

Tracking Progress in Peer-Delivered Family-to-Family Support

Bruno J. Anthony
Georgetown University

Celia Serkin
Montgomery County Federation of Families for Children's
Mental Health, Silver Spring, Maryland

Nicole Kahn
Georgetown University

Mary Troxel
University of Colorado School of Medicine and Children's
Hospital of Colorado, Aurora, Colorado

Jane Shank
Michigan Association for Children's Mental Health, Lansing, Michigan

Peer delivered, family-to-family (F2F) support—defined as the provision of outreach, engagement, knowledge, care coordination, and support to family members of children and youth with mental health challenges—is a rapidly growing and needed component of the service array. Progress is occurring toward greater specification of program models and core competencies for the parent support providers (PSPs) with lived experience providing these services; however, strategies to inform quality improvement and ensure accountability are lacking. The Family Journey Assessment (FJA), completed by PSPs and family members, fills this gap by tracking caregiver progress toward self-advocacy and self-efficacy. Analyses of 436 FJAs showed a reliable 3-component structure, reflecting progress in the recognition of needs, collaboration to access help from formal and natural supports, and activation of skills to cope with stress, enhance resilience, and develop and carry out plans of care. PSP feedback provided strong evidence for relevance and usability. Examination of FJAs at baseline and follow-up provides one of the first reports showing significant improvement in key indicators of benefit of F2F for participating families. The FJA holds promise as a measure of the impact of F2F services on key goals and as a way to identify benchmarks for focused and individualized peer-to-peer support depending on the family's level of need.

Keywords: family-to-family support, caregivers, children's mental health, outcomes

Peer delivered, family-to-family (F2F) support—defined as the provision of outreach, engagement, knowledge, care coordination and support to family members of children and youth with mental health challenges—is a rapidly growing and needed component of the service array (Hoagwood et al., 2008; Wisdom et al., 2014). These services evolved from a confluence of several factors: advocacy by families drawing on their own experience in accessing and managing the care of their children (National Federation of Families for Children's Mental Health, 2017); studies documenting high levels of burden and strain in families and its key role in driving service use (Angold et al., 1998; Godoy, Mian, Eisenhower, & Carter, 2014); the growth of the family-driven care

movement (Duchnowski & Kutash, 2007), in which families take on a primary decision-making role (e.g., goal setting, service design, outcome monitoring); and evidence indicating the importance of family involvement in treatment outcomes (Hoagwood et al., 2010). Family support and advocacy is provided through different organizational models in which services are administered through an independent, family-run, nonprofit organization; a mental health provider agency; or a combination of the two (Obrochta et al., 2011). Progress is occurring toward greater specification of core competencies and program models for F2F support; however, strategies to inform quality improvement and ensure accountability are lacking. The multipurpose Family Journey As-

This article was published Online First November 1, 2018.

Bruno J. Anthony, Departments of Pediatrics and Psychiatry and the Center for Child and Human Development, Georgetown University; Celia Serkin, Montgomery County Federation of Families for Children's Mental Health, Silver Spring, Maryland; Nicole Kahn, Center for Child and Human Development, Georgetown University; Mary Troxel, Department of Psychiatry, University of Colorado School of Medicine, and the Pediatric Mental Health Institute, Children's Hospital of Colorado, Aurora, Colorado; Jane Shank, Michigan Association for Children's Mental Health, Lansing, Michigan.

Nicole Kahn is now at the Gillings School of Public Health, University of North Carolina, Chapel Hill.

This research was supported in part by a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SM056495). All procedures performed in studies involving human participants were in accordance with the ethical standards of the Georgetown University Institutional Review Board and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Correspondence concerning this article should be addressed to Bruno J. Anthony, who is now at the Department of Psychiatry, Division of Child and Adolescent Psychiatry, University of Colorado Anschutz Medical Campus, Mail Stop A036/B130, 13123 E. 16th Avenue, Aurora, CO 80045. E-mail: bruno.anthony@ucdenver.edu

assessment (FJA) fills this gap. Its development and sensitivity to change in caregiver knowledge and skills is the subject of this article.

F2F support is provided by parents with lived experience of raising a child or youth with emotional, behavioral (including substance use), and/or mental health challenges. In this article, these individuals will be referred to as Parent Support Providers (PSPs), although other terms are employed (e.g., Family Peer Advocates, Family Support Partners, Family Navigators). This service enhancement addresses critical workforce shortages and has the potential to improve efficient delivery of clinical services. The goals of F2F support for caregivers include decreasing their internalized blame regarding their child's mental health challenges, helping them access formal and informal supports in their communities, increasing their understanding of the importance of their own self-care, expanding their knowledge of and engagement in their child's services, increasing their feelings of self-efficacy with regard to taking care of their child, enhancing their acceptance and appreciation of their child's challenges, and improving their ability to act in partnership with providers (e.g., Gyamfi et al., 2010; Wisdom et al., 2014).

Efforts to benchmark progress and assess the effect on families and youth of participating in peer support have been limited (Hoagwood et al., 2010). Most research has evaluated the impact of family-, clinician-, and team-led group programs with a structured format or curriculum.

Only a small corpus of studies has measured caregiver and youth outcomes to determine effectiveness of individualized, PSP-delivered support. Further, only a few have included a control group in the design. Results have been inconsistent in the effect of F2F services in increasing family access to, and participation in, services. Elliott, Koroloff, Koren, and Friesen (1998) reported that outreach by a family associate produced a higher rate of service initiation than a comparison group but did not influence continuation in treatment. Caretaker participation in Parent Connectors—a school-based, peer-to-peer program aimed at increasing the engagement of families in the education and treatment of their children who have emotional disturbance—resulted in more engagement in their child's services and students received more mental health services in school (Kutash, Duchnowski, Green, & Ferron, 2011). In contrast, Rodriguez and colleagues (2011) did not find an impact on caregiver access to or participation in F2F services provided by PSPs trained in the Parent Empowerment Program.

Examination of parent empowerment and self-efficacy in response to F2F support shows more consistent positive effects. Parents who were randomly assigned to trained PSPs showed significantly higher family and service system empowerment (Koroloff, Elliott, Koren, & Friesen, 1996), greater increases in advocacy for mental health services (Kutash et al., 2011), and greater gains in feelings of self-efficacy (Rodriguez et al., 2011) than parents in comparison groups. Finally, in regard to caregiver well-being, Ireys and Sakwa (2006) examined the effectiveness of a 15-month F2F intervention for parents with a child in treatment for serious emotional or behavioral disorders. Results showed greater increases in the intervention group in perceived social support and greater decreases in maternal anxiety.

Evaluation of individualized F2F support has been limited, in part, because definitions of the necessary skills, core services, and

goals have been lacking. To address these needs, the Substance Abuse and Mental Health Services Administration (2017) led an effort to identify core competencies needed by those who offer peer support services by convening diverse stakeholders, including consumers and subject matter experts. These competencies were derived in large part from the adult peer support literature. However, progress has been made toward specification of core competencies for F2F support (Purdy, 2010) as well as of program models, eligibility criteria for providers, and development of training resources (Olin et al., 2014; Wisdom et al., 2014). Several states have developed certification guidelines from this work to ensure that those in the field meet consistent and high standards of performance.

Headway has also been made on specifying the components of F2F support. From a comprehensive review, Hoagwood and colleagues identified salient components of family support (Hoagwood et al., 2010; Wisdom et al., 2014): (a) informational/educational support—facilitating learning about child behavior, mental illness, treatment options, service systems, and other resources; (b) instructional/skills development support—coaching the caregiver on how to deal with their child's problems and their own well-being; (c) emotional and affirmational support—promoting the caregiver's feelings of being understood and appreciated; (d) instrumental support—helping caregivers find and access specific services such as respite care and transportation; and (e) advocacy support—helping caregivers gain information about their rights and resources and negotiate to obtain services as well as working directly to find appropriate services for a caregiver or child.

Development of tools to assess the impact of these more articulated services of family peer support has shown little progress. Such tools are needed to determine the expected impact of F2F services on parents and their children as well as facilitate continuous quality improvement, individualize services, and ensure accountability for funders and supporters, leading to greater financial stability. In order to address the lack of a comprehensive measure to track family progress in F2F services, we developed the Family Journey Assessment (FJA; Anthony & Serkin, 2012), designed to be completed by PSPs in collaboration with caregivers. It is designed to support quality improvement and research and to help families and PSPs to better identify targets and benchmarks for focused family peer-to-peer support. Importantly, the FJA is linked to recognized core competencies and service components of F2F. This article describes the development process of the FJA and the answers to questions of its psychometric properties, feasibility, and sensitivity to change through implementation in the State of Michigan. The results provide some of the first evidence for the positive impact of F2F services and the potential usefulness of the FJA in supporting these services.

Method

Item Development and Description

A group of 10 experienced PSPs met on a regular basis to develop an initial pool of items, large enough to ensure that signs of the acquisition of specific knowledge and skills that indicated family progress relevant to the goals of family support were well represented. The item pool was organized into six different skill/

knowledge clusters linked to the components of recommended F2F services distilled by Hoagwood et al. (2010) as follows:

1. Emotional and affirmational support: items in clusters of (a) Self-Knowledge—appreciation and communication of the strengths and needs of their child and themselves; and (b) Family Well-Being—promotion of family welfare through appropriate decisions, support, and connections, and maintenance of a daily routine.
2. Instrumental support and advocacy support: items in clusters of (a) Collaboration—accessing help from formal and natural supports, including those who have similar experiences; and (b) Knowledge Utilization—using knowledge and skills gained to increase feelings of self-efficacy to effectively communicate (e.g., active participation, assertiveness).
3. Informational/educational support: items in the Information Seeking cluster—obtaining knowledge relevant to helping the family (e.g., relevant systems and other available community resources).
4. Instructional/skills development: items in the Coping cluster—development and implementation of plans to address stressors and handle crises to further self-care, resilience, and perseverance.

A 4-point Likert scale was devised for each item, reflecting the caregiver's level of need for F2F services, with the following items: 1 = *intensive*—does not demonstrate knowledge and skill described by the item to improve the current situation without active intervention from the PSP; 2 = *moderate*—needs extensive assistance and encouragement from the PSP to demonstrate knowledge and skill described by the item to improve the current situation; 3 = *supportive*—needs limited assistance from the PSP to demonstrate knowledge and skill described by the item to improve the current situation; and 4 = *empowered*—demonstrates knowledge and skill described by the item without assistance from the PSP.

The original pool of 47 items was culled and modified, and administration format and procedures were refined through discussion and consultation with other providers and experts at national meetings. In addition, in a pilot implementation study carried out in Maryland, six PSPs first watched four FJA interviews (two live, two videotaped), scored them, and discussed the administration and their ratings. Second, over the course of 3 months, PSPs administered the FJA to 32 families. Following each administration, parents were asked for their feedback on the interview, and PSPs kept a log of implementation issues, which were discussed in biweekly meetings. As a result of these steps, some items were deleted, added, or modified, and alterations were made to the procedure, including scripts to introduce the FJA, to elicit cluster-organized information, and to provide feedback to parents after scoring a set of items. With these modifications, the FJA consists of 36 items. A manual (Anthony & Serkin, 2012), including background, development summary, rating guidelines, behavioral anchors, and examples for each item and administration prompts, was developed along with other training materials. The Appendix

aligns the final set of 36 FJA items with the objectives of F2F support laid out in training manuals and guidelines from four different states.

The decision was made to employ a PSP-administered interview format to enhance the meaningfulness of the assessment to families, to allow consideration of culture and background, and to elicit information to inform the F2F process. The format is similar to other widely employed provider-completed outcome instruments, such as the Child and Adolescent Needs and Strengths (Lyons, 2009) and the Child and Adolescent Functional Scale Assessment Scale (Hodges, 2000), in which item selection is based on service need and anchors relate directly to clinical decision making.

Participants

A collaboration was formed between the developers and the Association for Children's Mental Health (hereafter, "the Association") in Michigan, the statewide family organization that offers information support and resources, referral, and advocacy for children and youth with mental, emotional, or behavioral disorders and their families. The Association recruits PSP applicants with lived experience based on self-assessment of their readiness to complete training demands and their skills in carrying out different F2F support tasks. The Association agreed to support the use of the FJA within their network of certified PSPs. Twenty-four PSPs were trained to administer the FJA (22 women, two men) and provided data for this report. Two thirds of the PSPs provided services through contracts with provider organization developed through the Association, and the remaining one third was hired directly by the Public Mental Health agency. The majority of PSPs worked in urban settings (70.8%).

PSPs administered a total of 436 assessments with 319 caregivers. FJAs were carried out with 281 caregivers at baseline, within 6 weeks of service onset. At 3 months from service onset, 111 caregivers completed FJAs, 77 of whom had also completed the baseline assessment. At 6 months from service onset, 43 caregivers completed FJAs, four of whom had also completed baseline assessments, 10 of whom who had also completed 3-month assessments, and 25 who had completed FJAs at baseline, 3 months and 6 months.

Caregivers providing input for baseline FJAs were primarily mothers (76.2%), and a large majority were White (65.1%) and had a high school degree or higher (71.6%). Most families were referred for F2F services by the mental health system (79.0%). The caregiver provided information for the child in the family whose mental health problems had prompted referral for F2F services. Two thirds of these children were male and they were spread relatively evenly across grade level, except for a smaller percentage attending 11th and 12th grades. Demographic patterns were substantially the same for caregivers completing FJAs at baseline and for the smaller groups completing follow-up assessments.

Procedure

FJA training. Instruction for PSPs on FJA administration, provided by the developers, consisted of an initial day-long group session beginning with presentation of rationale and background, administration procedures (described in the next section), and scoring guidelines. Participants then watched and scored a video

demonstration of the FJA, and trainers led a group discussion focusing on interview methodology and comparison of the participant's scores with rating standards. Finally, participants split into groups, with each individual administering the FJA, with another individual role-playing a caregiver and receiving feedback on their administration from the group and one of the trainers. In addition, examples of interviews with justification for item scoring were available on the FJA website.

FJA administration. Baseline administration is completed near the time of initial contact and then repeated at 3-month intervals or at the end of service. The FJA is designed to be integrated into the structure of F2F as a tool to help track the progress of the joint work of the PSP and caregiver. PSPs complete the FJA through discussion with the family member, beginning with general open-ended questions for each cluster area (e.g., "Tell me about how things are going with [child's name]" for the Self-Knowledge cluster), followed, if necessary, by targeted prompts (e.g., "Let's talk about what has caused [child's name] difficulties" for the Self-Knowledge cluster) to gain further information. If the general and specific prompts are unsuccessful in eliciting needed information, as a last resort, the specific item can be paraphrased. PSPs rate the family's progress from what they observe and hear during the interview as well as relevant information from other sources (e.g., mental health providers, school personnel) obtained outside of direct meetings with the family. The latter information is always validated with the family.

The need for a transparent process was paramount in the minds of the developers. Thus, at the end of each cluster, the PSP offers a general impression of the family's level of progress and asks for feedback. The manual provides prompts to elicit such feedback. For example, "It sounds like you have a great sense of what [child's name] needs to succeed. Maybe you are focusing so much on her needs that you have difficulty making time to take care of yourself. What do you think?" This feedback and reflection ensures that the PSP's interpretation of family progress matches the interpretation and experience of the caregiver. If parents disagree with the PSP's perception of their level of needed support, the reasons are discussed, and if compelling, the PSP may alter his or her rating.

PSP feasibility/validity survey. Participating PSPs who had at least 6 months of experience administering the FJA ($N = 22$) were asked to complete an online survey to assess feasibility and content validity 1 year after onset of FJA administration. The initial request with the link to an online survey was e-mailed to participants, and two further reminders were sent if PSPs did not respond. The survey first asked for demographic information (gender, PSP experience). A feasibility section followed, consisting of a general practicality question—"How comfortable are you using the FJA"—with four response options ("not comfortable," "a little comfortable," "comfortable," or "very comfortable"), followed by two questions to be answered for each of the 36 items, one tapping comprehension ("How easy is each item to understand?") and a second tapping implementation ("PSPs decide how to rate each item through conversation with the family. How easy is it to obtain the information that you need to respond to each item?"). PSPs were asked to respond on a 5-point scale from *very difficult* to *very easy*. Finally, the relevance or content validity of each FJA item to the process and goals of F2F support was assessed. This question

was also rated on a 5-point scale from *not at all relevant/related* to *very relevant/related*. All surveys were completed within a 3-week period.

Analysis

For the PSP Feasibility/Validity Survey, mean ratings were calculated for each item. In addition, for the relevance question, the content validity index (CVI) was employed to determine whether PSPs felt that the FJA items captured relevant aspects of family progress in F2F. The CVI, a widely used measure of content validity (e.g., Polit, Beck, & Owen, 2007), was calculated for each item by dividing the number of PSPs who provide a *relevant* (4) or *very relevant* (5) rating by the number of participating PSPs (Polit & Beck, 2006).

Principal component analysis was employed to analyze the structure of the FJA because our goal was to reduce the items down to a smaller number of components in order to create composite scores for use in subsequent analysis. Initial eigenvalues derived from the extraction process, evaluated with multiple criterion methods (Schönrock-Adema, Heijne-Penninga, Van Hell, & Cohen-Schotanus, 2009), indicated a three-component solution. Following an oblique rotation, component loadings, cross-loadings, and correlations between components on the pattern, structure, and correlation matrices were evaluated to decide upon the final structure of components (Henson & Roberts, 2006). The items within each component formed the different FJA scales, described in the Results section.

Mean scores for items within each scale, and for each total scale score, were calculated for FJAs at baseline and the 3-month and 6-month follow-ups. Paired-samples *t* tests were used to compare FJA item and scale scores from baseline administration to each follow-up administration. Repeated measure analyses were performed to examine the effect of administration period (baseline, 3-month follow-up, 6-month follow-up) on FJA scores for those caregivers who had the instrument administered to them at each time point.

Results

PSP Feasibility Survey

The survey was completed by 14 of 22 eligible PSPs, 64% of whom had 1 to 2 years of experience as a PSP, 22% had 3 to 4 years of experience, and 14% had 4 or more years of experience. The average number of FJAs administered by PSPs who completed the feasibility survey (one male, 13 females) and those who did not (one male, seven females) was quite similar, 13.8 (median = 11.5) and 12.9 (median = 11), respectively. Survey completers were allied with nine of the 12 organizations supporting PSPs, whereas noncompleters came from eight of the 12 organizations.

Overall, 12 of the PSPs completing the survey felt comfortable or very comfortable using the FJA and two felt a little comfortable. None reported being not comfortable with FJA administration. In general, PSPs felt that items were easy to understand (mean rating of 3.98, $SD = 1.15$, mode = 4) and very relevant to the goals of family support (mean rating = 4.11, $SD = 1.01$, mode = 5). Ratings of the ease in obtaining information from families to

respond to the item was slightly less positive ($M = 3.49, SD = 1.23, mode = 4$). For the understandability and relevance questions, all items had a modal response of 4 or 5. For the ease of response question, modes also fell mostly in the 4 to 5 range, although mean scores were somewhat lower. The mean CVI for all 36 items was 0.83, with item CVIs ranging from 0.71 to 0.86, providing evidence for strong content validity (Polit & Beck, 2006).

FJA Components

Table 1 presents the rotated pattern matrix for the baseline component structure, reflecting the unique contribution of each variable to each component unaffected by factor overlap. The first of the three scales, which accounted for almost 58% of the variance, was named Recognition (14 items). It includes most items from the Self-Knowledge cluster, with the highest loading items tapping the caregiver’s capacity to recognize the strengths and needs of their child as well as items related to the caregiver’s involvement in decision making affecting the family and the child’s care. This scale also includes moderate loadings from the

Knowledge Utilization cluster, reflecting skills in realistic and effective communication and advocacy around child and family issues.

A second scale, termed Collaboration (11 items), accounts for approximately 4% of the variance. Items loading strongly on this scale comprised all but one of those in the Collaboration cluster and some of those in the Knowledge Utilization cluster. They include those assessing the extent of connection with other families, especially through family support activities, use of resources coupled with an understanding of the constraints they might be operating under, as well as active participation in help-seeking activities. Two items from the Information Seeking cluster loaded moderately on the Collaboration scale, reflecting skills in gathering information and using it to navigate services systems.

Finally, 11 items loaded on the third scale, which accounted for 3.5% of the variance. The items included all those from the Coping cluster as well as two from both the Family Well-Being and Self-Knowledge clusters. The scale was termed Activation, because items concerned caregivers’ understanding of their own

Table 1
Loadings for the Pattern Matrix and Commonalities for the Three-Component Solution

Item	Recognition	Collaboration	Activation	h ²
1. Communicates needs related to culture, language, learning, and thinking styles in order to progress	.56	.14	.11	.55
2. Understands and accepts the child’s challenges	.95	.00	-.16	.76
3. Recognizes the child’s needs	.88	.05	-.09	.73
4. Recognizes own needs	.27	-.05	.59	.59
5. Sees challenges in an objective way	.64	.17	.09	.67
6. Separates the child’s challenges from family/own self-worth	.60	-.07	.30	.68
7. Recognizes own strengths	.27	-.04	.64	.70
8. Recognizes the child’s strengths	.68	.00	.19	.65
9. Believes own voice is important	.57	.05	.23	.60
10. Is involved in decision making within the family	.69	-.07	.21	.64
11. Participates in decision making with those involved in the child’s care	.67	.00	.23	.71
12. Feels connected and supported by formal child-serving systems	.45	.20	.14	.50
13. Accesses and feels supported by natural supports	.18	.02	.47	.49
14. Develops and maintains a daily routine	.17	.14	.55	.54
15. Gathers information, resources, or materials to improve the situation	.26	.55	.11	.68
16. Uses knowledge to navigate child-serving systems and other community-based resources	.23	.60	.08	.66
17. Works with others to achieve goals	.42	.40	.14	.73
18. Seeks assistance and works with others to find supports	.34	.40	.19	.68
19. Connects with families having similar experiences	-.14	.73	.14	.68
20. Demonstrates an understanding of others’ perspectives and the constraints of their situations	.35	.63	-.11	.71
21. Shares their story with others	-.06	.75	.08	.63
22. Participates in family support activities and events in person or through the internet	-.03	.87	-.11	.69
23. Uses knowledge about resources in the community and beyond in an effective way	.14	.66	.13	.70
24. Attends, participates in, and speaks up during meetings	.12	.63	.10	.64
25. Communicates effectively	.52	.21	.20	.73
26. Demonstrates effective advocacy	.52	.63	.10	.74
27. Is clear about the issues affecting the child and family and is able to discuss and communicate those issues in a constructive way	.62	.17	.62	.74
28. Utilizes the available spectrum of support	.43	.76	.04	.70
29. Understands that having a range of feelings is normal and is coping well nevertheless	.34	.18	.41	.66
30. Demonstrates resiliency and perseverance	.38	.17	.34	.63
31. Understands and takes care of self	-.12	-.04	.93	.70
32. Knows how to reduce stress	.03	.01	.78	.67
33. Handles crises effectively	.24	.09	.60	.71
34. Develops a plan of care	-.05	.29	.66	.78
35. Carries out the plan of care	-.07	.36	.63	.82
36. Possesses and uses coping skills	.20	.06	.65	.71

Note. Primary factor loadings are indicated in bold.

This document is copyrighted by the American Psychological Association or one of its allied publishers. This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

needs and strengths, use of skills to cope with stress and enhance resilience, and abilities to develop and carry out plans of care for their child, including dealing with crises.

Alpha level for each scale was high: .96 for Recognition, .94 for Community Collaboration, and .95 for Activation. No substantial increases in alpha for any of the scales were achieved by eliminating items.

Baseline Ratings

Descriptive statistics for each FJA item and the three scales for the 281 baseline FJA administrations are shown in Table 2. Average item and scale scores ranged between 2 and 3, indicating a moderate to supportive level of need, although individual item scores ranged across the need spectrum. Repeated-measures analysis examined differences in the baseline scale scores, with degrees of freedom corrected using the Greenhouse-Geisser estimate

(.939). The results showed significant variation among the scales, $F(1.88, 525.63) = 57.398, p < .001$, with contrasts indicating that the mean score for the Recognition scale was significantly higher (less support needed) than for both the Collaboration scale, $F(1, 280) = 83.83, p < .001$ and the Activation scale $F(1, 280) = 30.44, p < .001$.

Three further repeated-measures analyses were completed on baseline scale scores to examine between subject effects of caregiver education (<high school, high school degree, >high school degree), caregiver race (Black/African American, White), and child grade level (<1, 1–3, 4–6, 7–9, 10–12). Separate analyses were used because of differences in missing data for the between-subject variables. The differences in baseline scale scores among the FJA scales remained for each of the analyses. Only the main effect of caregiver education was significant, $F(2, 238) = 7.179, p = .001$. Caregivers with greater than a high school education

Table 2
Item and Scale Means (Standard Deviations) for All Caregiver Baseline FJAs and for FJAs Completed at Both Baseline and Follow-Up (3 Months, 6 Months)

FJA item	Baseline (n = 281)	3-month follow-up (n = 77)		6-month follow-up (n = 30)	
		Baseline	3 months	Baseline	6 months
Scale 1: Recognition	2.53 (.68)	2.53 (.65)	2.79 (.60)*	2.64 (.63)	3.14 (.67)*
1. Communicates needs related to culture, language, learning	2.64 (.80)	2.62 (.85)	2.80 (.73)	2.50 (.90)	3.17 (.70)*
2. Understands and accepts the child's challenges	2.45 (.87)	2.52 (.91)	2.80 (.84)	2.73 (1.02)	3.03 (.93)
3. Recognizes the child's needs	2.48 (.87)	2.51 (.84)	2.91 (.75)*	2.87 (.82)	3.07 (.83)
5. Sees challenges in an objective way	2.32 (.84)	2.27 (.82)	2.57 (.73)*	2.40 (.93)	2.77 (.82)
6. Separates the child's challenges from family/own self-worth	2.29 (.84)	2.35 (.85)	2.64 (.71)*	2.53 (.78)	3.03 (.81)*
8. Recognizes the child's strengths	2.45 (.86)	2.35 (.82)	2.78 (.84)*	2.57 (.86)	3.10 (.76)
9. Believes own voice is important	2.63 (.91)	2.63 (.89)	2.92 (.78)*	2.70 (.84)	3.17 (.70)
10. Is involved in decision making within the family	2.89 (.84)	2.97 (.86)	3.05 (.83)	2.93 (.83)	3.40 (.72)
11. Participates in decision making	2.86 (.85)	2.97 (.83)	3.10 (.75)	3.17 (.79)	3.30 (.70)
12. Feels connected and supported by formal child-serving systems	2.32 (.87)	2.25 (.86)	2.65 (.79)*	2.33 (.78)	3.17 (.79)*
17. Works with others to achieve goals	2.63 (.80)	2.55 (.84)	2.83 (.75)*	2.70 (.84)	3.23 (.77)
25. Communicates effectively	2.66 (.90)	2.62 (.80)	2.79 (.79)	2.77 (.90)	3.27 (.64)
26. Demonstrates effective advocacy	2.42 (.93)	2.42 (.95)	2.65 (.74)	2.33 (1.06)	3.07 (.87)*
27. Is clear about the issues affecting the child and family	2.46 (.90)	2.39 (.91)	2.62 (.74)	2.43 (1.04)	3.07 (1.00)*
Scale 2: Collaboration	2.31 (.69)	2.26 (.66)	2.56 (.64)*	2.19 (.65)	2.98 (.80)*
15. Gathers information, resources, materials	2.38 (.89)	2.21 (.85)	2.58 (.86)*	2.27 (.91)	2.87 (.97)
16. Uses knowledge to navigate child-serving systems	2.30 (.87)	2.13 (.83)	2.58 (.78)*	1.97 (.79)	2.90 (.96)*
18. Seeks assistance and works with others to find supports	2.55 (.85)	2.42 (.85)	2.72 (.77)*	2.47 (.82)	3.13 (.90)
19. Connects with families having similar experiences	1.73 (.82)	1.68 (.77)	2.04 (.90)*	1.52 (.74)	2.52 (1.02)*
20. Demonstrates an understanding of others' perspectives	2.32 (.90)	2.33 (.84)	2.47 (.84)	2.30 (.84)	3.07 (.87)*
21. Shares their story with others	2.57 (.99)	2.68 (.99)	2.86 (.96)	2.37 (.96)	3.13 (.86)*
22. Participates in family support activities and events	1.91 (.88)	1.87 (.87)	2.25 (.90)*	1.82 (.91)	2.89 (.96)*
23. Uses knowledge about resources in the community	2.28 (.88)	2.09 (.80)	2.52 (.80)*	2.13 (.90)	2.93 (.94)*
24. Attends, participates in, and speaks up during meetings	2.63 (.90)	2.77 (.84)	2.90 (.77)	2.55 (.95)	3.21 (.82)
28. Utilizes the available spectrum of support	2.43 (.89)	2.38 (.86)	2.68 (.74)	2.33 (.84)	3.10 (.88)*
Scale 3: Activation	2.31 (.68)	2.24 (.70)	2.61 (.57)*	2.19 (.63)	2.90 (.73)*
4. Recognizes own needs	2.28 (.84)	2.20 (.90)	2.67 (.72)*	2.21 (.98)	2.86 (.85)
7. Recognizes own strengths	2.33 (.85)	2.36 (.83)	2.71 (.69)*	2.30 (.76)	3.10 (.80)*
13. Accesses and feels supported by natural supports	2.26 (.97)	2.17 (.94)	2.51 (.91)	2.13 (.90)	2.93 (.98)*
14. Develops and maintains a daily routine	2.41 (.97)	2.29 (.92)	2.61 (.91)*	2.27 (.91)	3.10 (.80)*
29. Understands that having a range of feelings is normal	2.41 (.86)	2.38 (.89)	2.74 (.77)*	2.23 (.89)	2.87 (.86)*
30. Demonstrates resiliency and perseverance	2.63 (.88)	2.60 (.86)	2.90 (.75)	2.50 (.86)	3.10 (.84)
31. Understands and takes care of self	2.21 (.91)	2.12 (.86)	2.61 (.80)*	2.00 (.98)	2.77 (.82)*
32. Knows how to reduce stress	2.10 (.79)	2.00 (.77)	2.41 (.75)*	1.97 (.62)	2.73 (.87)*
33. Handles crises effectively	2.28 (.84)	2.22 (.86)	2.59 (.75)*	2.40 (.82)	2.90 (.96)
34. Develops a plan of care	2.29 (.90)	2.20 (.94)	2.59 (.73)*	2.10 (.92)	2.87 (.78)*
35. Carries out the plan of care	2.22 (.90)	2.13 (.93)	2.46 (.79)*	2.00 (.95)	2.70 (.84)*
36. Possesses and uses coping skills	2.29 (.80)	2.24 (.80)	2.54 (.74)*	2.23 (.82)	2.90 (.88)*

Note. Asterisks (*) indicate significant difference from baseline to follow-up, $p < .01$. FJA = Family Journey Assessment.

were rated as requiring less support than those with less education. This difference did not vary by scale.

Change From Baseline to 3-Month and 6-Month Follow-Ups

Analyses of FJAs administered to the same caregivers at baseline and each follow-up revealed a less intense need for F2F services over time. Table 2 also shows the means and standard deviations for each FJA item and the three scales for those FJAs administered to the same caregiver at both baseline and the 3-month follow-up and both baseline and the 6-month follow-up. Paired sample *t* tests compared item and scale means at baseline and each follow-up. Bonferroni adjustments were made for the number of comparison sets. For each scale, mean scores increased significantly from baseline to both 3- and 6-month follow-ups, reflecting lower need for F2F services. For each item, mean scores increased from baseline to follow-up with the highest score always occurring at the 6-month assessment. Items showing significant increases by the 3-month assessment included those tapping caretakers' understanding of the challenges and needs of the child and connecting with relevant supports (Recognition) as well as those related to identifying and gathering relevant information and supports to access services (Collaboration). Within the Activation scale, the scores on most items increased significantly from baseline to 3 months, reflecting growing caregiver independence in recognizing their own strengths, particularly developing and implementing plans for care and crisis response, and their own needs and associated coping and stress reduction techniques.

Figure 1 shows mean scores for those FJAs administered to the same caregiver at baseline, 3 months, and 6 months. Analyses used a multivariate, repeated-measures ANOVA, with a Greenhouse-Geisser correction for items that violated the assumption of sphericity and post hoc tests using the Bonferroni correction. The effect of time (baseline, 3 months, 6 months) was significant in the

multivariate analysis, $F(6, 92) = 7.74, p < .00001$ (Wilks $\Lambda = .442, \eta_p^2 = .335$) and for each FJA scale: Recognition, $F(1.48, 35.50) = 20.50, p < .00001$, Collaboration, $F(1.55, 37.13) = 25.01, p < .00001$, and Activation, $F(1.55, 37.21) = 25.93, p < .00001$. Post hoc tests revealed that for each scale, scores increased significantly from baseline to 3 months and to 6 months. Increases from 3 to 6 months were significant for the Recognition and Collaboration scales but not for the Activation scale. Repeated measures analyses were conducted on each FJA item. Of the 31 items that showed significant effects of time period on FJA scores, 10 showed reliable changes from baseline to 3 months, but all showed reliable changes from baseline to 6 months.

To further examine variation in the level of need of caregivers during F2F services, the change in the scale rating for each item from baseline to 3-month follow-up and from baseline to 6-month follow-up was categorized as either an increase (e.g., moderate to intensive), no change (e.g., moderate to moderate), or a decrease (e.g., moderate to supportive) in level of need. The percentage of FJAs falling into each category was then calculated for each item. Figure 2 displays the percentage for each need category (increase, no change, decrease), averaged over items, for each scale. At the 3-month follow-up, over all items, approximately 10% of FJAs showed increases, about 54% showed no change, and about 36% showed decreases in level of need. The pattern was roughly the same for each scale, although a greater percentage of FJAs showed a decrease in level of need for the Activation scale. At the 6-month follow-up, the relative percentages of no change and decrease in need were reversed from 3 months; over all items, slightly less than 10% of FJAs showed increases, about 37% showed no change, and about 54% showed decreases in level of need.

Discussion

The provision of F2F support is becoming an increasingly common and important component of the system of care for children and youth with significant mental health challenges. Both the Center for Medicare and Medicaid Services (2013) and the Substance Abuse and Mental Health Services Administration (2017) have identified parent peer support as one of the key services that can enable children with complex needs to live at home and participate fully in family and community life and strengthen the capacity of families to care for children at home. Almost every state has established systems to certify peer support specialists. In a recent survey by the Family Run Executive Director Leadership Association (FREDLA, 2014), over 109,000 families had received parent peer support in 31 states in the last year. Moreover, across the country, states are funding family and youth peer support through a variety of Medicaid mechanisms (e.g., state plan amendments, waivers, and administrative match). Initiatives to specify the goals of PSP-delivered services have progressed rapidly. However, efforts to assess the impact of this component of the service array have not kept up. Using the FJA, we present one of the first reports showing significant improvement in key indicators of success gathered from families participating in F2F.

The FJA was designed to both track outcomes as well as provide a structure to deliver systematic feedback to families participating in F2F support to guide the content and intensity of services. The FJA items dovetail well with goals of family support identified

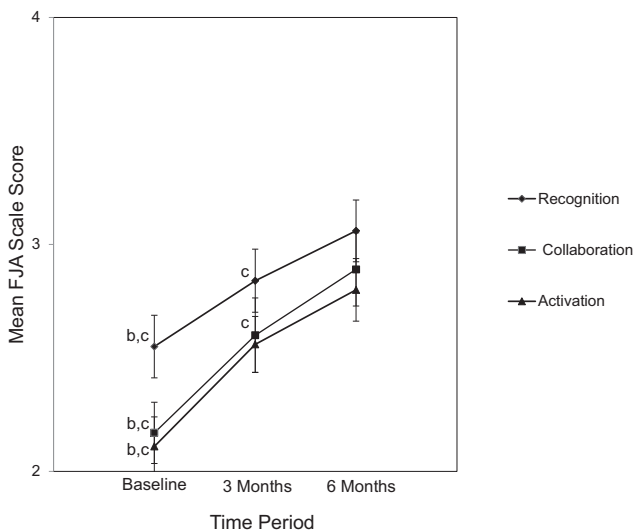


Figure 1. Mean FJA scale scores at each time point. Lowercase letters denote significant differences between time points: b = 3 months, c = 6 months. FJA = Family Journey Assessment.

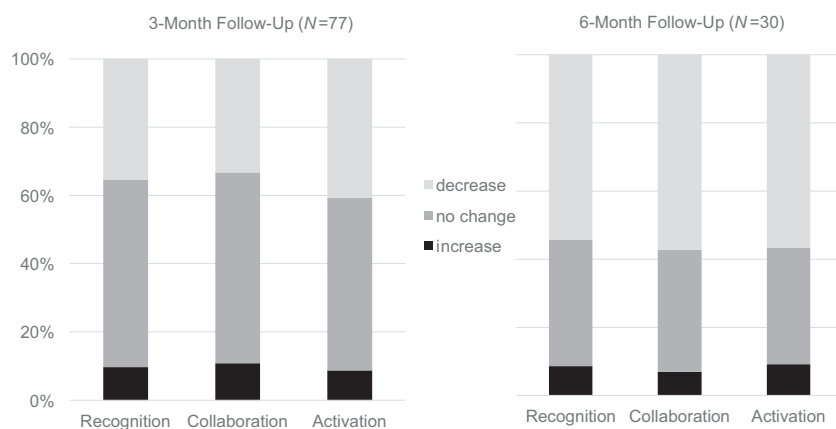


Figure 2. Percent of FJAs that showed an increase, decrease or no change in level of need from baseline to follow-up for each scale. FJA = Family Journey Assessment.

through survey and qualitative investigations (Hoagwood et al., 2010) as well as those developed by national organizations (e.g., Family Run Executive Directors Leadership Association, Federation of Families for Children's Mental Health) and state certification programs. Reports from widespread implementation by PSPs across the State of Michigan indicated that FJA items were viewed as easily understandable and relevant to the goals of peer support. In general, almost all of the items were viewed as clearly defined and face valid; measures of content validity derived from surveys with PSPs were uniformly high. Moreover, the FJA can be successfully integrated into F2F practice and administered by PSPs with varied background and experience, supporting the potential for widespread implementation.

A three-component solution proved to be the most parsimonious characterization of the structure of the FJA, with each possessing high consistency. Caregivers' need for support varied depending on the particular goals of F2F reflected in the different scales. At each time point, the Recognition scale score was higher than the other two scales, suggesting that caregivers were relatively more aware of the challenges they faced and necessary decisions to be made. Within the Recognition scale, baseline ratings of items indicated that caregivers needed the most support in identifying the strengths, challenges, and needs of the child, and in developing effective connections and advocacy with external resources. Others have found that low percentages of parents of children with significant psychiatric problems recognize these signs (Teagle, 2002) and report accessing needed services (Jensen et al., 2011). However, ratings made at 3 months showed relatively large and significant increases in most of the items reflecting these skills; PSPs seemed able to help caretakers get information and connect with relevant supports to access services for their children but had less consistent impact on the ability to effectively communicate these needs and use support.

Within the Collaboration scale, the need for support in gathering necessary information and supports, and using it effectively, dropped from baseline to 3-month assessments, and even more so at 6 months. Increases in these skills address the key barriers that families face in accessing appropriate mental health services for their children (Owens et al., 2002), finding compelling evidence for the long-term effectiveness of treatments, navigating the com-

plex and fragmented system of care, and experiencing stigma associated with mental health and mental health service utilization. Further, at baseline, caregivers needed the most support in connecting with other families with the same challenges but ratings at 3 and 6 months showed substantially less need for help in accessing this type of support. Connecting with others experiencing similar difficulties may be especially important in stigmatized problems, such as mental health, which may compromise usual support networks (Davison, Pennebaker, & Dickerson, 2000).

Finally, caregivers needed the most support in areas tapped by the Activation scale; eight of the 12 items requiring the most intense PSP support were contained in the scale. Caregivers were perceived as requiring significant help in taking care of themselves—recognizing their own needs, reducing stress, accessing support—and effectively dealing with crises with a coherent plan of care. If caregivers remained in F2F for at least 3 months, they showed a strong and significant decrease in need in these areas and all others covered in the Activation scale. Importantly, greater caregiver strain has been related to less improvement in child symptom severity with treatment (Accurso, Garland, Haine-Schlagel, Brookman-Frazee, & Baker-Ericzén, 2015) and a compromise in caregiver's ability to parent effectively, by impacting their own mental health (Borre & Kliwer, 2014). Moreover, higher levels of parenting strain impacts service engagement (e.g., Brannan, Heflinger, & Foster, 2003; Pellerin, Costa, Weems, & Dalton, 2010) and the use of more costly services (e.g., Bickman, Foster, & Lambert, 1996; Cook et al., 2004). Support provided by someone who has experienced the stress and disruption that often accompanies children's behavioral difficulties may be a particularly potent aspect of F2F support, potentially improving outcomes for families and children (Kazdin & Whitley, 2003).

Mean scores rose from baseline to 3 months and from baseline to 6 months for each component scale. Similarly, for those caregivers who completed all three assessments, scores on each scale rose from baseline to 3 months and from baseline to 6 months. In addition, scores on the Recognition and Collaboration scales increased from 3 months to 6 months, suggesting greater independence the more time caregivers spent in F2F.

The pattern of change over time suggested that the development of certain skills required a lengthier period of support: the ability

of caretakers to effectively communicate and advocate for their own needs, to share their own experience, to utilize available supports, and to respond to adversity. Scores on items reflecting these skills either showed significant increases from baseline to 6 months or did not show significant change. Items concerned with the extent of involvement of the caretaker in decisions about their child showed little change; however, baseline scores were higher than those of other items.

Examination of scores at baseline and 3- and 6-month follow-ups indicated that key caregiver outcomes of participation in family support services improved. Mean scores rose from baseline to 3 months and from baseline to 6 months for each component scale. Similarly, for those caregivers who completed all three assessments, scores on each scale rose from baseline to 3 months and from baseline to 6 months. In addition, scores on the Recognition and Collaboration scales increased from 3 months to 6 months, suggesting greater independence the more time caregivers spent in F2F.

Overall, with greater time spent in family support, caregivers evinced less need for PSP input to achieve the goals of this service; compared with baseline scores, 37% of FJA items were rated higher at 3 months and 54% at 6 months. It is important to note, however, that 10% of scores decreased and a substantial percentage stayed the same. PSPs and caretakers did not automatically increase their FJA ratings on follow-up evaluations, suggesting that they critically evaluated family progress. The FJA items were designed with anchors for the different levels of need so that they relate directly to decision making. This results in a measure that emphasizes the rater's ability to completely but concisely describe the needs and strengths of the caregivers in their journey in a way that is directly translatable into service planning, even without scale scoring. Also, given the growth of coordinated systems of support in children's mental health to craft and match services, supports and interventions to meet unique family needs, the FJA can allow for clearer communication with partners in the system of care. It provides ways to integrate key information from caregivers into the assessment of service needs and outcomes for children and youth, to increase joint service planning, development, and coordination.

The FJA holds promise as an important tool to support the integration of F2F services into the mental health service array. As states move toward managing services using value-based payment approaches (Centers for Medicare and Medicaid Services, 2013) and mandating workforce competencies (e.g., Boat, Land, & Leslie, 2017), service-related outcome measures become increasingly essential. Increasingly multipurpose tools, like the Child and Adolescent Needs and Strengths and the Child and Adolescent Functional Assessment Scale, are being used not only to monitor outcomes of services but also to support care planning and level of care decision making and to facilitate quality improvement initiatives. The FJA is the only such tool to directly focus on caregivers' progress in F2F services. Besides its sensitivity to treatment, it enhances the meaningfulness of the assessment to families and PSPs by eliciting information to inform the F2F process and to assist in treatment planning. Moreover, as children's mental health services increasingly focus on the needs and strengths of clients, assessments need to include strength-based components. The FJA focuses on measuring knowledge and skills that enhance a caregiver's capacity to deal with stress and adversity, creates a sense of

personal accomplishment, and promotes effective relationships with natural and formal supports. No other tool accomplishes all of these goals.

The study findings need to be considered in light of several points. First, the small sample size of those individuals who participated in FJA ratings at all three time points limits generalizability. However, the cross-sectional data were consistent with the longitudinal results. Second, the study did not include an external criterion of caregiver progress to formally evaluate sensitivity of the FJA to change.

Third, although the training procedures focused on appropriate administration and scoring and involved participant role-playing and feedback, we did not assess interrater reliability, nor did we obtain formal ratings of fidelity during the study except for discussions of administration issues between PSPs and the F2F coordinator as part of regular supervision. We have now expanded the training protocol to include the requirement that PSPs score two video administrations of the FJA, and that their ratings meet acceptable standards derived by the developers, which allows for calculation of interrater reliability. In addition, PSPs conduct an interview with an FJA staff member, role-playing a standard caregiver. The recorded interview is rated according to content and process aspects of quality indicators standards. PSPs receive feedback, and if they fail to meet standards, they are asked to conduct a second interview. In future work, we will assess interrater reliability as well as the process, content, and quality of FJA administration with methodologies such as the Standardized Parent Walkthrough (Wisdom, Olin, Shorter, Burton, & Hoagwood, 2011). Walkthroughs entail a trained individual, using a standard presentation, literally "walking through" services to observe processes and provider responses in an equivalent manner. Walkthroughs can uncover assumptions, inconsistencies, and limitations of routine practice.

Conclusion

Because parents are the key drivers of mental health services for their children, peer interventions delivered by professional family support specialists have become an increasing part of the mental health workforce. The current findings strengthen the position that family-delivered support is an important adjunct to existing mental health services and begins to answer the urgent need for rigorous evaluations of these services. Implementation of the FJA provided evidence for its feasibility, usability, consistency, and three-component structure. Most importantly, through use of the FJA, we found evidence to suggest that time spent in family support services leads to improvement in key F2F goals that have the potential to improve service engagement and mental health literacy, reduce stress, increase support, and enhance recognition of need. Moreover, the study showed that the more time families spend in F2F, the less they need PSP input to achieve their goals.

The FJA goes beyond assessment of outcomes by providing a model to link family goals and progress to F2F services. It holds promise as a tool to identify benchmarks for focused and individualized family peer-to-peer support and parental advocacy by targeting particular knowledge or skills, depending on the family's level of need. Future efforts will be focused on evaluating the FJA as a guide for service directions for PSPs and families, and as a tool to further F2F quality improvement and program redesign.

References

- Accurso, E. C., Garland, A. F., Haine-Schlagel, R., Brookman-Frazee, L., & Baker-Ericzen, M. J. (2015). Factors contributing to reduced caregiver strain in a publicly-funded child mental health system. *Journal of Emotional and Behavioral Disorders, 23*, 131–143. <http://dx.doi.org/10.1177/1063426614532948>
- Angold, A., Messer, S. C., Stangl, D., Farmer, E. M. Z., Costello, E. J., & Burns, B. J. (1998). Perceived parental burden and service use for child and adolescent psychiatric disorders. *American Journal of Public Health, 88*, 75–80. <http://dx.doi.org/10.2105/AJPH.88.1.75>
- Anthony, B. J., & Serkin, C. (2012). *Family Journey Assessment manual*. Retrieved from <http://gucchdtcenter.georgetown.edu/Activities/FamilyJourneyAssessment/Family%20Journey%20Assessment%20Manual.pdf>
- Bickman, L., Foster, E. M., & Lambert, E. W. (1996). Who gets hospitalized in a continuum of care? *Journal of the American Academy of Child & Adolescent Psychiatry, 35*, 74–80. <http://dx.doi.org/10.1097/00004583-199601000-00015>
- Boat, T. F., Land, M. L., Jr., & Leslie, L. K. (2017). Health care workforce development to enhance mental and behavioral health of children and youths. *Journal of the American Medical Association Pediatrics, 171*, 1031–1032. <http://dx.doi.org/10.1001/jamapediatrics.2017.2473>
- Borre, A., & Kliewer, W. (2014). Parental strain, mental health problems, and parenting practices: A longitudinal study. *Personality and Individual Differences, 68*, 93–97. <http://dx.doi.org/10.1016/j.paid.2014.04.014>
- Brannan, A. M., Heflinger, C. A., & Foster, E. M. (2003). The role of caregiver strain and other family variables in determining children's use of mental health services. *Journal of Emotional and Behavioral Disorders, 11*, 77–91. <http://dx.doi.org/10.1177/106342660301100202>
- Centers for Medicare and Medicaid Services. (2013). Clarifying guidance on peer support services policy - Medicaid. Retrieved from <https://www.medicare.gov/medicaid/benefits/downloads/clarifying-guidance-support-policy.pdf>
- Cook, J. A., Heflinger, C. A., Hoven, C. W., Kelleher, K. J., Mulkern, V., Paulson, R. L., . . . Kim, J. B. (2004). A multi-site study of Medicaid-funded managed care versus fee-for-service plans' effects on mental health service utilization of children with severe emotional disturbance. *The Journal of Behavioral Health Services & Research, 31*, 384–402.
- Davison, K. P., Pennebaker, J. W., & Dickerson, S. S. (2000). Who talks? The social psychology of illness support groups. *American Psychologist, 55*, 205–217. <http://dx.doi.org/10.1037/0003-066X.55.2.205>
- Duchnowski, A. J., & Kutash, K. (2007). *Family-driven care*. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies. Retrieved from http://cfs.cbcs.usf.edu/_docs/publications/fam_driven_care.pdf
- Elliott, D. J., Koroloff, N. M., Koren, P. E., & Friesen, B. J. (1998). Improving access to children's mental health services: The family associate approach. In M. H. Epstein, K. Kutash, & A. Duchnowski (Eds.), *Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices* (pp. 581–609). Austin, TX: Pro Ed.
- FREDLA. (2014). *Statewide family network grants: Building capacity for family run organizations*. Retrieved from www.fredla.org/wp-content/uploads/2016/01/Statewide-Family-Network-Grants_-February-2014-final.pdf
- Godoy, L., Mian, N. D., Eisenhower, A. S., & Carter, A. S. (2014). Pathways to service receipt: Modeling parent help-seeking for childhood mental health problems. *Administration and Policy in Mental Health and Mental Health Services Research, 41*, 469–479. <http://dx.doi.org/10.1007/s10488-013-0484-6>
- Gyamfi, P., Walrath, C., Burns, B. J., Stephens, R., Geng, Y., & Stambaugh, L. (2010). Family education and support services in systems of care. *Journal of Emotional and Behavioral Disorders, 18*, 14–26. <http://dx.doi.org/10.1177/1063426609333891>
- Henson, R. K., & Roberts, J. K. (2006). Use of exploratory factor analysis in published research. *Educational and Psychological Measurement, 66*, 393–416. <http://dx.doi.org/10.1177/0013164405282485>
- Hoagwood, K. E., Cavaleri, M. A., Serene Olin, S., Burns, B. J., Slaton, E., Gruttadaro, D., & Hughes, R. (2010). Family support in children's mental health: A review and synthesis. *Clinical Child and Family Psychology Review, 13*, 1–45. <http://dx.doi.org/10.1007/s10567-009-0060-5>
- Hoagwood, K. E., Green, E., Kelleher, K., Schoenwald, S., Rolls-Reutz, J., Landsverk, J., . . . Research Network on Youth Mental Health. (2008). Family advocacy, support, and education in children's mental health: Results of a national survey. *Administration and Policy in Mental Health and Mental Health Services Research, 35*, 73–83. <http://dx.doi.org/10.1007/s10488-007-0149-4>
- Hodges, K. (2000). *Child and Adolescent Functional Assessment Scale*. Ypsilanti, MI: Eastern Michigan University.
- Ireys, H. T., & Sakwa, D. D. (2006). Building family-to-family support programs: Rationale, goals, and challenges. *Strengthening Social Support. Focal Point: Research, Policy, and Practice in Children's Mental Health, 20*, 10–14.
- Jensen, P. S., Goldman, E., Offord, D., Costello, E. J., Friedman, R., Huff, B., . . . Roberts, R. (2011). Overlooked and underserved: "action signs" for identifying children with unmet mental health needs. *Pediatrics, 128*, 970–979. <http://dx.doi.org/10.1542/peds.2009-0367>
- Kazdin, A. E., & Whitley, M. K. (2003). Treatment of parental stress to enhance therapeutic change among children referred for aggressive and antisocial behavior. *Journal of Consulting and Clinical Psychology, 71*, 504–515. <http://dx.doi.org/10.1037/0022-006X.71.3.504>
- Koroloff, N. M., Elliott, D. J., Koren, P. E., & Friesen, B. J. (1996). Linking low-income families to children's mental health services: An outcome study. *Journal of Emotional and Behavioral Disorders, 4*, 2–11. <http://dx.doi.org/10.1177/106342669600400101>
- Kutash, K., Duchnowski, A. J., Green, A. L., & Ferron, J. M. (2011). Supporting parents who have youth with emotional disturbances through a parent-to-parent support program: A proof of concept study using random assignment. *Administration and Policy in Mental Health and Mental Health Services Research, 38*, 412–427. <http://dx.doi.org/10.1007/s10488-010-0329-5>
- Lyons, J. S. (2009). Knowledge creation through total clinical outcomes management: A practice-based evidence solution to address some of the challenges of knowledge translation. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 18*, 38–45.
- National Federation of Families for Children's Mental Health. (2017). *Advocacy, Policy and Legislative Resources*. Retrieved from <http://www.ffcmh.org/resources-advocacy>
- Obrochta, C., Anthony, B., Armstrong, M., Kalil, J., Hust, J., & Kernan, J. (2011). *Issue brief. Family-to-family peer support: Models and evaluation*. Atlanta, GA: ICF Macro, Outcomes Roundtable for Children and Families. Retrieved from <http://www.ffcmh.org/sites/default/files/Issue%20Brief%20%20Family%20to%20Family%20Peer%20Support%20Outcomes%20Roundtable%202011.pdf>
- Olin, S., Kutash, K., Pollock, M., Burns, B. J., Kuppinger, A., Craig, N., . . . Hoagwood, K. E. (2014). Developing quality indicators for family support services in community team-based mental health care. *Administration and Policy in Mental Health and Mental Health Services Research, 41*, 7–20. <http://dx.doi.org/10.1007/s10488-013-0501-9>
- Owens, P. L., Hoagwood, K., Horwitz, S. M., Leaf, P. J., Poduska, J. M., Kellam, S. G., & Ialongo, N. S. (2002). Barriers to children's mental health services. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*, 731–738. <http://dx.doi.org/10.1097/00004583-200206000-00013>
- Pellerin, K. A., Costa, N. M., Weems, C. F., & Dalton, R. F. (2010). An examination of treatment completers and non-completers at a child and

- adolescent community mental health clinic. *Community Mental Health Journal*, 46, 273–281. <http://dx.doi.org/10.1007/s10597-009-9285-5>
- Polit, D. F., & Beck, C. T. (2006). The content validity index: Are you sure you know what's being reported? Critique and recommendations. *Research in Nursing & Health*, 29, 489–497. <http://dx.doi.org/10.1002/nur.20147>
- Polit, D. F., Beck, C. T., & Owen, S. V. (2007). Is the CVI an acceptable indicator of content validity? Appraisal and recommendations. *Research in Nursing & Health*, 30, 459–467. <http://dx.doi.org/10.1002/nur.20199>
- Purdy, F. (2010). *The core competencies of parent support providers*. Rockville, MD: National Federation of Families for Children's Mental Health. Retrieved from <http://ffcmh.org/wpcontent/uploads/2011/08/3CompetenciesBrief.pdf>
- Rodriguez, J., Olin, S. S., Hoagwood, K. E., Shen, S., Burton, G., Radigan, M., & Jensen, P. S. (2011). The development and evaluation of a parent empowerment program for family peer advocates. *Journal of Child and Family Studies*, 20, 397–405. <http://dx.doi.org/10.1007/s10826-010-9405-4>
- Schönrock-Adema, J., Heijne-Penninga, M., Van Hell, E. A., & Cohen-Schotanus, J. (2009). Necessary steps in factor analysis: Enhancing validation studies of educational instruments. The PHEEM applied to clerks as an example. *Medical Teacher*, 31, e226–e232. <http://dx.doi.org/10.1080/01421590802516756>
- Substance Abuse and Mental Health Services Administration. (2017). *Core competencies for peer workers*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tac/core-competencies.pdf
- Substance Abuse and Mental Health Services Administration. (2017). *Family, parent and caregiver peer support in behavioral health*. Retrieved from <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers>
- Teagle, S. E. (2002). Parental problem recognition and child mental health service use. *Mental Health Services Research*, 4, 257–266. <http://dx.doi.org/10.1023/A:1020981019342>
- Wisdom, J. P., Lewandowski, R. E., Pollock, M., Acri, M., Shorter, P., Olin, S. S., . . . Hoagwood, K. E. (2014). What family support specialists do: Examining service delivery. *Administration and Policy in Mental Health and Mental Health Services Research*, 41, 21–31. <http://dx.doi.org/10.1007/s10488-013-0526-0>
- Wisdom, J. P., Olin, S., Shorter, P., Burton, G., & Hoagwood, K. (2011). Family peer advocates: A pilot study of the content and process of service provision. *Journal of Child and Family Studies*, 20, 833–843. <http://dx.doi.org/10.1007/s10826-011-9451-6>

Appendix

Crosswalk of FJA Item Clusters and Peer-Delivered Family-to-Family Support Objectives

FJA clusters and items	Family-to-family support objectives			
	Families Together in New York State, Inc. Family Peer Advocate ^a	Tennessee Certified Family Support ^b	Michigan Parent Support Partner Project ^c	Washington State, Peer Support Counselor ^d
Information seeking				
<ul style="list-style-type: none"> Gathers information, resources or materials to improve the situation Uses knowledge to navigate child-serving systems and other community-based resources 	<ul style="list-style-type: none"> Help parents gain information about appropriate resources, services, and supports to make informed decisions Help families understand mental health diagnoses, medication, and treatment options 	<ul style="list-style-type: none"> Educate caregivers regarding diagnoses, cause of disorders, treatments Help caregivers obtain information to make sound, informed choices Help caregivers acquire skills, abilities, and knowledge Assist caregivers in learning how to access community resources and specialty services Assist with system navigation 	<ul style="list-style-type: none"> Assist parents in understanding their children's diagnosis, supports, and available services Provide information to the family so they can make informed choices on what is best for their child and family Provide information to increase the caregiver and family's understanding, access, the assessment process, family-centered practice, and community resources Assist with system navigation 	<ul style="list-style-type: none"> Pass on skills, tools, and information Assist peers in navigating systems that serve them

(Appendix continues)

Appendix (continued)

FJA clusters and items	Family-to-family support objectives			
	Families Together in New York State, Inc. Family Peer Advocate ^a	Tennessee Certified Family Support ^b	Michigan Parent Support Partner Project ^c	Washington State, Peer Support Counselor ^d
<p>Collaboration</p> <ul style="list-style-type: none"> • Works with others to achieve goals • Seeks assistance and works with others to find supports • Demonstrates an understanding of others' perspectives and the constraints of their situations • Connects with families having similar experiences • Shares their story with others • Participates in family support activities and events in person or through the internet 	<ul style="list-style-type: none"> • Facilitate effective, productive, and respectful family-provider partnerships • Assist the family to discuss and implement strategies recommended by clinicians • Provide information to parent about how to access and engage in mental health services • Model nonadversarial advocacy • Provide opportunities for families to connect and expand their circle of support from one another and to develop their leadership skills 	<ul style="list-style-type: none"> • Facilitate collaborative working relationships with providers, school staff, and other professionals • Connect youth and family with services and supports based on their strengths and needs • Encourage development of formal and informal support • Teach caregivers to work with mental health professionals in order to obtain the services they want • Teach and role model the value of all who care for a child or youth 	<ul style="list-style-type: none"> • Demonstrate effective collaboration • Facilitate access to services • Increase parents' involvement and ability to partner with service providers • Support parent's and family member's participation in family-centered practices, person-centered planning, and in treatment, services, and supports 	<ul style="list-style-type: none"> • Develop peers who partner with professionals rather than work with them in adversity • Develop formal supports • Assist in cross-system collaboration • Make a plan of action, go through a chain of command
<p>Knowledge utilization</p> <ul style="list-style-type: none"> • Uses knowledge about resources in an effective way • Attends, participates in, and speaks up during meetings • Communicates effectively • Demonstrates effective advocacy • Is clear about the issues affecting the child and family and is able to discuss and communicate those issues in a constructive way • Utilizes the available spectrum of support 	<ul style="list-style-type: none"> • Help families connect to, and participate in, services, system navigation, and linkage • Help prepare parents for meetings to assure their voice is heard • Increase parents' feelings of self-efficacy • Empower families by increasing their skills • Coach constructive self-advocacy skills • Increase self-reliance • Address barriers that may prevent full participation in services • Empower families to express their fears, expectations, and anxieties to promote positive effective communication 	<ul style="list-style-type: none"> • Teach relevant skills needed for effective advocacy and navigation of the child-serving systems • Assist caregivers in articulating their goals and objectives for their family • Assist caregiver in making positive treatment choices for their child and family • Assisting caregivers in becoming advocates for their child through knowledge, skills, and confidence 	<ul style="list-style-type: none"> • Help parents voice their opinion, needs, and goals, and expand opportunities for family choice and voice • Demonstrate effective communication • Increase confidence and competence • Provide support and assists parents/family members to speak for themselves • Provide education and training to and assist families in preparing for meetings regarding their children • Facilitate access to services 	<ul style="list-style-type: none"> • Empower to access resources • Help parents express their voice and make their own choices • Communicating with important support networks • Coach on communication skills • Building self-advocacy skills

(Appendix continues)

Appendix (continued)

FJA clusters and items	Family-to-family support objectives			
	Families Together in New York State, Inc. Family Peer Advocate ^a	Tennessee Certified Family Support ^b	Michigan Parent Support Partner Project ^c	Washington State, Peer Support Counselor ^d
<p>Self-knowledge</p> <ul style="list-style-type: none"> • Communicates needs related to culture, language, learning, and thinking styles in order to progress • Understands and accepts the child's challenges • Recognizes the child's needs • Recognizes own needs • Sees challenges in an objective way • Separates the child's challenges from family/own self worth • Recognizes own strengths • Recognizes the child's strengths • Believes that own voice is important 	<ul style="list-style-type: none"> • Work with families to identify and express strengths, needs, and priorities for their child • Help strengthen parent's sense of self • Support the families in discovering their strength and concerns 	<ul style="list-style-type: none"> • Identify the power of caregiver's beliefs and values and how they support or work against success • Assisting caregivers in obtaining services responsive to individual needs and culture • Increase understanding of child's needs • Help families identify and utilize strengths to achieve goals 	<ul style="list-style-type: none"> • Provide information to increase the caregiver and family's understanding of their child's needs 	<ul style="list-style-type: none"> • Help parents choose culturally and linguistically competent supports, services, and providers • Assist peers in identifying their own strengths • Focus on strengths • Build self-worth
<p>Coping skills</p> <ul style="list-style-type: none"> • Understands that having a range of feelings is normal and is coping well nevertheless • Demonstrates resiliency and perseverance • Understands and takes care of self • Knows how to reduce stress • Handles crises effectively • Develops a plan of care • Carries out the plan of care • Possesses and uses coping skills 	<ul style="list-style-type: none"> • Help parents identify ways to take care of themselves • Help families identify goals and track progress • Inspire hope 	<ul style="list-style-type: none"> • Foster a sense of hope and create and facilitate activities to support resiliency • Aid in the development of strengths-based family and individual goals • Help caregivers combat negative self-esteem, overcome fears, and solve problems • Teach caregivers to create their own family and individualized plan of care • Assist caregiver in articulating goals, objectives, and plan of care • Assist caregivers in developing problem-solving skills to respond effectively to child and/or family crises • Model effective coping techniques 	<ul style="list-style-type: none"> • Teach skills to effectively manage the day-to-day challenges of raising youth with SED • Help decrease caregiver stress 	<ul style="list-style-type: none"> • Help parents find hope • Identify resilience in parents' lives in the past and help them apply those skills to their current situation • Practice individual self-care • Help peers set goals and break those goals down into a workable plan • Develop a crisis plan • Help parents to develop a solution-focused coping style • Model positive coping skills to manage stress

(Appendix continues)

Appendix (continued)

FJA clusters and items	Family-to-family support objectives			
	Families Together in New York State, Inc. Family Peer Advocate ^a	Tennessee Certified Family Support ^b	Michigan Parent Support Partner Project ^c	Washington State, Peer Support Counselor ^d
Family well-being				
<ul style="list-style-type: none"> • Is involved in decision making within the family • Participates in decision making with those involved in the child's care • Feels connected and supported by formal child-serving systems • Accesses and feels supported by natural supports • Develops and maintains a daily routine 	<ul style="list-style-type: none"> • Help families ensure their perspective is included to promote shared decision-making • Reduce stigma, isolation, blame, and hopelessness • Help families to develop informal and formal networks of support • Enhance the quality of life by integration and supports for families in their own communities • Help families identify and support their involvement in faith, leisure, and recreational activities 	<ul style="list-style-type: none"> • Promote thoughtful, informed decision making • Link caregivers with activities and groups in community based on strengths and cultural interests • Assist caregivers in establishing and maintaining informal and formal supports 	<ul style="list-style-type: none"> • Decrease isolation • Link the family, based on strengths and cultural interests, with activities and groups in the community 	<ul style="list-style-type: none"> • Strategize with family members • Develops natural and informal supports • Perceiving different options

Note. FJA = Family Journey Assessment; SED = Serious Emotional Disability.

^a <http://www.flpn.org/Forms/FPA/FPA-Credential-Information-FAQ.pdf>; http://www.nyssuccess.org/images/Final_Definition_1.23.14.pdf. ^b <https://www.tn.gov/behavioral-health/for-providers/additional-resources/certified-family-support-specialist-program/tennessee-family-support-specialist-guidelines-and-forms.html>. ^c <http://www.acmh-mi.org/get-information/acmh-projects/parent-support-partner-project/cmhs-interested-bringing-parent-support-partners-community/>; <https://macmh.org/sites/default/files/attachments/files/%2330%20Parent%20Support%20Partner%20For%20Waiver%20Conference%202014.pdf>. ^d <https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Peer%20Support/Youth%20Family%20Certified%20Peer%20Counseling%20Manual.pdf>.

Received October 5, 2017

Revision received January 10, 2018

Accepted March 7, 2018 ■