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## Family Peer Advocates: A Pilot Study of the Content and Process of Service Provision

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### Abstract

Professional family peer advocates are increasingly employed by public mental health systems to deliver family-to-family support that reduces barriers families face in accessing children's mental health care. These services, however, are neither uniformly available nor standardized. This pilot study describes the process, content and context of family-to-family support services. Simulating a parent seeking services, a trained standardized parent participated as a client in meetings with advocates in four programs and collected data through structured observations, a structured survey, and session audiotapes. The “walk-through” process was determined to be feasible and acceptable to family peer advocates as a way of evaluating services. Four family peer advocates provided an average of 25 services during each 2-session simulation with the standardized parent, including the following: information and educational support, instruction and skills development, emotional and affirmational support, instrumental support, and advocacy. Findings also revealed variability in the range of services provided and identified challenges in aspects of service provision, such as boundaries of advocate roles, availability of confidential service environments, and addressing crises and parent concerns about child safety. This paper provides the first in-depth look at services provided by this emerging workforce.

### Keywords

Parents; Mental health; Child; Public advocacy; Process improvement

## Introduction

The family support and advocacy movement in children's mental health has been evolving in the US since the late 1980s, its development concurrent with the expansion of community-based services for families and children (Hoagwood et al. 2008). Although traditional models of family support have been provided by clinicians, a core element of the newest models for family support are delivered in a peer-to-peer format, by family members who are current or former parents or caregivers of children with identified mental health needs (Hoagwood 2005; Koroloff et al. 1994; Koroloff and Elliott 1996; National Federation of Families for Children's Mental Health [NFFCMH] 2008; Osher et al. 2008). Professional family peer advocates are increasingly employed by public mental health systems to deliver family-to-family support that reduces barriers families face in accessing children's mental health care (Hoagwood et al. 2008; Gyamfi et al. 2010). This emerging workforce also addresses provider shortages within the field of behavioral health (Annapolis Coalition on Behavioral Health Workforce 2007). Family peer advocates serve as peers to model, coach, and support parents in their journey to understand, cope with, advocate for and negotiate various service systems (Davis et al. 2010; NFFCMH 2008). Because of their personal experience, they often have credibility with parents and are able to engender trust; family peer advocates are therefore, valuable in assisting parents in becoming more actively engaged in their child's services (Gyamfi et al. 2010; Hoagwood 2005; Koroloff et al. 1994; Koroloff and Elliott 1996; Osher et al. 2008; Robbins et al. 2008).

Despite this expansion in family-to-family support services, data on the content of peer-to-peer mental health services and their impact on clients are limited (Hoagwood 2005; Doughty and Tse 2010). Peer-to-peer models are often grassroots efforts and have typically received limited funding for evaluation. This is particularly true of peer-to-peer services in child mental health services. A recent review, for example, found very few family-to-family programs collected outcome data, and of those that did, most relied on weak evaluation designs (e.g., pre-post or post only without comparison groups) and had no follow-up assessments (Hoagwood et al. 2010). In contrast, peer-to-peer models for adults have been subjected to more rigorous study, particularly within the past two decades. A recent review of 29 peer-to-peer programs for adults, for example, showed more than half ( $n = 17.59\%$ ) used a randomized design to evaluate services (Doughty and Tse 2010). Similar to the peer-to-peer efforts for children and families, adult peer-to-peer models provide several core supportive components such as providing linkages to services and advocacy, either delivered solely by consumers or as part of a team of professionals. However, a major difference from the child models is that many adult programs offer consumer-delivered intensive case management services. Notably, Doughty and Tse's (2010) review found this was a clear strength of these models, as they enhanced practical needs, such as employment and housing stability, either as well as or beyond professionally delivered services. Not surprisingly, adult evaluations of peer-to-peer services include outcomes of interest that are directly targeted via the provision of case management (e.g., securing employment, housing, financial support, service use), in addition to symptom reduction and functional improvements. Less certain was the impact of adult models upon symptom recovery, functioning, and satisfaction with services, although several studies found clients were more apt to be truthful with consumers about their service experiences than with non-consumer clinicians.

Hoagwood's recent (2010) review and synthesis of family support programs identified five distinct components recommended for provision of family-to-family services:

- a. *Informational/educational support* about child behavior/development, course of mental illness and its impact, treatment options, child and family service systems and other resources;
- b. *Instructional/skills development*, including skill building directed at coaching caregiver on effective ways to address their child's illness or associated behaviors and/or skill-building directed at addressing caregiver's personal well-being (e.g., communication, problem-solving, crisis management, anger/anxiety/stress management skills);
- c. *Emotional and affirmational support* such as shared communication between providers and families to promote caregiver's feelings of being affirmed, understood and appreciated;
- d. *Instrumental support* including concrete services such as respite care, transportation, and flexible funds for emergencies;
- e. *Advocacy*, including the provision of specific information about parental rights and resources (e.g., legislation, entitlements), coaching on ways to effectively negotiate for services, or provision of direct advocacy to obtain services for a caregiver or child, and leadership skill building to develop caregiver as an advocate at policy and service system levels.

The service components identified through this review provide a framework for examining this emerging service in New York State's children's public mental health system. In this manuscript, we describe a standardized parent walk-through to assess the process, content and context of such services. Walk-throughs consist of having an individual pose as a customer and literally “walk through” agency procedures for obtaining services, beginning with a request for service and continuing through intake interviews and service receipt (Ford et al. 2007).

### Family Peer Advocates in New York

In 2002, the New York State Office of Mental Health created a network of family support programs to bridge the gap between parents of children with mental health needs and mental health service systems. Family support programs in New York State provide an array of services to support and empower families, but are not clinical programs. The goal of family support is to reduce family stress and enhance each family's ability to care for their child. Currently, New York family peer advocates work in approximately 400 family support programs statewide, with plans to double the number of family peer advocates over the next 2 years, establish a certification process for the professionalization of these advocates, and allow family support programs to be billable under state regulations (New York State Office of Mental Health 2008). Consistent with results from a national survey of certified peer specialists (Salzer et al. 2010) and other exploratory studies (Davis et al. 2010), a survey of family support programs in New York City revealed that the variety of services provided by family peer advocates vary by program such that services are neither uniformly available nor standardized (Roussos et al. 2008). Roussos et al. (2008) described services provided in New York City as including, but not limited to, information provision, caregiver support, liaison with various child serving systems (e.g., schools, family court), service coordination, recreational services for children, community outreach activities, crisis counseling, parenting skills, case management and advocacy. Currently, family support programs in New York are not required to provide quality assurance or monitor the quality of their services (Roussos et al. 2008). As the New York State Office of Mental Health moves to integrate family support services into the continuum of care in the public child mental health system—and as other states incorporate family advocacy services—it is critical to understand the range and quality of services provided by family peer advocates across

various programs, as well as to monitor how such services might be responsive to the needs and goals of families. In order to move family support services into the mainstream of more traditional mental health services, it is also imperative to develop metrics for monitoring and assessing the quality of family support programs.

### **A Novel Method to Develop Quality Indicators for Family-to-Family Support Services**

In established health services, quality indicators focus on clinical outcomes, safety, efficiency, continuity, and responsiveness (Arah et al. 2006). In family-to-family support services, however, there is substantial variability across programs (Roussos et al. 2008), which highlighted the need to more carefully characterize and understand this emerging service. To develop and operationalize quality indicators for family support services, our research team developed a walk-through protocol to begin characterizing the process, content and context of family support services.

Adapted from computerized clinical guideline development (Horsky et al. 2003), business and management (Gustafson 2004), and medical training (Carney et al. 1999), walk-throughs have been used in behavioral health to identify areas for improvement in admission procedures (Ford et al. 2007) and to pilot screening processes for a clinical study (Fussell et al. 2008). Fussell et al. (2008) incorporated the use of a standardized patient, often used in diagnostic studies to assess provider sensitivity to specific presented symptoms (Carney et al. 1999), to standardize the walk-through procedure. This direct observation of practices provides more information than indirect methods such as chart reviews or questionnaires (Beullens et al. 1997; Carney et al. 1999). In addition, walk-throughs can uncover assumptions, inconsistencies, and limitations of routine practice, and are useful in generating ideas for improving organizational processes (Ford et al. 2007), a critical issue as New York State moves to integrate family-to-family support services within the larger array of public children's mental health services.

Because no guidelines for the provision of family peer advocate services currently exist, we conducted standardized parent walk-throughs to assess the services of family peer advocates across four programs in New York. This pilot was conducted to assess the feasibility and acceptability of this new method within the children's mental health arena. The protocol used multiple methods of assessment (observation, checklist, debrief interview with family peer advocate) to assess the process, content, and context of family peer advocates' services.

The purpose of this paper is to describe the results of standardized parent walk-throughs to describe the (a) feasibility and acceptability of the walk-through process to family advocates, (b) the content of services provided, and (c) the process of service provision. Further, we illustrate the feasibility of this methodology and how qualitative analysis of data collected using this innovative method can potentially be used to provide a first-person narrative account of the service encounter and identify factors of strength and areas for improvement in service provision and provide a baseline of family peer advocate response to a specific caregiver scenario (Ford et al. 2007; Gustafson 2004; Horsky et al. 2003). Based on this pilot walk-through of four programs, we will refine this method for use in future walk-throughs across a larger sample of programs, so that findings can be used to establish standards of care and guide training to improve family peer advocate services in New York.

## **Methods**

This project was reviewed by the Institutional Review Board of the New York State Psychiatric Institute; this study was determined to be not subject to IRB oversight. Both the family peer advocate and the standardized parent agreed to participate in this project, following the principles outlined in the Declaration of Helsinki (World Medical Association

2000). Briefly, we created a scenario designed to reflect a typical parent seeking services from a family peer advocate and trained a family peer advocate working with us as a researcher to present these symptoms accurately and consistently as a “standardized parent.” To understand the process, content, and context of family peer advocate services, our standardized parent conducted walk-throughs with four family peer advocates working in the field in family support service programs.

### **Family Support Programs**

This pilot was conducted at four programs providing family peer advocate services in New York State. These programs were identified with the aid of the New York State Office of Mental Health. As part of a regular monthly meeting of family support program directors, family support programs were informed of the pilot study and four volunteers were solicited to participate in this pilot study to help the research team assess the feasibility and utility of the walk-through method for collecting information on family support programs. Table 1 summarizes key characteristics of the participating programs and of each program's participating family peer advocate.

### **Standardized Parent**

Our multi-disciplinary team, which included a psychologist, a social worker, and a family peer advocate, collaboratively created a family scenario to reflect a typical case. The standardized parent portrayed a single mother with three children (7- and 10-year-old girls and a 14-year-old son). In the scenario, she is seeking family support services because of concerns related to her son, who has Attention Deficit Hyperactivity Disorder (ADHD), symptoms of conduct disorder, a history of special education services, and family court involvement for shoplifting; the school recently recommended a day treatment program after her son was suspended for throwing a stapler at another student. The standardized parent is highly overwhelmed with managing her son's behavior at home and tracking his activities; she has concerns about losing her job due to the demands of addressing her son's difficulties, her son's safety, and a desire to obtain a higher level of services for her son.

A family peer advocate who collaborates on our research projects was trained as the standardized parent to use the walk-through procedure and was instructed to adhere to the specific set of characteristics and issues pertinent to the standardized parent. A research assistant facilitated the walk-through protocol by introducing the project to the family peer advocate, taking notes during the family peer advocate's interview with the standardized parent, and conducting the debriefing interview. The standardized parent, who was instructed to stay in role during the walk-through protocol, took part in all walk-throughs in this pilot. The standardized parent was asked to try and think and feel as the caregiver whose situation she was portraying, and to document those observations and feelings.

### **Walk-Through Protocol**

The team of researchers and family peer advocates created a standardized parent walk-through protocol to assess the process, content and context of family peer advocate services. See Table 2 for a description of the walk-through procedures. The walk-through consisted of the following components: (a) initial contact with program; (b) first face-to-face meeting; (c) second face-to-face meeting, and (d) debrief and interview. Two meetings were simulated based on evidence that one initial session is not sufficient to gather complete information about provider intervention practices (Beullens et al. 1997). We created a structure for program contacts and documentation of interactions that included a checklist for the standardized parent and audiotaping all face-to-face encounters. At the end of the walk-through procedure, a research assistant conducted a debrief to assess family peer advocate reactivity to the standardized parent walk-through procedure and a structured qualitative

interview, focused on the context of family peer advocate services within the program, including the role of advocate with caregivers and other staff in the program, and perception of program culture and climate.

## Procedure

We solicited Family Support program directors to take part in this study at a regular monthly meeting of family support program directors. Research staff contacted directors who expressed interest during the monthly meeting at a later time via phone to explain the study purpose and procedure. All four volunteers agreed to participate. The standardized parent, following the protocol, called the program to request services using a scripted family scenario, created to present specific child and family problems and tested with family peer advocates for accuracy and believability (Horsky et al. 2003). A trained research assistant accompanied the standardized parent to the appointments. At the first face-to-face meeting, the research assistant explained the study procedure to the family peer advocate, obtained permission to audiotape sessions, and unobtrusively made field notes about the interactions between the standardized parent and advocate. No deception was used (i.e., the family peer advocate knew at all times that we were conducting a walk-through). We chose not to use deception (i.e., so the family peer advocate did not know which parent was the “standardized parent”), because our other study using a similar no-deception walk-through (Ford et al. 2007), the method was accurate in determining agency procedures and generating ideas for improved services. Two face-to-face meetings were included to gather complete information about provider intervention practices (Beullens et al. 1997).

Following each contact, the standardized parent completed documents about the interaction, including processes (e.g., paperwork, intake process, orientation meetings, etc.) and content (e.g., information or referrals, advocacy, affirmational support), as well as any observations and reactions about the interaction. For the follow-up appointment, the standardized parent stated the child's symptoms had not improved. At the end of the second meeting, the research assistant conducted a debriefing to answer questions from the family peer advocate about the research study, interviewed the family peer advocate regarding the advocate's reactions to the walk-through procedure, and conducted a structured qualitative interview to understand the context of family-to-family services within the program. The interview included questions regarding advocate integration with other service providers, challenges of the job, and suggestions for improving advocate services (Interview guide available upon request).

Due to the variability in how programs were structured, the walk-through protocol had to be adjusted. These adjustments were primarily related to the initial contact between the standardized parent and family peer advocate. For example, the research team and the standardized parent developed specific ways to initiate family support services depending on program eligibility requirements (See additional information in Results). Thereafter, elements of the walk-through protocol were standard across all programs.

## Qualitative Analysis

We analyzed all transcribed data and field observation notes, focusing on the validity of the standardized parent portrayal and the process, content, and context of the family support services. Audiotapes from the walk-through were transcribed and data were examined with the field notes completed by the standardized parent and research assistant. Researchers and family peer advocates on the research team reviewed all information and collaboratively interpreted the data.

To ensure accuracy of the standardized parent portrayal, two members of the research team reviewed and rated all material on key issues and concerns portrayed by the standardized parent; overall inter-rater agreement was 100% for the standardized parent's statements regarding: (a) her son's ADHD symptoms and conduct problems; (b) her son's special education involvement; (c) family court involvement; (d) parent's concern about child safety; (e) parent expressing feelings of being overwhelmed, with fears of losing job and ability to manage child; (f) concerns about child's school placement, day treatment and need for additional services.

To address the process, content, and context of the family support services, a coding scheme was developed based on a list of preliminary descriptive codes derived from family support components, including informational/educational support, instructional/skills development, emotional and affirmational support, instrumental support, and advocacy (Hoagwood et al. 2010). We conducted chi-square analyses of the similarity of family peer advocates responses in each area, hypothesizing that they would respond similarly to the standardized parent reporting identical problems.

Due to the exploratory nature of this study, we also used inductive methods for generating codes. Two authors reviewed transcribed material and field observation notes and independently created a set of descriptive categories of any additional indicators of quality care in family support services. The authors created a preliminary list of codes that identified common components that occurred across the four walk-throughs. During this process, disagreements were resolved through discussion and consensus with the larger multidisciplinary team.

## Results

Results are presented in three areas: (a) feasibility and acceptability of the walk-through process to family advocates, (b) the content of services provided, and (c) the process of service provision.

### Feasibility and Acceptability of the Walk-through Process

All four family peer advocates felt that the standardized parent's presentation was highly typical of families receiving services from their program. Three family peer advocates said the walk-through procedure, being audio-taped, and having a research assistant present was "normal" and comfortable. One advocate expressed feeling nervous initially, but said that the RA and standardized parent "made it easy" for her to participate. All advocates said they were confident that they did what they normally would with a real caregiver. Overall, they felt that the walk-through accurately captured how they typically deliver services.

There was variability in how the standardized parent was able to access and initiate family support services for herself. Eligibility requirements varied: two provided family support services regardless of child or family status; the other two programs required the caregiver to have a child that meets the program-based requirements, such as involvement of child across multiple systems (e.g., mental health, school, juvenile justice, welfare) or met criteria for being at risk for out of home placement. Except for one program where the child and family had to be evaluated and referred by a mental health team, these programs generally accepted caregiver self-referrals, where caregivers could initiate services by directly calling the program. Only one program required caregivers to attend an orientation session. Except for one program, the standardized parent was not asked to complete any paperwork during the initial meetings.

## Content of Services Provided

Services offered varied across family peer advocate providers in response to the same parent vignette, with a mean of 25 services offered (SD = 4.62) per family peer advocate. An analysis of transcripts revealed that advocates offered mostly information ( $n = 39$  mentions) and emotional support ( $n = 30$ ), compared to fewer mentions of advocacy ( $n = 15$ ), instructional/skills development ( $n = 11$ ), and instrumental support ( $n = 5$ ). Table 3 provides a summary of supportive activities provided by each of the four participating Family Peer Advocates in response to standardized parent scenario.

Information offered by all advocates regarded specific psychiatric services ( $n = 10$ ), such as outpatient counseling, day treatment; group-based services offered for youth ( $n = 8$ ), such as groups focused on anger management, siblings or gender-specific issues; and crisis services ( $n = 4$ ). The next most common component offered by family peer advocates regarded emotional and affirmational support ( $n = 30$ ); advocates consistently demonstrated empathy ( $n = 8$ ) and employed a range of other techniques including active listening ( $n = 7$ ), stating shared experiences of child-rearing ( $n = 6$ ) and normalizing ( $n = 2$ ) to provide emotional support.

Family peer advocates were consistent about provision of advocacy services ( $n = 15$ ), including offering to attend meetings with parents ( $n = 5$ ), offering to obtain information or facilitate connections ( $n = 5$ ), and discussing legal rights with the family ( $n = 4$ ). Fewer services were provided for instructional ( $n = 11$ ) or instrumental ( $n = 5$ ) support.

## Process of Service Provision

In addition to coding the content of family peer advocate service encounters, we also identified areas of service provision that could be important to understanding the quality of family-to-family support services. These include: (a) orienting the caregiver to family-to-family support services; (b) challenges in advocates' roles and boundaries; (c) facilities or location of services; (d) advocate responses to caregiver crises and concerns; and (e) integration of family peer advocates to other mental health services.

**Orienting Caregiver to Family Peer Advocate Services**—Programs varied in how they oriented the caregiver to family support services, ranging from a formal orientation meeting for a group of parents to an overview of services at the first meeting. The standardized parent described feeling overwhelmed and confused by the amount of information and referrals provided to her during these initial meetings. In particular, she noted that when family support services were not provided in the context of a program for her child, she was at times confused about the roles of the advocates vis-à-vis her child's needs. She observed that her confusion and feelings were at times not detected by the family peer advocate. The standardized parent noted that information provided was easier to understand when key information (e.g., name, type/purpose, and phone number of program) was summarized and written down by the advocate at the end of the meeting. Consequently, even though the types of information or referrals provided across the agencies were quite similar, the utility of the information to an already overwhelmed caregiver was improved when key information as they pertain to her immediate needs was specifically highlighted for the caregiver.

**Family Peer Advocate Role and Boundaries**—Advocates typically used their own experience to help build credibility and trust with families they work with. However, they varied in their ability to effectively share or disclose their personal experiences. When effective, advocates smoothly alluded to their own experiences to align with and provide hope to the caregiver. Such disclosure was judged less useful or appropriate when an

advocate over-generalized her own experiences to the caregiver's, such as by identifying and focusing on specific services she had personally used and recommending them based on her own positive experiences with the service/program rather than on her knowledge about the family's situation. The standardized parent expressed discomfort and concerns in a particular situation when the advocate overstepped his/her role by asking to take what appeared to be a parental and/or therapeutic role in directly working with her child.

**Facilities or Location of Services**—Family peer advocates varied in where they met with parents; the location was often based on parent choice. Thus, depending on where meetings were set up, privacy was a concern when such meetings were conducted in public places (e.g., restaurants). In one agency, meetings between the standardized parent and family peer advocate were conducted in a large open room where other advocates and program staff worked, creating significant discomfort for the standardized parent, particularly when their interactions were interrupted by another advocate who asked questions and provided additional referrals to the parent.

**Caregiver Crisis and Safety Concerns**—In general, family peer advocate response to the standardized parent's significant concerns about her child's safety was to provide the caregiver with a specific crisis number to call when a safety or crisis emerged. However, no advocate instigated a more thorough discussion of a potentially dangerous situation to determine if a more immediate response (e.g., connection to a crisis hotline) was indicated. The concern about adequacy of safety and crisis guidelines or protocol was also highlighted when a real parent in crisis was observed during an orientation meeting at one of the sites. The standardized parent and research assistant observed significant discomfort among the attendees, and expressed their own discomfort with the family peer advocate's lack of immediate response to the parent. This interaction consequently resulted in the standardized parent's lack of confidence in the advocate's ability to provide family support, even though the advocate “said all the right things” at a subsequent meeting.

**Integration of Family Peer Advocate Services within other Mental Health Services**—The degree to which family peer advocates work with other service providers varied from program to program and depended in large part on the availability of other services within the program. There was no consistent model for how advocates were integrated with other staff in the program; advocates may work as part of a larger clinical team, or function quite autonomously by providing adjunctive services on an as needed basis. While these family peer advocates demonstrated knowledge about services provided outside their own program, their primary function appeared to be a linkage or facilitator to additional community-based services. Family peer advocate perceptions of the culture and climate of their program also varied, as opportunities for collaboration, integration and advancement varied across settings.

## Discussion

Results from this walk-through indicate the feasibility of this methodology for collecting rich process and content data about family support services. Specifically, this approach was found to be “normal” and “simple” by the participating family peer advocates: family peer advocates indicated they reacted to the standardized parent as they would to any other parent, that audiotaping did not disrupt the sessions.

Relevant data concerning specific process and content practice elements that characterize family peer advocate services were identified and we were able to compare the content (e.g., information provision, emotional support, skill development, advocacy) and process (e.g., paperwork burden) of family peer advocate services. Conducting two face-to-face sessions

(instead of one), having researchers compare standardized parent notes and checklist responses to the audiotapes of sessions, and including family peer advocates in the review of data increased reliability and validity. In studies using a similar no-deception walk-through by practitioners with little training, the method was accurate in describing agency procedures and generating ideas for improved services (Ford et al. 2007).

The potential utility of the walk-through methodology for assessing the process and content —i.e., the so-called “black box” of services in a real-world context was clearly demonstrated. Quantitative data and observations indicated specific areas for improvements, including those around (a) confidentiality issues, (b) appointment interruptions, (c) incomplete assessment of parent concerns (i.e., child's home behavior and safety), and (d) volume of information provided to a parent who was overwhelmed. Qualitative data provided richer and contextualized information about the nature of these areas of concerns. For example, confidentiality issues related to the lack of privacy for meetings, generating significant discomfort for the parent. While the number of referrals provided by the family peer advocate may well be interpreted as a positive quality indicator, within the context of a parent who is already highly distressed and overwhelmed, the volume of information had an unintended impact of confusing the parent. These are similar to concerns previously noted in walk-throughs of professional drug treatment counselors (Ford et al. 2007; Fussell et al. 2008). Interventions suggested are similar: improving the informed consent or orientation process; informing staff engagement and interaction with clients; and reducing burdensome, redundant, or slow processes.

The qualitative analysis also indicated important strengths of family peer advocate services, including (a) emotional support from a peer with shared experiences, (b) linkages to local community resources, (c) information about parent rights, and (d) connections to other caregivers and youths. The strengths of the family support service highlighted in this case study are consistent with data from a national survey of parents with children who had emotional and behavioral disorders. For example, 72% of Medicaid families using family support services to provide outreach, information and support as part of a federally mandated health care benefit called Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children identified emotional support as the most helpful aspect (Friesen 1990). In a study of such low-income families, parents who worked with family peer advocates following a EPSDT referral were more likely to initiate mental health treatment services; family support services did not influence family likelihood of adhering to, completing or dropping out of treatment (Koroloff and Elliott 1996). The authors speculated that better service outcomes may have been achieved if families continued to have access to family support services throughout the process of mental health treatment.

This case study also highlighted issues that require additional attention as New York State moves forward to integrate family support services into the continuum of mental health services. While family peer advocates were found to provide many of the identified service components common to other family support programs, there was variability from setting to setting. A consistent issue noted related to the lack of clear protocol for addressing potential safety concerns or crisis situations; perceived adequacy and/or immediacy of advocate response to a crisis situation was found to influence the standardized parent's confidence and comfort in working with an advocate. In creating a more seamless system of care, the boundaries and overlap of care responsibility between peer support services and clinical services need to be clearly articulated and implemented. This finding is consistent with anecdotal reports from family peer advocates across the state about challenges related to role expectations, responsibilities and boundary issues (J. Rodriguez & M. Penn, personal communication). Guidelines and protocols (e.g., around confidentiality, safety, crisis issues) will be essential to help family peer advocates understand their roles and responsibilities,

and to provide effective family support services within the mental health system (Davis et al. 2010).

## Limitations

This exploratory study has several limitations. First, the walk-through methodology used in this study focused only on the first two meetings of family-to-family support services. While this method provided rich insights into the content and process of services, this method also provides a limited view of the service process. It is quite likely that the content and process in the initial relationship-building phases of services may look different than later phases of the services encounter, and this cross-sectional view does not adequately capture shifts in service focus (e.g., from information provision to skill building) over time. Second, we examined the services of four self-selected family peer advocates within four service agencies, which is only a fraction of the approximately 400 family peer advocates currently employed in NY State and of many more family advocates employed nationally. Even so, we identified family support components in the services that advocates provided to the standardized parent, which suggests that this was a useful process to develop quality indicators for family peer advocates. Third, an observational procedure without deception raises the possibility of family peer advocates presenting themselves in the most favorable light; although this likely occurred, the data from the standardized parent walk-through suggested both strengths of family-to-family support services and areas for additional research and were not wholly positive responses. However, family peer advocates reported that the procedure was very realistic and that they behaved similarly as they would toward real-world parents.

## Conclusions

This study clearly demonstrates the value of walk-through methodology in adding descriptive detail to typical approaches for developing quality indicators for services. Data collected via this method provided rich, contextualized information about the nature of family-to-family support services, including the perspective and experiences of users of such services. By collecting data that go beyond consumer satisfaction and frequency of service use, these rich data have the potential to highlight more specific information that can influence the successful integration of this emerging service, as well as key training needs for family peer advocates.

Despite anticipated concerns about the acceptability and feasibility of this methodology, the standardized parent walkthrough was found to be a feasible method for obtaining detailed process and content data about family support services. It was acceptable to the family peer advocate and resulted in quality data. When repeated across multiple family peer advocates, these data likely have the complexity and clarity to create quality indicators and fidelity measures; when used to assess other behavioral health services, the standardized parent walk-through can provide valuable insights to improve services.

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**Table 1**  
**Descriptive characteristics of participating family support service programs**

	Site 1	Site 2	Site 3	Site 4
Agency characteristics				
Number of employees	2,200	600	8	2,000
Average number of clients served per year	65,000	2,000	200	7,100
Program characteristics				
Number of employees	50	59	8	6
Average number of clients served per year	350	78	200	12*
Location	Urban	Urban/suburban	Urban	Urban/suburban
Number of family advisors employed	3	8	4	2
Participating family peer advocate characteristics				
Gender	Female	Female	Male	Female
Race	Caucasian	Caucasian	African–American	Caucasian
Years as a family advisor	7	5	10	3

\* Refers to clients served at any given moment; no statistics available on yearly number of clients served because it is a new program

**Table 2**  
**Standardized parent walk-through procedures**

The standardized parent followed the following walk-through procedures for each walk-through	
1	The standardized parent arranges with the program director to conduct the walk-through
2	The standardized parent calls the agency to request an appointment with a family peer advocate, obtains permission from advocate to conduct walk-through, and documents the interaction on process and content checklist *
3	The standardized parent and research assistant meet with family peer advocate, obtain consent, and explain procedure The goal of the procedure is to learn more about family peer advocate services We will walk through an initial appointment with the standardized parent; treat her as you would any other client There will be an opportunity to debrief and ask questions at the end The audiotape, transcription, and all other materials will be seen only by the study team, and the family peer advocate's identity will not be revealed
4	The standardized parent expresses concerns as indicated in script and improvises as needed to answer specific questions, while staying consistent with vignette
5	After the first meeting is concluded, everyone can take a break, then continue to second meeting with standardized parent concerns of, "No changes since last meeting"
6	When the second meeting is concluded, the research assistant conducts a debriefing interview, * which includes Assess the family peer advocate's response to the standardized parent walk-through procedure Assess the perception of the accuracy of standardized parent portrayal of an actual parent Answer questions the family peer advocate may have
7	The research assistant and standardized parent prepare summary of information obtained in walk-through

\* Available from authors upon request

**Table 3**  
**Supportive activities provided by family peer advocates (FPA) in response to standardized parent**

Strategy	FPA 1	FPA 2	FPA 3	FPA 4
Informational/educational support				
Advocacy services			1	2
Care coordination/case management services		1	2	
Crisis services	1	1	1	1
Diversion services	1			1
Evaluation services			1	
Group therapy (anger management, social skills, girls circle)	1	3	2	2
Information about specific treatment programs	1		1	2
Mentoring/tutoring services	1		1	
Psychiatric services (e.g., counseling, day treatment)	2	1	4	3
Role of advocate	1			
School information (rules of suspension)	1			
Instructional/skills development				
How to get a psychiatric evaluation			1	
How to obtain/read a service plan	1		1	
How to help child generally				1
How to set house rules	1			
Coaching (e.g., how to complete an application for services)	2			2
How to write a letter to administrator	1		1	
Emotional and affirmational support				
Normalizing (e.g., it's scary)		2		
Empathy (e.g., I understand your fear)	2	1	4	1
Removing blame (e.g., It's not your fault)		1	2	
Offer of availability to listen		1	1	
Active listening	5	1		1
Shared experience (e.g., advocate stating child also receives services)		4	2	
Statement of hope or action (e.g., "We are going to rectify this situation")	1			1
Instrumental support				
Respite and parent aid services	2	2		1
Advocacy				
Legal rights (e.g., right to request a re-evaluation)	1	1	1	1
Offer to attend meetings with parent	2	1	2	
Offer to find information/facilitate service connections	1	1	1	2
Teaching leadership (e.g., teaching parent how to self-advocate)	1			