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Interorganizational Relationships among Family Support Organizations and Child Mental Health Agencies

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Abstract

This study examined: 1) qualitative aspects of close working relationships between family support organizations and child mental health agencies, including effective and ineffective characteristics of the relationship and aspects that they would change, and 2) the impact of the working relationship upon the family support organization. Semi-structured interviews were conducted with 40 directors of family support organizations characterized as having a close working relationship with a child mental health agency. Three main themes emerged regarding the quality of the working relationship: a) interactional factors, including shared trust, communication, collaboration and service coordination; b) aspects of the inner context of the family support organization, mental health agency, or both, including alignment of goals and values and perceptions of mental health services; and c) outer contextual factors external to the organizations, such as financial and county regulations. Responses to the perceived impact of the relationship was divided into two themes: positive impacts (e.g. gained respect, influence and visibility), and negative impacts (e.g. lack of trust). This study lays the foundation for future research to better understand the mechanisms underlying interorganizational relationships in communities among

different types of providers to create a more seamless continuum of services for families of children with mental health conditions.

Keywords

family support organizations; peer-to-peer support; family support

A persistent problem in children's mental health services is service silos, administratively separate agencies serving the population of children with mental health needs and their families. Numerous reports over at least three decades have underscored the segmentation of the so-called "system" responsible for serving children and families (Garland et al., 2000; Garland, Landsverk, Hough, & Ellis-Macleod, 1996; Institute of Medicine, 2001; Stroul & Friedman, 1994).

The asymmetry created by multiple service agencies separately responsible for providing services to children with mental health needs creates difficult challenges for parents or caregivers (hereafter called parents for brevity) seeking services for their children. This includes lengthy waitlists delaying service initiation (McKay & Bannon, 2004), poorly coordinated care (Heflinger, 1996; Saxe, Cross, & Silverman, 1988), a poorly trained workforce providing ineffective services (Weissman et al., 2006), piecemeal service plans (Nyre, Vernberg, & Roberts, 2002), and other significant barriers to access and continuity (Kataoka, Zhang, & Wells, 2002; Wang et al., 2006).

In part to mitigate this fragmentation and asymmetry, a new set of service organizations targeted specifically towards supporting parents has arisen. These family advocacy, education and support organizations (hereafter called family support organizations) are often not for profit (501C3) entities established for the purpose of supporting parents by providing education, information, referrals, advocacy, and sometimes direct services. They are typically staffed by other parents, referred to as peer parents, who have experienced the challenges of seeking services for their children, who are credible and trusted by other parents, and who provide peer-to-peer support. Some family support organizations are affiliated with national associations, such as the National Alliance for Mental Illness (NAMI) and the National Federation of Families in Children's Mental Health, although there are also unaffiliated family support organizations.

Family support organizations are growing in numbers (Hoagwood et al., 2008). Some states, such as Florida and New York, are establishing training programs and credentialing processes to formalize and professionalize the work of peer parents within these organizations (Families Together in New York State; Florida Peer Network, Inc.). Peer parents are embedded within mental health service agencies in several states: For example, they are part of a team of specialists for families of children at risk of hospitalization in New York State waiver programs. Although no exact data exists on the prevalence or distribution of family support organizations, nor of peer parents working with them, membership in the formal associations has risen over the past decade (NAMI; National Federation of Families for Children's Mental Health).

Family support organizations provide needed, adjunctive support services that are targeted towards meeting the needs of parents rather than children, and typical child-serving mental health agencies are targeted towards children's clinical or case management needs: Thus, these two types of services are essentially complementary. The field's understanding about the working relationships between family support organizations and mental health agencies serving children is limited, however. A core element of high quality, coordinated and continuous community services includes alliances and networks that link service providers and families (Institute of Medicine, 2001; Morrissey, 1992; Morrissey, Johnsen, & Calloway, 1997). Health care coordination models such as the Chronic Care Model (Institute of Medicine, 2001; Wagner, 2010) identify community-based interorganizational linkages as a core component. The seminal monograph defining a children's mental health system of care (Stroul & Friedman, 1994) identified coordinated services as an essential principle. Thus, a collective and interlocking network of working relationships among service providers, in high quality community services, is necessary to provide care that is seamless and responsive to the needs of the entire family. Yet whether there are factors inherent in working relationships between family support organizations and mental health agencies that encourage or dissuade collaboration is an important, but currently unanswered question.

The purpose of this paper is to describe the nature and impact of close relationships between family support organizations and mental health agencies, specifically, 1) the effective and ineffective components of these relationships, 2) the characteristics of the relationship that the family support organization would change, and 3) the perceived impact of these working relationships from the perspectives of family support organizations. Enhancing our knowledge about these linkages from the perspective of family support organizations is the first step in a relatively nascent line of inquiry, the overall goal being to facilitate the formation of and ongoing collaboration between systems serving children and families.

Methods

Procedure

Based on the responses from the 2005 survey, we categorized the working relationships between the 226 family support organizations and mental health services agencies from five questions: whether family support organizations 1) had a governance role (decision-making ability) within the mental health clinic, 2) had representation at clinic meetings, 3) were responsible for allocating clinic resources, 4) received information about child or family outcomes from the clinic, and 5) had formal working relationships, such as paid employment by clinic staff within the family support organization. Family support organizations that engaged in four or five of these activities were classified as having a *close* working relationship, those who engaged in between one and three activities were categorized as having *some* working relationship, and no affirmative responses were categorized as having *no* working relationship.

In 2007, we randomly selected a sample of 120 directors to participate in a follow-up study: Directors were stratified by these three relationship categories, yielding a final sample of 40 directors that had a close working relationship, 41 that had some relationship, and 39 that had no current working relationship. Directors provided information about their

organization, including its size, structure, source(s) of financial support, provision of services, number of employees, and affiliation with a national organization. Directors from the 40 family support organizations that were characterized as having a close working relationship also participated in a qualitative interview by telephone to uncover effective and ineffective aspects of these relationships, characteristics of the relationship that the family support organization would change, and examine the partnership's impact upon the family support organization. We believed that of all participants, those who reported having a close working relationship would provide the most information regarding these factors. The appropriate Institutional Review Board provided oversight for human subjects protection and approved all study procedures.

Participants

The sample consisted of 40 directors of family support organizations that were characterized as having a close working relationship with a mental health agency.

Data Collection

All interviews were conducted by telephone and lasted approximately one hour in length. Consistent with previous national studies conducted by the investigative group, an experienced survey interviewer took notes. We developed a semi-structured interview guide to collect information about the quality, strengths, weaknesses, and the impact of working relationships between mental health organizations and family support organizations. An example of items we asked participants include the following: “what are the characteristics of this partnership that make it work especially well,” “every relationship between organizations has complications. What are the characteristics of this partnership that do not work well?” and, “what has been the impact of this partnership on your organization?” Interview questions also included dates of creation/incorporation and other descriptive characteristics. A copy of the instrument is available upon request.

Data Analysis

A thematic content analysis was conducted with data gathered from the agencies with a close working relationship to capture their perceptions of the effective and ineffective aspects of the partnership, characteristics of the relationship that the family support organization would change, and the impact of their relationship upon the family support organization. Using a methodology (Willms et al., 1992) rooted in grounded theory (Glaser & Strauss, 1965), interview notes taken by an experienced survey interviewer were analyzed in the following manner. First, all data were reviewed to develop a broad understanding of content as it relates to the project's specific aims and to identify topics of discussion. Second, transcripts/notes were coded to condense the data into analyzable units. Segments of text ranging from a phrase to several paragraphs were assigned codes based on a priori (i.e., from the interview guide) or emergent themes (also known as open coding) (Strauss & Corbin, 1990). Third, codes were then assigned to describe connections between categories and between categories and subcategories (also known as axial coding) (Strauss & Corbin, 1990). The final list of codes consisted of a list of themes, issues, accounts of behaviors, and opinions associated with interorganizational collaborations. Fourth, we generated a series of categories arranged in a treelike structure connecting text segments grouped into separate

categories of codes or “nodes” to further the process of axial or pattern coding to examine the association between different categories. Within specific codes (e.g., shared values and goals), we included only one answer per person per category to ensure that no group or category was overrepresented. However, if a respondent gave two distinct responses for the same theme (e.g. trust, communication are both interactional codes), each would count separately within the relevant theme. Frequencies were then computed for each category. Fifth, the technique of constant comparison was used to further condense the categories into broad themes that were then linked together into a heuristic framework by identifying instances in texts where themes were found to “co-occur” (i.e., different codes assigned to the same or adjacent passages in the texts).

Results

We present an analysis of the demographic and organizational data provided by directors of the 120 family support organizations to contextualize the sample. Most family support organizations (n=102, 85%) served up to 500 persons annually: 16 (13.3%) served over 500 persons. Almost all of the family support organizations (n=96, 80%) were affiliated with a national family advocacy organization, such as the National Alliance on Mental Illness (n=47, 40%), the National Federation of Families for Children's Mental Health (n=21, 18%) and Mental Health America (n=13, 11%).

All but one family support organization was not-for-profit (n=119, 99.17%), and most (n=106, 88.3%) had an oversight board, such as a Board of Directors, that governed their organization. Over half (n=72, 60%) of 102 directors reported mental health consumers were members of their Board of Directors.

The majority of family support organizations (n=113, 94.2%) provided services to adults and children, and 96 (80%) had a discrete division or unit representing families and children in their organization. Almost all (n=115, 96%) provided direct services to families, and most commonly, advocacy support (n=103, 86%); over three-quarters (n=92, 77%) also linked families to services. Approximately one-third (n=39, 32.5%) were financially supported by the mental health system: few (n=23, 19.2%) generated revenue through fee-for-service.

Two significant differences regarding the structural and organizational characteristics of groups were uncovered: 1) family support organizations that had no working relationship with a national family advocacy organization were significantly less likely to partner with a mental health agency than those with some (53.9% vs. 87.8%, $p=0.0016$) or a close (53.9% vs. 97.5%, $p=0.0019$) relationship, and, 2) organizations with a close working relationship were significantly more likely to have staff that generated revenue via fee for service than those with some working relationship (30.0% vs. 12.2%, $p=0.0557$).

Qualities of Working Relationships

Responses provided about the effective and ineffective characteristics of the partnership, and whether there were aspects of the relationship that directors would change, were grouped into three themes: 1) interactional factors between the family support organization and mental health agency, including shared trust, communication, collaboration and service

coordination; 2) aspects of the inner context of the family support organization, mental health agency, or both, including alignment of goals and values and perceptions of mental health services; and 3) outer contextual factors external to the organizations, such as financial and county regulations. Responses to the perceived impact of the relationship was divided into two themes: positive impacts (e.g. gained respect, influence and visibility), and negative impacts (e.g. lack of trust).

Analysis of data gathered from the 40 directors of family support organizations that had a close working relationship with a mental health agency yielded 57 responses from 38 directors about effective characteristics of the working relationship, 47 responses from 39 directors regarding ineffective characteristics of the working relationship, 37 responses from 35 directors about what they would change about this relationship, and 46 responses from 38 directors about the impact of the working relationship upon their organization. Responses are presented in Table 1 and organized thematically below.

Effective components

Most (n=42 73.7%) responses described interactional factors as effective components of the working relationship. Almost half of interactional factors spoke about trust, openness and accessibility, and/or mutual respect; approximately one-third of the sample described enhanced service coordination and collaboration between the family support organization and mental health agency, and nine (21.4%) cited positive and ongoing communication between organizations. One director remarked about the importance of trust and openness by the mental health agency, stating, “Trust-I don't know of any family member or staff member who would be afraid to speak up. The staff's willingness to learn from families and recognize parents' expertise in knowing most about their children.”

Thirteen (22.8%) responses described inner contextual factors; within this theme, most spoke of an alignment between organizations regarding their culture, priorities, procedures, and shared values and goals. According to one director, the family support organization and mental health agency fostered a close working relationship because they shared a similar mission and history.

Only two responses (3.5%) referred to outer contextual factors, and both cited external incentives to partner, including receipt of funding and participation in a multi-year project that emphasized family involvement at all stages.

Ineffective components

Again, interactional factors (n=21, 25.5%) were most commonly cited as ineffective components of the working relationship. Communication issues, including miscommunications, feeling disempowered and without a voice by the mental health agency, and feeling that the agency withheld information from the family support organization, were the overwhelming problems cited by directors. Additional problems included competition over funding and conflict with clinic staff, primarily because of staff attitudes and perceptions about families and family support. One director summed up the discordance between his family support organizations and clinic staff in the following way:

“There are still some staff who have the dinosaur mentality and blame families for their children's problems.”

After interactional factors, outer contextual difficulties (n=13, 27.7%) were mentioned. These included external constraints, particularly fiscal and county regulations and not having resources like money and time to maintain the relationship. As reported by one director, increased oversight and paperwork, coupled with ever-changing staff at the county level, made maintaining their working relationship tenuous at best.

Seven (14%) responses cited clinic staff turnover and dissatisfaction with clinic services and the absence of programs for families as reasons for ineffective relationships. These types of issues fall within the category of inner contextual factors.

Of note, six participants (12.8%) stated that there was nothing about their partnership that did not work well; as said by one director, “Truthfully, there are no drawbacks to the relationship.”

Changes to the relationship

Directors were primarily focused on changing outer contextual factors (n=13, 35.1%), and specifically, improving external constraints such as county regulations, bureaucracy, and fiscal impediments to collaboration. Directors felt that the bureaucracy, fiscal tightening and lack of funding for needed staff and programs were major impediments to serving families and collaborating with mental health agencies.

After outer contextual factors, over a quarter of participants (n=10, 27%) said they would change nothing about their relationship, or if anything, have it evolve and expand. Respondents suggested the relationship could deepen and “*grow more in other areas*,” for the benefit of the community. As noted by one director, he “would like to see it merge into a deeper level of support on a community basis.”

With respect to changes, 9 (24.3%) responses referred to interactional factors; of them, all but one suggested they would improve the communication between the family support organization and agency. Directors wanted greater and clearer communication, and multiple directors suggested having family support organization and agency staff attend each others' meetings. The hope, as stated by one director, was that through better communication, the family support organization would have a voice in the decisions being made about services for families.

Five responses (13.5%) focused on inner contextual factors-of them, most described changing clinic services, and specifically, adding programs; the remaining two responses sought to change staff attitudes and reduce turnover. Directors argued for agencies to hire staff that embodied their philosophy of caring for families, and to eliminate providers who saw their work as just a job.

Impact of the working relationship

Lastly, directors remarked about the positive and negative impacts of their partnership on the family support organization. Most responses (n=43, 93.5%) were positive: Of them, the most common response was that the family support organization gained respect, influence, and visibility in the community as a result of the relationship. One director remarked that the relationship improved their credibility with other agencies in the community, while a second noted the relationship “has helped increased awareness and visibility of our organization.”

The second most common positive impact was that the relationship enhanced the collaboration and coordination of services for families through the provision of knowledge, staff, referrals, and shared participation at events. Ultimately, directors believed this collaboration reduced fragmentation and enhanced service delivery for children and families. A director described the impact of their relationship in this way, “We can draw from their strength and vice versa. We work together to help those with mental illness.”

Approximately 20% suggested the relationship improved their service delivery and knowledge base, which some saw as benefitting both the family support organization and the mental health agency. In the words of one director, their relationship “has had a very positive impact on both organizations, it has improved our knowledge base and things have gotten better for both of us.”

Discussion

Family support organizations are a growing subsystem of community-based organizations that provide family support to parents. Because they offer adjunctive services to parents of children with mental health problems, they are often seen as filling large gaps that exist in communities for parents through the provision of emotional support, information about resources, treatment options, and child and family service systems, and advocacy for parental rights and resources on local, state, and national levels (Hoagwood et al., 2010). The findings of this study suggest close partnerships between family support organizations and mental health agencies provide specific benefits to family support organizations. Specifically, directors reported their organizations gained from the agency's knowledge and expertise, and received needed resources, such as office space and funding, to ensure their stability and sustainability. Directors also reported enhancements to service delivery and coordination, and a renewed energy to advocate for families.

Additionally, interactional factors appeared to be powerful drivers, and impediments, of close working relationships. Effective characteristics that were mentioned by directors included openness, accessibility and trustworthiness, while poor communication, and to a lesser extent competition over funding and dissatisfaction with clinic services, impeded effective working alliances. Through these accounts, a picture of high functioning mental health agencies emerged; those that are trustworthy, accessible and open to new ideas and viewpoints; agencies that are willing to collaborate on services and programs, and those capable of having open and ongoing communication

The study's findings also illuminated positive characteristics of family support organizations that may foster working relationships. Directors' responses suggested that family support organizations that were able to adjust their values to accommodate their partners were successful in maintaining a close relationship. As noted by one director, "we've changed our mode of thinking so that now we believe that families are not always right." Although speculative, these results suggest a key feature of successful collaborations between family support organizations and mental health agencies is the family support organization's adaptability to accommodate different ideologies and practices in service of a greater goal to collaboratively serve families.

These findings should be interpreted cautiously due to several limitations, including the small sample size, the homogeneity of the sample, and limited descriptive information about the family support organizations and their day-to-day interactions with mental health agencies. Further, although we utilized an experienced interviewer, taking notes of the interviews, versus audiotaping, might have resulted in incomplete or erroneous data. These limitations, and that all information about the mental health agencies was provided by family support organization directors, indicates the potential for biases and inaccuracies cannot be ruled out.

The field would benefit from additional research, with a larger, heterogeneous sample of family support organizations and perspectives from multiple stakeholders.

Additionally, although efforts to minimize coercion were in place (e.g. making all efforts to maintain the family support organization's confidentiality), directors may not have responded accurately to problematic aspects of the relationship out of fear of negative consequences, particularly given several of the family support organizations partnered with county-supported mental health clinics that contributed material support. And finally, although the authors derived the typology of working relationships from theoretical knowledge and experience about interorganizational collaborations, the typology has not been standardized or tested.

In light of these limitations, this study is a preliminary step towards understanding the nature of working relationships between family support organizations and the mental health system, and effective and ineffective components of the relationship. A logical next step is to identify and foster qualities that encourage the growth and sustainability of close working relationships, and better understand the impact of family support/mental health partnerships upon organizational and family-level outcomes. Several next steps in this line of research are needed; the first is to survey mental health agencies about their perspectives in order to provide a comprehensive picture about the quality and impact of close working relationships between two very distinct institutions that often have divergent philosophies and objectives, as well as the factors that foster and impede building and maintaining these working alliances. Second, future research is needed to uncover the benefits of close working relationships upon service delivery and family outcomes. While some research suggests interorganizational collaborations reduce duplicative services and enhance service coordination and effectiveness (Lehman et al., 2009; Nowell, 2009), it is unclear whether this literature extends to these partnerships, which are inherently unique because family

support organizations typically provide support to parents while mental health agencies primarily focus on the needs of the child (Hoagwood et al., 2010). Given these ideological and practical differences, family support organization/mental health working relationships may in fact streamline service provision, improve child outcomes, or impact families in other fruitful ways, such as by creating a network of services to assist families by providing a range of educational, supportive, preventive, and clinical services. These networked or linked services are likely to fill a hole in the community service system.

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Table 1**Components of Working Relationships**

Characteristics that Make it Work Well	N (57 responses)	%
Interactional		
Trust, openness/accessibility, mutual respect	17	40.5%
Collaboration/coordination	14	33.3%
Communication	9	21.4%
Clinic Support: services/referrals	1	2.4%
Other	1	2.4%
Total	42	73.7%
Inner Context		
Organizational	6	46.2%
Shared values and goals	5	38.5%
Clinic staff stability	1	7.7%
Satisfaction with clinic services and/or staff	1	7.7%
Total	13	22.8%
Outer Context		
External factors (financial)	1	50%
External facilitators to collaboration	1	50%
Total	2	3.5%
Characteristics That Do Not Work Well	N (47 responses)	%
Interactional		
Communication issues	12	57.1%
Competition over funding	3	14.3%
Dissatisfaction with clinic services	3	14.3%
Conflict of interest	1	4.8%
Competition over leadership	1	4.8%
Other	1	4.8%
Total	21	25.5%
Outer Context		
External constraints to collaboration	6	46.2%
Lack of resources	4	30.8%
Organizational	3	23.1%
Total	13	27.7%
Inner Context		
Clinic staff turnover	3	42.9%
Organizational	2	28.6%
Dissatisfaction with clinic services	2	28.6%
Total	7	14.9%
Nothing		
Nothing	6	100%
Total	6	12.8%

What FSOs would change about the relationship	N (37 responses)	%
Outer Context		
Improve external constraints	11	84.6%
Less dependence upon resources	2	15.4%
Total	13	35.1%
Nothing/Develop Further		
Nothing	7	70%
Grow	3	30%
Total	10	27.0%
Interactional		
Improve Communication	8	88.9%
Respect	1	11.1%
Total	9	24.3%
Inner Context		
Change clinic services	3	60%
Reduce staff turnover	1	20%
Improve organizational factors	1	20%
Total	5	13.5%

Impact of this Relationship on Your Organization	N (46 responses)	%
Positive Impacts		
Gain in respect, influence, and visibility	12	27.9%
Collaborative working relationship	10	23.3%
Improved service delivery and knowledge base	9	20.1%
Improved organizational climate	6	14.0%
Material support	6	14.0%
Total	43	93.5%
Negative Impacts		
Less influence due to clinic turnover	1	33.3%
Clinic doesn't attend FAO meetings	1	33.3%
Lack of trust	1	33.3%
Total	3	6.5%