without understanding which resource would best fit their needs. In many cases, participants think the parents either give up on finding services for their child or do not access the right service for them since school staff cannot make recommendations like, "I think your child needs to see a psychiatrist for an ADHD diagnosis."

> *I actually have a typed-up sheet that has all the resources in the area. A lot of them are no longer existent in there, but I tell them, "Because I can't specifically refer, this is who I suggest you go to." I can kind of make my little statements about referring, but I give them that sheet and I tell them to call their insurance to see who they work with within that.*
>
> —Gainesville

Culture: Referral sources brought up the difficulty in navigating different cultures, mores, and beliefs in order to connect families with services. There are large immigrant and refugee populations in one rural community, including those from South Asian and African countries who speak dozens of different languages and whose lives back home differ wildly from rural Texas life. Especially when it comes to accessing counseling, many cultures—including Hispanic, Caribbean, and Sudanese—are resistant to the idea of talking to a stranger about their intimate family issues, which makes it challenging for participants to make referrals.

> *That's part of our Hispanic culture that—and I'll speak for myself. Part of growing up, our parents would instruct us that, "You don't say anything, you mind your manners, you do what is needed, and don't be putting any of your stuff in there." In all essence, they're telling you, "Don't talk, don't communicate, don't say," and that's part of our culture.*
>
> —Carrizo Springs

Parental fatigue with systems: Several referral sources spoke about how navigating the various agencies and programs to access care can take its toll on parents, and that many drop out along the way because they are overwhelmed by the process. Eligibility requirements, extensive paperwork, and intimidating questions from doctors or staff can cause parents to give up seeking services.

> *Some of the challenges is the tedious paperwork that goes with it that is sometimes very repetitious, and it can be a deterrent for the individual itself that is needing the counseling.*
>
> —Carrizo Springs

Confidentiality: Several referral sources brought up the importance of confidentiality in their small rural communities, especially with perceived stigma around receiving counseling. Participants identified not wanting others to know that they are receiving counseling as a barrier for their families. In small towns, even having a car parked outside of a certain building can be a public signal

of what people are doing privately, leading some parents to take great pains to access services away from prying eyes. This was a much more pronounced concern in rural focus groups than in the general population groups.

> *I think small towns—everybody knows everybody else's business, so I think that's part of the stigma. They're afraid of what the neighbors are going to say, what their pastor is going to say. I think a lot of it comes down to not only the cultural stigma, but also just the small-town stigma.*
>
> —Gainesville

> *We have what was known as the "back door people." Those were the people that came in after five o'clock through the back door with their child or themselves because they did not want anyone to see. It's a big deal to see* [a counselor].
>
> —Dumas

★ Notable Practice

One participant outlined a successful parenting skills program in his community that avoided advertising itself using labels that may turn off certain families. The program also provided dinner for attendees.

> *Again, depending on the parenting classes that you're having* [and] *the particular topics as well—so it could be that maybe if it's going to be social services or good parenting, they might want to attend instead of a mental health, ADHD type of a topic, because then the stigma comes in. I used to work part time with Family Service Association. When you feed families, they'll also come, because it's also another warm meal that they might not have at home, so that also brings in a lot of people in our area. We call it Families and Schools Together. That was an awesome program.*
>
> —Carrizo Springs

Ideal Program

When asked what would be the ideal program to serve families in their rural communities, referral sources said the following.

- Face-to-face psychiatrists and counselors
- Competitive compensation for case managers (to reduce turnover)
- Minimized paperwork
- Lighter caseloads
- Free or sliding-scale services for families
- Well-maintained buildings
- Transportation
- An underground parking garage so that a family's vehicle was not readily recognizable to passersby
- Home counseling
- A multipurpose meeting space to prevent neighbors from automatically recognizing that a family is there for counseling
- Appointments outside of normal work hours

STAR and Dissemination

As with the general-population referral sources, most rural referral sources had not heard of STAR or were not aware that the local STAR agency offered free family counseling services. When told that STAR operates in every Texas county, several participants were skeptical that their rural county was covered. They asked for specifics about how many counselors were actually located in their community with the expectation that they only operate out of larger cities. It is very important to rural referral sources to know exactly what STAR resources are available to families in their town and what resources will require transportation and travel time.

> Participant 1*: I didn't know about the STAR program, and I worked for the Texas Department of Health and Human Services. I've never heard of it.*
> Participant 2*: I do because someone mentioned it once.*
> Participant 3*: Do you know how many times I could have given them information* [about STAR] *because I see people every day?*
>
> —Dumas

There was confusion around the name "STAR" and the various agency names. Several participants were puzzled when the moderator explained what the program is and how it is administered by various agencies around the state, asking clarifying questions as they attempted to understand who in their community offered this free counseling.

Some participants had heard of STAR—and a few had referred families to the program—but overall did not feel that the families benefitted from the services. In their rural communities, resources are spread too thin, they said.

> *I used* [STAR] *last year a few times, but I didn't use it again. I think the young man that was doing it—I think it was up and coming when he first contacted me, so I referred two or three families to him. Then the families called me and said that they had not heard back from him and that they had reached out to him, so they felt there was not follow-through on it. I emailed him and told him this family has contacted me, I faxed this referral to you, what is the status of this? It was him, and I think he had several counties. It wasn't just Grayson County. Again, one counselor with how many all of us are sending him. I stopped referring …. I don't think it was realistic. From when I talked to him, the poor guy sounded just overwhelmed. I don't think he had just Grayson County. He tried to explain to me. He was very apologetic. He was so sorry, but it was him and he had Grayson, and I think he said Fannin County. I know that he was swamped. Again, it goes back to, I think, the caseload that he has was part of why he couldn't follow through on it.*
>
> —Gainesville

One school counselor said she had sent 100 referrals to STAR just in the first five days of this school year. Since she had only just sent the referrals, she could not gauge the overall reaction, but a few parents had already called her to ask why they were contacted by STAR counselors, insistent that they did not need their services.

> *I've already had two phone calls from parents going, "What is this STAR? Who are these people? Why do you want them?" One of the parents—I said, "You said you and your daughter got into a fistfight, and the police were involved," because she's raising the grandkid. Daughter shows up out of the blue and wants to take the kid, and she says, "You're not taking the kid." There was a fistfight. The police showed up. She's telling me all about this, and I'm like, OK, this is a family issue, so this needs to go to STAR. She's calling me going, "Why are you sending me to STAR? I don't want a counselor."*
>
> —Dumas

Current STAR Materials

When reviewing the state STAR brochure, participants pointed out that parents do not like to be told that their child is "at-risk." For that reason, they did not like the STAR acronym.

When reviewing the local STAR agency's brochure, participants were disappointed that no local office was listed for their town and they assumed that like many resources, STAR counseling would only be available to those who could travel to a large neighboring city. They said they would want to see a local office listed, the number of counselors available locally, and the counselors' qualifications.

Dissemination

Referral sources said parents in their communities use Facebook and that this would be a great channel through which to advertise STAR services. In one community, participants said they liked the questions listed in the state STAR brochure, such as "Can't talk with your youth anymore?" and thought they would work well to grab parents' attention in Facebook ads.

Findings: Healthcare Provider Focus Groups

Background and Objectives

SUMA conducted three focus groups with healthcare providers[1] who could potentially refer youth and their families to the STAR program in July and August 2017. While most focus group participants were physicians, the participant makeup also included other healthcare professionals (e.g., a nurse practitioner and medical assistant). All participants served a significant portion of low-income patients, worked directly with children, and were in a position to suggest counseling or other similar services to families.

Table 1: Participant Totals for
STAR Healthcare Provider Focus Groups (*N* = 22)

Location	Agency Serving This Location	Total
Houston	DePelchin Children's Center	6
San Antonio	Baptist Children and Family Services (BCFS)	8
Amarillo	Texas Panhandle MHMR	8

The objectives of the research were to:

- Explore healthcare providers' perspectives on the mental healthcare and counseling needs of their patient population.
- Learn about existing community resources for children who need counseling or mental healthcare.
- Identify barriers to counseling and mental healthcare services from the provider perspective.
- Determine if providers are a viable referral source for the STAR program and if so, the communication channels, strategies, and materials needed to engage them.
- Explore unique counseling and mental healthcare needs of rural communities.

[1] For the sake of readability, research participants will be referred to as "providers" or "participants."

Findings

Perspectives on Mental Healthcare and Counseling Needs

Healthcare providers' comments and concerns about family dynamics and societal issues that impact the mental health needs of the children they care for mirrored those of referral partners and parents. Providers said children are negatively impacted by divorce, abandonment, illicit drug use among parents and youth, bullying, and inappropriate use of technology. They also reported an increase in the number of children with depression, anxiety, and ADHD. These findings were conclusive across all groups.

Divorce: Participants in every group expressed concern about the negative impact of divorce, and the resulting single-parent household, on the overall health of children. Many said it causes stress for the child, and from a medical standpoint, can also result in poorer care simply because communication between parents is compromised.

> *Mom comes in saying that something happened when the patient was with dad … so a lot of the medical treatments and following up with them and doing the right thing—it sort of breaks down with that miscommunication with the family.*
>
> —Houston

Illicit Drug Use: In every group, providers recounted the negative impact of widespread parental drug use on youth and families. Doctors in Amarillo said there has been such a surge in methamphetamine use that newborn babies are sent home with their drug-addicted mothers if they live with relatives who do not use drugs. They blamed this on increased drug use and the corresponding lack of foster families, which has overburdened the CPS system. Other drugs described as prevalent by providers include heroin and other opioids, and prescription drugs.

> Female: *Even in the last year, the meth use in pregnancy seems to have skyrocketed to the point that* [for] *some of those babies, the mom has tested positive in pregnancy. Sometimes Mom is taking her baby home with her from the hospital, where before those would all have been removed from the mom until she proves that she's clean.*
>
> Moderator: *Because there's so many?*
>
> Female: *Yes, because there's so many. There's no one else to take them. The system is overloaded, so they are making these safety plans to go back into the situation where this occurred during pregnancy in the first place.*
>
> —Amarillo

Illicit drug use among youth is also a problem, according to participants. Providers in two groups reported the problem of youth going to parties and taking random prescription medications, which are stolen from parents or another source.

> *The kids will have big cocktail-and-pill parties where they take pills from their parents, dump them in a bowl and everyone just takes them. Just one blood pressure med …. I used to see that a lot* [in the ER].
>
> —Amarillo

Grandparents Raising Children: Providers in every group said many children are being raised by grandparents and great-grandparents due to parental abandonment. Grandparents are challenged to care for the children because of their own declining health, they added.

> *Often the grandparents are having a health issue themselves. We see a lot of great-grandparents, too. We have quite a few families. It's very hard sometimes for them to get the kids to the office to get checked out.*
>
> —Amarillo

Challenges Created by Technology: Similar to the potential parent groups, participants in every provider group discussed the impact of technology on families and children. Some expressed concern over cyberbullying, children sending sexually explicit pictures or text messages (known as "sexting") at an early age, and the pressure faced by children to live up to the images and lifestyles they see on social media. Others said there is a digital divide in which parents do not understand how their children use technology and thus cannot monitor their usage.

> *Parents in low socioeconomic class—they don't have the education or knowledge in terms of what their kids are actually living right now. They're living in a world of technology and Instagram …* [Parents are] *a step behind in terms of knowing what their kids are actually exposed to and doing, and it limits them to actually be able to take better care of them.*
>
> —Houston

Lack of Parenting Skills: Some providers said that many parents simply lack parenting skills or the knowledge to address common medical issues.

> *It really is amazing how some parents literally don't know what to do when their child is sick. New parents that come in—the child's got fever.* [I ask,] *"Did you give him anything for the fever?" "No, what was I suppose to give him?" It's one of the few animals that doesn't know how to take care of their offspring.*
>
> —Houston

Participants in two of the groups expressed concerns about obesity and the unhealthy lifestyles that lead to it. Some expressed frustration because many parents themselves are obese and not incorporating the necessary changes into their family habits to address their resulting health problems. While not a mental healthcare concern per se, providers said that obesity does impact a child's overall health, which includes mental health.

> *I wish there was more access to behavioral therapy for the parents and the family. It's a challenge to be talking to the kid about obesity and all that when the parent is a 300 pounder.*
>
> —San Antonio

Providers in two groups also said many patients have large families (i.e., families with many children living in the same household). They said these situations negatively impact the care and health of the children, because parents do not have the time and money to provide proper care and attention to every child in the family.

Physicians' Observations on Specific Mental Health Conditions

Several providers in the groups had been practicing for a great number of years, and many of them commented on the large number of children who suffer from depression and anxiety. In response to the question of what has changed in medicine, one doctor gave an answer that summarizes what many had expressed.

> *Mental health. I don't know if I was just missing the diagnosis early on in my practice, but now it's at all levels:* [pediatric]*, teenagers, adults. I used to see it in adults in* [geriatric]*, but I didn't see it in pedi and adolescents as much. Now I see … a lot of depression, anxiety.*
>
> —San Antonio

Providers also reported an increase in ADHD diagnoses among children, a finding which is also consistent with what was stated in the referral and parent focus groups and in the one-on-one interviews with parents.

In a related concern, providers also said that parental attitudes about medications can also affect a child's care. Some parents do not want their children medicated, while other parents want to use medications to control their children inappropriately, they said.

> *They want you to give them a stimulant to help with the behavior but they need proper parenting.*
>
> —Houston

The following conversation between two doctors and the focus group moderator illustrates the common, but differing, attitudes about medication for children.

Participant 1:	I have parents come in that have gotten a lot of medications from other doctors and, "I don't want my child taking this many medicines," or they're having side effects and interactions from all the different medicines. They're like, "I don't think they need to be on all these meds." I see that more, because they're wanting to trim back.
Participant 2:	It may be the population because we have a low income population and most of our patients want to get the disability check, so they're happy to overmedicate.
Moderator:	For the children?
Participant 2:	They're happy to get the diagnosis because until the age of 18 they're going to get a check for each and every child. In my population they push for "I want the disability. I want them diagnosed." Many of them do want them on medication because it's easier to deal with because they become calmer, they're more focused on their little games and not running around jumping and being active, and the teachers are not complaining. That's what I find in a lot of my children.

—San Antonio

Barriers to Mental Healthcare or Counseling

Providers described barriers that families face regarding mental healthcare. These barriers often echoed what potential referral sources and parents themselves said and included: acquiring transportation; a lack of providers; cost; a fear of getting fired if they miss too much work, and stigma toward receiving mental healthcare. Participants also described the impact of regulations, insurance, and Electronic Medical Records (EMRs), all of which are not a direct barrier for families but rather affect the provider's own ability to deliver mental healthcare to families.

Transportation: Participants consistently labeled transportation as a barrier. In rural areas, transportation problems are compounded by the distance that families must drive to access healthcare, they said. Providers also stated that parents may not have reliable transportation or the ability to afford fuel. Or, they may only have one vehicle that the working parent needs.

> *Especially if they've got one family vehicle, and Dad is working, and they'd like to take the kid to the appointment but they don't want Dad to lose his job.*
>
> —Amarillo

> *You can't send them back to the daycare because he has pink eye, and then Mom is like, "I have to have my child in daycare. I missed two days this month."*
>
> —Houston

Lack of Pediatric Psychiatrists and other Specialists: Some barriers providers described were unique to their profession and include a resounding concern over a lack of pediatric psychiatrists, especially in rural areas. Doctors in Amarillo also reported a lack of pediatric specialists in general.

> *A lot of times, they give up. Even when you give them appointments seeing psychiatry, for example, six months ahead before they see a psychiatrist. They give up. Access to psychiatry, especially pediatric psychiatry, would be nice. Even* [for] *adults, it's months.*
>
> —San Antonio

> *I would say for our population, the biggest difficulty we have is if we do have a child that needs a specialist referral. It can sometimes be extremely difficult to find one that will take their insurance.*
>
> —Amarillo

In San Antonio, two doctors spoke about their patients who live in rural communities and saw a psychiatrist via telemedicine. One described how a patient received a psychiatrist evaluation.

> *Two hours from here. I sent a patient for a psychiatric evaluation. They went to the center and it's a little room. It's a camera, and some psychiatrist from somewhere just talks to them and tells them this and that. I don't know if that works or what.*
>
> —San Antonio

Providers also consistently reported that fewer doctors take Medicaid, creating further strain for families who rely on the program as their only insurance option.

> *If they are on Medicaid, they are very, very limited on who they can go to.*
>
> —Houston

The number of providers that accept Medicaid is decreasing. Even families that are willing to travel to Fort Worth, for Cook's [Cook Children's Medical Center] *it's going to be four to six months to get an appointment for ENT* [ear, nose, and throat] *with them, too.*

—Amarillo

Regulations, Insurance, and Electronic Medical Records: Participants said a number of barriers related to regulations, insurance, or EMRs have created changes in the practice of medicine.

As mentioned in the section *Physicians' Observations on Specific Mental Health Conditions*, many of the participating doctors had been in practice for many years. They said that now, as opposed to years past, providers have to schedule an increased number of appointments a day due to insurance reimbursement rates. This change results in shorter appointment times, which is a barrier to dealing with mental health concerns because they take time to address. Regardless, some participants said they do take the necessary time with these patients, even though it negatively affects their schedules and pushes back other patients' appointments.

When I went into private practice, you could make a living seeing 15 patients a day. Now, if you're not seeing 35 to 40, you're going to be broke.

—Houston

Providers also described the use of EMRs as a barrier because they interfere with their ability to establish the kind of personal relationships they have had with their patients in the past. Those relationships help them recognize unmet mental health needs, they said.

I spend so much [more] *time on the EMRs than actually seeing the patient …. It's more about what you actually document than what you do for the patient.*

—Houston

Furthermore, providers said that the regulations result in increased paperwork, which takes time away from patient care. They also complained that insurance controls how they practice medicine, including the medications they prescribe. All of the concerns they expressed about the current state of being a doctor impact the care they provide, including mental healthcare.

It's not the patients. It's the regulations and the amount of documentation that is required for us to stay in the profession.

—Houston

It's policing us all the time, and that takes away our pleasure of really taking care of children because that's really what my love is.

—Houston

I've been here since '66. I did all my training here, Bexar County. Then I started the practice with a senior pediatrician. It has changed a lot. Initially it was always fun, but then later on we were controlled with "you cannot do this, you cannot do that. And insurance—all new insurance that will tell you how long your patient will be there or when they are going to be dismissed, very controlling. Then they tell you what medicine to give, and it's getting worse.

—San Antonio

Special Challenges of the Immigrant Population

Providers in every group gave accounts of each community's diverse cultural mix and the challenges this can present for mental healthcare or counseling—as well as healthcare in general. These challenges include language barriers and cultural norms that impact care. Providers most often talked about the increased time needed to communicate with immigrant populations, who tend to have limited English language skills. They also talked about how foreign the United States healthcare system is to many of these populations. A lack of knowledge in itself creates unique challenges for both the provider and patient, participants said.

> *Where I'm at, we see a lot of immigrant families—a lot of people from Afghanistan, Iran, Iraq, Egypt. We see people that speak Burmese and Arabic and all sorts of different languages, and that takes a lot of time, extra time because we have to either get a translator on the phone …*
>
> —San Antonio

> *When you get to Western medicine, their minds are blown. It is nothing they are used to at all. That's a whole other visit, is how to go to a pharmacy, how to pick up a refill, what is a refill.*
>
> —Amarillo

Referral Issues

During each discussion, providers were asked a number of questions about the logistics of referring to mental health providers or to an organization that provides counseling. They said it is easier for them to refer patients to counseling than to psychiatric care because there is such a dearth of child psychiatrists. They also reported some pushback from parents when they suggest counseling or that their child may need mental healthcare, because some parents see it as a poor reflection on their parenting. Other parents welcome the recommendation for counseling or a pediatric physiatrist.

Providers reported that one of their biggest challenges when they refer a family to another service is follow-through. Again, they said the barriers for parents include lack of time or insurance coverage. Participants also expressed frustration in not knowing if the family ends up being seen because they often do not hear back from the provider to which they have referred.

> *They don't have time to go to their ADHD therapy or their speech therapy. They miss the appointments. They've got to go to work.*
>
> —Houston

Attitudes about Parenting Classes

The moderator also explored the topic of parenting classes. While providers said parenting classes would be helpful, they expressed doubt that parents would attend. Some said those who do attend are not necessarily the ones who need classes.

Participants said they would recommend parenting classes if they knew where to send patients. The idea of hosting classes at medical facilities was explored, but some providers were hesitant to have families in their offices after hours. Some did say they would provide an introduction at a parenting class as a way to endorse it.

Amarillo providers were enthusiastic about the idea of parenting classes for children with ADHD. This idea emerged as the focus groups were conducted and was only tested in this site.

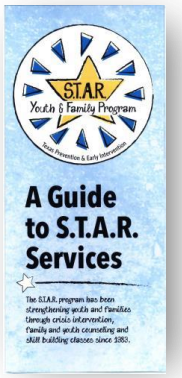
Knowledge of STAR Program

Participants in San Antonio were unaware of the STAR program, whereas those in Houston and Amarillo had used local programs in the past but did not know services were still available. They also lacked knowledge about STAR because the program is under the umbrella of large agencies that offer multiple services. They were more aware of the other services offered by those agencies than STAR.

Providers in general wondered why they did not know about STAR because they would like to refer families to the program.

> *Why has it been around, and all of us are seasoned pediatricians and nobody has a clue about this program?*
>
> —Houston

Promotion of STAR Services



When participants were asked to review promotional materials from STAR, the vast majority said they would distribute the state-issued blue brochure. However, they did have some recommendations for improvement. In particular, they wanted to know more about the professionals employed by STAR. They wondered, are they social workers, counselors, or psychiatrists?

Providers expressed enthusiasm about learning more about STAR because some of their patients would benefit from the services. They consistently said it is important for a STAR representative to come to their practice and introduce the program's services to their office staff. Many said the best way to do this is to provide lunch and educate staff through a lunch-time meeting. They said that having organizations provide lunch is standard practice when introducing their services.

Additionally, it is important for multiple members of their clinical staff (including medical assistants, administrative personnel, and nurse practitioners) to be acquainted with STAR services, since they often handle referrals, and that a lunch meeting is a good way to educate most of the staff at once.

> *There's a new imaging place. I've got Houston Imaging. They call and talk to the staff. "I want to bring you guys sandwiches." The staff is like, "OK, today" Just sandwiches or pizza, and we're going to talk about something. They're happy to get that.*
>
> —Houston

Providers strongly suggested making sure they receive a short follow-up if they refer a patient to STAR, even if it is just a notification that the patient has been seen. Referrals must be timely, and the process should involve as little paperwork as possible.

One doctor recommended designing a specific card that could be given to a patient and is identifiable as a referral to STAR from a doctor. This would also help STAR staff identify patients who were referred by doctors. Some providers want to call and set the appointment themselves.

> *Can I have an appointment? I have Mary right here. What's your next available? When she leaves out of the office, I'm saying this is the address, this is the date and time.*
>
> —Houston

In conclusion, healthcare providers expressed a need for STAR's services and would welcome a program representative to visit their office and introduce the program to their staff. They also want a follow-up informing them that the family they referred did seek services.

National Review

Summary

STAR is unique in that it is a statewide program that offers free counseling with no waitlist to any family with the goal of stabilizing families in crisis and keeping children in their homes. While there are programs that share some of those features, SUMA uncovered only a few other state-level programs—and no national-level programs—that closely resemble STAR. One of these programs operates in Florida, and the other is a federal grant which is used for the same purposes as STAR's funding in six states.

SUMA interviewed staff from the two programs that map closest to STAR's structure, goals, and populations served: the Florida Network of Youth and Family Services and the Title IV-E Waiver Demonstration California Well-Being Project.

Methodology

SUMA conducted a national search to determine if programs similar to STAR exist and to identify national trends on family support services for youth and parents of youth ages 6-17. The purpose of this review is to provide STAR leadership with potential collaborations, partnerships, and notable practices. The majority of the research was conducted via internet searches; however, SUMA reached out to local, state, or national officials for further explanation of any promising trends or programs when appropriate. SUMA visited more than 150 websites to conduct this review.

SUMA determined which keywords to use for the internet searches by asking state-level staff which terms may correlate to the program's mission and services, as well as by studying the background information documents for relevant terms. Additionally, SUMA searched "search term + state name" to attempt to identify statewide programs similar to STAR. Examples of search terms used to compile this review include the following.

- Youth counseling
- Family counseling
- Free counseling
- Behavior change program
- Youth resiliency program
- Child abuse prevention program
- At-risk youth program
- At-risk youth counseling
- Social emotional learning program
- State-funded family counseling
- Short-term counseling
- Crisis counseling
- Family preservation programs

Programs and initiatives were ruled out and excluded from this review if they did not meet any of the inclusion criteria shown in Table 1. Programs that met some of these criteria are included in the section titled *Programs that Share Elements with STAR* to provide a wider look at the landscape of youth and family programs across the country.

Table 1: Program Criteria for Inclusion in National Review

Criteria	Rationale
Is this a program run and/or funded by the state?	A state-run/funded program will map more closely to STAR's structure and has unique challenges not faced by national, county, or city programs.
Does this program serve youth ages 6-17 and their parents?	STAR's capacity to serve families as well as youth makes it different from youth-only programs. Also, programs for youth 0-5 tend to differ in application and structure from programs for older children and teens.
Are this program's services offered free of charge?	The program's free counseling lowers the barrier to entry for families significantly more than programs that require insurance or income-based sliding scale payment, and are thus not comparable.
Does this program offer youth and family counseling?	Youth and family counseling is STAR's core offering.
Is this a short-term program?	STAR is focused on short-term intervention, so long-term or residential programs are not applicable to this review.

In addition to web searches, SUMA surveyed directors of agencies that contract with STAR and senior staff at the Texas Network of Youth Services (TNOYS) and National Network for Youth (NN4Y), and they were only aware of a few STAR-like programs: the Florida Network of Youth and Family Services and the Family and Youth Services Bureau's Basic Center Program.

In addition to a deep dive into the two programs most like STAR, SUMA included information on the following topics in this review.

- STAR-adjacent programs
- National networks and program listings
- Trending program models
- Parent-facing program names

Florida Network of Youth and Family Services

The Florida Network of Youth and Family Services, Inc. (the Florida Network)[1] is a not-for-profit statewide association representing 29 agencies that serve homeless, runaway and troubled youth ages 6 and older as well as their families. For more than 40 years, the Florida Network has provided services as a "Children In Need of Services (CINS)/Families In Need of Services (FINS)" agency, as defined by Florida statute, in order to prevent juvenile delinquency, encourage good choices and healthy family relationships, and keep youth and families together in their homes.

Structure: The 29 member agencies cover the whole state: nine are neighborhood partners embedded in high-need areas and must have a majority-minority board, and 20 are emergency shelters. The network of service providers offer a variety of options to suit the needs of youth and families seeking help with problems at home, school, or anywhere. Each CINS/FINS provider has unique programs to meet the needs of their local communities, but they all provide the fundamental components of the CINS/FINS statute: emergency shelter services and individual and group counseling. The Florida Network provides to their member agencies quality improvement, contract management, data collection and research, advocacy, public education, public policy development, and training and technical assistance.

History: The Network was established as a way to share training among emergency shelters across the state and has evolved into the managing entity for the CINS/FINS statute in 1992, when the Florida Legislature privatized services to the CINS/FINS population. Centralized client intake and assessments were removed from the Florida Department of Health and Rehabilitative Services (DHRS) and were contracted out to the community-based Network agencies. Funding and oversight of CINS/FINS services moved from the DHRS to the state's Department of Juvenile Justice (DJJ) in 1994. According to a cost-savings study of the Network conducted in 2011 by the Justice Research Center of Tallahassee, "Findings from the cost effectiveness evaluation suggest that more than $160 million in subsequent DJJ juvenile justice placement expenses were avoided as a result of Florida Network non-residential and residential shelter services. Investing in Florida Network's services is economically beneficial, with a nearly $5.50 return for every dollar invested in quality preventions programs for youth at-risk for delinquency. A dollar invested today is multiplied in future for Florida's children and families."

Today, the Network is funded through the DJJ with the mission of preventing children from entering the juvenile justice system. Once a child is adjudicated, they can no longer receive these services.

SUMA conducted a telephone interview with John Robertson, who is the Network's program services director and oversees the third-party auditor and site observations.

[1] https://www.floridanetwork.org/

Providing services: Network agencies offer short-term counseling with the average being 12 sessions, or about 90 days, and families can and do return later if they need more counseling. The reasons for which families enter services include:

- Children running away or being at large in the community
- Divorce and blending families
- Illicit drug and alcohol use by youth or parents
- School pressures
- Flight by the child between both parents' houses
- Children who are self-managing at a high level but are known to live in an unstable home

Each agency has its own policies around caseloads, and the Network does not mandate a cap. Robertson said agencies staff up according to which cases they are receiving. Each agency has a clinical director and therapists licensed for individual sessions. A typical caseload for a counselor is 10 families at a time, sometimes up to 20, according to Robertson. Each case remains open for as long as the family needs the counseling. The frequency of sessions vary according to family need and the counselor's discretion, and thus a family could have an open case for a year and participate in just 12 sessions, or a family could have 12 sessions in the course of a few months.

One model used by counselors is Stop Now And Plan (SNAP)[2], an evidence-based behavioral model that provides a framework for teaching children who are struggling with behavior issues, and their parents, effective emotional regulation, self-control and problem-solving skills. The primary goal of SNAP is to help children to stop and think before they act, and keep them in school and out of trouble.

Referrals: Families enter services through referrals from the courts, schools, and some self-referrals. Behavior in school is driving their referrals, said Robertson, and Network agencies try to address family dynamic and ability. For instance, if a child under 10 years old is frequently truant, this is regarded as a parenting issue and could be tied to other complicating factors such as lack of transportation or work schedule. Many referrals are due to poverty, and Network partners are only equipped to treat the behavior stemming from poverty, not the source or material needs.

Measurement and evaluation: The Network measures success mainly by how long after services the children stay out of contact with the juvenile justice or child welfare systems. Two full-time data staff use a proprietary information management system, NetMIS, which collects services, billing, and risk factors data. The Network conducts 30-, 60-, and 120-day follow-ups with families, though Robertson noted that keeping tabs on families after they leave services is challenging.

For intake and evaluation purposes, counselors use Florida's Prevention Assessment Tool[3] (PAT) and the Achenbach Child Behavior Checklist[4]. Robertson said the Child Behavior Checklist is seen as valuable and provides the Network with reliable evaluation data. The state requires certain tools

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[2] https://childdevelop.ca/snap/about-snap
[3] http://www.djj.state.fl.us/docs/probation-policy-memos/prevention-assessment-tool-10-2014-final.pdf?Status=Master&sfvrsn=2
[4] http://www.aseba.org/preschool.html

to be used by all agencies, and some use additional evaluation tools. Robertson was unsure if he was at liberty to provide SUMA researchers with names or details concerning those tools.

Outreach: Every agency used to have a full-time dedicated outreach worker, but with changes in contracts and disruptions in funding, the position has morphed into a split development and outreach role. Employees in this role are now being tasked with both raising money for the agency and conducting community outreach, but as many agencies emphasize fundraising, they are incentivized to arrange more donor events and have less time for outreach as a consequence. The state used to fund an outreach position until the recent change to a fee-for-service model, and Robertson said he wished member agencies could return to staffing dedicated outreach personnel. Outreach is sometimes the CEO's responsibility or it is assigned to interns who do not necessarily understand the nuances of the Network, said Robertson. Outreach events are logged in the NetMIS database. The Network produces a universal brochure[5] in three languages for their agencies. Agencies are also free to create and distribute any of their own marketing materials. Robertson said agencies are asking for more TV commercials and billboards to raise awareness among the general public, but both are expensive.

The Network has based their outreach on the Safe Place program[6] national model. Safe Place posts yellow signs in various locations around the community, which signify that any child can walk into a building with the sign and ask employees for help (as they are trained to provide assistance). This model initially served as a framework to the counselors, who also walk into locations with the Safe Place sign—such as schools and libraries—to offer their counseling services and educate community members who had already demonstrated a commitment to helping children about the Network's available services.

Politically, the Network is very active and conducts outreach and advocacy to all state officials, according to Robertson. The Network also aids its agencies by setting up meetings with local representatives to make sure they are on the radar of all local officials. They have a full-time communications staff member who manages their social media, which is geared toward policy makers rather than referral sources or parents.

Working with schools: The Network covers all 67 school districts in the state, each of which operates as their own "tiny kingdom," said Robertson, and it is up to local agencies to develop relationships with their own district. It is critical for agency staff to attend their local school board meetings to stay abreast of what is happening in the schools. The Florida Department of Education is viewed as impenetrable and thus not a viable partner for the Network, even though Network staff maintain strong partnerships with other state-level departments. The Network relies on school resource officers (SROs) for referrals, said Robertson. She noted that SROs are engaged in helping children who could benefit from the Network's services and that SROs and Network staff attend each other's conferences to maintain a strong partnership.

Agency meetings and conferences: The Network holds a yearly meeting of all the member agency directors, which Robertson describes as "critical." They have also convened a Quality Improvement Committee, which meets three times a year and comprises the most important and

[5] https://www.floridanetwork.org/wp-content/uploads/2016/09/FN_Brochure_FINAL_English_NewCover.pdf
[6] http://www.nationalsafeplace.org/

dedicated staff, including agency directors, clinical directors, shelter directors, some CEOs, and some senior agency staff. All new policies are rolled out at this mini-conference. Attendees come to the Florida Capitol on a Wednesday, hold meetings and breakout sessions all day on Thursday, and then hold meetings for a half day on Friday. Robertson said that the most important aspect of the conference is community building and bonding among agencies during downtime, when they can vent about frustrations and share tips with peers.

Title IV-E Waivers

In 1994, the U.S. Congress established Section 1130 of the Social Security Act, giving the U.S. Department of Health and Human Services the authority to approve state demonstration projects involving the waiver of certain provisions of titles IV-E[7] and IV-B, which govern federal programs relating to foster care and other child welfare services. Title IV-E waivers have been used by 23 states in three distinct ways[8]:

1. To subsidize foster child placement/guardianship with relatives and non-relatives outside the foster care system.
2. To flexibly provide new or expanded services that prevent out-of-home placement and/or facilitate permanency (California, Florida, Indiana, North Carolina, Ohio, and Oregon), which is most similar to STAR.
3. To provide services to families in which parental substance abuse places children at risk of maltreatment or out-of-home placement.

The six states listed in item 2 of the above list use the "flexible funding" clause of the waiver. While those flexible funding demonstrations vary widely in terms of scope, service array, organizational structure, and payment mechanisms, they all shared the core concept of allocating fixed amounts of Title IV-E dollars to local public and private child welfare agencies in an effort to provide new or expanded services that prevent out-of-home placement and/or facilitate permanency. The fundamental assumption underlying flexible funding demonstrations was that the cost of these services would be offset by subsequent savings in foster care expenditures. Evidence from several states suggests that the availability of flexible IV-E funds increased child and family access to a wider array of child welfare programs and services. Findings regarding the impact of flexible funding demonstrations on child welfare outcomes are less conclusive, although Indiana documented statistically significant positive findings in the areas of placement prevention, exits to permanency, and placement duration. In addition, a number of states and counties (e.g., Florida and Alameda and Los Angeles counties in California) documented large declines in their foster care populations, although the extent to which these decreases are attributable to their flexible funding demonstrations or to broader changes in child welfare policy and practice is unclear.

[7] https://www.acf.hhs.gov/sites/default/files/cb/waiver_summary_final_april2013.pdf
[8] https://www.acf.hhs.gov/sites/default/files/cb/waiver_profiles_vol2.pdf

California's Title IV-E Program

The Title IV-E Waiver Demonstration California Well-Being Project (formerly the Capped Allocation Project or CAP)[9] enables the state to examine whether flexibility in the use of Title IV-B and Title IV-E funds for programming helps achieve safety, permanency, and well-being for children and youth involved in the child welfare and juvenile justice systems. California is one of 20 states that have elected to use the Title IV-E waiver authority to reduce the number of children in foster care while maintaining child safety and is the only state to include probation agencies in the demonstration project. Any foster care savings that occur as a result of the waiver demonstration must be reinvested by the participating counties in child welfare services program improvements.

Project goals include:

- Improve the array of services and supports available to children and families involved in the child welfare and juvenile probation systems.
- Engage families through a more individualized casework approach that emphasizes family involvement.
- Increase child safety without an over-reliance on out-of-home care.
- Improve permanency outcomes and timelines.
- Improve child and family well-being.
- Decrease recidivism and delinquency for youth on probation.

History: California has participated in this waiver demonstration project since 2007 and is now halfway through a five-year extension. The waiver project is administered by counties. The California Department of Social Services (CDSS) started initially with two counties as a pilot for the first year and now has nine counties participating.

A 2012 evaluation[10] of the program found an increase in the percentage of children receiving pre-placement services and a decrease in the percentage of children receiving services in permanent placement. This was done through the PICO[11] evaluation planning framework used by the Permanency Innovations Initiative, which seeks to "build the evidence-base in child welfare by engaging Grantees in a comprehensive and rigorous evaluation strategy designed to better understand which interventions work and for which populations of children, youth, and families." A lesson learned in this evaluation is that innovations need to be monitored by looking at the fiscal, services, and outcomes information side by side.

SUMA conducted a telephone interview with Cathleen Kloose, manager of the Title IV-E Waiver Unit in the CDSS Children and Family Services Division, to learn more about California's Title IV-E program.

Structure: CDSS has about 3,000 employees, and the Title IV-E Waiver Unit that Kloose leads is composed of three staff members and an intern. Kloose and her team work closely with staff in

[9] http://www.cdss.ca.gov/inforesources/Foster-Care/Title-IV-E-Waiver-California-Well-Being-Project
[10] http://www.childsworld.ca.gov/res/pdf/FinalEvaluationReport.pdf
[11] https://www.acf.hhs.gov/sites/default/files/opre/pii_approach_to_evaluation_brief_508.pdf

accounting, legal, research, and their executives. Kloose said she is excited by the work they do with the Title IV-E waiver because it allows them the flexibility to do what is necessary for each unique family. Their program offers preventative services for keeping children with their families and for doing what is in the best interest of the child.

Providing Services: In addition to the core services of Wraparound[12] and Safety-Organized Practice[13], counties are given the flexibility to offer additional interventions to serve specific community needs. Based on the initial pilot experience, CDSS decided to limit the number of interventions that agencies were able to offer to two per county, which Kloose said helps to capture reliable, measurable outcomes data. These additional interventions include:

- Evidence-based parent training programs
- Commercial sexual exploitation of children (CSEC) awareness and identification programs
- Multidimensional family therapy
- Supporting families in transition
- Enhanced prevention and aftercare
- Family finding
- Kinship support
- Family coaching

★ Notable Practice

California uses Child and Family Teams (CFTs) for child welfare programs, which can include anyone who is interested in the well-being of the child, including parents, pastors, school officials, grandparents, etc. This approach is similar to a personalized version of Texas' Community Resource Coordination Group (CRCG). In California, a child is required to have a CFT within the first 60 days of entering the child welfare or probation foster care placement. CFT meetings are used for case-planning purposes, placement determination, emancipation planning and/or safety planning. Most counties hold CFT meetings in providers' offices, but it is considered a best practice to have them in off-site areas, such as libraries.

Barriers: Transportation can be a barrier for families, and while some counties offer bus passes, it could take some families most of the day to travel to the site where services are offered. Another barrier is the family's culture. Partners tell Kloose that having somebody come to their home is the hardest thing for families to accept. Hiring culturally competent practitioners is an important best practice because they can easily communicate with the family and build trust with them while helping to culturally translate jargon associated with the core services. One family would lift their garage door up halfway to speak to the practitioner until they were able to build trust, Kloose said.

Measurement and evaluation: The program is still trying to establish meaningful and consistent measurement tools, according to Kloose. An evaluator has been hired to help in this endeavor. In terms of collecting outcome measures, the program relies on the Child Welfare Services/Case Management System (CWS/CMS), a statewide digital tool used by workers in the

[12] http://www.childsworld.ca.gov/res/TitleIV-E/Wraparound_Model.pdf
[13] http://bayareaacademy.org/wp-content/uploads/2013/05/SOP-Handout-Booklet-9-20-12.pdf

child welfare system to access case information, but one drawback is that not every county uses that system. Participating agencies offer pre- and post-surveys to families, but administering the surveys has presented a workload problem, and the program has received pushback from unions in some counties.

Based on feedback from the federal team that oversees the waiver program to have her reports tell more of a story, Kloose said she accompanied her state team on two-day site visits at their partner agencies and asked the agencies to share their experiences in whatever ways they wanted. Kloose said this meant that each site visit was completely different, and her team was able to gather more success stories from agencies to include in their reports to the federal team.

Outreach: A majority of families that participate in services are referred to the program. From what Kloose has observed, counties already have enough referrals and do not need more families, so they do not engage in much parent-facing advertising. A communications firm was hired to put together a document for families on what to expect from Wraparound. The firm also created a PowerPoint that explains Wraparound for either the family or when trying to communicate with an external stakeholder.

The waiver program started a newsletter[14] early on to share success stories in layman's terms, since the program is so multifaceted and hard to explain, said Kloose. The state provides some of the newsletter content, and the agencies provide their success stories. The newsletter is used by agencies to help explain services to community organizations when trying to get memorandums of understanding signed. The newsletter is primarily electronic, though some agencies also print and distribute it.

Agency meetings and conferences: Program partners hold quarterly collaborative meetings as well as an annual meeting. Kloose described these events as fostering a "team environment," and they include external stakeholders and her state staff. Partners feel free to share both struggles and successes openly and find great value in these educational sharing sessions, she said. The quarterly collaborative meetings include facilitated sessions, panels, and breakout sessions. Meeting organizers try to place counties with similar interventions or community needs together into small groups to discuss lessons learned, success stories, and tools. Kloose said they work with Casey Family Programs, who are strong proponents of the waiver, to maintain relationships with the agencies and facilitate meetings. Agency directors have a monthly meeting at the state office for high-level, peer-to-peer discussions about what is and is not working for their county. The directors value these meetings, according to Kloose, and the meetings have been productive. After the first few, Kloose's team put together more topic-focused agendas for the meetings, such as evaluations or data collection.

Kloose also attends a national annual meeting[15] for all states that participate in the waiver. She said she usually looks to Florida and Ohio for inspiration and guidance, since they have been involved in the waiver longer.

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[14] http://www.cdss.ca.gov/Portals/9/TitleIVEWaiver/Fall2016.pdf
[15] http://www.2016nccan.com/pdfs/2016-Grantee-Meeting-Agenda_CB-Waivers.pdf

North Carolina's Title IV-E Program

Under the federal waiver of Title IV-E regulations, 38 volunteer counties in North Carolina are using Title IV-E funds to develop and implement strategies for improving outcomes for children who are at risk of entering out-of-home care. The demonstration began on July 1, 1997, and expanded from 19 to 38 counties effective October 2004. An evaluation team based at the Jordan Institute for Families at the University of North Carolina at Chapel Hill[16] prepared a report assessing the impact of the wavier on the rate of entries to out-of-home care, lengths of stay, and re-entry to care for the period from 1997 through 2001. Based on the results of that study, the U.S. Children's Bureau decided to authorize the expansion of the demonstration and extend it until 2009.

The evaluation of the original demonstration was conducted in several stages and utilized a variety of research methods. North Carolina's longitudinal child welfare database provided the basis for assessing progress toward key outcomes of the waiver demonstration. With the database, it is possible to estimate the risk of out-of-home placement[17] in each county among children who have experienced an initial substantiated report of abuse and/or neglect, and then to compare differences in outcomes in demonstration and comparison counties. The placement database supported similar analyses of length of stay and re-entry to care. A cost analysis tracked expenditures for out-of-home care and program administration for the duration of the demonstration. The benefits of the demonstration were measured in terms of improving the safety of children while reducing reliance on out-of-home care, reducing lengths of stay, and improving permanency outcomes within current cost levels.

SUMA made several attempts to interview key staff involved in the program but did not hear back from them.

Florida's Title IV-E Program

In 2014, Florida renewed its Title IV-E Waiver for another five years to continue the state's positive progress in reducing the number of children in out-of-home care and providing necessary support and prevention services for improved child welfare. The waiver allows federal foster care funds to be used for any child welfare purpose rather than being restricted to out-of-home care as generally required under federal law. It enables funds to be used for a wide variety of child welfare services, including prevention, intensive in-home services to prevent placement of children outside the home, reunification, and foster care.

The waiver was first introduced and implemented under Gov. Jeb Bush in 2006. The goal of the waiver was to support changes in the state's child welfare system in order to maintain child safety and improve outcomes for children and families served the by the Florida Department of Children and Families (DFC) and its community-based partners. After expiring in 2011, the waiver was extended in three-month increments and will now be renewed until 2019.

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[16] http://www.unc.edu/~lynnu/prstn22703.pdf
[17] http://www.unc.edu/~lynnu/plcrisk.pdf

The Florida Coalition for Children (FCC)[18] comprises over 60 agencies involved with the Title IV-E waiver. Their mission is to "advocate on behalf of Florida's abused, abandoned, neglected, and at-risk children, and to support the agencies and individuals who work on their behalf. Some FCC member agencies overlap with those of the Florida Network of Youth and Family Services. Member agencies care for nearly 50,000 children and families in crisis each year and pay annual dues to have access to the following benefits:

- Opportunities to join councils and committees.
- Participation in statewide workgroups and task force groups.
- Personalized PINs to participate in secure conference calls, including weekly membership calls and committee calls.
- Detailed legislative analysis and updates.
- Access to a member network of over 60 child welfare agencies.
- Opportunities to showcase their agency's events, job opportunities and more in a member newsletter, which reaches over 2,000 subscribers.
- Discounted registration rates for events, including an annual conference.
- Access to an exclusive Members Only Portal (called FCC InSite), which includes a member directory, news articles, white papers, committee documents and more.

SUMA made several attempts to interview key staff involved in the program but did not hear back from them.

[18] https://www.flchildren.org/

Programs That Share Elements with STAR

In the course of conducting internet searches, SUMA identified the following programs that have objectives and features similar to STAR but did not meet the criteria to be profiled in this review.

STAR-Adjacent Programs

Name	State	About	Services	Funding	Type
Bill Wilson Center	California	Bill Wilson Center provides services to more than 5,100 children, youth, young adults and families in Santa Clara County through our various programs. Additionally, they reach more than 32,000 clients through our Street Outreach and crisis line programs. Bill Wilson Center programs focus on housing, education, counseling, and advocacy. Bill Wilson Center is committed to working with the community to ensure that every youth has access to the range of services needed to grow to be healthy and self-sufficient adults. Bill Wilson Center has been providing services to runaway and homeless youth since 1973.	Adoption Program Centre for Living with Dying Child Abuse Treatment Program Contact Cares Crisis Residential Center Critical Incident Stress Management Drop-In Center Family and Individual Counseling Family Advocacy Services Foster Care Services Healing Heart Juvenile Justice Diversion Services LGBTQ Outreach Maternity Group Home Mental Health Services Parent-Child Interaction Therapy Parenting Class Peacock Commons Quetzal House Safe Place School Outreach Counseling SOS Crisis Hotline 408-278-2585 Transition Age Youth Mental Health Services Transitional Housing Placement Program Transitional Housing Program Volunteer Case Aide Program Youth and Family Mental Health Services	Federal, State, Private Donations	Provider
CEDARS	Nebraska	For nearly seven decades, thousands of vulnerable children and youth have found safe refuge and a new beginning at CEDARS. One of Nebraska's most trusted child-service organizations, CEDARS makes sure that children feel safe and secure. At the same time, they provide parents, foster families, and partnering agencies the support they need to	Life Skills Reporting Center for Juvenile Justice Family Support and Skills Classes Healthy Families Home Visiting Pre and Post Natal Partners in Permanency (PIP) Sixpence Early Childhood Home Visitation Program	Collaboration with Lincoln/Lancaster County Health Department, Federal, State, Private Donations	Provider

Name	State	About	Services	Funding	Type
		care effectively for children. CEDARS responds to both immediate and long-term needs in serving abused, neglected and homeless children and families in need of support. All programs are accredited by the well-respected National Association for the Education of Young Children (NAEYC) and/or the Council on Accreditation (COA).	for Teen Parents Out-Of-Home Residential Services		
First 5 California	California	In 1998, voters passed Proposition 10, adding a 50-cent tax to each pack of cigarettes sold to create First 5 California, also known as the California Children and Families Commission. First 5 California is dedicated to improving the lives of California's young children and their families through a comprehensive system of education, health services, childcare, and other crucial programs. Since its creation, First 5 California has brought these critical services to millions of parents, caregivers, and children ages 0 to 5, and is striving to reach thousands more every day. First 5 California distributes funds to local communities through the state's 58 individual counties, all of which have created their own local First 5 county commissions. Eighty percent of the annual revenues are allocated to the 58 county commissions, while the remaining 20 percent fund the state's overall guiding programs and administrative costs. The amount of funding provided to each First 5 county commission is based upon the area's birth rate. Funds are used to address the local needs of communities statewide.	211 Phone Line Respite shelter care Court Appointed Special Advocates for Children (CASA) Zero to Five Early Intervention Partnership Counseling for families of children 0 to 5 and pregnant women http://www.stanprop10.org/pdf/contract-programs.pdf	State Tax	State Initiative
National Child Traumatic Stress Network's Partnering with Youth and Family Committee	National	The PWYF Committee strives to promote partnerships between trauma-informed service providers and the youth, families, and caregivers receiving services. Partnerships are based on mutual respect, a common commitment to healing, and shared responsibilities for planning, selecting, participating in, and evaluating services and supports.	Offers practitioners resources for implementing a PWYF model http://www.nctsn.org/resources/topics/youth-and-family-partnerships	Funded by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), US Dept. of Health and Human Services	Committee
Children's Mental Health Wraparound Pilot	West Virginia	Children's Mental Health Wraparound Pilot is a pilot project of the W.Va. Bureau for Behavioral Health and Health Facilities available in 6 counties to parent of children aged 0-	Wraparound is a process of supporting children and families to make plans to stay in their homes and communities and reach	State-funded	State program

Name	State	About	Services	Funding	Type
		21 with a mental health diagnosis, or an intellectual or developmental disability (I/DD) combined with serious behavioral or mental health concerns, affecting the child at home, school, or in the community and putting him or her at risk of out-of-home placement.	their hopes and dreams.		
Department of Social Services, Children and Family Services Division	California	The Children and Family Services Division provides leadership and oversight of county and community agencies in the implementation of child welfare services programs through regulations, training, technical assistance, incentives and program evaluations.	The Children and Family Services Division contains 6 branches consisting of: Children's Services Operations and Evaluation Branch The CMS Support Branch Child Protection and Family Support The Foster Care Audits And Rates Branch Child and Youth Permanency Branch The Office of the Foster Care Ombudsman	State funding	State Department
Basic Center Program	National	HHS Family and Youth Services Bureau's Basic Center Program (BCP) helps create and strengthen community-based programs that meet the immediate needs of runaway and homeless youth under 18 years old. In addition, BCP tries to reunite young people with their families or locate appropriate alternative placements. Additional grants from the FYSB are similarly specific in the services that must be offered and are focused on homeless youth and family violence. Grantees that overlap with STAR: LifeWorks, Connections Individual and Family Services, Catholic Charities Diocese of Lubbock	Up to 21 days of shelter Food, clothing and medical care Individual, group and family counseling Crisis Intervention Recreation programs Aftercare services for youth after they leave the shelter	National	National Program

Name	State	About	Services	Funding	Type
Walk-In Counseling Center	Minnesota	Walk-In Counseling Center is a nonprofit founded by a group of psychologists in 1969 in response to the unmet need for accessible mental health services in the Twin Cities. They have provided free mental health counseling to help thousands of people address issues of depression, anxiety, chemical abuse/dependency, trauma, domestic violence and a variety of other emotional and interpersonal concerns. Their mission is to provide free, easily accessible mental health counseling to people with urgent needs and few service options. Their overarching goal is to help people stabilize during a time of crisis and resolve problems before they become severe. They achieve this goal by involving approximately 180 volunteer mental health clinicians each year who provide the services. They estimate the value of their volunteer clinic services at more than $24 million over the past 47+ years.	Free individual counseling Child care during counseling Walk-in, first come first serve appointments	Foundations, and private donations	Provider
Minneapolis School Based Clinics Program	Minnesota	In the Minneapolis School Based Clinics Program, students self-refer or are referred by staff, parents, or administrators. Convenient: Students can be seen during the day in school so parents don't have to take time off from work Affordable: Our goal is to provide services to all students regardless of insurance status. Services are provided at low or no cost to families whether or not a student has insurance. Insurance is billed whenever possible to help cover the costs of care. We may send a bill for mental health service co-pays if student has private insurance. Opportunity: Students are seen by staff specializing in caring for adolescents Lifestyle: Students gain practice in managing their own healthcare Confidential: School Based Clinics abide by the same client confidentiality policies as your neighborhood clinic	Social Work and Mental Health Counseling (depression, anxiety, stress, family and relationship issues, academic issues, and planning for the future.) Assessment includes psychosocial screening given to all new clients and a formal diagnostic assessment for all clients participating in ongoing therapy services. Health Assessment and Physical Exams Reproductive Health Nutrition Counseling Wellness Promotion	State-funded	State program
Second Judicial District Court Youth and Family Counseling	New Mexico	YFC's mission is to work with youth who enter the juvenile court system and their families in order to solve problems and reduce the likelihood of the child returning to court. Services do not require insurance and	Family therapy, individual therapy (when indicated), group therapy (groups are formulated based on the clinical needs of referred juveniles)	State funding	State program

Name	State	About	Services	Funding	Type
(YFC)		are free of charge. Juveniles and families are referred through the agencies of the juvenile justice system. Court ordered clients have priority.	Substance abuse counseling Anger management Assessment and referral (on a limited basis) Treatment services for the Juvenile Drug Court Program Treatment services for the Juvenile Probation Diversion Program		
State Children's Trust Fund	California	The State Children's Trust Fund (SCTF) was established as a separate fund in the state treasury in 1983 for the purpose of child abuse and neglect prevention. The Legislature specified the Office of Child Abuse Prevention as responsible for administering programs and projects with the SCTF's annual allocation. Welfare and Institutions Code Section 18969 limits administrative costs to no more than five percent of the annual allocation. The SCTF is derived from moneys from state income tax voluntary donations, a percentage of birth certificate fees from state vital statistics, and a portion of specialty license plate revenue. The Legislature's intent for the SCTF includes: Funding of large-scale dissemination of information that will promote public awareness regarding the nature and incidence of child abuse and neglect and the availability of services for intervention including but not limited to, the production of public service announcements, well-designed posters, pamphlets, booklets, videos, and other media tools. Funding of research and demonstration projects that explore the nature and incidence and the development of long-term solutions to the problem of child abuse. Funds may also be used for evaluation, research, or dissemination of information concerning existing successful program models. Funding of innovative, child-centered approaches which indicate promise of quality, cost-effective services to prevent child abuse and neglect. Funding to provide ongoing public awareness through activities that will promote the charitable tax deduction for the trust fund and seek continued contributions.	Programs currently supported by the SCTF include: California Evidenced Based Clearinghouse, an organization investigating and scientifically rating the evidence and effectiveness of child abuse and neglect programs and ancillary programs that support parents and children through training, research, and direct services. Free online mandated reporter training allows ease of learning for the multitude of mandated reporters of child abuse and neglect. General training modules are offered in English and Spanish. Modules targeted to specific professions, such as teachers, nurses and clergy are also offered. Public awareness campaigns for child safety concerns such as Shaken Baby Syndrome, Safe Surrender Baby Law, and Fetal Alcohol Spectrum Disorder prevention. Training programs for family resource specialists to support parents and strengthen families through the utilization of the five protective factors. Training conferences for increasing parent leadership in community-based child abuse and neglect prevention efforts; and increasing awareness of domestic violence in families and the effects upon child development and growth.	State funding	State Fund

Name	State	About	Services	Funding	Type
Child Abuse and Trauma (CHAT)	California	CHAT offers children's counseling services funded by Medi-Cal and the California Office of Emergency Services to serve child and adolescent victims of abuse and trauma. The multidisciplinary staff is committed to using effective, evidence-based and clinically informed treatments, such as Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) and Seeking Safety. These treatment models have proven successful in helping children and parents learn new skills in responding to traumatic life events, improve family communication, manage behavior problems, and decrease risk for future harm. A child or adolescent may qualify for CHAT funded services if they are victims of: Physical abuse Sexual abuse or exploitation Emotional abuse Neglect Domestic or family violence (including high conflict divorce) Child endangerment (including parental substance abuse) Child abduction School and community violence (including bullying) Community hate crimes and acts of terrorism	Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) Seeking Safety	State funded	State Program
The Brookline Center for Community Mental Health	Massachusetts	The Brookline Center for Community Mental Health provides affordable mental health care and community-based social services that help individuals and families lead healthier, safer, and fuller lives while building the strongest, healthiest community possible. They open their doors to every Brookline resident, regardless of ability to pay or severity of condition. With a team of nearly 100 clinicians, staff in every Brookline public school, and partnerships with healthcare providers and public agencies, The Brookline Center plays an essential public health role for Brookline and neighboring communities. They fill unmet needs, coordinate diverse services, and create a safety net of support for children, adults, and families as they regain health and stability. More than a third of care they provide is in services not covered by private or public insurance.	Individual counseling Family counseling School-based support Group counseling Housing and basic needs Community collaboration Care and case management	Foundations and private donations, State and Federal Funding	Provider

Name	State	About	Services	Funding	Type
Family Thriving Program (FTP)	California	The FTP is a home visitation program with mothers of infants. FTP uses cognitive reframing as a method for correcting parents' biased understanding of the relationship between themselves and their children. It has been proposed that a skewed view of the parent-child relationship may contribute to child abuse and neglect. FTP is an enhancement to home visitation models that incorporates cognitive appraisal methods to assist parents in becoming "competent and independent problem solvers." To do this, parents receiving the enhancement are asked by home visitors to review recent parenting problems. Using a series of questions aimed at identifying the problem's cause, the home visitor arrives at a strategy for addressing the problems raised by the parent, and the home visitor follows up on the results of the strategy in subsequent home visits. FTP has been tested as an enhancement to the Healthy Start home visitation program.	Parenting skills Home visiting	State funded	State program

National Networks and Program Listings

The following sources represent national mental health and child-focused networks and programs that may provide resources and trainings of interest to STAR staff.

Source	About	Link to Additional Information
Promising Practices for Child Abuse and Neglect Prevention Programs	Promising Practices for Child Abuse and Neglect Prevention Programs is a list of evaluated child abuse and neglect programs. The program aims to address or prevent child emotional, physical, or sexual abuse; child neglect; and child safety, broadly defined. This includes outcomes associated with parenting practices related to child abuse and neglect.	http://www.promisingpractices.net/programs_topic_list.asp?topicid=16
National Alliance for the Mentally Ill (NAMI)	NAMI serves families of adults with chronic mental illness and provides curricula and presentations for parents, children, and school staff about mental illness.	https://www.nami.org/Find-Support/NAMI-Programs/NAMI-Basics
Federation of Families for Children's Mental Health (FFCMH)	The National Federation works to develop and implement policies, legislation, funding mechanisms, and service systems that utilize the strengths of families. Its emphasis on advocacy offers families a voice in the formation of national policy, services and supports for children with mental health needs and their families. FFCMH is a national family-run organization linking more than 120 chapters and state organizations focused on the issues of children and youth with emotional, behavioral, or mental health needs and their families.	https://www.ffcmh.org/resources
Mental Health America (MHA)	Founded in 1909, MHA is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the overall mental health of all Americans, with over 200 affiliates in 41 states, 6,500 affiliate staff and over 10,000 volunteers. Their website offers resources for parents and children such as their Back to School toolkit that addresses topical issues such as ADHD and cyberbullying.	http://www.mentalhealthamerica.net/back-school#parents
Child Welfare Information Gateway	The Child Welfare Information Gateway offers information and reports on state child abuse and neglect prevention programs and activities. It includes reports on both multiple and individual states.	https://www.childwelfare.gov/topics/preventing/prevention-programs/reports/

Trending Program Models

Family-Based Recovery

National Conference of Child Abuse and Neglect (NCCAN) 2016 Presentation: *Family-Based Recovery 2007-2016: Lessons Learned from Implementing an Innovative In-Home Substance Abuse Treatment Model for Families with Young Children*

- Family-based in-home treatment can effectively meet the needs of mothers and fathers struggling with the dual challenges of substance abuse recovery and parenting infants and toddlers.

- Family-Based Recovery (FBR) integrates substance abuse treatment and infant mental health intervention with the goal of preventing child maltreatment and family disruption. Nine years of outcome data suggest that FBR is a promising model.

- This model is similar to the third way states use Title IV-E waivers (to provide services to families in which parental substance abuse places children at risk of maltreatment or out-of-home placement) and was mentioned by the director of Connections Individual and Family Services as an audience they wish they could better serve.

Peer-to-Peer or Family-Youth-Provider Partnerships

National Child Traumatic Stress Network (NCTSN): Partnering with Youth and Family (PWYF) Committee

- The PWYF Committee strives to promote partnerships between trauma-informed service providers and the youth, families, and caregivers receiving services. The mission of the NCTSN's Partnering with Youth and Families Collaborative Group is to "build a partnership among youth, families, caregivers, and professionals based on mutual respect, a common commitment to healing, and shared responsibilities for planning, selecting, participating in, and evaluating trauma services and supports."

- "And peer support might be an important way to help some families in treatment. A mother and adolescent daughter who'd received TF-CBT [Trauma-Focused Cognitive Behavioral Therapy]…the young woman said that she really wished that when she'd started she'd had someone who had been through the treatment already who could just tell her what to expect. It can be so important when someone is just entering treatment for a peer to say, 'I've been through treatment here, and this is how it helped me, and this is what it's going to be like, and if you're afraid about anything, you can call me.'"

- Noted benefits:
    - Increased participation of youth and families with diverse cultural perspectives strengthens the relevance and cultural competence of agency services.

    - Participation of youth and families in Network center planning and evaluation strengthens their sense of ownership in Network activities and further empowers them to create change.
    - Ongoing input from youth and families enables Network centers to continually improve quality of information and services related to child trauma and its treatment.
    - Including youth and families supports the formation of a movement that works toward increasing public awareness of child traumatic stress and advocacy for better policies and services.
    - Youth and families can be powerful agents for spreading the word about services to others who need help. They can also serve as wonderful mentors and examples to their peers.
- PWYF has many resources for organizations to help them implement these strategies, including information about compensating youth and families for their time and effort.

NCCAN 2016 Presentation: *Integrating Peer Support Specialists in Child Welfare: Lessons from Sobriety Treatment and Recovery Teams (START)*

- Incorporating direct support from peers in recovery into child welfare practice is an emerging strategy that acknowledges the dual need for child safety and engaging caregivers in services.

- START is a model in which full-time peer support specialists are paired with child welfare social workers.

NCCAN 2016 Presentation: *Partnering with Families through Peer-to-Peer Support: A Capacity-Building Approach to Implementing Parent Programs in Child Welfare*

- Parents with experience in child welfare provide mentoring and support to other parents who are entering the system.

- This program uses the Parent Partner Program Navigator, a web-based tool created to guide child welfare administrators, supervisors, and workers in building capacity in this area.

Parent-Facing Program Names

Throughout the entire project, SUMA researchers heard from various audiences that the name "Services to At-Risk Youth (STAR)" can be a barrier to enrolling families who could benefit from the program's services because parents say they do not see their families as being "at-risk." Rather, parents, STAR staff, and potential referral sources said that the program name could be improved by making it positive and strength focused. The following are programs that share features with STAR and whose names are positive.

- ParentFurther[19]: a practical, research-based web resource for families and those who work with them that emphasizes relationship- and asset-based strategies for dealing with the everyday challenges of parenting.
- Keep Connected[20]*:* a parent engagement program developed by the Search Institute that helps parents navigate the transition to the teen years, designed for schools and other organizations to partner with parents in building developmental relationships.
- SafeCare[21]: an in-home parenting curriculum in which parents are taught how to interact in a positive manner with their children, recognize hazards in the home, and recognize and respond to symptoms of illness and injury. The curriculum typically consists of 15-20 weeks' worth of visits.
- OneToughJob.org[22]: provides parents with access to the information and resources available at Massachusetts Children's Trust programs and the latest and greatest parenting information, ideas, on-the-ground resources, and a bridge to help parents find other moms and dads who have asked the same questions and faced similar challenges.

[19] https://www.parentfurther.com/
[20] http://page.search-institute.org/KC-Institute?_ga=2.30152317.397904459.1513636692-603019217.1513636692
[21] http://safecare.publichealth.gsu.edu/
[22] http://www.onetoughjob.org/

Rural Mental Health: Promising Practices

Introduction

SUMA's primary research shows—and secondary research affirms—that there is significant need for mental health services in rural Texas and, indeed, across the nation. According to 2015 data from the Substance Abuse and Mental Health Services Administration (SAMHSA), 18.3% of residents of non-metropolitan counties had some sort of mental illness in the past year, which amounts to more than 6 million people.[1] According to the Western Interstate Commission for Higher Education[2]:

- More than 60% of rural Americans live in mental health professional shortage areas.
- More than 90% of all psychologists and psychiatrists, and 80% of Masters of Social Work (MSWs), work exclusively in metropolitan areas.
- More than 65% of rural Americans get their mental healthcare from their primary care provider.
- The mental health crisis responder for most rural Americans is a law enforcement officer.

As of 2015, 185 Texas counties lacked a single psychiatrist, essentially leaving over 3 million Texans without practical access to care. Further, 149 of these counties were without a licensed psychologist, while 40 lacked a single social worker.[3] The issues at hand are partially the result of Texas' immense size and an uneven and vast population distribution. Additionally, the most disadvantaged and under-resourced communities are often those with the most severe need for mental health providers.

Despite its prevalence, the misconceptions, myths, and cultural taboos associated with mental illness may be the most significant barriers that keep people with mental disorders from seeking and receiving treatment in rural areas. Factors that may influence rural residents to avoid seeking care include:

- Lack of understanding and knowledge of mental illness, sometimes even among healthcare staff.
- Prejudice or stigma toward people with mental health disorders, often based on fear and unease.
- Secrecy about mental illness in the community and general hesitancy to seek care.
- Perceived lack of confidentiality and privacy in small towns with closely tied social networks.

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[1] "Results From The 2015 National Survey On Drug Use And Health," Detailed Tables, Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality, September 8, 2016, https://www.samhsa.gov/samhsa-data-outcomes-quality/major-data-collections/reports-detailed-tables-2015-NSDUH.

[2] Dennis F. Mohatt, "Rural Mental Health: Challenges and Opportunities Caring for the Country," WICHE Mental Health Program.

[3] Eric Lindholm, "What is Texas Doing Wrong When it Comes to Rural Mental Health?," January 20, 2017, http://hogg.utexas.edu/rural-mental-health.

To build a comprehensive policy framework around rural behavioral health reform, the Health Resources and Services Administration (HRSA) recommends a multi-pronged approach to expand the following[4].

- Availability: Chronic shortages of mental health professionals exist, and those professionals are more likely to practice in urban centers.
- Accessibility: Rural residents often travel long distances to receive services, are less likely to be insured for mental health services, and are less likely to recognize an illness.
- Affordability: Many rural residents struggle to afford health insurance, co-pays, or paying for care if they do not have health insurance.
- Acceptability: The stigma of needing or receiving mental healthcare and the fewer choices in trained professionals who work in rural areas create barriers to care.

Promising Practices

SUMA's primary research with parents, providers, and stakeholders in rural areas of Texas affirms the mental health challenges experienced by other U.S. rural communities. Our research on emergent or promising practices for rural mental health features successful projects that can serve as a source of ideas and provide lessons others have learned. The promising practices we explore address at least one of the four expansion areas identified by HRSA: availability, accessibility, affordability or acceptability.

This report will provide case studies that highlight creative partnerships, practices, and funding models that provide mental health services for youth and families. The case studies presented are drawn largely from a compilation of innovative U.S. models published by the Federal Office of Rural Health Policy (FORHP).

Areas that hold promise and demonstrate innovation include:

- Telemedicine and telecounseling
- School-linked and school-based mental health collaborations
- Integrated primary care and behavioral care clinic model
- Mental health workforce development and community-based training

[4] "The Future of Rural Behavioral Health" Policy Brief, National Rural Association, February 5, 2015, https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/The-Future-of-Rural-Behavioral-Health_Feb-2015.pdf.

Telemedicine and Telecounseling

Telemedicine has great potential to expand access and improve the quality of rural healthcare. Although telehealth is broader in scope, the American Telemedicine Association and many other organizations use the terms telemedicine and telehealth interchangeably. Telehealth can reduce burdens for patients, such as travel to receive specialty care, and can improve monitoring, timeliness, and communications within the healthcare system.

Using telehealth to provide specialty services is more feasible for rural healthcare facilities than staffing the facilities with specialist providers. Telehealth allows specialists to visit rural patients virtually, improving access to healthcare as well as offering a wide range of specialty care to rural communities via telemedicine, including psychiatry and counseling. Three key factors are driving telemedicine's increase in popularity: faster internet connections, the near-universal adoption of smartphones and tablets as personal devices, and the emergence of commercial software platforms that support the real-time scheduling and billing of videoconferences between doctors and patients.[5]

With the implementation of the Affordable Care Act (ACA), the federal government announced the move toward encouraging and including telehealth services in healthcare coverage. However, the ACA only implemented telehealth at the federal level through Medicare; the power to determine which, if any, telehealth services are covered by Medicaid remains largely within the powers of individual states. Currently, Washington, D.C. and 45 state Medicaid programs provide at least some reimbursement for telehealth, with behavioral health experiencing the most rapid expansion of reimbursement policies.[6]

Some states have been quite successful in implementing telemedicine for their rural populations; the Georgia Partnership for TeleHealth's 2007 *Rural Health Initiative* will provide $100 million over the following 20 years in rural capital bonds and $11.5 million over three years for a statewide telemedicine program. The Mississippi Diabetes Telehealth Network, a statewide remote care management program launched in 2014 by the University of Mississippi Medical Center's Center for Telehealth, saved roughly $400,000, reduced A1C levels by 1.7%, and saw no emergency room visits or hospitalizations among the 100 residents involved in the initial six-month pilot.[7]

Texas has lagged behind other states regarding telehealth physician-patient encounters mainly because its laws have created the most stringent clinical practice rules for telemedicine providers when compared to in-person practice. However, in May 2017, Texas Governor Greg Abbot signed Senate Bill 1107, which enabled physicians to utilize telemedicine services with patients they have not met in person. The new law will improve access to providers, especially for the rural residents of Texas.[8]

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[5] "Will 2017 Be the Year for Telemedicine," The VoIP Report, December 20, 2016, http://thevoipreport.com/curated-news/2017-year-telemedicine/.

[6] "Medicaid Reimbursement," Robert J. Waters Center for Telehealth & e-Health Law, http://ctel.org/expertise/reimbursement/medicaid-reimbursement/.

[7] Eric Wiclund, "Mississippi Scales Up Its Telehealth Network," mHealthIntelligence, February 3, 2016, https://mhealthintelligence.com/news/mississippi-scales-up-its-telehealth-network.

[8] Erin Dietsche, "Texas law marks turning point in telemedicine," MedCity News, May 30, 2017, https://medcitynews.com/2017/05/texas-law-telemedicine/.

Telecounseling is also on the rise, as technology, infrastructure, and supporting research has steadily progressed over the past decade. Telecounseling within schools can encompass a broad array of services, including supplementing traditional therapy with the use of mobile apps for monitoring symptoms and counseling at home. The most common telecounseling approach is to use videoconferencing platforms to provide face-to-face counseling. Projects conducted in other states indicate that telecounseling holds promise particularly among youth, who are digital natives and typically comfortable with video communications. The CEO of a mental health center in rural northeast Minnesota had this to say about video conferencing and youth:

> *Children, mostly middle-school-age, seem to "engage" more quickly via telepresence. Our outcomes are improving with teenagers, and that was surprising to me because I didn't think this was going to work. But teens—their mode of communication is through electronics and doing FaceTime, and so they engage quicker, and they tend to get to the heart of their issues much faster with having the screen as the barrier and not having to go into someone's office and have that physical presence.*[9]

SUMA's research yielded few rural telecounseling programs in Texas targeted to youth or families aside from the work being done by the Texas A&M Health Science Center at the Telehealth Counseling Clinic. However, in March 2017, Liberty Resources was awarded funding by the Central Texas Chief's Association in conjunction with the Texas Juvenile Justice Department to implement a telecounseling program in the Central Texas region. The program goal was to divert at-risk youth from progressing in the juvenile justice system. Liberty Resources delivers individual and family therapy sessions according to each youth's individual treatment plan via online telecounseling. As the program progresses, plans are in place to deliver counseling and psychiatric services and possibly expand service delivery to schools and homes. Initial outcomes data indicates this program has been highly successful.

Telecounseling programs must be compliant with the Health Insurance Portability and Accountability Act (HIPAA) to protect client confidentiality. Most HIPAA-compliant sites will require the therapist to sign a HIPAA-compliant business associate agreement. Encrypted, compliant video platforms are available from a wide variety of vendors. Interviewed stakeholders indicated that additional automated systems such as encrypted email, electronic signature software, and online appointment scheduling are key to a robust, successful telecounseling program. For example, teachers or parents can receive emails or text reminders for their children's counseling sessions. Stakeholders also suggested counselors be in office buildings, libraries or schools for increased privacy and HIPPA compliance, even though the client may be situated in a public space during the counseling session.

While telehealth offers new opportunities for care, there are also a number of barriers prevalent in rural communities. These issues need to be addressed for successful telehealth programs and include:

- Many rural communities do not currently have access to internet connection speeds that support the effective and efficient transmission of data to provide telehealth services.

[9] Charles Taylor, "Tele-behavioral health care reaches rural residents," National Association of Counties, March 6, 2017, http://www.naco.org/articles/tele-behavioral-health-care-reaches-rural-residents.

- Affordable broadband is needed to support telehealth and health information exchange in order to increase access to quality care.
- Initially, the lack of face-to-face communication may seem awkward for some patients, but as meetings continue, most patients appear more comfortable with the virtual appointments.
- The cost of supporting telehealth can be barrier because many small organizations do not have the financial means to build and support a telehealth network. Finding a low-cost solution is essential to building a sustainable network.
- Complex Medicaid reimbursement models for telemedicine and telecounseling vary by state and pose significant cost barriers to schools and other organizations.
- Additional challenges restricting the adoption of telehealth in rural areas include malpractice, HIPAA and privacy concerns, data security, prescribing, and credentialing.

The following case studies illustrate ways to expand access in rural areas to behavioral care services via telehealth.

Using Telehealth Counseling and Community Health Workers in Rural South Texas[10]

Madison County is part of the seven-county region known as the "Brazos Valley." Almost 20% of residents surveyed have been diagnosed with depression or anxiety, and 35% reported that they cannot easily get access to needed services. The Center for Community Health Development (CCHD) came together in 2011 to identify local organizations that could help activate mental health and substance abuse prevention and treatment services. Partners involved in the newly formed Madison Outreach and Services through Telehealth (MOST) Network included local and state universities, substance abuse centers, clinics, churches, school districts, hospitals, and the county health department.

Summary

- **Need:** More mental health and substance abuse prevention and treatment services in rural Texas.
- **Intervention:** A network was formed to bring counseling services through telehealth systems and community health workers to the Brazos Valley.
- **Results:** The program improved health outcomes, increased general knowledge of the impact of substance abuse, and raised awareness of services among Hispanic residents.

Services Provided: MOST Network's primary focus became finding a way to link behavioral and mental healthcare services that utilize telehealth in urban communities to rural residents. To better serve the Latino community, the Network also trained community health workers (CHWs) to introduce Spanish-speaking residents to health and social services. Under supervision, doctoral-level psychology students from Texas A&M University offer counseling services in both English and Spanish from the Telehealth Counseling Clinic (TCC). Counselors connect with patients who are located in rural clinics electronically via video or phone. The MOST Network found that telehealth-based counseling circumvented obstacles to counseling such as client physical disabilities, social anxiety, geographic isolation, and financial and time constraints.

Results: After the 3-year grant period, the MOST Network saw the following results.

- Assessments showed that telehealth-based mental health services improved the overall mental health of clients in Madison County. In all, 44 unique clients were seen via telehealth, with an average of eight mental health counseling sessions each and a total of 487 sessions.
- CHWs led classes for 27 adults and 19 adolescents. By the end of their course, adult attendees saw a 27-point average increase in knowledge related to substance abuse, and a 7-point average increase in adolescent clients.

[10] "Using Telehealth Counseling and Community Health Workers in Rural South Texas," Rural Health Information Hub, https://www.ruralhealthinfo.org/community-health/project-examples/856.

- Prior to MOST, there were no Latino-focused services related to health and social services within Madison County. Throughout the course of the grant, two individuals completed the 160-hour training certification program to become CHWs.
- CHWs met with 24 Hispanic individuals and were able to refer their clients to various services. Hispanic clients made up 9% of those who received telehealth services and 18% of those who received CHW services.

Using Telehealth Counseling to Reduce Juvenile Recidivism in the Texas Justice System

In 2015, the 84th Texas Legislature passed Senate Bill (SB) 1630, requiring the Texas Juvenile Justice Department (TJJD) to finalize a regionalization plan by August 31, 2016. The plan would keep more adjudicated youth within their home regions by accessing available local post-adjudication facility capacity. Liberty Resources was awarded funding in March 2017 by the Central Texas Chief's Association in conjunction with the TJJD to implement a telecounseling program in rural South Texas near Corpus Christi. The program goal was to divert youth assessed as low- and medium-risk of recidivism from progressing in the Texas juvenile justice system.

Summary

- **Need:** Reduce adolescent recidivism and progression in the juvenile justice system, particularly for at-risk populations in rural South Texas.
- **Intervention:** Engage families and youth to participate in telecounseling for risk reduction.
- **Results:** Initial pilot outcomes indicate this model is successful in reducing the number of at-risk adolescents getting arrested or revoked, and increasing the number of teens staying in school.

Services Provided: Liberty Resources delivers individual and family therapy sessions according to each youth's individual treatment plan via online telecounseling. Part of the success of this program is based on the inclusion and active engagement with the parents and caregivers. As the program progresses, plans are in place to deliver counseling and psychiatric services and possibly expand service delivery to schools and homes.

Results: Initial outcomes data indicates this small pilot program has been highly successful. Quantitative evaluation tools were developed based on Multisystemic Therapy (MST). MST is an intensive family- and community-based treatment program that focuses on addressing all environmental systems that impact chronic and violent juvenile offenders—their homes and families, schools and teachers, and neighborhoods and friends.

After the pilot grant period, Liberty Resources saw the following results:

- Of the 15 youth with opportunities for program completion:
  - 100% were not placed or revoked during treatment.
  - 93% were not discharged due to lack of engagement.
  - 100% did not experience arrests during treatment.
  - 93% of parents/caregivers included in treatment were assessed to have improved parenting skills.
- Comparable results were reported for a smaller but similar pilot project in the rural North Texas counties of Fannin and Lamar.

School-based Telemedicine for Students in Rural North Carolina[11]

Using telemedicine to connect patients to quality healthcare providers is a proven way to increase access to health services, especially in rural areas. However, the idea of a school-based telemedicine program is unique. Health-e-Schools was created by the Center for Rural Health Innovation (CRHI) to enhance the way healthcare is delivered to students in rural schools in western North Carolina. Healthcare professional shortages pose many challenges for parents and their children. Often, parents are forced to miss multiple hours of work to drive their child to a healthcare facility for a basic examination or consultation when answers could have been given much more efficiently by staying in the school setting. Students also miss more school as a result of the long commute and time taken to receive health services. Many rural children do not receive adequate care due to time or money constraints. Health-e-Schools was created in 2011 to address these concerns about efficiency, cost, and transportation.

Summary

- **Need:** Rural school children lack proper healthcare resources within the school setting.
- **Intervention:** Health-e-Schools provides health services to students via teleconferencing using video conferencing and special equipment.
- **Results:** Health-e-Schools increases access to primary healthcare, increases attendance in the classroom, and decreases the amount of time that parents or guardians must take off of work to bring their child to health-related

Services Provided: Schools participating in Health-e-Schools offer services to all students, regardless of insurance plan or ability to pay. The sliding fee scale is used for those who are uninsured, but no patient is turned away due to type or lack of insurance. Parental or guardian written permission must be given to use these services. School faculty and staff are also eligible to utilize these services. Onsite school nurses are able to connect sick students with healthcare providers through this program. Health-e-Schools employs a full-time, off-site family nurse practitioner who uses teleconferencing as a means to see students. At this time, mental health telecounseling is not offered due to Medicaid funding barriers.

Results: The Health-e-School program has seen the following results:

- Health-e-Schools increases attendance in the classroom and decreases the amount of time that parents or guardians must take off from work to bring their child to appointments.
- Three schools began implementing this telehealth program in 2011. The following year, it grew to 10 schools. In 2013, it again expanded to 14 schools.

[11] "School-based Telemedicine for Students in Rural North Carolina," Rural Health Information Hub, https://www.ruralhealthinfo.org/community-health/project-examples/806.

- In 2014, Health-e-Schools received funding from the Duke Endowment through the Mission Health Center for Telehealth to allow for its expansion into more schools in additional communities.
- The Duke Endowment grant has allowed for twice as many students to be reached by Health-e-Schools in 2014—from 4,000 to 8,000—in 22 rural schools. This funding also made it possible for program expansion to a fourth district, adding six more schools in 2015.
- The Duke Endowment continued to support Health-e-Schools expansion, adding 11 more sites in the fall of 2016. Local grants in Burke County will allow for even further expansion in Burke County, with portable equipment that school nurses will take with them in between schools as they travel.

The successful establishment of the Health-e-Schools network led to CRHI being the recipient of the President's Award for Health Delivery, Quality and Transformation from the American Telemedicine Association in 2014.

Church-based Telehealth Counseling in Rural North Dakota[12]

In many rural areas, factors such as geography, cost, and stigma prevent residents from seeking the mental health services they need. To combat these issues, Lutheran Social Services of North Dakota (LSSND) implemented a telehealth counseling system. Each Lutheran Social Services office in the state contains a space for teleconferencing. Since not all North Dakota communities have an LSSND office, teleconferencing spaces can be located in Lutheran churches and other community spaces across the state. Lutheranism is the most common Christian denomination in North Dakota, so most communities have churches that are already affiliated with LSSND. These churches can easily house a teleconferencing space if they are interested. The service is open to all community members regardless of religious affiliation. The program established its first telehealth portal in a congregation in the summer of 2016.

Summary

- **Need:** Provide mental health services to rural residents in North Dakota.
- **Intervention:** Lutheran Social Services of North Dakota (LSSND) provides telehealth counseling through its offices and communities' Lutheran churches.
- **Results:** In the first year of practice, LSSND's Abound Counseling has brought greater access to quality mental healthcare for young children.

Services Provided: Patients gain access via telehealth or in person to a network of full-time and part-time mental health providers. While provider specializations vary, Abound Counseling has a strong concentration of providers who work with children as well as a group of therapists who specialize in working with veterans, active duty military members, and their families. The telehealth counseling program through LSSND is a fee-for-service mental health practice. Abound Counseling is a provider with most health insurances and Medicaid/Medicare. For patients who are unable to pay, LSSND has a limited charitable care fund.

Results: To date, Abound Counseling has brought greater access to quality mental healthcare for young children, especially those engaged with the child welfare system.

Barriers encountered during this pilot included provision of adequate training so that providers would feel comfortable conducting sessions via telehealth and onsite staffing by volunteers. Program success was dependent upon collaboration with people who had a solid base and presence in the local community.

[12] "Church-based Telehealth Counseling in Rural North Dakota," Rural Health Information Hub, https://www.ruralhealthinfo.org/community-health/project-examples/943.

Connecting Behavioral Health Experts with Residents via Telehealth in Rural Minnesota[13]

The Arrowhead region of Minnesota, located in the northeast part of the state, covers seven counties and three Native American tribes, all of which are designated "mental health professional shortage areas." Because rural areas have few behavioral health services, the Arrowhead Telepresence Coalition (ATC) was launched in January 2016 to host the charter telehealth project called "Collaborative Integration in Person Centered Services: Integrated Behavioral Health." ATC gives geographically-separated behavioral health providers and patients the sense of being together during a virtual appointment. This allows for the diagnosis and treatment of behavioral health disorders and brings coinciding services to the Arrowhead region.

Summary

- **Need:** Individuals in northeastern Minnesota who experience mental health crises have often taken action in ways that are harmful to themselves or others.
- **Intervention:** The Arrowhead Telepresence Coalition (ATC) connects behavioral health providers to rural patients in traditional and nontraditional medical settings through a telehealth platform.
- **Results:** The service is used by 257 registered users in seven Minnesota counties and three American Indian tribes.

Services Provided:

For schools: telepresence expands access to mental health crisis stabilization and ongoing care in schools. School therapists who are located far away from rural areas can connect with students in a matter of seconds. It has also allowed for students who have participated in a treatment program outside of school to continue care virtually while remaining in the school building.

For rural hospitals and primary care providers: integrates behavioral crisis response into hospital emergency rooms and provides clinical consultations for rural healthcare providers.

For tribal health and human services: the Minnesota Department of Health has been using telepresence to connect people to clinicians from the Human Development Center.

For jails and law enforcement: providing telepresence has introduced new services and improved on old ones at Carlton County Jail. Inmates can now be connected to a mental health or chemical dependency specialist to receive help onsite, rather than having to be transported to an offsite location. Pharmacists can also provide virtual education to inmates on the medications they are receiving from afar.

Results: As of July 14, 2017, there were 257 users registered with the ATC telemental health platform. These users have reported the following benefits.

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[13] "Connecting Behavioral Health Experts with Residents via Telehealth in Rural Minnesota," Rural Health Information Hub, https://www.ruralhealthinfo.org/community-health/project-examples/975.

For behavioral health providers:

- Increased engagement with patients
- Increased productivity
- Elimination of drive time to patients in rural locations

For patients:

- Access to behavioral health services for children and adolescents in rural northeastern Minnesota has improved.
- Students are able to stay in school for behavioral health appointments, reducing time away from the classroom.
- Children have been observed to engage more quickly with therapists.

Integrated Primary Care and Behavioral Care Clinic Model

In recent years, health policy experts and healthcare providers have begun to encourage closer integration of mental or behavioral health and primary care services. Integration can increase access to mental healthcare services, particularly in rural communities, and can increase quality of care through enhanced coordination of services. In rural areas, where behavioral health workers and primary care providers are in short supply, integration is vitally important.

Numerous studies have shown that typically, patients in rural areas who need mental health services see their primary care provider first. Often it is the primary care provider who initially diagnoses the need for mental health services. In addition, a high percentage of mental healthcare for rural patients is already provided by primary care providers, so integrating the services of a mental healthcare provider into primary care setting can expand on what is already being done.

The integration, or even the co-location, of mental health services with primary care services can also help to reduce or eliminate the effects of the powerful social stigma associated with mental illness in many rural areas. Social stigma prevents many rural citizens from obtaining needed services, but it is less of a deterrent when behavioral health professionals see patients in primary care settings. The integration of behavioral health and primary care services also reduces the challenge of maintaining anonymity. Several referral sources in SUMA's primary research described how some parents do not want to be seen receiving counseling. Even having a car parked outside of a certain building can be a public signal in small towns of what people are doing privately, leading some clients to take great pains to access services away from prying eyes. These parents may be more willing to seek mental healthcare from the more common and accepted primary care clinic.

However, there are a number of challenges with integrated primary care and behavioral services. The reimbursement offered by payers such as Medicaid, Medicare, and private insurers has a significant impact on the ability of rural providers to offer mental health services. Rural health clinics may be reluctant to start providing mental health services when reimbursement rates are low. In addition, high no-show rates among mental health clients and high numbers of uninsured patients further exacerbates the issue of low reimbursement rates paid by Medicaid and others. A study by the Maine Rural Health Research Center showed a key element in the development of services is the presence of an internal mental health champion. Internal champions are typically clinicians or administrators, who identify the need for services and undertake their implementation. Champions serve as motivators and problem-solvers; help to overcome barriers; and direct necessary resources to support service development.[14]

[14] John Gale, MS, Stepenie Loux, MS, Barbara Shaw, JD, and David Hartley, PhD. "Encouraging Rural Health Clinics to Provide Mental Health Services: What are the Options?" Research and Policy Brief, University of Southern Maine: Muskie School of Public Health, May 2010, https://muskie.usm.maine.edu/Publications/rural/pb/mental-health-services-Rural-Health-Clinics.pdf.

Integrated Service Delivery Model in Rural Michigan to Address Depression and Substance Abuse[15]

Cross-Walk was developed by the Upper Great Lakes Family Health Center in Marquette County, Michigan, where many residents are in need of behavioral health treatments. Cross-Walk was formed by a collaboration of health-centered groups with a vision to design a health system that offers behavioral healthcare within a primary care setting. Primary care clinical staff, care managers, and providers were trained in motivational interviewing and dialectical behavioral therapy skills to evaluate their patients' needs for behavioral assistance. In 2016, they also opened a dental practice within the Upper Great Lakes Family Health Center. When creating patient treatment plans, primary, behavioral, and dental care providers collaborate to ensure patients are receiving well-rounded care. This avenue was set up in order to reach the community through various method of care.

Summary

- **Need:** Address and treat substance abuse and depression in the Upper Great Lakes region.
- **Intervention:** A program that integrates behavioral healthcare into primary care services was developed in Michigan's Marquette County.
- **Results:** The collaborative efforts strengthened care management services in local healthcare facilities, as 344 patients were referred to a behavioral health specialist.

Services Offered: Primary and behavioral health staff use screening methods to identify patients in need of behavioral health services. Once a patient's screening confirms the necessity of further assistance, they can enroll in an enhanced behavioral health treatment plan. A case manager works with the patient, providers, and other staff to coordinate the patient's care services. The patient can receive individual and family counseling from behavioral health practitioners to decrease depressive and/or substance abuse symptoms.

The patient can also receive dental care from dentists, hygienists, and dental assistants within their primary care setting. By the end of 2016, Upper Great Lakes Family Health Center added a psychiatrist to the healthcare team to provide additional support for their mental/behavioral healthcare team.

Results: Specific successes during the 3-year grant period included the following.

- 344 patients referred to a case manager, and 95% were compliant with treatment plans.
- 68% improvement in depressive symptoms; 58% of patients surveyed reported improvement in well-being as a result of integrated care.

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[15] "Integrated Service Delivery Model in Rural Michigan to Address Depression and Substance Abuse," Rural Health Information Hub, https://www.ruralhealthinfo.org/community-health/project-examples/837.

Barriers: Cross-Walk encountered several barriers during their implementation but took action steps to confront them and build a successful program.

Issue:	Providers experienced resistance from patients when counseling was initially recommended.
Solution:	Cross-Walk suggested providers personally introduce patients to a behavioral health practitioner, helping to break the ice for the patients.
Issue:	Patients were not as comfortable agreeing to see a "behavioral health practitioner."
Solution:	The title, "behavioral health practitioner," was changed to "health coach" to make the specialist seem more approachable. The provider introduced the coach as someone who would teach skills to help cope with the patient's issues. As a result, patients became more willing to have a direct referral.
Issue:	A high number of patients were not showing up for scheduled behavioral health appointments.
Solution:	Cross-Walk implemented the "Plan, Do, Study, Act" quality improvement project, which included an appointment automated reminder call system, educating providers, reinforcing processes, and using dialectical behavioral therapy skills with patients. As a result, the no-show rate reduced from 33% to 27% in the next quarter.
Issue:	Clinical education and patient communication was lacking.
Solution:	Motivational interviewing methods were used to educate clinical staff on how to help patients use their strengths to help accomplish their health goals.

Eight-county Collaborative Care Model in Rural Pennsylvania to Address Behavioral Health Issues[16]

Dickinson Center, Inc. (DCI) was originally established to provide outpatient psychiatric care to rural northwestern Pennsylvania. The organization, which operates in eight rural counties, has become a regional provider of mental health, intellectual disability, and children's prevention services. More recently, DCI noticed an increase in the number of missed medical appointments as well as patients neglecting to take prescribed medications or follow through with medical treatment plans. To make it easier for patients to comply with treatment, the Community Care Behavioral Health Organization piloted a service integration model within DCI, a behavioral health facility. This integrated care facility was named "Total HEALTH" and has become a one-stop shop for patients to receive behavioral and primary healthcare services.

Summary

- **Need:** A facility that offers both behavioral and primary healthcare services for the ease of patients in northwestern Pennsylvania.
- **Intervention:** A pilot project was launched at one behavioral health facility that added a primary care and pharmaceutical component to provide a one-stop shop for patients.
- **Results:** Patients have become more willing to follow through with treatment plans and attend appointments. Partnering healthcare facilities have also experienced positive medical outcomes of enrolled patients.

Services Offered: Total HEALTH operates using a team-based model of care, where multiple professionals work together to meet the needs of the patient. The team is made up of the following professionals: the primary care physician treats physical conditions; the psychiatric physician treats mental conditions; the health navigators serve as the patient's wellness advocate through blended case management, mobile psychiatric rehabilitation, psychiatric rehabilitation, and peer specialists; and the wellness nurse acts as the liaison between the behavioral and physical components of care.

In addition to the mental/behavioral health services that DCI offers, Total HEALTH helps patients who are enrolled in the program through the following services.

- Exercise groups and diabetes/nutrition education
- Transportation scheduling through the Area Transportation Authority of North Central Pennsylvania
- Assistance with insurance to help maintain existing policies and/or secure new coverage
- Wellness nurse as a resource to the patient and staff
- Compliancy education to emphasize the importance of showing up for appointments, taking medication, and following through with treatment plans
- Appointment assistance such as scheduling, navigation, and reminders
- Medication education

[16] "Eight-county Collaborative Care Model in Rural Pennsylvania to Address Behavioral Health Issues," Rural Health Information Hub, https://www.ruralhealthinfo.org/community-health/project-examples/901.

Results: Total HEALTH has grown from serving only 10 patients to now serving more than 100. Additional accomplishments that Total HEALTH and the Patient-Centered Outcomes Research Institute (PCORI) discovered through patient evaluations include:

- Decrease in depression
- Decrease in hospital stays and emergency room visits
- Lowered components of lipid profiles
- Decrease in diabetes
- Improvements in patient compliancy

Total HEALTH received the 2014 Rural Health Program of the Year Award from the Pennsylvania Office of Rural Health.

School-linked and School-based Mental Health Collaborations

Students with undiagnosed or untreated mental health issues are among the most pressing concerns in schools across rural Texas, directly impacting student attendance, behavior, and readiness to learn. Schools represent a natural option for linking youth to mental health prevention and intervention. Receiving services through schools removes many barriers to accessing traditional community-based services in rural areas, including lack of transportation, cost, and limited family engagement. Remarkably, across the U.S. about 75% of children and adolescents who are able to access mental health services do so in a school setting.[17]

Some of the most effective approaches to improving mental health among youth look beyond traditional therapeutic approaches and explore a host of possibilities for collaborating with school staff, students, families, and community members. These "wraparound" approaches and interventions may include giving teachers and school staff tools they can use in the classroom to better manage children with mental health needs as well as resources to link families to in the community; parent coaching and education; and individual, family and group therapy, among other community-based services and supports.

Effective school-linked and school-based mental health collaborations overcome many obstacles facing rural youth by coordinating resources among schools, the community, and county agencies. They build partnerships between the education and mental health systems and can include special education programs to deliver resources to children with mental health disorders. School-linked partnerships provide treatment on campus, connect students to community-based providers, train teachers on identifying trauma and other mental health needs, and much more. School-Based Health Centers (SBHC) provide a variety of services to improve the overall health of students and their family members, including primary care, immunizations, health screenings, and health education. Some SBHCs also offer behavioral health and substance abuse services, oral health services, vision and hearing screenings, and reproductive health services.

Currently, some of the most innovative work in the field of school-based mental health is around suicide prevention, particularly with the provision of youth leadership training to recognize and help struggling peers. Motivational interviewing and trauma-informed counseling for children also represent promising approaches to improving mental health outcomes. School-based telehealth counseling, though still underutilized, holds vast promise for improving the mental health and lives of rural youth.

The case studies in this section highlight creative community partnerships, practices, and funding models that provide mental health services for students and are aimed at improving outcomes in academics, behavior, social and emotional health, and juvenile and criminal justice.

[17] "Best Practices in School Mental Health," Issue Brief #19, Child Health & Development Institute of Connecticut, February 20, 2013, https://www.chdi.org/publications/.

Communitywide Collaboration to Improve Adolescent Mental Health Awareness in Rural Mississippi[18]

"I Got You: Healthy Life Choices for Teens" (IGU) is a community health outreach program developed by Central Mississippi Residential Center in partnership with area schools, local law enforcement, the Mississippi Department of Mental Health's Bureau of Alcohol and Drug Services, Care Lodge Domestic Violence Shelter, Mississippi State University Extension Service, and the Mississippi Attorney General's Office. Its purpose is to improve the mental health of local students in rural, east central Mississippi by increasing knowledge and perception of mental illness. The original project area included eight Mississippi counties, with current outreach to 15 counties.

Summary

- **Need:** Improve the mental health of students in rural, east central Mississippi.
- **Intervention:** An intensive community mental-health outreach program was implemented for eighth graders in a nine-county area in Mississippi.
- **Results:** Students improved their ability to recognize mental health issues (high-risk behaviors) and their self-concept.

Services Provided: IGU has evolved into an intensive half-day intervention modeled after the evidenced-based SOS Signs of Suicide Prevention Program. This program reaches approximately 5,000 students each year with a defined curriculum. Students travel to local community colleges and Central Mississippi Residential Center's facility during school hours to learn about cyberbullying, self-injurious behavior, suicide prevention, dating violence, and alcohol/drug abuse prevention. Growth in the project's outreach now includes student attendance as 8th graders, versus previous years' programs offering a repeat attendance for 10th graders. At the program's completion, participants know how to recognize high-risk behavior, understand why it is important to seek help, and become familiar with available resources.

Results: Post-program surveys continue to indicate the significant positive student impact:

- 95% of students believed the program would make a difference in their lives.
- 79% of students reported they "learned a lot" from the program.
- Improved self-concept and awareness of healthy relationships.
- Stronger anti-bullying orientations and anti-drug dispositions.
- Decreased stigmatization of mental illness and greater mental health awareness.
- Participating schools report academic performance improvements, improved student coping skills, and decreased behavior-related office referrals.

Barriers: Initial challenges this program faced include:

[18] "Communitywide Collaboration to Improve Adolescent Mental Health Awareness in Rural Mississippi," Rural Health Information Hub, https://www.ruralhealthinfo.org/community-health/project-examples/817.

- Initial lack of space to accommodate student
- Securing the evaluation component
- Speaker availability

Replication: In order to create a similar program, it is important to:

- Consider partnering with local community colleges as program hosts in order to accommodate more students and provide students the opportunity to learn about continuing their education.
- Develop collaborative relationships that contribute to community building.
- Work with schools to develop policy changes regarding how teachers communicate and respond to student mental health needs.

Youth Leadership Training and Suicide Prevention in Rural Utah[19]

In 2014, Utah had the 5th highest rate of youth suicides in the country. Suicide is the leading cause of death in the state among children ages 10-17. A program called Hope4Utah has been working since 1999 to break this silence in rural and urban communities. In 2004, Hope4Utah implemented Hope Squads, school-based peer leadership programs in which students learn how to identify warning signs of suicide or other mental health concerns in their peers and alert adults to those students who may be at risk of hurting themselves. Students nominate peers who are trustworthy and helpful to become Hope Squad members.

Summary

- **Need:** Reduce youth suicide rates in Utah.
- **Intervention:** Hope Squads are peer leadership programs in schools across the state that train youth to look after their classmates and refer those with suicidal thoughts or other mental health concerns to adult advisors.
- **Results:** Surveys indicate that Hope Squad members increase and retain their knowledge of suicide and increase help-seeking behaviors after completing training.

Services offered: Schools select staff members to serve as advisors. Oftentimes, the advisor is a school counselor, but school psychologists, social workers, parents, teachers, and other staff members can fulfill this role as well. Some schools select a total of two to three advisors, while other schools select one advisor per grade level involved. In addition to lessons called PHASEs (Promoting Hope and Student Empowerment), the Hope Squad curriculum contains a three-year integration program available for high schools, middle schools, and elementary schools:

- Hope Squad Fundamentals: Select and train advisors and students.
- Hope Squad Essentials: Deepen members' understanding of mental health issues, such as resiliency and grief.
- Hope Squad Connections: Encourage members to train family members and the community.

Results: Hope Squads are located in 12 rural Utah communities, and the program has expanded to 50 squads in other states including Texas (pilot partners include Paschal High, McLean Middle, McLean 6th, Lily B. Clayton Elementary, and Tanglewood Elementary, all located within Fort Worth ISD), Alaska, Idaho, Indiana, North Carolina and Wyoming.

Two school-based surveys of Hope Squads show that its members not only increase their knowledge of suicide and intervention techniques (measured by a pretest and posttest) but members also retain this knowledge when they return to the program the following school year. Hope Squads also increases members' help-seeking behaviors and the number of referrals for help. It also decreases the stigma associated with mental health.

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[19] "Youth Leadership Training and Suicide Prevention in Rural Utah," Rural Health Information Hub, https://www.ruralhealthinfo.org/community-health/project-examples/948.

Barriers: They included getting buy-in from administrators and the community; securing enough time and funding for rural schools to receive and complete training; breaking down the myth that you can't talk about suicide; and ensuring parents and administrators that Hope Squads are not teaching students to act as counselors. Instead, students are taught to act as a bridge to counselors.

School-based Mental Health Outreach Program Serving Adolescents in Rural Washington

Washington state ranks 48th in the nation in mental illness prevalence and access to mental healthcare. In Anacortes, a rural town on Fidalgo Island, access to mental healthcare is limited due to transportation challenges, geographic location, provider availability, and cost. After losing funding for mental health, the Anacortes School District collaborated with Island Hospital to start a school-based mental health outreach program that serves adolescents, school staff, and families with psychiatric and behavioral health concerns. Clinic providers are located onsite in Anacortes public schools several days per week. Through this partnership, a School District Safety Assessment Team was developed and included local law enforcement officers, district administrators, mental health providers, and school counselors. They conducted risk and threat assessments for youth who engage in threatening verbal or physical behavior at school.

Summary

- **Need:** Anacortes, Washington, has limited access to mental healthcare services. In addition, psychiatric or behavioral health services were sparse for students in the Anacortes School District.
- **Intervention:** Island Hospital opened the Psychiatry & Behavioral Health Clinic, which serves patients on their campus and at schools located in the Anacortes School District.
- **Results:** Over 2,500 mental health and social work appointments have been facilitated at Anacortes public schools. Thousands more appointments have been provided at the clinic to meet the mental health needs of the community.

Services Provided: Services for students and school staff in the Anacortes School District include monthly mental health consultations at Island Hospital's Psychiatry & Behavioral Health Clinic; year-round access to services on Island Hospital's campus; clinical adolescent depression outreach at a local Boys & Girls Club; and clinical representation at a community-wide Youth Substance Abuse Task Force. The program also has grown to utilize clinic-supervised, masters-level interns to extend access and facilitate more visits.

Results: In 2015, the Island Hospital Foundation gave designated funds to help offset the lack of Medicaid reimbursements, supporting patient access to services by covering transportation to the clinic, copays, and other barriers to care. The additional funding has enabled access to hundreds of individual therapy and psychiatric appointments for Medicaid patients, meeting the hospital's initial vision to create a program that met the psychiatric and behavioral needs of the most vulnerable patients. Thousands of appointments have been provided by clinic staff to meet the mental health needs of the community. Since 2012, the school-based intervention program has facilitated more than 2,500 mental health and social work appointments at public schools in the Anacortes School District.

Barriers: Island Hospital's Psychiatry & Behavioral Health Clinic has run into several difficulties while providing services. Medicaid reimbursement rates have not been able to cover the cost of providing care to Medicaid-insured patient. In the first five years of operation, the clinic lost nearly $1 million. This led to the clinic's difficult decision to stop accepting Medicaid patients in order to save on cost. As a result of the decision, the clinic was able to balance their budget, but primary care clinicians had to manage psychiatry and behavioral health cases, and the emergency room experienced an increase in psychiatric admits. To solve this problem, the Island Hospital Foundation designated funds in 2015 to support access for Medicaid-insured patients. Another difficulty at the beginning of the clinic's operation was due to the demand for services. Only six months after opening, appointments were scheduled several months out. Immediate needs for services could not be met. To address this dilemma, the clinic hired a second psychiatrist and a psychiatric nurse practitioner.

Training and Building Youth Leadership to Address Adolescent Suicide and Mental Illness[20]

The Teck John Baker Youth Leaders Program is a student leadership training and suicide prevention program that incorporates the Alaska Native Inupiaq culture into a unique curriculum based on the Foundation for Healthy Generations' Natural Helpers program. This program began in response to the high rate of student suicide in rural Northwest Arctic Borough, Alaska. The teen suicide rate in this area was 7 times higher than the statewide teen suicide rate. Furthermore, Alaska has a long-standing battle with suicide and has the highest overall rate of suicide in the country.

Summary

- **Need:** The teen suicide rate in rural Northwest Arctic Borough, Alaska, was 7 times higher than the statewide teen suicide rate.
- **Intervention:** The Teck John Baker Youth Leaders Program trains student leaders to effectively give support to struggling peers and appropriately deal with social issues.
- **Results:** The number of teen suicides in the Northwest Arctic Borough decreased from eight in 2008 to five in 2009 (when the program first began) and has successfully dropped and remained at zero every year since.

Services Provided: The primary goal of this program is to train students to be leaders, which naturally includes the health and wellbeing of their peers. This extends to reducing school bullying, helping classmates who are struggling with harmful relationships, and interventions for teens battling substance abuse. Specific training is given to the youth leaders to provide comfort and seek adult aid for students having suicidal thoughts or suicidal ideation.

Each year, the program selects middle and high school students from all 11 villages in the rural school district who stand out among their peers as trusted friends in a wide variety of social and friend groups. These selected students are the true influencers of the social subgroups in schools and villages. They receive their first leadership training in the rural hub of Kotzebue. Each student then receives additional leadership training in his/her own village. Then youth leaders come up with their own way to teach what they have learned, and three youth leaders are chosen to travel to the next village and help with the training process.

Youth leaders return from training with the responsibility to:

- Support their peers.
- Use a behavioral intervention with elementary and middle school students who commit minor offenses.
- Share knowledge with their classmates about substance abuse, violence, bullying, trauma, adverse childhood experiences, and suicide.

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[20] "Training and Building Youth Leadership to Address Adolescent Suicide and Mental Illness," Rural Health Information Hub, https://www.ruralhealthinfo.org/community-health/project-examples/850.

- Plan positive school and village events, such as organizing trash pickups in the community or hosting basketball tournaments.

School employees advise the Youth Leaders Program teams throughout the year. Together, they focus on:

- Implementing health promotion and prevention activities that promote self-efficacy and positive identity development.
- Encouraging positive cultural and social identities.
- Purposefully linking the students to adult mentors as a source of support and guidance.

Results: The number of teen suicides in the Northwest Arctic Borough decreased from eight in 2008 to five in 2009 (when the program first began) and has successfully dropped and remained at zero every year since. As of 2015, more than 125 students have served as social captains.

Mental Health Workforce Development and Community-based Training

Health and policy experts generally agree that one of the most significant challenges in rural and frontier communities is the lack of mental health professionals providing mental health services. In January 2017, HRSA's Data Warehouse identified 2,451 mental health professional shortage areas designated in nonmetropolitan counties around the U.S. (Health professional shortage areas, or HPSAs, are the federal government's measure of shortages in the healthcare workforce.) It is estimated that it would take more than 948 practitioners to remove the designations.[21]

According to the Hogg Foundation's *Mental Health Guide: Understanding Systems and Services in Texas*, 206 out of the state's 254 counties were designated as full or partial mental HPSAs as of July 2015.[22] An article published in the journal *Psychiatric Services* reports that higher levels of unmet need for mental health professionals exist in counties that were more rural and had lower income levels.[23]

In 2015, the National Rural Health Association issued a policy brief detailing workforce development strategies that involve various recruitment and retention enhancements. These included student loan repayments, bonuses, and other financial incentives. Programs must also focus on minimizing the effects of professional isolation to support rural behavioral health providers.[24] So far, Texas has been unsuccessful at hiring and retaining mental health professionals at an appropriate rate to match a growing population. However, last year State Sen. Charles Schwertner sponsored a bill aimed at helping pay off the loans of approximately 100 medical health professionals who choose to work in underserved, rural areas. Efforts like this are helpful, though not nearly enough to address a complex, multi-faceted employment shortage.

Other promising approaches to building community response capacity involve mental health training for community members, including teachers, ministers, coaches, nurses, and law enforcement.

With regards to innovative utilization of its community population, San Antonio has long been praised for its collaborative approach to mental healthcare. Although a mostly urban area, the city's successful model of care, which begins with law enforcement, holds promise for rural communities.[25] Thousands of emergency responders are trained in mental healthcare application and emergency management. The police department has a designated mental health unit, trained to mediate conflict and control crisis situations. The members of this team often act more as

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[21] "Mental Health Health Professional Shortage Area (HSPA) Detail," Preformatted Reports: Health Resources and Services Administration Data Warehouse, https://datawarehouse.hrsa.gov/Tools/HDWReports/Reports.aspx.

[22] "Mental Health Guide: Understanding Systems and Services in Texas", Hogg Foundation for Mental Health, 3rd Edition, 2016, https://hogg.utexas.edu/wp-content/uploads/2016/11/Mental-Health-Guide-2016.pdf.

[23] Kathleen C. Thomas, M.P.H., Ph.D. Alan R. Ellis, M.S.W. Thomas R. Konrad, Ph.D. Charles E. Holzer, Ph.D. Joseph P. Morrissey, Ph.D, "County-Level Estimates of Mental Health Professional Shortage in the United States," October 1, 2009, https://www.ncbi.nlm.nih.gov/pubmed/19797371.

[24] "Future of Rural Behavioral Health," Policy Brief, National Rural Health Association, February 2015, https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/The-Future-of-Rural-Behavioral-Health_Feb-2015.pdf.

[25] Scott Helman, "The San Antonio way: How one Texas city took on mental health as a community – and became a national model," *Boston Globe*, December 10, 2016, https://www.bostonglobe.com/metro/2016/12/10/the-san-antonio-way-how-one-texas-city-took-mental-health-community-and-became-national-model/08HLKSq1JdXSTZppaECk2K/story.html.

counselors than as cops. This model has diverted more than 100,000 people from jail to treatment facilities and community services.

On a national scale, the National Alliance for Youth Sports offers training on coaching young athletes who might have a mental health challenge, as it affects participants in all sports and at all levels. Case studies involving middle or high school coaches as mental health advocates seem relatively sparse in U.S. health literature. However, several research studies about the use of coaches to improve mental health outcomes in Australia have been published.

Perhaps one of the most successful and widely implemented mental training for community members is the international Mental Health First Aid project; since 2008, more than 1 million people in the U.S. have received training.

Mental Health First Aid Trains Rural Community Members[26]

Mental Health First Aid (MHFA) is an early intervention public education program that teaches the public how to assist someone experiencing a behavioral health crisis. MHFA teaches the skills needed to identify, understand, and respond to individuals who may be experiencing signs of a mental illness or substance use disorder. The training is especially useful in rural communities, where access to mental health services may be limited. Rural MHFA is a way to build community-level capacity to identify mental health and substance use concerns early and for rural residents to increase their confidence to intervene and refer people to the resources that do exist. MHFA is a way to increase the level of baseline knowledge about mental health and substance abuse and to decrease the negative perceptions often associated with them.

Summary

- **Need:** Rural areas face challenges in access to mental health services, including shortages of mental health providers.
- **Intervention:** This eight-hour course trains rural community members to recognize mental health and substance abuse issues and learn how to help someone who is developing a mental health concern or experiencing a mental health crisis.
- **Results:** Numerous studies of this method have found that course participants are better able and more likely to help others regarding mental health issues.

Services Provided: MHFA was first created in Australia in 2001. The training program has been used successfully throughout Australia, including in rural areas. It has been adapted in 23 other countries, including the U.S. Mental Health First Aid USA is managed by the National Council for Behavioral Health.

MHFA training is offered through an eight-hour course in which participants learn about:

- Risk factors and warning signs for mental health issues
- Information on depression, anxiety, trauma, psychosis, and substance use disorders
- A five-step action plan to assess a situation, identify appropriate interventions, and help those in need access mental health services
- Resources available to help people experiencing a mental health issue

[26] "Mental Health First Aid Trains Rural Community Members," Rural Health Information Hub, https://www.ruralhealthinfo.org/community-health/project-examples/725.

Audiences for this training include:

- Law enforcement
- First responders
- Primary care providers
- Nursing home staff
- Schools and teachers
- Faith-based organizations
- Employers and the business community
- Higher education staff and students
- Military, veterans, and family members
- Populations working with older adults
- Policymakers
- Mental health advocacy organizations
- Shelter volunteers

Results: Since 2008, more than 1 million people across the U.S. have been trained. Research studies examining this approach have found that participants of the MHFA course have:

- Improved knowledge of mental illnesses and treatments
- Knowledge of appropriate strategies for helping others
- Confidence to provide assistance regarding mental health issues

Training Rural Clergy and Chaplains to Improve Veteran Mental Health[27]

According to a September 2013 *Journal of Religion and Health* article, a study of veterans with depression and post-traumatic stress disorder (PTSD) found that 47% were open to seeking help from clergy and 12% had sought clergy assistance. Clergy can serve as partners in assisting veterans with reintegration into civilian life and in leading the community to reduce the stigma associated with accessing mental healthcare.[28] In 2009, the Veterans Health Administration Office of Rural Health funded the original Rural Clergy Training Project to deliver one-day workshops to community clergy and chaplains. This project evolved into the Community Clergy Training Program to Support Rural Veterans Mental Health (CCTP). The CCTP offers free interactive training sessions to educate rural clergy and chaplains about the unique health issues and readjustment difficulties common to veterans. The goal of the CCTP is to provide rural clergy with specific skills in supporting veterans and their families and to better equip clergy with the resources and information necessary for referring veterans in need of physical or mental healthcare to VA (U.S. Department of Veterans Affairs) and community facilities.

Summary

- **Need:** Educate rural clergy and chaplains about the ways they can help improve veterans' access to physical or mental healthcare by referring veterans to available resources.
- **Intervention:** Trained VA chaplains and U.S. Army Reserve chaplains provide free interactive training sessions to rural community clergy partners.
- **Results:** Since 2010, more than 4,000 clergy members, chaplains, behavioral health professionals, and others supporting rural veterans have participated in a Community Clergy Training Program (CCTP) event.

Services Provided: The CCTP offers multiple modules that cover a variety of topics related to veteran reintegration. The first two interactive sessions address conflicts between military and civilian culture and the challenges of readjusting to civilian life, common combat and military service-related health concerns, and pastoral care with veterans and their families. The second two sessions focus on working with and referring to VA and community mental healthcare providers and building a network of community support for veterans, service members, and military families.

The interactive viewing events are free for rural community clergy partners and are designed to achieve the following.

- Improve clergy understanding of veteran and military culture.
- Educate on the common physical, mental, emotional, and spiritual issues that veterans deal with after returning from war zones.

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[27] "Training Rural Clergy and Chaplains to Improve Veteran Mental Health," Rural Health Information Hub, https://www.ruralhealthinfo.org/community-health/project-examples/740.

[28] Bonner LM, Lanto AB, Bolkan C, Watson GS, Campbell DG, Chaney EF, Zivin K, Rubenstein LV, "Help-seeking from clergy and spiritual counselors among veterans with depression and PTSD in primary care," September 2013, https://www.ncbi.nlm.nih.gov/pubmed/23297184.

- Provide awareness for clergy to make referrals, not diagnoses.
- Create a referral process to assist veterans in accessing healthcare and the VA and community resources available to them.
- Help veterans readjust and reintegrate with their families and communities.
- Assist clergy in using their positions within the community to impact public opinion and reduce stigma

Results: Overall, rural community clergy reported an improved understanding of veteran issues and development of veteran-focused ministries. In addition, there have been increases in efforts to reduce mental health stigma and increases in veteran referrals to VA and community-based healthcare.

Appendix A: Research Guides

STAR Parent Interview Guide

Date:
Interviewer:
Organization Name:
Location:

Thank you for taking the time to visit with me. My name is XX and I am working on behalf of the State of Texas. We are conducting interviews with parents whose children or families have received services from (INSERT PROGRAM NAME HERE).

This is a confidential conversation. That means that I will not share your name with anyone. What you say will not be connected with your name. If you receive any kind of services from the state, they cannot be impacted based on anything you share with me today.

My goal today is to learn from you about what worked and what could be improved. Please share openly and honestly so that we can take this information and help other families. This is not a test, there are no right or wrong answers. This will be about an hour.

Do you have any questions for me?

- ❑ *Yes*
- ❑ *No*

Then we will begin.

I. Background Information

1. Will you please tell me a little bit about your children and who in your family accessed services from (INSERT PROGRAM NAME)?
   - ❑ Child
   - ❑ Family

2. How long did your family receive services?

3. What brought you to (INSERT PROGRAM NAME) for services? Please just share what you are comfortable with.

II. Referral

4. How did you first learn about (INSERT PROGRAM NAME)?
   - ❑ School staff
   - ❑ Physician
   - ❑ Friend/Family
   - ❑ Juvenile Court/Probation
   - ❑ Faith-based organization
   - ❑ Others- _____ (moderator list)

5. What did they tell you about (INSERT PROGRAM NAME)?

6. What were your initial impressions of what you heard?

7. Tell me step-by-step how you started with Star (or program name)? *Moderator leads them through the process of what got them to sign up.* **Probe:** What motivated you to sign up?

8. What if any challenges did you have signing up?

9. What worked well?

10. How long did you wait before the first appointment?

11. How would you describe the ease of signing up for services?
    - ❑ 1- Not easy
    - ❑ 2- Somewhat easy
    - ❑ 3- Easy
    - ❑ 4- Very easy

12. What do you think could be done to make this referral or sign-up process easier for families?

III. Intake/Assessment

13. What do you remember about the initial meeting/intake process?

14. Who participated in that meeting? Where was that meeting?

15. How could that initial meeting be improved?

16. *Moderator shows the parent the Protective Factors Survey*. Do you remember filling this out at your appointment?
    - ❑ Yes
    - ❑ No

17. How honest do you think you were when you first completed this form?
    - ❑ 1 - Not honest
    - ❑ 2 - Somewhat honest
    - ❑ 3 - Honest
    - ❑ 4 - Very honest

18. Please take a couple minutes to read through these questions. *Moderator gives the parent the Protective Factors Survey*:

    Had you thought about these questions before you started services?
    Which if any of these questions did you find helpful?
    What is the purpose of these questions? Did the intake staff member explain the purpose of this question to you?
    - ❑ Yes
    - ❑ No

    Which if any of these questions do you find confusing?

19. Did you complete this form at the end of services?
    - ❑ Yes
    - ❑ No
    - ❑ My family is still receiving services

20. Has anyone reviewed or discussed your survey responses with you?
    - ❑ Yes
    - ❑ No

IV. Services

21. I'd like to spend some time talking with you about the services your family received. What services did your family receive?
    - ❑ Individual counseling (private meeting with the counselor and child)
    - ❑ Family counseling (private meeting with the counselor and family)
    - ❑ Youth skills (group class with other children)
    - ❑ Parenting skills (group class with other parents)
    - ❑ Other services?

22. Are you currently receiving services?
    - ❑ Yes
    - ❑ No

23. If not, why did services end?
    - ❑ The time ran out and we could not receive more services
    - ❑ My child's behavior improved and we did not need services anymore
    - ❑ I was unable to go to services so they had to close the case.

    Probe: Can you please tell me a little about the barriers to you going to services?

24. How many sessions total did your child attend?

25. How many sessions total did your family attend?

26. Was your child able to attend all of the individual counseling sessions that were scheduled? Why or why not?

27. Were you able to attend all of the parent counseling sessions that were scheduled? Why or why not?

28. How frequently did your child receive services?
    - ❑ Weekly
    - ❑ Every two weeks
    - ❑ About once a month
    - ❑ Less than monthly

29. What are your thoughts about that frequency?
    - ❑ It was the right amount
    - ❑ It was not enough
    - ❑ It was too much

    What makes you give that answer?

30. How often did a parent or caregiver participate in services?
    - ❑ Weekly
    - ❑ Every two weeks
    - ❑ About once a month
    - ❑ Less than monthly

31. What are your thoughts about that frequency?
    - ❑ It was the right amount
    - ❑ It was not enough
    - ❑ It was too much

32. What makes you give that answer?

33. Were you able to receive services in a location that was convenient for you and your family? If no, please tell me a bit about that?
    - ❑ Yes
    - ❑ No

34. Where did your child receive services? *Moderator, if family received services, ask:* Where did you receive services*?*

35. What were the benefits of receiving services at this location? What were the challenges of receiving services at this location?

36. How would you describe the ease in which you as a parent were able to participate in services?
    - ❑ 1 - Not easy
    - ❑ 2 - Somewhat easy
    - ❑ 3 - Easy
    - ❑ 4 - Very easy

    What makes you give that answer?

37. What were the challenges for you and your family in accessing and receiving services? **Probe:** transportation, hours/work schedules, childcare for other children

38. What would make it easier for parents to participate in services?

39. Would being able to have some sessions over the phone make a difference in participating in services? Would texting about appointment reminders or scheduling logistics with the counselor make a difference? What else would have made it easier for you as a parent to be engaged in the process?

40. What worked well for you and your family in accessing and receiving services?

41. Do you feel that your child received the services that they needed? Please tell me a bit about that.
    - ❑ Yes
    - ❑ No

42. How effective do you feel the services were for your child?
    - ❑ 1 - Not effective
    - ❑ 2 - Somewhat effective
    - ❑ 3 - Effective
    - ❑ 4 - Very effective

    What makes you give that answer?

43. How effective do you feel the services were for your family?
    - ❑ 1 - Not effective
    - ❑ 2 - Somewhat effective
    - ❑ 3 - Effective
    - ❑ 4 - Very effective

    What makes you give that answer?

44. Did this program help reduce your family conflict?

45. What advice from the counselor has stuck in your mind? Was there anything they said to make you feel positive about the counseling experience?

46. Were you referred to any services while you were enrolled in the program or as part of a discharge plan?
    - ❑ Yes
    - ❑ No

    If so, which services were helpful?

47. What would you tell another parent about the STAR (program name) services?

48. Have you recommended STAR services to other parents? Would you?

49. What, if any, changes do you think it made to the way you parent?

50. What if any changes have you seen in your child's behavior?

51. Do you think this program helped your family from needing to seek other services?
    - ❑ Yes
    - ❑ No

    Tell me about that:

52. How could services with (INSERT PROGRAM NAME) be improved?

53. Any final thoughts you would like to share?

Thank you for your time and feedback!

STAR Staff Focus Group Guide

Moderator begins by introducing the concept, process, and purpose of the focus group. She will also lay ground rules for the discussion, explain the purpose of the tape recording equipment, and assure participants that their remarks are confidential in the sense that their names will never be attached to their statements.

I. Introduction

- Please introduce yourself and tell us how long you have been with STAR, your title, and a little about the work you do for STAR.

II. Services Provided

- Describe a day in your work life. Who are you seeing? What are you doing?

- What are the most common challenges you see youth and their families in the STAR program experiencing? (specify, not as listed on the registration form)

- Which protective factors are most commonly addressed through STAR services?

- What needs do you meet in the community? Are there any needs that are unmet? **Probe**: Truancy? Drugs and alcohol? Parent therapy/counseling?

- How long do youth typically stay engaged in services? How long do caregivers remain engaged in services?

- What factors lead to caregivers having limited engagement in services? What factors lead to youth having limited engagement in services?

- What would your recommendations be for increasing youth engagement? What would your recommendations be for increasing caregiver engagement?

III. Assessment

- Can you walk us through your assessment process? Who conducts it?

- Are any specific assessment tools or instruments used? Who is it given to? (the youth, the parent, others?) **Probe:** Protective Factors Survey, Psychosocials, Child and Adolescent Functional Assessment Scale (CAFAS), Self-Sufficiency Matrix (SSM), Child and Adolescent Needs and Strength CANS))

- Do you use responses on the Protective Factors Survey to help inform service delivery for youth and/or families? How is this done?

- How do you use information gathered on these surveys to tailor service delivery to the youth or family?

- What parts of the assessment process work well for you?

- Are there improvements needed to the assessment process for the STAR program at your agency?

- What other measurements or data do you use to assess outcomes of your clients?

- How do you know if a client's situation is improving? How do you determine if a client is ready to be discharged?

III. Training

- How do new staff receive training? Who provides it?

- How do you stay current on skills and learn about best practices?

- What training would you like? Probe: Conferences? Specific topics?

IV. Community Relationships and Referrals

- How well known is STAR in your community?

- How do you let people in your community know about STAR? **Probe:** What materials do you use?

- How do people find out about STAR in your community? Are there specific referral sources in your community? How do you promote STAR to potential referral sources?

- What do people in your community know about STAR? How do they refer to/call it? How much education is needed for people to understand the scope of services STAR provides?

- Do you think there are any reasons people in your community would not use STAR?

- What is needed to better promote STAR in your community?

- Which programs similar to STAR are well known in your area? How do people learn about those? Why do you think they are well known?

- How do you refer to the program? Do you call it STAR?

- How do people respond to the name STAR?

- Are you responsible for conducting outreach for the STAR program? Who creates and implements the outreach and community engagement plan for your program? If you are primarily responsible for this, do you feel like you need more support?

- How could working with referral sources be improved? **Probe:** What materials do you give them? How are they educated about STAR?

- What kinds of organizations do you work with in a collaborative manner?

- *Moderator makes a list of these and then asks the following questions for each (**Probes** for school; juvenile justice; CPS, hospitals)*:

    - How would you describe your relationship with [insert institution/organization here] **Probe**: What works in terms of collaborating with them? What are the challenges?

- How could working with other organizations in your area be improved?

- Do you know what other PEI funded programs are in the area you serve? How do you learn about other PEI funded program in your area or across the state?

V. Conclusion

- What support do you need that you are not getting in order to improve services to your community?

- If there were a new STAR provider starting up in a different part of the state, what advice would you give them to help them be successful?

- How would you want the STAR program to change to better support your community?

- I would like to go around the table and ask each of you what you think is the single most important thing for the people who are administering STAR at the state level to hear about your challenges, unmet needs in your community, or best practice in your community or STAR program?

Thank you very much for your time!

Potential Referral Source
Focus Group Guide

I. Introduction

Moderator *begins by introducing the concept, process, and purpose of the focus group.*

- *Lay ground rules for the discussion (no right or wrong answers, speak one at a time, etc.).*
- *Explain the purpose of the tape-recording equipment.*
- *Assure participants that their remarks are confidential in the sense that their names will never be attached to their statements.*

Purpose of group*: The purpose of this group is to discuss the needs of families in community raising children between the ages of 7 and 18. You all represent organizations that intersect with that segment of your community. That is what you all have in common.*

Moderator *asks each participant to introduce themselves, your organization and position; and give a high-level overview of services that your organization offers to the community.*

II. Serving Families and Children

- ***Moderator*** *lays various picture cards around the room and on the table.*
  You all are in positions where you have to refer families to services which could help their children between 7 and 18. Please take a moment to view as many cards as possible and choose the photograph that best illustrates what it is like to refer a family to services they need. We will go around the room and everyone can share their thoughts and photograph.

- What is it like to serve families in your communities?

- What's the most challenging aspect?

- What works well?

- What are some of the things that families in your community are dealing with? ***Moderator*** *lists issues on a flip chart.* **Probe:** How do these kinds of situations impact families?

- How do you see parents addressing these issues? **Probe:** Either appropriately or inappropriately?

- What kind of support would help parents address these issues?

III. Referrals

- What programs does your organization currently refer families to?

- For what reasons do you refer families to other resources outside of what your organization provides?

- Which programs do you refer out to most often? Why?

- What is the average time from when you refer to when a client received services? What is the ideal time?

- What must an organization do in order for you to consider referring families to them? **Probe:** Processes? Approvals? Memorandum of Understanding?

- What makes a good referral partner? **Probe:** How do they keep you up to date? How did you learn about their services in the first place? How do you choose where to refer families to?

- What kind of communication do you receive from organization to which you refer? **Probe:** Would you expect to be updated about the progress? How frequently? Through what channels? What would that feedback look like?

- Is there a referral partner that you work with that is a particularly good model of promoting themselves or communicating with you? I want the details of how they relate to you and your organization? ***Moderator*** *writes responses on a flip chart.* **Probe:**
  - How did you first learn about them?
  - How frequently do they communicate with you?
  - Through what channel?
  - What's the single best thing they do to engage you and encourage you to continue referring to them?

- What is the #1 reason referrals fail?

- What is the #1 reason referrals succeed?

IV. Resources and Stigma

- Where could families go to get help for their children? Who could they turn to? ***Moderator*** *writes ideas on a flip chart.*

- Are there parenting classes in your community? **Probe:** Who offers them? What do you know about them? Are they individual classes or a series? Do they use a specific curriculum? Is there a cost associated with them?

- What barriers would prevent parents from attending a parenting class? **Probe:** Time transportation, availability, cost, desire? What if they classes were free?

- Do you think there is a stigma associated with taking parenting classes?

- What about family and child counseling in your community? **Probe:** Who offers that? What do you know about their counseling services? Do they use a specific model? Is there a cost associated with it?

- What barriers would prevent parents from participating in family or child counseling? **Probe:** Time, transportation, availability, cost, desire? What if the counseling was free?

- Do you think there's a stigma associated with "counseling"?

V. Ideal Program

- What needs are currently unmet in your community for families with children 7 to 18? What services do you wish were offered?

- If you were making a program that provided all of the things you all listed earlier, what would that look like? ***Moderator*** *writes ideas on a flip chart.*
  Probe:
  - What would they provide?
  - Where would they provide it?
  - When would it be available?
  - How would you learn about it? School, religious leaders?
  - What would you call it?
  - How much would it cost?

VI. STAR

- Have any of you heard of the STAR program or [local agency name]? What have you heard about that program? ***Moderator*** *explains the STAR program.*

- *If they have not heard of the STAR program, the* ***moderator*** *explains what services are offered from STAR.*

- Would you consider referring families to services from STAR? Why or why not?

- What would STAR need to do to receive referrals from your organization? **Probe:** Who would they need to contact at your organization? What would they need to tell that contact?

- What would make it easy for you to refer families to STAR services? **Probe:** Referral forms? Designated point of contact? Periodic communication? Calls, emails, in person visits?

VII. Materials Testing

- I am going to give you some materials to read and review, and then we will talk about each of them. ***Moderator*** *passes out materials.*
    - *CONNECTIONS brochure with STAR insert*
    - *Texas Panhandle STAR brochure*
    - *SCAN STAR flyer*
    - *DePelchin STAR flyer*
    - State STAR brochure

Questions for Each Material

- What are your top-of-mind thoughts about this brochure?
- How useful is it for informing you about the program?
- How useful would it be for informing parents the program?
- What information is missing?
- What other tools better help you promote this program?

VIII. Dissemination

- We have looked at some materials and discussed ideas about family support. What is the best way to inform families about these things? **Probe**: Social media, community organizations, where you go on a daily basis?
- Are there any programs you currently refer to that have particularly effective marketing materials? What makes them especially strong?

IX. Conclusion

- In closing, what is the most important thing you think STAR can do to expand their network of referral sources in your community?

Thank you for your time!

STAR Agency Director
Interview Guide

I. Introduction

I am working on behalf of Prevention and Early Intervention at the Texas Department of Family and Protective Services. Our company, SUMA Social Marketing, is an independent research company helping gather information about community needs and about the STAR program.

We are conducting this research to help inform the STAR program. This is not an evaluation of your program. We are interested in learning from you about your community- what needs your programs meets and what needs in the community still need to be addressed. We are also interested in learning a bit about how you promote your program and how clients learn of your STAR program.

The interview will take about one hour and everything you say to me is confidential.

1. Please tell me a little about your position: what you do and how long you've been doing this type of work.

2. Could you please give me a sense of the structure of your organization? How many offices do you have? How many employees? What positions? Where are the offices?

3. Please explain to me your STAR funded services; What are their names? Who are they offered to? How are they delivered? Where are they delivered? Who is delivering the service? Let's go through each one.

II. Population Services and Services

4. Please describe the population for whom you provide services. Where are they located? Rural? Urban?

5. What do you think are the biggest barriers to each of the groups we just mentioned?

6. How would you describe their reasons for accessing services?

7. What are your most underserved areas and why do think that area is underserved?

8. Which services are most accessed?

9. Which services are least accessed?

10. Which services do you wish you offered but don't?

11. What do you believe the unmet needs in your community to be?

III. Assessment Process

12. Can you please walk me through your Assessment for the STAR Program?

13. What do you think works in this process? What do you think could be improved?

IV. Measurements and Best Practices

14. Is your organization collecting outcome measures that are not currently required by the STAR program? If so, please describe to me what you are collecting and how you are collecting it?

15. What benefits do you see from the children and families who have graduated from the STAR program? How do you know these are benefits? How do you capture and measure these benefits?

16. How do you stay up to date on best practices and interventions? Where do you learn about these?

17. What information do you not have that would be helpful to you?

V. Referrals and Marketing

18. Are there other agencies that offer the same services in your area?

19. What kind of strategies do you use to engage families?

20. How do you target engaging families and youth that are more at risk for entering the child welfare or juvenile justice systems?

21. Please describe for me how your clients learn of your program and your services? Specific referral organizations?

22. Will you please provide me with a list of the organizations from whom you receive referrals?

23. How does your organization work with these referral sources? Specific outreach? What materials do you use to conduct your outreach?

24. What educational, marketing or programmatic aspects of STAR do you think are most likely to engage and motivate parents (and the population the stakeholder works with)?

25. What other programs, like STAR, are you aware of either in other states or on a national level?

26. Moderator will recap what we have learned from the annual reports and will then ask the following questions: How have you connected with these other partners in your area? Can you tell me a little bit about that process and how it is working?

27. How do you work with the schools? What are the benefits and/or barriers to getting into and working with the schools?

28. Do you use the name "STAR" to refer to the STAR-funded services you provide? Do you use the STAR name or logo when discussing services funded by STAR with parents and youths? If not, is there another brand or name you use to refer to those services?

VI. Discussion on Future Staff Meeting

As part of our scope of work we would like to come and conduct a meeting with your staff. This is also to learn and is not an evaluation of your program. We want to hear from them, since they are providing direct service, about what they believe the community needs are that are being met and what are the unmet needs. We are also interested in what they think are good referral sources and how they market the program.

We are envisioning these meetings as 2-hour lunch meetings. We will bring in lunch to your organization and have an informal discussion. (Moderator will explore the best way to bring staff from various geographic locations together)

How does that sound to you? Are there any specific challenges we should be aware of? Any dates that are off limits?

We will be back in touch soon to continue the conversation about the meeting.

Thank you so much for your time today.

Potential Parent
Focus Group Guide

I. Introduction

- ***Moderator*** *begins by introducing the concept, process, and purpose of the focus group.*

    - *Lay ground rules for the discussion (no right or wrong answers, speak one at a time, etc.).*
    - *Explain the purpose of the tape-recording equipment.*
    - *Assure participants that their remarks are confidential in the sense that their names will never be attached to their statements.*

- ***Purpose of group****: The purpose of this group is to discuss your family and raising your child between the ages of 7 and 18. That is what you all have in common.*

- ***Moderator*** *asks each participant to introduce themselves, share their name and a little bit about their children and how old they are.*

II. Raising Children

- ***Moderator*** *lays various picture cards around the room and on the table.*

- Please take a moment to view as many cards as possible and choose the photograph that best illustrates what it is like for you raising your oldest child between 7 and 18. We will go around the room and everyone can share their thoughts and photograph.

- What's the best part about being a parent?

- What's the most challenging part of being a parent?

- What concerns do you have about your child's daily life?

- What are some of the ups and down that your child is dealing with on a daily basis? ***Moderator*** *is moving the conversation towards a psychosocial discussion.*

- How do you as a parent address these things?

- What do you wish you could do?

- What kind of support would help you address these things?

III. Resources and Stigma

- Think back about the most challenging time you've had with your child. You don't have to share details but what did you do in that moment?
  - What did you do?
  - Who did you rely on to help you?
  - Did you reach out to anyone/a service provider in the community? Who was it?
  - What was helpful?

- So far we have been discussing how challenging it is to raise children. During these challenging times, what support do you wish you would have had available to you? ***Moderator*** *writes ideas for desired services on a flip chart.* **Probe:** What about parenting classes? Realistically, would you have time in your schedule to go attend a class? What barriers would prevent you from participating in counseling? Time transportation, availability, cost, desire? *(**Probe** for when or what kind of schedule would make it work for you? Where in the community?)*

- What does counseling mean to you? What do you think counseling looks like? **Probe:** Length? Short? Long?

- What thought first comes to mind when you hear the word "counseling"?

- How does the word "counseling" make you feel? ***Moderator*** *probes to get to feelings, not thoughts.*

- What are your thoughts about attending counseling for either yourself or your child attending?

- What barriers would prevent you from participating in counseling? **Probe:** Time transportation, availability, cost, desire?

- ***Moderator*** *draws on previous conversation and what has been said about counseling.* Is there a stigma associated with "counseling"? Why do you think that is?

- What other words would you suggest instead of "counseling"? **Probe:** What do you think of family support, family guidance, family counseling, short-term counseling?

IV. Ideal Program

- If you were making a program that provided all of the things you all listed earlier, what would that look like? ***Moderator*** *writes ideas on a flip chart.* **Probe:**
  - What would they provide?
  - Where would they provide it?
  - When would it be available?
  - How would you learn about it? School, religious leaders?
  - What would you call it?
  - How much would it cost?

V. Website Testing and STAR

- *Participants will use tablet to go to HelpandHope.org.* ***Moderator*** *will lead participants through the "Help Where You Are" section to see what services are available in their county.*

- Who is this website for?

- Is this website for you?

- Looking at the "Services Offered" column, how would you use those services? Are they for you?

- What do you think about the term "at-risk"? Who do you think of when you hear that term?

- Have any of you heard of the STAR program or DePelchin Children's Center? What have you heard about that program? *If they have not heard of it,* ***Moderator*** *explains the STAR program.*

- Would you consider accessing services from STAR? Why or why not?

VI. Materials Testing

- I am going to give you some materials to read and review, and then we will talk about each of them. ***Moderator*** *passes out materials.*

STAR State Brochure

Moderator *asks participants to circle the parts or words that are appealing to them and to put an X over parts that are not appealing.*

- What parts of this brochure did you circle that were appealing to you? Tell me why you circled them.

- What parts of this brochure did you cross out that were not appealing to you? Tell me why you crossed them out.

STAR Agency Marketing Materials

Moderator *asks participants to take a few minutes to review the following materials and then be ready to discuss what they liked and disliked about them:*

- *CONNECTIONS brochure with STAR insert*
- *Texas Panhandle STAR brochure*
- *SCAN STAR flyer*
- *DePelchin STAR flyer*

- What are your top-of-mind thoughts about these materials?
- Who do you think this is for?
- What catches your eye or attention?
- What do you like?
- What do you dislike?
- What words jump out?
- What do you think about the colors, font, etc.?
- What are the most important bits of information from these materials?
- How important are these services to you and your family?
- What would you do after seeing these?

VII. Dissemination

- We have looked at some materials and discussed ideas about family support. Where would you expect to find these materials?
- What is the best way to inform you about these things? **Probe**: Social media, community organizations, where you go on a daily basis?

VIII. Conclusion

- In closing, what is the most important thing you think an organization such as STAR can provide to families?

Thank you for your time!

Appendix B: Field Test Materials

PROTECTIVE FACTORS SURVEY

(Program Information-- For Staff Use Only)

Agency ID _____ **Participant ID #** _____

1. Date survey completed: ____/____/____ ☐ **Pretest** ☐ **Post test**

2. How was the survey completed?

☐ Completed in face to face interview
☐ Completed by participant with program staff available to explain items as needed
☐ Completed by participant without program staff present

3. Has the participant had any involvement with Child Protective Services?

☐ NO ☐ YES ☐ NOT SURE

4.a. Date participant began program (complete for pretest) ____/____/____

4.b. Date participant completed program (complete at post test) ____/____/____

5. **Type of Services**: Select services that most accurately describe what the participant is receiving.

☐ Parent Education
☐ Parent Support Group
☐ Parent/Child Interaction
☐ Advocacy (self, community)
☐ Fatherhood Program
☐ Planned and/or Crisis Respite
☐ Homeless/Transitional Housing
☐ Resource and Referral
☐ Family Resource Center
☐ Skill Building/Ed for Children
☐ Adult Education (i.e. GED/Ed)
☐ Job Skills/Employment Prep
☐ Pre-Natal Class
☐ Family Literacy
☐ Marriage Strengthening/Prep
☐ Home Visiting
☐ Other (If you are using a specific curriculum, please name it here) _____

6.) Participant's Attendance: (Estimate if necessary)

A) **Answer at Pretest:** Number of hours of service offered to the consumer: _____

B) **Answer at Post-test:** Number of hours of service received by the consumer: _____

This survey was developed by the FRIENDS National Resource Center for Community-Based Child Abuse Prevention in partnership with the University of Kansas Institute for Educational Research & Public Service through funding provided by the US Department of Health and Human Services.

PROTECTIVE FACTORS SURVEY

Agency ID _____ **Participant ID #** _____

1. Date Survey Completed: _/____/____ **2. Sex**: ☐ Male ☐ Female **3. Age (in years):** _____

4. Race/Ethnicity: (Please choose the ONE that best describes what you consider yourself to be)

☐A Native American or Alaskan Native
☐B Asian
☐C African American
☐D African Nationals/Caribbean Islanders
☐E Hispanic or Latino
☐F Middle Eastern
☐G Native Hawaiian/Pacific Islanders
☐H White (Non Hispanic/European American)
☐I. Multi-racial
☐J Other _____

5. Marital Status:

☐A Married ☐B Partnered ☐C Single ☐D Divorced ☐E Widowed ☐F Separated

6. Family Housing:

☐A Own ☐B Rent ☐C Shared housing with relatives/friends
☐D Temporary (shelter, temporary with friends/relatives) ☐E Homeless

7. Family Income:

☐A $0-$10,000 ☐B $10,001-$20,000 ☐C $20,001-$30,000
☐D $30,001-$40,000 ☐E $40,001-$50,000 ☐F more than 50,001

8. Highest Level of Education:

☐A Elementary or junior high school ☐B Some high school ☐C High school diploma or GED
☐D Trade/Vocational Training ☐E Some college ☐F 2-year college degree (Associate's)
☐G 4-year college degree (Bachelor's) ☐H Master's degree ☐I PhD or other advanced degree

9. Which, if any, of the following do you currently receive? (Check all that apply)

☐A Food Stamps ☐B Medicaid (State Health Insurance) ☐C Earned Income Tax Credit
☐D TANF ☐E Head Start/Early Head Start Services ☐F None of the above

10. Please tell us about the children living in your household.

	Gender		Birth Date (mm/dd/yy)	Your Relationship To Child (check one)						
	Male	**Female**		A Birth parent	B Adoptive parent	C Grand-parent	D-Sibling	E-Other relative	F-Foster Parent	Other
Child 1										
Child 2										
Child 3										
Child 4										

If more than 4 children, please use space provided on the back of this sheet.

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PROTECTIVE FACTORS SURVEY

Part I. Please ***circle*** the number that describes how often the statements are true for you or your family. The numbers represent a scale from 1 to 7 where each of the numbers represents a different amount of time. The number 4 means that the statement is true about half the time.

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
1. In my family, we talk about problems.	1	2	3	4	5	6	7
2. When we argue, my family listens to "both sides of the story."	1	2	3	4	5	6	7
3. In my family, we take time to listen to each other.	1	2	3	4	5	6	7
4. My family pulls together when things are stressful.	1	2	3	4	5	6	7
5. My family is able to solve our problems.	1	2	3	4	5	6	7

Part II. Please *circle* the number that best describes how much you agree or disagree with the statement.

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
6. I have others who will listen when I need to talk about my problems.	1	2	3	4	5	6	7
7. When I am lonely, there are several people I can talk to.	1	2	3	4	5	6	7
8. I would have no idea where to turn if my family needed food or housing.	1	2	3	4	5	6	7
9. I wouldn't know where to go for help if I had trouble making ends meet.	1	2	3	4	5	6	7
10. If there is a crisis, I have others I can talk to.	1	2	3	4	5	6	7
11. If I needed help finding a job, I wouldn't know where to go for help.	1	2	3	4	5	6	7

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PROTECTIVE FACTORS SURVEY

Part III. This part of the survey asks about parenting and your relationship with your child. For this section, please focus on the child that you hope will benefit most from your participation in our services. Please write the child's age or date of birth and then answer questions with this child in mind.

Child's Age _____ or DOB ____/____/____

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
12. There are many times when I don't know what to do as a parent.	1	2	3	4	5	6	7
13. I know how to help my child learn.	1	2	3	4	5	6	7
14. My child misbehaves just to upset me.	1	2	3	4	5	6	7

Part IV. Please tell us how often each of the following happens in your family.

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
15. I praise my child when he/she behaves well.	1	2	3	4	5	6	7
16. When I discipline my child, I lose control.	1	2	3	4	5	6	7
17. I am happy being with my child.	1	2	3	4	5	6	7
18. My child and I are very close to each other.	1	2	3	4	5	6	7
19. I am able to soothe my child when he/she is upset.	1	2	3	4	5	6	7
20. I spend time with my child doing what he/she likes to do.	1	2	3	4	5	6	7

This survey was developed by the FRIENDS National Resource Center for Community-Based Child Abuse Prevention in partnership with the University of Kansas Institute for Educational Research & Public Service through funding provided by the US Department of Health and Human Services.

Prevention and Early Intervention Protective Factor Survey for Caregivers

PROGRAM STAFF USE ONLY		
THIS SURVEY IS A:	☐ **PRE-TEST**	☐ **POST-TEST**

IF THIS IS THE **POST-TEST** FOR THIS FAMILY MEMBER, HAS HE/SHE COMPLETED THE PROGRAM?

☐ YES, this family member has completed the program.

☐ NO, this family member has not completed the program.

PEIS # Identificion de Cliente: _____

Primer nombre del participante:	Apellido del participante:
FDN:	FECHA DE HOY:

Gracias por tomar el tiempo para completar este cuestionario. La información se usará para evaluar el programa. Para cada pregunta, por favor, conteste según su propia opinión o experiencia en vez de tratar de contestar por su familia. Háganos el favor de contestar francamente. No hay respuestas buenas ni malas.

Si tiene alguna pregunta sobre una de las afirmaciones o sobre la escala de respuestas, hable con el personal del programa. Por favor, no se salte ninguna pregunta.

Parte I. Por favor lea la frase y después circule el número de la respuesta que indica mejor la frecuencia que la frase es verdad para usted y su familia. Los números representan una escala de 1 a 7 donde cada número representa diferentes cantidades de tiempo. Por ejemplo, el número 4 representa que la frase es verdad la mitad del tiempo.

	Nunca	Muy Raramente	Raramente	La Mitad del Tiempo	Con Frecuencia	Muy Frecuentemente	Siempre
1. En mi familia se discuten los problemas.	1	2	3	4	5	6	7
2. Cuando discutimos, mi familia escucha ambos puntos de vista.	1	2	3	4	5	6	7
3. En mi familia, tomamos tiempo para escucharnos el uno al otro.	1	2	3	4	5	6	7
4. Cuando las cosas van mal, mi familia se une.	1	2	3	4	5	6	7
5. Mi familia es capaz de resolver nuestros problemas.	1	2	3	4	5	6	7

Parte II. Por favor circule el número que describe mejor la cantidad con la cual esta de acuerdo o en desacuerdo con cada frase.

	Totalmente en desacuerdo	Muy en desacuerdo	Un poco en desacuerdo	Neutral	Un poco de acuerdo	Muy de acuerdo	Totalmente de acuerdo
6. Tengo a otras personas que me escuchan cuando necesito hablar sobre mis problemas.	1	2	3	4	5	6	7
7. Cuando me siento sola/o tengo a varias personas con las cual puedo hablar.	1	2	3	4	5	6	7
8. No tuviera ninguna idea a donde ir si mi familia necesitara comida o alojamiento.	1	2	3	4	5	6	7
9. No sé a donde ir por ayuda si tengo dificultad con pagar mis cuentas o deudas.	1	2	3	4	5	6	7
10. Si hay alguna crisis, tengo con quien hablar.	1	2	3	4	5	6	7
11. Si necesitara ayuda a buscar empleo, no sabría a donde ir.	1	2	3	4	5	6	7

Parte III. Esta parte de la encuesta pregunta sobre ser padre/madre y su relación con su hijo/a. Para esta sección **por favor enfóquese en el niño/a que usted espera se beneficiará más de su participación en nuestros servicios**. Por favor escriba la edad del niño/a y responda a las preguntas 38-55 con relación a este niño/a en mente.

Edad del niño/a _____

	Totalmente en desacuerdo	Muy en desacuerdo	Un poco en desacuerdo	Neutral	Un poco de acuerdo	Muy de acuerdo	Totalmente de acuerdo
12. Hay muchas veces cuando no sé que hacer como madre o padre.	1	2	3	4	5	6	7
13. Sé como ayudar a mi hijo/a aprender.	1	2	3	4	5	6	7
14. Mi hijo/a se porta mal sólo para disgustarme.	1	2	3	4	5	6	7

Parte IV. Por favor díganos con que frecuencia pasa lo siguiente.

	Nunca	Muy Raramente	Raramente	La Mitad del Tiempo	Con Frecuencia	Muy Frecuentemente	Siempre
15. Cuando mis hijos se portan bien, lo reconozco y se los digo.	1	2	3	4	5	6	7
16. Cuando disciplino a mi hijo/a, pierdo el control.	1	2	3	4	5	6	7
17. Me siento feliz cuando estoy con mi hijo/a.	1	2	3	4	5	6	7
18. Mi hijo/a y yo nos sentimos muy cercanos uno al otro.	1	2	3	4	5	6	7
19. Puedo consolar a mi hijo/a cuando algo le molesta.	1	2	3	4	5	6	7
20. Paso tiempo con mi hijo/a haciendo lo que le gusta.	1	2	3	4	5	6	7

Works Cited

From: Friends National Resource Center (2004). Family Support Outcomes Survey. Chapel Hill,N.C., http://www.friendsnrc.org/outcome/resources.htm#survey.

Service Components of the S.T.A.R. program.

1. Free crisis hotline available 24/7.
2. Face-to-face counseling for family and youth.
3. Emergency short-term shelter for youth who run away or who are unable to stay at home because of family conflict.
4. Individual, family and youth counseling to help reduce conflict.
5. Skill-building classes to help parents and caregivers learn how to handle difficult situations.
6. Skill-building classes for youth to help them gain coping skills and meet their needs in a positive way.

Field Test Materials: State-issued Brochure
SUMA Social Marketing

Find S.T.A.R. Services

To find a S.T.A.R. program near you go to www.helpandhope.org and click on "Find Help", or contact the Texas Youth Hotline at:

www.TexasYouth.org
Call: 1-800-989-6884
Text: 512-872-5777

S.T.A.R. Youth & Family Program
Texas Prevention and Early Intervention

Stock Code No. P20949-0000
December 2015

A Guide to S.T.A.R. Services

The S.T.A.R. program has been strengthening youth and families through crisis intervention, family and youth counseling and skill building classes since 1983.

S.T.A.R. offers services that make families stronger and better able to handle the stresses of life.

Youth

- Do you feel all alone?
- Do you feel like no one understands you?
- Are you always fighting with your parents?
- Do you feel like you just want to get away?
- Are you having trouble at school?
- Are there problems affecting your grades?

Services and Eligibility

S.T.A.R. program contracts with community agencies to offer confidential family crisis intervention, individual and family counseling, short-term emergency shelter care, and youth and parent skill-building classes.

S.T.A.R. offers short-term services to youth ages 0-17 and their families who are dealing with conflict at home, school attendance issues, delinquency, or have a youth who runs away from home.

S.T.A.R. focuses on strengthening families and helping youth and parents be more resilient.

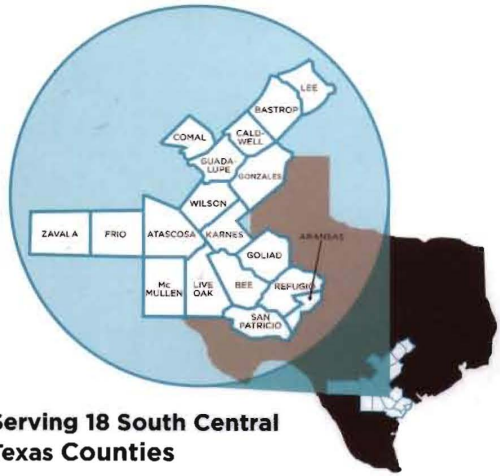
S.T.A.R. services are available at no cost in every Texas county.

S.T.A.R. services are not for families with an open CPS investigation or youth who have been adjudicated delinquent by a juvenile court.

All services available at no cost

Parents

- Is your family fighting or in conflict?
- Do you feel like you're often in crisis?
- Can't talk to your youth anymore?
- Is your youth skipping school?
- Is your youth getting in trouble at school?
- Does your youth have behavioral problems or runs away from home?
- Could you benefit from learning skills to better handle parenting situations?



Serving 18 South Central Texas Counties

New Braunfels
Administration/Counseling/Shelter
1414 W. San Antonio St.
New Braunfels, TX 78130
830-629-6571

TLP House
705 Comal
New Braunfels, TX 78130
830-620-0214

Aransas County
2902 Traylor Blvd., Ste. 203/202
Rockport, TX 78382
361-729-4774

Atascosa County
1010 Zanderson
Jourdanton, TX 78026
830-769-3225

Bastrop County
11 N. Hasler Blvd., Ste. 15
Bastrop, TX 78602
512-581-4370

Bee County
1400 W. Corpus Christi St., Ste. 14
Beeville, TX 78102
361-358-2282

Caldwell County
1022 State Park Rd.
Lockhart, TX 78644
512-398-6833

Comal County
2376 Bulverde Rd., Ste. 108
Bulverde, TX 78163
830-438-2458

Gonzales County
624A St. Paul St.
Gonzales, TX 78629
830-672-5446

Guadalupe County
700 FM 78, Ste. 203
Cibolo, TX 78108
210-659-9067 • 830-303-0329

Live Oak County
502-B Houston St.
George West, TX 78022
361-449-1331

San Patricio County
209 Cedar Dr., Ste. B
Portland, TX 78374
361-643-7631

South Shelter
209 Lang Rd.
Portland, TX 78374
361-643-4130

Wilson County
559 10th St., Ste. 2
Floresville, TX 78114
830-393-0856

Zavala County
1311 FM 582
Crystal City, TX 78839
830-374-5267

CONNECTIONS 24-HOUR CRISIS HOTLINE
800-532-8192

SAFE PLACE

Texas Department of Family & Protective Services
Universal Child Abuse Prevention Program
Texas Child Abuse Hotline
1-800-252-5400

United Way

CONNECTIONS
INDIVIDUAL AND FAMILY SERVICES

EMPOWERING YOUTH.
CONNECTING FAMILIES.
BUILDING FUTURES.

Many reasons...

For a brighter future.

"Providing Youth, Families and Communities Opportunities for a Brighter Future."

Our Mission

"Providing Youth, Families and Communities Opportunities for a Brighter Future."

Our Vision

We envision communities where every individual is safe, valued and has the opportunity to lead a meaningful life.

Our Purpose

- Prevention of Child Abuse, Substance Abuse & Juvenile Crime
- Strengthening Family Relationships
- Preparing Youth for Successful Futures

Our Services

Counseling Services
Short- and Long-Term Counseling for:
- Children
- Teens
- Families
- Adults*
- 24-Hour Crisis Intervention

Residential Services
- Short-term emergency shelter for **youth** ages 5 to 17 years ond, in crisis, and experiencing a family conflict, homelessness, runaway-behavior, abuse or neglect
- Transitional living program for **youth** ages 15 to 21 years old, providing job training, education assistance and adulthood transition*

Life Skills Training
Educational presentations on a variety of topics:
- Anger Management
- Family Communication Skills
- Life Skills, Social Skills
- Problem Solving/Stress Management Skills
- Divorce Recovery
- Parenting Classes/Support Groups
- Self-Esteem
- Substance Abuse Resistance & Refusal Skills
- Truancy Prevention/Intervention
- Conflict Resolution
- Bullying

Referral Services
A link to other agencies for services not provided at Connections Individual and Family Services, Inc.

Major Government Funding Sources:
- Department of Health and Human Services
- Texas Department of Family and Protective Services
- Texas Department of State Health Services
- S.T.A.R. Youth and Family Program, Texas Prevention and Early Intervention

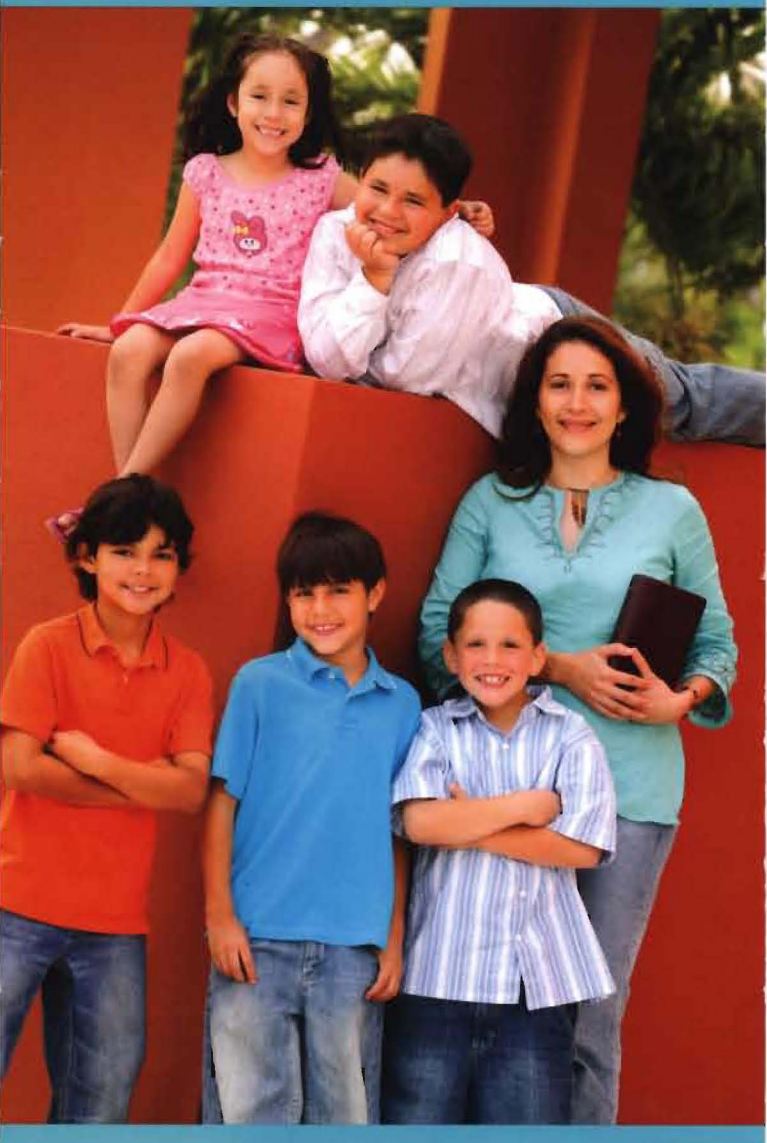
CONNECTIONS
INDIVIDUAL AND FAMILY SERVICES

NOTE - Services available by location. Call 830-629-6571 for further information.

S.T.A.R.

SERVICES TO AT-RISK YOUTH

PROGRAM INFORMATION



CONNECTIONS

INDIVIDUAL AND FAMILY SERVICES

EMPOWERING YOUTH.
CONNECTING FAMILIES.
BUILDING FUTURES.

SERVICES TO AT-RISK YOUTH

The Services to At-Risk Youth (STAR) Program is a state-funded, free-of-charge, prevention/early intervention program for youth and families dealing with issues of running away, truancy, delinquent behavior or family conflict. Youth ages 0 to 17 are eligible unless they or their families are involved with Child Protective Services, or have been convicted of a delinquent offense.

The STAR program provides the following services:

- Crisis Intervention for youth and families in conflict.
- Individual, family and group brief solution-focused counseling designed to help youth and families recognize and apply their own strengths to problem solving.
- Skills-based training for youth using nationally recognized curricula to address issues of self-esteem, anger management, positive friendships, negative peer pressure, making good choices, developing coping skills, and more.
- Parenting classes, using nationally recognized curricula, addressing issues of communication, limit setting and behavior management.
- Emergency Youth Shelter Programs (located in New Braunfels and Portland) that allow for short-term respite while the youth and family work out the crisis situation. Shelter placement available for youth ages 10 to 17.

All services in the STAR program are conducted by trained counselors, most of whom are master's level counselors or licensed professional interns. The agency also uses master's level university students to provide services as part of an internship experience.

For more information contact:

www.connectionsnonprofit.org
24-Hour Crisis Hotline: (800) 532-8192

Connections Individual and Family Services, Inc. is a non-profit 501(c)(3) agency providing valuable support and guidance through services to youth and families in eighteen counties of the South Central Texas area.

LOCAL AND REGIONAL OFFICES:

Amarillo/Canyon Office:
1500 S. Taylor Street
Amarillo, Texas 79101
Phone: 359-2005
Fax: 359-2020

Borger Office:
412 N. Main
Borger, Texas 79007
Phone: 274-2297 or 676-5097

Clarendon Office:
111 S. Kearny
Clarendon, Texas 79226
Phone: 874-3504 or 341-0200

Hereford Office:
426 Main, Suite D
Hereford, Texas 79045
Phone: 364-6111 or 676-1577

Pampa Office:
1224 N. Hobart
Suite 10
Pampa, Texas 79065
Phone: 669-3371 or 674-5854

Dalhart Office:
701 E. 10th
Dalhart, Texas 79022
Phone: 244-7297 or 681-3457

Perryton Office:
410 S. Eton
Perryton, Texas 79070
Phone: 435-3601 ext. 241 or 681-3457

After Hours call: (806) 359-6699 or 1-800-692-4039

Servicios para jóvenes y sus familias que están arriesgo de problemas con la escuela, la ley o en la familia.

STAR

Si tiene usted un joven entre la edad de 0 y 17, el joven
★ Ha abandonado el hogar, o
★ Ha faltado la escuela, o
★ Es un delincuente, o
★ Hay un conflicto en la familia
Llame para servicios gratis incleyendo consejos y apoyo para el joven y la familia, o son victimas de abuso o descuido.

Texas Panhandle Mental Health Mental Retardation (TPMHMR)
1500 S. Taylor Street
Amarillo, Texas 79101
(806) 359-2005
Despues de las horas de negocios llame a:
(806) 359-6699 o 1-800-692-4039
Fondado por el Departamento de Servicios de Familia y Regulación del estado de Tejas

Services To At Risk Youths and Their Families

STAR

A FAMILY BASED PROGRAM

Texas Panhandle MHMR
Mental Health
Mental Retardation

THERE IS NO CHARGE FOR STAR SERVICES!

Funded by Texas Department of Family And Protective Services

What is the STAR Program?

★STAR - family-based program providing short-term counseling.

★STAR - provides crisis resolution / interventions to reduce delinquency / family conflict.

★STAR - serves youths and their families in the upper 21 counties of the Panhandle.

Families are eligible* if they have a youth
ages 0 to 17
and that youth
has **run away**, or
been **truant**, or
been **delinquent**, or
experienced **family conflict**, or
experienced **abuse or neglect.**

* EXCEPTIONS: Youths who are on adjudicated probation or have a current CPS investigation are not eligible for these services. Call for additional information.

Who Can Make A Referral?

Parent or youth…
School Counselors…
Juvenile probation officers…
Other child-serving agencies…

Call the local STAR office for additional information & eligibility requirements.

Services To At-Risk Youths

STAR

and their Families

24 Hour Crisis Hotline
359-6699 or 1-800-692-4039

What Kind Of Services Are Provided?

★ Family and Youth Short-term Counseling

★ Youth Coping Skills Training including
- communication
- problem solving
- anger management
- decision making
- conflict resolutiuon

★ Youth Based Groups

★ Crisis Intervention

★ Parent Education/Parenting Training Skills

★ Consultation/Collaboration with other Youth-Serving Agencies

★ Case Management linking families to additional resources, as needed

★ Emergency Care Services/Short-term Shelter Services

★ UCAPS-Universal Child Abuse Prevention Services

SCAN

S.T.A.R. Youth & Family Program
Texas Prevention and Early Intervention

FREE COUNSELING

YOUTH

- *Do you feel all alone?*
- *Do you feel like no one understands you?*
- *Are you always fighting with your parents?*
- *Do you feel that you just want to get away?*
- *Are there problems affecting your grades?*

PARENTS

- *Is your family fighting or in conflict?*
- *Do you feel like you're often in crisis?*
- *Can't talk to your youth anymore?*
- *Is your youth skipping school?*
- *Does your youth have behavioral problems or runs away from home?*
- *Could you benefit from learning skills to better handle parenting situations?*

Hundreds of families turn to SCAN's STAR program each year in an effort to manage challenges including family conflict, school attendance, first time offenses and runaway issues. Youth and families facing these obstacles work with a counselor to identify their strengths as building blocks for developing the skills they need to be successful. If you would like more information please call: **Michelle Saldana (956)724-3177 ext. 808**

STAR COUNSELORS

Maria Cisneros	**956-724-3177 ext. 109**	**mlcisneros@scan-inc.org**
Melissa Ruiz	**956-724-3177 ext. 111**	**melissaruiz@scan-inc.org**
Marissa Pellegrin	**956-724-3177 ext. 110**	**marissa.pellegrin_2298@scan-inc.org**
Melissa Reyna	**956-724-3177 ext. 134**	**melissa.reyna@scan-inc.org**
Jessica Santos	**956-724-3177 ext. 126**	**jessica.santos@scan-inc.org**

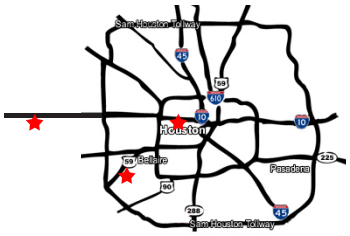
STAR youth and family program

FREE Individual and Family Counseling, Parenting Support and Child Abuse Prevention Services

ISSUES WE ADDRESS

DePelchin supports families by providing assistance for an array of issues, including:

- Running Away
- Truancy
- Family Conflict
- School Problems
- Impulse Control
- Depression
- Anxiety
- Fighting
- Harming Self or Others
- Behavioral Problems
- Grief/Loss
- Divorce
- Bullying
- Low Self-Esteem



We also offer skills-based training groups for youth as well as caregivers that focus on problem solving, goal setting and parenting skills. These classes are of no cost and are held at the Memorial location.

CONTACT US

Harris County: **713-664-3459** | Fort Bend and Waller Counties: **281-261-1341**

STAR OFFICE LOCATIONS

DEPELCHIN - MAIN CAMPUS (HARRIS COUNTY)
4950 Memorial Drive, Houston, TX 77007, (713) 664-3459

DEPELCHIN – STAFFORD (FORT BEND COUNTY)
12300 Parc Crest Drive, Stafford, TX 77477, (281) 261-1341

BROOKSHIRE LOCATION (WALLER COUNTY)
531 FM-359 Road S, Brookshire, TX 77423, (281) 261-1341

STAR services are of no cost.

S.T.A.R. Youth & Family Program
Texas Prevention and Early Intervention

DePelchin
CHILDREN'S CENTER
A brighter tomorrow for children and families in Texas.