12-31-2014

Child Welfare Involved Caregiver Perceptions of Family Support in Child Mental Health Treatment

Geetha Gopalan
University of Maryland School of Social Work, GGOPALAN@ssw.umaryland.edu

Mary Acri
New York University School of Medicine, mary.acri@nyumc.org

Marina Lalayants
Silberman School of Social Work at Hunter College, mlalayan@hunter.cuny.edu

Cole Hooley
McSilver Institute for Poverty Policy and Research at New York University, colehooley@gmail.com

Eddie Einbinder
New York University Silver School of Social Work, ere249@nyu.edu

Follow this and additional works at: https://digitalcommons.library.tmc.edu/jfs

Child Welfare Involved Caregiver Perceptions of Family Support in Child Mental Health Treatment

Acknowledgements

Introduction

Children who are involved in the child welfare system manifest higher rates of behavioral difficulties in comparison to youth within the general population. According to the National Survey of Child and Adolescent Well-Being, 33-43% of youth whose families were investigated by child protective services (90% of whom remained at home following the investigation) manifested clinical/borderline externalizing behavioral difficulties, while comparable estimates for the general population range from 5-7% (Administration for Children & Families [ACF], 2005; Burns et al., 2004). At the same time, their families experience substantial barriers to accessing and engaging in mental health services, such as concrete and logistical barriers (e.g., lacking money for transportation and childcare, competing demands for families mandated to receive multiple services by child welfare authorities) (McKay & Bannon, 2004; Kemp, Marcenko, Hoagwood, & Vesneski, 2009). Additionally, negative perceptions about mental health and treatment, including stigma and prior negative experiences with other services providers and child welfare staff, reduces service use (Anderson, 2006; Kerkorian, McKay, & Bannon, 2006; McKay & Bannon, 2004; Kemp et al., 2009). As a result, most children with mental health problems who are involved in the child welfare system do not receive needed treatment (Burns et al., 2004), while those who are able to engage in treatment are likely to terminate before receiving therapeutic benefit (Lau & Weisz, 2003).

Untreated mental health need among children is detrimental to the entire family, particularly among those involved in the child welfare system. Children with behavioral difficulties are at increased risk for future maltreatment (Black, Heyman, & Slep, 2001; Schumacher, Slep, & Heyman, 2001), and families often voluntarily place children with severe behavior problems into out-of-home placement (Barth, Wildfire, & Green, 2006). Longer-term consequences of untreated behavioral issues include increased risk for criminal involvement, substance abuse, and risky sexual behavior (Brown, Danovsky, Lourie, DiClemente, & Ponton, 1997; Gillmore, Morrison, Lowery, & Baker, 1994; Inciardi, Pottieger, Forney, Chitwood, & McBride, 1991; Lewis, 2010; Morris, Baker, & Huscroft, 1992; Schaeffer, Petras, Ialongo, Poduska, & Kellam, 2003; Weber, Elfenbein, Richards, Davis, & Thomas, 1989). The services required to address these compounded needs result in substantial expenditure increases (up to 10 times), making youth behavioral difficulties a costly public health concern (Scott, Knapp, Henderson, & Maughan, 2001). Thus, enhancing access to service use is a high priority, particularly amongst families who are involved in child welfare.

Peer-delivered services offer promise for connecting vulnerable families to needed resources, including mental health care (Acri, Olin, Burton, Herman, & Hoagwood, 2013; Chinman, et al., 2006; Chinman, Young, Hassell, & Davidson 2008; Solomon, 2004). In the adult health and mental health fields, peers, who themselves have a health or mental health problem, provide outreach, education, and in some cases, therapeutic services to individuals who are at-risk or in treatment (Auslander, Haire-Joshu, Houston, Rhee, & Williams, 2002; Chinman et al., 2008). In the child mental health system, peers are typically caregivers of children with mental health challenges who are trained to provide family support, including instruction/skill development (e.g., parenting strategies, anger management and stress reduction techniques), emotional support, and instrumental services (e.g., transportation, respite, childcare). Including family support as part of child mental health treatments may optimize services by addressing many of the family-level issues (e.g., caregiver strain and mental health), which could derail treatment engagement and outcomes (Barnard & McKeganey, 2004; Leslie, Aarons, Haine, & Hough, 2007; Petterson & Albers, 2001; Reyno & McGrath, 2006).

A newer model of family support service delivery in child mental health interventions consists of an interdisciplinary team composed of a mental health professional and a peer. Team-delivered interventions have been associated with important caregiver outcomes including: increased knowledge of mental health services, an enhanced sense self-efficacy, high satisfaction with services, and increased social support and reduced isolation (Hoagwood et al., 2010). A lesser-studied area of inquiry involves how caregivers perceive services co-led by a peer, and if there are any additive benefits to involving a peer in child mental health interventions. In the adult mental health literature, for example, peers have been shown to deliver services as effectively as other professionals (e.g., case managers; Chinman et al., 2008) as well as offer unique benefits (e.g., foster caregiver empowerment and self-care; Hoagwood et al., 2010). Whether this is true of co-led child mental health interventions, and particularly amongst families with complex needs such as those involved in the child welfare system, is not clear.

The purpose of this study is to describe caregiver perceptions of a co-led model for children with behavioral problems among families with complex needs (i.e. child welfare involvement), and to explore whether there are any additive benefits associated with utilizing peers as part of a team service delivery model. The current undertaking derives from a larger effectiveness study that examined the impact of a Multiple Family

Group (MFG) service delivery model for children with disruptive behavior disorders and their families--also known as the 4Rs and 2Ss Family Strengthening Program (Chacko et al., in press; Gopalan et al., in press; Gopalan et al., 2014; Gopalan, Fuss, & Wisdom, in press; Gopalan & Franco, 2009; McKay et al., 2011; Small, Jackson, Gopalan, & McKay, in press). Within this model, interdisciplinary peer-clinician teams provided treatment to low-income, inner-city families, which included a substantial proportion of families reporting child welfare involvement. Briefly, the MFG model integrates therapeutic principles from family therapy, behavioral parent training, and group therapy. Weekly group sessions involve six to eight families (including caregivers, identified child with behavioral difficulties, and siblings) over the course of four months. Additionally, MFG addresses barriers to treatment and promotes positive service experiences for youth and their families. The larger study, which began in October, 2006 and concluded in October, 2010, enrolled 320 children (n= 225 Experimental MFG group; n= 95 Services as Usual group) between seven and 11 years of age who met criteria for Oppositional Defiant Disorder or Conduct Disorder and their families. See Chacko et al. (in press) and McKay et al. (2011) for a more thorough description of the MFG service delivery model and the study from which the current project derives. To date, MFG has been shown effective in reducing child behavioral difficulties and improving youth social skills when compared to services as usual (Chacko et al., in press; Gopalan et al., in press). This model may be beneficial for child welfare involved families as an innovative mental health intervention focused on engaging and retaining low-income, urban minority families, reducing childhood behavioral difficulties, and addressing inner-city service capacity limitations. Consequently, before MFG can be tested exclusively with child welfare involved families, understanding how child welfare involved caregivers respond to the intervention will identify where modifications, if any, may be necessary.

Methods
Study Procedures
For the current qualitative study, Institutional Review Board approval was obtained to recruit caregivers from the experimental (active) arm of the MFG effectiveness study who indicated child welfare services involvement at baseline. Involvement was operationalized as ever having an open child welfare case, child placed in foster care, referred and/or mandated by a child welfare organization to bring their child to counseling, referred by child welfare agency to seek other services, as well as those

adult caregivers who indicated seeking services in order to receive full custody of their children or to avoid having their children removed from the home. MFG effectiveness study staff identified n= 74 caregivers who met this inclusion criteria and made initial telephone and letter contact. Research staff for the current qualitative study contacted the 57% (n= 42) who indicated initial interest to explain procedures, risk, and benefits. Following the 2nd contact, n= 25 (34% of eligible participants) consented to participate (7 refused, 4 unreachable, 5 ineligible, and 1 moved out of state). These participants were purposively sampled to represent a range of MFG sessions (0% to 100%). Specifically, we aimed to recruit up to 25 participants in this study and ensure that the distribution of participants across of the range of MFG session attended (0% to 100%) was balanced. Breaking down this distribution into quartiles (0-25%, 26-50%, 51-75%, 76-100%), we attempted to recruit 6-7 participants within each quartile. The total sample size was sufficient in number to achieve analysis saturation.

Data Collection

MFG effectiveness study data, demographic and child welfare history information were collected from each participant. Additionally, participants completed a semi-structured interview developed by the first author that focused on factors which influenced participants' decision to enroll and remain in MFG, their prior experiences with child welfare and mental health services, their knowledge of resources within the community, and service delivery recommendations. Interviews took place between October 2010 and August 2011, conducted by the first author and 2 bilingual (English/Spanish) interviewers, in participants' homes (n= 16), private rooms at local child mental health clinics (n= 6), and private rooms at the research institution (n= 3). Interviews were audiotaped and were between 60-90 minutes in length (n= 23 in English, n= 2 in Spanish). Upon completion of data collection, participants received $4.50 in public transportation expenses and a $30 gift card.

Sample

Table 1 presents participants' demographic information. Seventy-six percent (n= 19) resided in inner city, urban communities, and 24% (n= 6) resided in neighboring suburban neighborhoods. Participants ranged in age between 26 and 57 (Mean= 37.24, SD= 9.09). Fifty percent of participants (n= 11) reported they were no longer involved in child welfare services upon enrollment into the MFG effectiveness study, while 37% (n= 8) indicated they were referred to child mental health treatment by child

protective services. However, participation in the MFG effectiveness study was entirely voluntary, with no participants officially mandated to attend MFG sessions. Reasons for child welfare involvement reported by participants included: substance abuse, neglect (including educational and medical neglect), physical abuse, sexual abuse, and domestic violence. Information regarding exact dates of child welfare involvement was not collected as part of the MFG effectiveness study. Participants attended an average of 58.92% of MFG sessions (SD= 28.43). A median of 46 weeks had elapsed between the last MFG session attended and time of interview for participants (Mean= 55 weeks, SD= 30.21 weeks, Range: 20-124 weeks). Using bivariate tests (i.e., t-test, chi-square), no significant differences were found on demographic variables between participants in the current study (n= 25) to the remaining child-welfare involved, experimental participants from the MFG effectiveness study who were not enrolled in the current study (n= 59).

Analysis

All interviews were transcribed verbatim (Spanish language transcripts translated and transcribed) and verified for accuracy. Guided by grounded theory methodology (i.e., open coding, saturation, concurrent data collection and analysis), interview data were coded using *a priori* categories related to enrollment and retention in MFG, prior child welfare and mental health experiences, knowledge of community resources, and service delivery recommendations. Emergent themes emanating from the data (e.g., benefits of MFG) were also coded. Once agreement on code definitions was achieved, interviews were divided among 3 coders, including the first author. Research staff utilized Atlas.ti to store, code, and retrieve text. A random sample of 24% of interviews (n= 6) were coded by a secondary coder to evaluate coding reliability (# of correct coding by primary and secondary coders out of total # of codes required; Miles & Huberman, 1994). Among all codes at this stage, reliability was established at 80%.

The current study focused on themes associated with retention in MFG and participants' perceptions of MFG benefits. Using this subsection of the data, we conducted additional coding analyses. The codebook for the current study included *a priori* codes corresponding to an existing typology of family support services (Hoagwood et al., 2010; Olin et al., 2014) which include (a) Emotional support (i.e., supportive listening, validation, facilitating comfort and trust), (b) Instrumental support (i.e., services such as transportation, meals, childcare), (c) Instructional support (i.e., instruction/skill development, including parenting strategies, anger

management and stress reduction techniques), and (d) Informational support (i.e., information and education about community resources, child development, and mental health conditions). A final category, Advocacy Support (i.e., provision of information about parental rights and resources, as well as skill building to help the parent advocate for their child's services; Hoagwood et al., 2010), was not included within these *a priori* codes, as the MFG program did not incorporate these services. The codebook for the current study was further augmented with clarifying codes (e.g., staff: Peer; staff: clinician) emerging through the re-reading of the transcript data. Check-coding procedures involved primary and secondary coders (3rd and 4th authors) iteratively coding 1-2 pages of transcripts, meeting with the first and 2nd authors to resolve discrepancies, refine code definitions, and assess level of reliability. We repeated this process until primary and secondary coders achieved at least 80% reliability. Subsequently, the primary coder coded the entire subsection of transcript data, while the secondary coder concurrently analyzed 20% (n= 5 interviews) of the transcript data to establish final inter-rater reliability for the current study. Final percentage coding reliability for the current study was 91%. A constant comparison technique was utilized to analyze participant responses organized by family support categories (e.g., Emotional support) in order to summarize agreements and discrepancies among participants. Summaries of participant responses with corresponding exemplar quotations from the transcript text are included. Participant responses within each family support category were also compared for support provided by peers vs. those provided by clinicians.

Results

Summary descriptions of participant responses with exemplars are presented by family support category. Twenty-three participants provided responses for both emotional and instrumental support categories (92%), followed by n= 13 participants for instructional support (52%), and 7 participants for informational support (28%). Across all support categories, 16 (64%) participants also provided responses related to the additive benefit of peers.

Emotional support

Of the n= 23 participants who provided responses about emotional support, most participants (n= 18, 78%) indicated benefits emanating through their interactions with group facilitators (both clinicians and peers). Participants reported that facilitators were attentive, and took the time to ensure participants understood all aspects of MFG. This feeling of trust

and "genuine" care ascribed to facilitators promoted positive service experiences. Many participants stated staff members were "helpful" to parents by answering questions they had, or directing them to resources to find answers. This increased parents' satisfaction and eagerness to attend the MFG sessions. Moreover, one participant stated that the "love and compassion" they felt from the facilitators led her to "wish […] that we didn't have to stop seeing them".

> "Come, come eat. They'd make the kids, come eat. If my kids didn't have something, they made sure they had, they made sure they didn't feel as if they couldn't. They made them feel comfortable. There was times where if I was in a bad mood, I would try to not bring that mood there, they could tell. They would pull me to the side, are you okay? Do you need anybody to speak to? They were genuine. They were good people. They didn't just do it because it was their job. They did it because they wanted to be there."

A smaller number of participants (n= 5, 22%) reported that emotional support helped them to develop social competence; "it was helping me work on my thing about being around people". One participant remarked that the ability to share and be involved in the "social gathering" applied not only to parents but also to children who reaped enjoyment and benefits from participation.

> "And then my daughter who is very shy, it was even bringing her out, and she was speaking up more, and to have them there and to express their feelings about one another and what they liked about each other and what they didn't like about each other."

Group facilitators were also instrumental in developing and maintaining an emotionally supportive group dynamic. Most participants (n= 20, 87%) indicated that the emotional support from other group members was a crucial benefit of the MFG program. Participants appreciated the supportive atmosphere, which allowed them to discuss personal problems with other family members, exchange parenting techniques, and vicariously understand how other families resolved particular situations.

> "We [were] allowed to talk amongst ourselves about our kids, you know, and some of the things we were going through and how we dealt with it […] you can find out other ways of handling things."

"[…] I also liked it because one could find relief, de-stress, one would talk and share the problem so between the families we would each share the problem, maybe one more than the other was more serious, or more sad, so it like makes you happy, it's touching and listening to it, one would participate also so I liked it."

Through this process, many participants became aware of the commonalities of their experiences. Themes of "I'm not alone" and "we don't have it that bad" were common for both parents and children. As a result, participants reported feeling understood and accepted by other group members.

"Even one of my girls noticed and said 'oh we thought we had it bad but we don't have it that bad.' And it was good for them to see that other kids may not have the things they have and don't get the things they get. They got to see that other kids have to do chores and things at home."

"[…] sometimes I think I'm the only one, like they say, you're drowning in a cup of water, you have problems, and when you go there and you see all the parents that are going through the same thing, you be like oh wow, and all of a sudden something, like your mind goes ding, like it opens up, I don't know, like an open door or something, something goes click. You be more, like at ease or something."

Consequently, group members bonded closely with each other. According to one parent,

"Actually, I felt that they needed more time. My kids were just starting to get used to the whole idea of meeting every week, so there was no one thing I could say made me want to leave [….] everybody became so close that it was like, it wasn't like a group any more, it was family."

However, not all participants reported benefits of emotional support in MFG. A few participants (n= 4, 17%) indicated difficulties in connecting with other group members and facilitators.

"I signed up for the group because I thought it would be nice to be

around other families, other people, maybe get to know other people, or become familiar with others that are going through the same thing, and maybe possibly make a connection, but that didn't happen, so I didn't feel, I really didn't feel comfortable "

Instrumental support

Twenty-three participants noted the provision of instrumental support, including transportation expenses (e.g., Metrocards, car fare), meals, childcare, and gift cards for study participation. Close to half of these participants (n= 11, 48%) indicated that the instrumental support minimized barriers to participation. Childcare, in particular, was highly endorsed (n= 7, 30%) as a primary factor in allowing participants to attend. As stated by one caregiver,

"The childcare was crucial, because me being a single parent and don't really have a lot of family support, that was crucial to me. That was more crucial than the Metro card and dinner because I would have most likely not have been able to participate, or I would have had to participate on a smaller scale because I wouldn't be able to be here because that 4 year old wants to play, or watch TV or do something else."

Other parents (n= 5, 22%) specifically identified the provision of transportation support as facilitating attendance to MFG sessions in the form of pre-paid public transportation voucher or equivalent carfare distributed in cash.

"The transportation was very helpful because I am considered what you call low income, so gas is expensive, so it was very helpful and it played a big part. It made it more easier for me and the family to be able to attend and not have to miss because I didn't have the finances […]"

Meals offered during MFG sessions also alleviated participation burdens for a few parents (n= 3, 13%).

"It was a great help because the days, the evenings we attended I didn't have to worry about cooking dinner, or cooking dinner and having to rush, or leaving there and needing to rush home to make dinner, so it was very helpful,"

Although not specifically indicated as essential to participation, the instrumental support offered through MFG served to improve the overall quality of the program experience for most participants who provided responses in this category (n= 20, 87%), incentivizing continued participation. Participants reported that the instrumental supports were "convenient", and "helpful" by eliminating work for parents ("Because I ate dinner, I didn't have to cook."). At the same time, the sheer act of offering these concrete supports made participants feel that the program developers were "genuine" in their desire to address all the needs of families, that the time and effort spent by parents was "valued".

> "It meant they actually thought, they thought about the needs of the family. Those are primary needs that families might need in order to participate somewhere."

> "It was shocking to me at first because I didn't think it was going to be true, for me, I can say that I'm the type of person, I don't rely on anyone. I don't expect anyone to be there for me. I'm used to it just being me and my children. When I started going in, and I genuinely saw there was someone offering help, whether it was a [transportation voucher], whether it was are you hungry, whether it was do you need to sit down and speak, whether it was do you need me to help you with anything, do you need me to look up anything for you? That was unexpected for me, but it was genuine. So I guess me saying that was one of the things, I can honestly say it made me want to come. Everything was genuine."

The childcare, in particular, was helpful for parents so that they could fully engage in MFG sessions. Parents acknowledged that caring for younger children would be distracting, and appreciated the ability to focus solely on the needs of their child with behavioral difficulties.

> "It was great. It was good to be offered the childcare. That way it wouldn't be so distracting having a smaller child, because when you have a littler children, it's hard to concentrate."

Furthermore, offering meals during session facilitated a family-like atmosphere that participants appreciated. As a result, parents were able to spend quality time with their children during group sessions.

"Always, you need that. You need that. When you come in there, the kids are all antsy, they're hungry […] it's dinnertime. They always say nothing like having conversation over dinner. That was one of our main thing that the kids were complaining that we were eating here and eating there, and they sit down in time to eat [….] the therapist was like that was a very important time, you sit down, we have to have breakfast together, we have to have lunch, we have to do dinner. It was very important for the therapist for us to continue doing that"

While the majority of responses within the instrumental support category were positive, there were some instances where participants expressed having difficulties with some of the services, or did not report any benefit (n= 4, 17%). For example, one participant mentioned the food was not appealing to her family:

"[the food had] no flavor, no taste, the juices and stuff, you know they got, I mean, I kind of took his advice, we were bringing our own, we were bringing our own food, or we'll eat after we leave."

Additionally, one parent expressed feeling guilty about receiving this type of support:

"Sometimes I'd feel bad. Not bad it was more guilt. Because I wasn't used to that, but when I saw everyone else, I said 'OK.' I would say to my husband, 'they have to pay you to attend?' That's what I would say, well that was what I thought, no? I wasn't accustomed to that, you know how it is, if you want someone to help you with something, you have to pay, to go to the doctor, you have to pay. So she said no, on the contrary they pay you which made me feel a bit guilty but when I saw that everyone else seemed fine with accepting the money, I said 'OK.'

Other participants expressed that, while they appreciated the gesture of instrumental support, its provision was not a determining factor in their continued participation in the group.

"I have my own money for a metro card . . . I could eat before I left, so it made no difference. It was a nice offering, you know."

Instructional support

Of the 13 participants who provided responses about instructional support, almost all (n= 12, 92%) indicated this was a beneficial aspect of their MFG experience. Instructional support referred to provision of primarily parenting, communication, and anger management skills. Skills were enhanced through didactic instruction as well as engaging activities like role plays.

> "I would have moments that I would scream, and I would tantrum just like my boy. I learned to control myself, to silence myself, to understand my boy so in part it helped my boy and it helped me too."

> "Well, the activities was fun. It wasn't borin. It wasn't like I was being lectured. You know, we got to do little fun activities with the kids."

Importantly, facilitators encouraged discussion among group members to exchange information, so that participants could receive instructional support from each other.

> "Because it makes sense that we are not the only ones going through this, we're not alone. Sometimes we think we're the only one having issues but nobody's perfect, we've all got problems or experiences with raising children. There may be a situation you might not know how to manage and sometimes you can learn from other people's experiences how to deal with a situation. Whenever they would talk, I would say 'well at least I'm learning,' no?"

Fewer comments (n= 3, 23%) referred to the negative aspects of instructional support. Primarily, these responses referred to aspects of role modeling ("There was times I didn't want to do the role play"). These caregivers wanted more techniques to discipline negative behaviors, and felt that some of the strategies were not transferrable across families. As noted by one caregiver,

> "[…] When we talked about rules, they tried to make it as general as possible, but what works in my house doesn't necessarily work for other families. Some families need really intense rules […] Sometimes they related and sometimes they didn't [...]"

Informational support

All seven of the participants who provided responses regarding informational support, indicated that they benefitted from the ability to receive information about and referrals to other social service programs, as well as information on child development and mental health issues. This was provided through existing information possessed by the provider, or the provider's direct actions to research information for the caregiver. As noted earlier, facilitators also encouraged a group dynamic where information between group members could be shared. One caregiver referred to "networking" in order to get information about other social service programs and resources.

> "No, what made me stay? The networking, I guess the information, the information that was being given, and how would you say, just everything that was needed…"

Caregivers also appreciated information received about how to deal with children with ADHD, behavioral issues, as well as child developmental information.

> "I stayed there because it's helpful. They explain things. You ask them a question, they explain things about yourself and your child too, and about growing up, bout your child growing up, yeah. Like he's a teenager now and they can help, and they can help him out, you know, being a teenager. He 13, so they can help him out by talking to him about being a teenager, cause it's not easy for a woman to explain to a boy, you know, growing up, it takes a man to do that, you know."

At the same time, one participant (14%) reported that she would have appreciated more information about "programs for the kids", suggesting more information about family-friendly and child-centric recreational activities might have been more helpful.

Unique benefits of a peer facilitator

Finally, a number of participants (n= 16, 64%) reported on their unique perceptions of peer facilitators. Within the emotional support category, participants felt comfortable being with facilitators who had undergone a similar set of experiences, which, in turn, encouraged their retention. Participants felt emotionally secure with the peer facilitator with whom they were able to directly exchange parenting techniques, identify

and connect, and feel comfortable around knowing that they were not the only one undergoing their experiences:

> "Um, I felt that they um, they were parents just like myself and they, they had overcome challenge themselves, and they had to bring, they brought something to the table because they were exposing their own experiences and they brought it to the table and they were willing to help clients and families who were part of the clinic to help them see you can, you know, you can do it because I did it, and I'm a clinician now, or I'm working in the system, you know, so it's something to look forward to."

In contrast, participants expressed concerns about being understood by group facilitators who didn't have children ("I said it's going to be hard for them to understand like us because we have kids."). Other concerns entailed whether clinicians were sufficiently experienced, especially those they perceived as "too young". In particular, participants reported apprehension about disclosing personal stories for fear of misunderstandings about parenting style and being potentially re-reported for abuse. Such parents felt more understood by the peer vs. the clinician facilitator about parenting strategies ("Um, well, the parents and the parent facilitator, she understood what I was saying"). For some participants, this resulted in their reticence to disclose too much information to clinicians.

> "Like for me, I didn't want to, like, tell them too much because I didn't want them to feel like I'm telling too much and they don't understand it. You know, like, I didn't want to talk a lot"

However, perception of emotional support from peer facilitators was also impacted by participants' expectations of what peers could offer. If participants expected peers to be willing to offer up their personal experiences in parenting, and the peer failed to do so, negative reactions ensued. This was experienced by one participant quoted below:

> "I thought that she would counsel us and explain to us about what she did for her son […] I thought that, o.k, she was the parent, I thought she was going to say, oh I feel like this, this is happening to me, my son was like this and this, but no. […] I didn't hear anything like that [...] It's good to have a parent, but if that parent isn't open to tell us yes, this is what I did wrong, and this is what I have been doing, and I have also been getting help for this, I feel

frustrated […]"

Results for instrumental, instructional, and informational support did not yield any specific statements about the difference between peer and clinician facilitators. However, the following quote suggests that the peer facilitator was particularly knowledgeable to community resources where parents could get clothes, food, or other items for their children (Instrumental Support).

"She was the greatest. I liked her. Like she would talk to me every day, every time she saw me, just to ask me how I was doing, how they boys were, she always asked, she, you know, she always offered, like if you need any clothes, or you need anything for your kids, any food, she was really nice. I liked her."

Another participant indicated the specific benefit she received from instructional support through the peer facilitator.

"I mean, like I said, to know, for somebody else to know what you're going through with your kid is good, you know, because they can teach you things that you don't know, how to set rules, how to set boundaries, stuff like that. I didn't know all of that, and when they spoke of the group, like I said, it was a pretty good experience.

Finally, one participant reported what it was like receiving information support from a peer facilitator.

"Yeah, it was helpful cause you know, they helping you too. They helping you gain information, if you have any questions, like say, say the group wasn't in session and you know, you had questions about something, they was even to answer your questions without any hesitations, so…"

Discussion

Peer-delivered models, either alone or as part of a team, are growing in popularity as states are professionalizing this growing workforce through developing credentialing standards and making their services billable. Results of this study are encouraging, and suggest a co-delivered child mental health intervention was perceived as facilitating engagement in services and enhancing the quality of the treatment experience. Engagement in this context refers to the emotional investment

and commitment to treatment above and beyond simple compliance with attending sessions (Staudt, 2007). Co-delivery by a peer was perceived as having the additive benefits of deepening caregivers' engagement, normalizing their difficulties and concerns, and enhancing their comfort and feelings of emotional security because of their shared experiences. Importantly, participants were more likely to trust peers than clinicians with sensitive information related to parenting. Disclosing such information has beneficial implications for treatment success if facilitators are provided with a more accurate account of what occurs at home. These findings are particularly encouraging given child welfare-involved families commonly face a complex set of stressors which makes accessing services and fully engaging in treatment particularly challenging. Considering the risks of untreated child mental health problems to the child and family, these results hold promise for enhancing engagement amongst a vulnerable population.

Promoting engagement, hope, credibility, and emotional security through the use of peers is particularly important for families whose children remain in the home following a child welfare investigation. Such families continue to struggle with multiple and co-occurring stressors, in addition to issues leading to child maltreatment investigation. Typically, child welfare investigations themselves are perceived as contentious for families (Kemp et al., 2009). As a result, families are often reticent to engage in formal services after having prior negative service experiences (Domian, Baggett, Carta, Mitchell, & Larson, 2010; Kerkorian et al., 2006), such as those typically encountered by those investigated for child maltreatment (Kemp et al., 2009). Families frequently fear being re-reported for maltreatment (Gopalan, Fuss, & Wisdom, in press), yet their difficulties will continue to exacerbate and become more entrenched unless effectively addressed. Including peers within child mental health treatment teams may be a promising strategy to encouraging full treatment engagement among families involved in the child welfare system.

Results of this study are consistent with the previous literature regarding the types of family support delivered to caregivers and the potential for additive benefits in utilizing peers as part of child mental health interventions (Hoagwood et al., 2010). Specifically, we found numerous exemplars and rich description of the typology of family support previously conceptualized by Hoagwood et al., (2010). Moreover, no further categories of support were identified within the data. As a result, the current study validates the family support typology, and supports its increased use as a theoretical framework for family peer support in child

mental health services. Importantly, findings indicate that some participants responded negatively to the peer-based model. Such information suggests that not everyone may seek out or want peer-based services. To our knowledge, there is little to no discussion in the literature on family support in child mental health regarding negative perceptions of peer-based services.

As a result, future research is needed to identify reasons why peer-based services are accepted or rejected, as well as discern for whom peer-based services are most helpful. Another step in this line of inquiry is to test whether, in fact, family support, and, in particular, support that is peer-delivered enhances engagement in services. There is precedent within the adult health and mental health literature for peer-led services as a means to improve access; whether these findings translate to the child mental health system, and if they are associated with retention and participation quality over time, remains to be determined. Importantly, future research is needed to conceptualize and test how integrating peers in child mental health services may impact child-level treatment outcomes.

The MFG model may also have utility within other settings frequently accessed by families following a child welfare investigation. As noted previously, 90% of child maltreatment investigations result in children remaining at home with their primary caregivers (Burns et al., 2004). In many states, local child welfare authorities contract with community-based organizations (CBOs) to provide a comprehensive array of placement prevention services for families mandated or referred by child authorities following maltreatment investigations (Barth et al., 2006; Hurlburt, Barth, Leslie, Landsverk, & McCrae, 2007), as well as a small proportion of families with similar difficulties voluntarily seeking placement preventive services (Citizens' Committee for Children, 2010). Funded by the National Institute of Mental Health, research is currently underway to develop strategies for implementing MFG to be delivered in placement prevention services (R21MH102544, Principal Investigator: Gopalan) by bachelor's level caseworkers as a way to increase access to child mental health interventions within a child welfare platform. One big question for this work will entail how much the influence of peers alone affects treatment outcomes within this context. Future projects will assess the impact peers as MFG co-facilitators with caseworkers have within placement preventive services settings. Additionally, little has been written about what is needed to successfully implement programs involving collaboration between peers and caseworkers within child welfare settings. Future research in this area is needed to understand what organizational supports are necessary to achieve such collaboration

in child welfare service delivery.

There are several limitations to this study that warrant mention. First, participants attended, on average, 58% of MFG sessions despite targeted attempts to recruit participants who dropped out of MFG early or attended few sessions. As a result, participant responses are more representative of those more likely to have attended MFG, compared to with sporadic attendance or premature termination. Additionally, a broad definition of child welfare involvement was utilized in this study, which limits our ability to tease apart results by maltreatment type, as well as status of investigation and child welfare involvement during MFG participation. For those participants where a considerable amount of time had elapsed between participating in MFG and interviews for the current study, they often struggled to recall their MFG experience. Given that the data did not specifically present information about cultural strengths, we were unable to address this area within this particular study. That said, the lack of exploration about cultural strengths is a limitation as there may be cultural factors at play.

To our knowledge, however, this is one of few studies that present child welfare involved caregiver's perceptions of family support, and the additive benefit of peers. As peer-delivered services become more common within the public child mental health system, discerning consumer perceptions of peers as an emerging workforce, and whether peers do, in fact, hold additive, unique benefits in connection to child mental health services will have important implications for the health and welfare of child welfare-involved families. Given the chronic engagement challenges that child welfare involved families present to child mental health and child welfare systems, understanding how peers can be integrated into existing service delivery options holds the promise of improving engagement, and ideally, treatment outcomes among vulnerable families with complex service needs.

Table 1. Caregiver Demographic Characteristics: Current qualitative study vs. remaining child welfare involved participants in MFG effectiveness study experimental condition

	Participants recruited to current qualitative study (n = 25)[a] Data from current Qualitative Study	Remaining child welfare involved participants in MFG effectiveness study experimental condition (n = 59)[a] Data from MFG Effectiveness Study
Relationship Status		
Single	11 (44%)	22 (37%)
Married	10 (40%)	19 (32%)
Separated	2 (8%)	13(22%)
Divorced	1 (4%)	3 (5%)
Other	1 (4%)	2 (3%)
Sex		
Female	25 (100%)	56 (95%)
Male	0 (0%)	3 (5%)
Employment Status		
Unemployed	10 (40%)	20 (34%)
Disabled	2 (8%)	10 (17%)
Student	5 (20%)	4 (7%)
Part-Time	2 (8%)	11 (19%)
Full-time	2 (8%)	3 (5%)
Other	2 (8%)	3 (5%)
Retired	1 (4%)	1 (4%)
Ethnicity		
African American/Black	12 (48%)	19 (31%)
Hispanic/Latino	11 (44%)	29 (49%)
Pacific Islander/Asian	0 (0%)	1 (2%)
Other	2 (8%)	4 (7%)
Caucasian/White	0 (0%)	7 (12%)
Income		
Less than $9,999	14 (56%)	26 (44%)
$10,000 - 19,999	5 (20%)	13 (22%)
$20,000 - 29,999	4 (16%)	10 (17%)
$30,000 - 39,999	1 (4%)	5 (9%)
$49,000 - 49,999	0 (0%)	0 (0%)
Over $50,000	0 (0%)	3 (5%)
Education Level		
Less than high school	14 (56%)	21 (36%)
Completed high school	6 (24%)	28 (47%)
Completed college	4 (16%)	6 (10%)
Completed graduate/ professional school	1 (4%)	4 (7%)
Age (Mean ± SD)	35.28 ± 8.67	35.25 ± 7.51
% Attendance in MFG (mean ± SD)	58.92 ± 28.43	55.39 ± 33.42

Note: Numbers may not add up to n=25 and n=59 due to missing data
a. % is out of complete sample size for each group (n = 25 and n=59)
      This table was previously published in Gopalan, Fuss, & Wisdom (in press).

References

Acri, M., Olin, S.S., Burton, G., Herman, R.J., & Hoagwood, K.E. (2013). Innovations in the identification and referral of mothers at risk for depression: Development of a peer-to-peer model. *Journal of Child and Family Studies,* 1-7. Published online.

Administration for Children & Families. (2005). *CPS sample component wave 1 data analysis report.* Washington DC: Administration for Children & Families.

Anderson, C. (2006). Why lower income mothers do not engage with formal mental health care systems: Perceived barriers to care. *Qualitative Health Research*, *16*, 926-943.

Auslander, W., Haire-Joshu, D., Houston, C., Rhee, C. W., & Williams, J. H. (2002). A controlled evaluation of staging dietary patterns to reduce the risk of diabetes in African-American women. *Diabetes Care*, *25*(5), 809-814.

Barnard, M., & McKeganey, N. (2004). The impact of parental problem drug use on children: What is the problem and what can be done to help? *Addiction, 99*(5), 552-559.

Barth, R.P., Wildfire J., Green R.L. (2006). Placement into foster care and the interplay of urbanicity, child behavior problems, and poverty. *Am J Orthopsychiatry*, *76*(3), 358-66.

Black, D.A., Heyman, R.E., & Slep, A.M.S. (2001). Risk factors for child physical abuse. *Aggression and Violent Behavior,* 6(2-3), 121-188.

Brown, L.K., Danovsky, M.B., Lourie, K.J., DiClemente, R. J., & Ponton, L.E. (1997). Adolescents with psychiatric disorders and the risk of HIV. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(11), 1609-1617.

Burns, B.J., Phillips, S.D., Wagner, H., Barth, R.P., Kolko, D.J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*(8), 960-970.

Chacko, A., Gopalan, G., Franco, L., Dean-Assael, K., Jackson, J., Marcus, S., & McKay, M.M. (in press). Multiple family group service model for children with disruptive behavior disorders: Child outcomes at post-treatment. *Journal of Emotional and Behavioral Disorders.*

Chinman, M., Lucksted, A., Gresen, R., Davis, M., Losonczy, M., Sussner, B., & Martone, L. (2008). Early experiences of employing consumer-providers. *Psychiatric Services, 59*(11), 1315-1321.

Chinman, M., Young, A.S., Hassell, J., & Davidson, L. (2006). Toward the

implementation of mental health consumer provider services. *The Journal of Behavioral Health Services & Research, 33*(2), 176-195.

Citizens' Committee for Children. (2010). *Keeping track of New York City's children, ninth edition.* New York: Author.

Domian, E.W., Baggett, K.M., Carta, J.J., Mitchell, S., & Larson, E. (2010). Factors influencing mothers' abilities to engage in a comprehensive parenting intervention program. *Public Health Nursing, 27*(5), 399-407.

Gillmore, M.R., Morrison, D.M., Lowery, C., & Baker, S.A. (1994). Beliefs about condoms and their association with intentions to use condoms among youths in detention. *Journal of Adolescent Health, 15,* 228-237.

Gopalan, G., & Franco, L. (2009). Multiple family groups to reduce disruptive behaviors. In A. Gitterman & R. Salmon (Eds.), *Encyclopedia of social work with groups.* New York: Routledge.

Gopalan, G., Franco, L., Dean-Assael, K., McGuire-Schwartz, M., Chacko, A., & McKay, M. (2014). Statewide Implementation of the 4 Rs and 2 Ss for Strengthening Families. *Journal of Evidence-Based Social Work, 11*, 84-96.

Gopalan, G., Chacko, A., Franco, L.M., Dean-Assael, K.M., Rotko, L., Marcus, S.M., Hoagwood, K.E., & McKay, M.M. (In Press). Multiple Family Group service delivery model for youth with disruptive behaviors: Child outcomes at Six-Month follow-up. *Journal of Child and Family Studies.*

Gopalan, G., Fuss, A., & Wisdom, J. (In Press). Multiple family groups to reduce child behavior difficulties: Influences on retention for child welfare-involved caregivers. *Research on Social Work Practice.*

Hoagwood, K. E., Cavaleri, M. A., Olin, S. S., Burns, B. J., Slaton, E.,Gruttadaro, D., et al. (2010). Family support in children's mental health: A review and synthesis. *Clinical Child and Family Psychology Review, 13*, 1–45.

Hurlburt, M.S., Barth, R.P., Leslie, L., Landsverk, J., & McCrae, J. (2007). Building on strengths: Current status and opportunities for improvement of parent training for families in child welfare. In R. Haskins, F. Wulczyn, & M.B. Webb (Eds.), *Child protection: Using research to improve policy and practice* (pp. 81-106). Washington DC: Brookings Institute Press.

Inciardi, J., Pottieger, A.E., Forney, M.A., Chitwood, D.D., & McBride, D.C. (1991). Prostitution, IV drug use, and sex-for-crack exchanges among serious delinquents: Risks for IV infection. *Criminology*, *29*(2), 221-235

Kemp, S. P., Marcenko, M. O., Hoagwood, K., & Vesneski, W. (2009). Engaging parents in child welfare services: Bridging family needs and child welfare mandates. *Child Welfare, 88*(1), 101-126.

Kerkorian, D., McKay, M., & Bannon, W. M. J. (2006). Seeking help a second time: Parents'/caregivers' characterizations of previous experiences with mental health services for their children and perceptions of barriers to future use. *American Journal of Orthopsychiatry, 76*(2), 161-166.

Lau, A.S., & Weisz, J.R. (2003). Reported maltreatment among clinic-referred children: Implications for presenting problems, treatment attrition, and long-term outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(11), 1327-1334.

Leslie, L. K., Aarons, G. A., Haine, R. A., & Hough, R. L. (2007). Caregiver depression and medication use by youths with ADHD who receive services in the public sector. *Psychiatric Services, 58*(1), 131-134.

Lewis, C. F. (2010). Childhood antecedents of adult violent offending in a group of female felons. *Behavioral Sciences & the Law, 28*(2), 224-234.

McKay, M. M., & Bannon, W. (2004). Engaging families in child mental health services. *Child and Adolescent Psychiatric Clinics of North America, 13*, 905-921.

McKay, M.M., Gopalan, G., Franco, L., Dean-Assael, K., Chacko, A., Jackson, J., & Fuss, A. (2011). A collaboratively designed child mental health service model: Multiple family groups for urban children with conduct difficulties. *Research in Social Work Practice, 21*(6), 664-674.

Miles, M.B., & Huberman, A.M. (1994). *Qualitative data analysis* (2nd Ed.). Thousand Oaks, CA: Sage.

Morris, R., Baker, C., & Huscroft, S. (1992). Incarcerated youth at risk for HIV infection. In R. DiClemente (Ed.), *Adolescents and AIDS: A generation in jeopardy* (pp. 260-274). Newbury Park: Sage.

Olin, S.S., Williams, N., Pollock, M., Armusewicz, K., Kutash, K., Glisson, C., Hoagwood, K.E. (2014). Quality indicators for family support services and their relationship to organizational social context. *Administration & Policy in Mental health, 41*, 43-54.

Petterson, S. M., & Albers, A. B. (2001). Effects of poverty and maternal depression on early child development. *Child Development, 72*(6), 1794-1813.

Reyno, S. M., & McGrath, P. J. (2006). Predictors of parent training efficacy for child externalizing behavior problems--A meta-analytic review. *Journal of Child Psychology and Psychiatry, 47*(1), 99-111.

Schaeffer, C. M., Petras, H., Ialongo, N., Poduska, J., & Kellam, S. (2003). Modeling growth in boys' aggressive behavior across elementary school: Links to later criminal involvement, conduct disorder, and antisocial personality disorder. *Developmental Psychology, 39*(6), 1020-1035.

Schumacher, J.A., Slep, A. M.S., & Heyman, R.E. (2001). Risk factors for child neglect. *Aggression and Violent Behavior, 6*(2-3), 231-254.

Scott, S., Knapp, M., Henderson, J., & Maughan, B. (2001). Financial cost of social exclusion: Follow up study of antisocial children into adulthood. *BMJ: British Medical Journal, 323*(7306), 191.

Small, L., Jackson, J., Gopalan, G., & McKay, M. (in press). Meeting complex family needs through the 4Rs 2Ss Family Strengthening Program. *Research on Social Work Practice.*

Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal, 27*(4), 392-401.

Staudt, M. (2007). Treatment engagement with caregivers of at-risk children: Gaps in research and conceptualization. *Journal of Child and Family Studies, 16*(2), 183-196.

Weber, F., Elfenbein, D., Richards, N., Davis, A., & Thomas, J. (1989). Early sexual activity of delinquent adolescents. *Journal of Adolescent Health Care, 10,* 398-403.