

# Family Support in Children's Mental Health: A Review and Synthesis

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**Abstract** A comprehensive review of structured family support programs in children's mental health was conducted in collaboration with leadership from key national family organizations. The goals were to identify typologies of family support services for which evaluation data existed and identify research gaps. Over 200 programs were examined; 50 met criteria for inclusion. Programs were categorized by whether they were delivered by peer family members, clinicians, or teams. Five salient components of family support were identified: (a) informational, (b) instructional, (c) emotional, (d) instrumental, and (e) advocacy. Clinician-led programs were heavily represented ( $n = 33$ , 66%), followed by family-led ( $n = 11$ , 22%), and team-delivered ( $n = 6$ , 12%) programs. Key differences between programs delivered by clinicians or by peer family members were found in the degree of emphasis, research methodology, and outcomes. However, the content of the

components was similar across all three program types. There are both important differences in emphasis across typologies of family support provided by clinicians, family members, or teams as well as important similarities in content. Family-delivered support may be an important adjunct to existing services for parents, although the research base remains thin. A research agenda to promote more rigorous evaluations of these services especially those delivered by peer family members is critical.

**Keywords** Family support · Peer family support · Family-based services · Children's mental health

## Introduction

Since the late 1980s, the family support and advocacy movement in children's mental health have been evolving in the United States, its development running concurrent with the expansion of community-based services for families and children (Hoagwood et al. 2008). Provision of family support is not new. Involvement of parents in child psychotherapies is generally part of standard practice (Weisz 2004). Within the field of children's mental health services, peer-delivered family support has been in existence for at least 25 years and has been a major emphasis within the National Federation of Families for Children's Mental Health (Robbins et al. 2008). Studies have documented that parents often report high levels of stress and strain in managing their child's mental health needs and accessing services (Angold et al. 1998; Wu et al. 1999), and caregiver strain is known to be a key driver of service access (Costello et al. 1996; Farmer et al. 1997). Thus, attention to the needs of parents and ways to support parents as they seek care for their children is fairly well accepted.

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Yet, parent support has also been peripheralized in children's mental health services. It has received far less research attention than other components of healthcare (Ireys et al. 2001). It is only recently that peer-delivered family support has become a billable service in some states. In addition, only recently that program models have been structured, documented, and manualized such that they can be examined and replicated. The newer program models, rapidly emerging as an adjunctive service, are delivered by current or former parents/caregivers (hereafter called parents) of children with identified mental health needs who provide a range of services, including emotional support, information about mental health services, and direct advocacy (Hoagwood 2005; Koroloff et al. 1994, 1996; National Federation of Families for Children's Mental Health (NFFCMH), [www.ffcmh.org](http://www.ffcmh.org), 2008; Osher et al. 2008). Because of their personal experience, peer family advisors often have credibility with parents, are able to engender trust, and can therefore assist parents in becoming more actively engaged in their child's services (Gyamfi et al. 2009; Hoagwood 2005; Koroloff et al. 1994, 1996; Osher et al. 2008; Robbins et al. 2008).

National surveys indicate that the number of professional peer family advisors (also known as family-to-family advisors or advocates) providing direct services to parents is increasing, and organized family associations are encouraging the growth of these kinds of family support services (Gyamfi et al. 2009). Results from a MacArthur Foundation and Robert Wood Johnson Foundation-funded national survey of 225 directors of local family education/advocacy organizations suggest that there are over four million parents (probably duplicative numbers) who are members of national associations for parents of children with psychiatric needs. This includes the National Alliance on Mental Illness (NAMI), Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), National Federation of Families for Children's Mental Health, and Mental Health America. Training programs to assist parents in becoming active leaders with other parents are offered by NAMI and CHADD. Yet, despite this expansion, we know very little about the content of these programs or their impact on either parents or children's mental health outcomes (Hoagwood 2005). Rigorous studies of family support programs in children's mental health are exceptionally rare.

Studies outside of children's mental health have shown that peer-delivered services can promote health behaviors. For example, programs in which peers provide outreach, emotional/social support, or educational services result in improved eating habits among women at risk for diabetes (Auslander et al. 2002), decreased cocaine use (Egelko et al. 1998; Galanter et al. 1998), improved health among persons with heart and lung disease or diabetes (Lorig and Holman 2003), reduced smoking among cancer survivors (Emmons

et al. 2005), decreased high-risk behaviors associated with HIV exposure (Kegeles et al. 1996; Wright et al. 1998), and improved usage of HIV medications (Broadhead et al. 2002; Lyon et al. 2003; Williams et al. 2006).

While the relative impact of peer-delivered vs. professionally delivered support services has not been examined in mental health, this has been reported in the health literature. For example, studies have shown that both peer-led and professionally led support groups for adults caring for elderly parents were associated with benefits in social networking. However, there were differences between the two. The peer-led group showed the greatest benefit in enhancing caregivers' connections to their social network while the professionally led group displayed the largest improvement in enhancing caregivers' psychological status (Toseland et al. 1989). This suggests a difference in emphasis between these types of support.

Studies in the health literature also suggest that peer-led services tend to be used by individuals with stigmatizing illnesses. For instance, Davison et al. (2000) found that the use of self-help was the highest among individuals with AIDS, alcoholism, and cancer, whereas it was the lowest for those with serious but less stigmatizing illnesses such as heart disease. The authors concluded that stigmatizing illnesses may adversely impact support networks and thus may be especially relevant to individuals with illnesses that may compromise their social supports.

Because the problem of stigma is pervasive within children's mental health and has been well documented (Hinshaw and Cicchetti 2000; US Department of Health and Human Services (DHHS) 1999, 2001), one can speculate whether persistent stigma is contributing to the rise in the popularity of family support. Irrespective of speculation, however, it is surprising that so little research attention has been paid to this expanding area. As noted, there have been very few studies that have delineated the components of family support, which have examined its content—looked inside the black box—or that have examined the comparative impact of different types of models.

Despite the limited attention, studies of families enrolled in the largest federally funded service program in children's mental health (i.e., the Community-based Children's Mental Health Service Program of SAMHSA) have found that family education and support services provided by peer family members are used by about one-third of families (Gyamfi et al. 2009). In addition, parents receiving this service report greater levels of strain than parents not receiving these services. In contrast to peer-led models, professionally led family support programs have a long and distinguished history in both adult and children's mental health. A recent review of 30 randomized trials conducted by McFarlane et al. (2003), for example, found family psychoeducational programs decreased symptoms, reduced relapses and

rehospitalizations, and increased the rates of employment and participation in vocational rehabilitation. Further, these programs were associated with improved health and enhanced well-being among families (McFarlane et al. 2003).

So, while some types of family support programs (i.e., clinician led) have been examined, ambiguity exists as to (a) whether the content of support differs across program models (i.e., those led by peer family members or those led by clinicians); (b) the relative emphasis given to different types of support within these categories; and (c) the level of research support for and types of outcomes associated with different program models. Given the expansion of family support services nationally, its addition to the armamentarium of billable clinical services in some states (e.g., New York), and its promise as an adjunctive service for children with mental health needs, a synthesis of the literature is overdue.

This paper extends and builds upon several other reviews. A paper by Hoagwood (2005) about family-based services focused on service processes (e.g., engagement, alliance, expectancies, choice). It did not differentiate between family-led and clinician-led models, nor did it identify components of programs. The review did find that basic definitions of family support services, attention to the core components, and rigorous evaluations of program models were lacking. A recent synthesis of the parent-to-parent literature (excluding clinician-delivered models) again highlighted the paucity of rigorous research on these services for parents (Robbins et al. 2008).

This paper is intended to review a broad range of family support services and to document core components, research findings, and outcomes. It encompasses all delivery models (i.e., family led, clinician led, and team based). Identification of this broader range entailed looking beyond studies reported only in the academic literature. This paper focuses on family support services or programs that have a clear structure or have been manualized so that the specific content of the core components could be identified. It compares the specific support components across different delivery models and the context within which such activities are conducted (e.g., settings, level of integration of family support into treatment). In doing so, we provide an operational definition for the various components of family support in the interest of enhancing clarity and consistency within this somewhat amorphous body of literature. This synthesis represents an important first step toward developing a comprehensive framework and logic model by which to advance research in this area and identify effective program models.

We define family support as services directed at meeting the needs of parents or caregivers of children with mental health needs with the explicit purpose of helping parents/caregivers (a) clarify their *own* needs or concerns; (b) reduce

their sense of isolation, stress, or self-blame; (c) provide education or information; (d) teach skills; and (e) empower and activate them, so that they can more effectively address the needs of their families.

In our paper, we include services and programs directly targeted at parents and caregivers of children with identified mental health needs. We include all services or programs that have been evaluated since 1990. We did not establish criteria with respect to the rigor of the design. Instead, any program that had been evaluated was included. We chose to do so because, as noted, we wanted to both provide a conceptual structure for this emerging area of study and highlight areas for advancing a more rigorous research agenda. We believed that reviewing the data that exists—even if minimalist—is a logical first step.

The paper describes 50 distinct programs and their major family support components, examines how types of support may vary according to provider type, and the context within which such services are provided (e.g., as a component of the child's treatment or a program that the parent can access regardless of the child's status in treatment). Further, the impact of these programs on caregiver, child and service-related outcomes are summarized.

Specifically, our review addresses the following questions:

1. What types of family services, interventions, or programs are available for parents or caregivers of children or adolescents with identified mental health needs?
2. Who provides these services and in what context are these services typically delivered (e.g., offered in conjunction with the child's treatment, stand-alone programs that parents can access independently). Are services affiliated with family organizations?
3. What are the strengths and limitations of the existing data on family services, interventions, or programs?

The overall goal of this review is to synthesize the findings with attention to setting a stronger research agenda for this emerging area of study and enhancing the policy relevance of that scientific agenda.

## Methods

A comprehensive search of articles on services, interventions, or programs targeted at the needs of parents or caregivers of children or adolescents with identified mental health needs included the following:

- Computer searches of PSYCinfo and Medline systems from 1990 to present, using the following terms: Family or parent support, skill training, psychoeducation, parent management training, children's mental health, supportive, adjunctive, health, education, and mental health.

- Website and Google searches.
- Direct contact with representatives of national family support organizations (Bazelon Center, Children and Adults with Attention-Deficit/Hyperactivity Disorder [CHADD], Child and Adolescent Bipolar Foundation, National Federation of Families for Children's Mental Health, Mental Health America [MHA], National Alliance on Mental Illness [NAMI]) to identify national, state, and local level programs.
- Discussions with national experts from the major national family advocacy organizations (e.g., NAMI, CHADD, and National Federation, MHA).
- Programs from widely recognized published reviews and compendiums including:
  - 2006 Report by the American Psychological Association Working Group on Psychoactive Medications for Children and Adolescents
  - 2007 Biennial Report by the Hawaii Department of Health, Child and Adolescent Mental Health Division on Effective Psychosocial Interventions for Youth and Behavioral and Emotional Needs (Chorpita and Daleiden 2007)
  - The Substance Abuse Mental Health Services Administration (SAMHSA) guide for selecting evidence-based practices for children and adolescents with disruptive behavior disorders
  - SAMSHA National Registry of Effective Practices
  - 2008 Journal of Clinical Child & Adolescent Psychology's special issue review of Evidence-Based Psychosocial Treatments for Children and Adolescents (Silverman and Hinshaw 2008)
  - 2008 Parent to Parent: A Synthesis of the Emerging Literature (Robbins et al. 2008)
  - Reviews of BPT programs for conduct, oppositional, and AD/HD, such as those by Chronis et al. (2004), Gavita and Joyce (2008), and Mah and Johnston (2008)

We deliberately cast a wide net to include services, programs, or other types of interventions that offered education, skills training, emotional support, concrete support, or advocacy directly to parents/caregivers. We included interventions that were provided directly by parents to parents (i.e., family-led programs); those that were provided by clinicians (e.g., as a component of cognitive behavioral or other treatments for children's disorders); and those that were delivered by a team composed of a family member and a clinician. The pool of included programs also ranges in terms of site (e.g., where they are offered) and whether they are independent or affiliated with either family support organizations or with child treatments. The critical issue was that the support was targeted directly at addressing the parent's own needs as a caregiver, not the child's needs.

While many preventive interventions include services that target parent or caregiver support, we exclude them in this review for parsimony and clarity. These are being reviewed and will be published in a separate monograph.

#### Inclusion and Exclusion Criteria

Family services, interventions, or programs are *included* if they:

1. Provide educational (information), instructional (parent skill building), emotional, instrumental (concrete help), or advocacy (advocacy skill training) support for caregivers of children/adolescents with mental health conditions. A focus on caregiver needs is essential.
2. Have been published (as journal articles, chapters, or dissertations) between 1990 and 2008 or are available (via personal communication).
3. Provide more than a didactic workshop.
4. Are part of a child's treatment and include an additional, separate caregiver support component.
5. Have a formal curriculum or structure.
6. Have some evaluative data or are currently being studied.

Family services, interventions, or programs are *excluded* if they:

1. Are targeted for parents of children with other health or developmental conditions (e.g., diabetes, intellectual disabilities, substance abuse).
2. Are part of a preventive intervention for parents/caregivers designed to mitigate the emergence of mental health issues in children.
3. Are clinical interventions whose parent component aims to improve the child's outcome. This may occur through the provision of information (e.g., education about illness and treatment), or of behavior management skills or other skills to assist the child in complying with a treatment protocol. These types of informational and instructional support for parents while important are typically considered part of the standard of care for children, have been extensively reviewed elsewhere (e.g., Burns et al. (2009), for the SAMHSA Implementation Resource Guide; Silverman and Hinshaw 2008) and therefore are not reviewed here. They are included ONLY if they contain a specific component targeting parents/caregivers needs.
4. Do not have a specific focus on enhancing parent's well-being or reducing parent stress.

Based on the criteria outlined above, we reviewed over 200 family service programs or interventions. Of these, 50 met the above criteria and were included in this review (Table 1).

**Table 1** List of family support interventions meeting inclusion criteria

Intervention or program name	Source
<i>Family led</i>	
1. Keys for Networking: Targeted Parent Assistance	Adams et al. (2006)
2. Parent to Parent	CHADD ( <a href="http://www.chadd.org">www.chadd.org</a> )
3. Parent Empowerment Program	Hoagwood et al. (2009)
4. EPSDT (Early and Periodic Screening, Diagnosis, and Treatment Program) Family Associate Program	Koroloff et al. (1996)
5. Parent Connectors	Kutash et al. (2006)
6. NAMI Basics Program	NAMI ( <a href="http://www.nami.org">www.nami.org</a> )
7. NAMI Hand to Hand	NAMI ( <a href="http://www.nami.org">www.nami.org</a> )
8. NAMI Visions for Tomorrow	NAMI ( <a href="http://www.nami.org">www.nami.org</a> )
9. Parents' Empowerment Academy	New Jersey Parents' Caucus ( <a href="http://www.newjerseyparentscaucus.org">www.newjerseyparentscaucus.org</a> )
10. Parent Empowerment Classes	Passages Spokane (a chapter of the Federation of Families for Children's Mental Health and the Child and Adolescent Network of NAMI, <a href="http://www.ffcmh.org">www.ffcmh.org</a> )
11. Partnership to Support Families	Passages Spokane (a chapter of the Federation of Families for Children's Mental Health and the Child and Adolescent Network of NAMI, <a href="http://www.ffcmh.org">www.ffcmh.org</a> )
<i>Clinician led</i>	
1. CBFT (Cognitive Behavioral Family Therapy) for OCD	Barrett et al. (2004)
2. CBT+FAM (Cognitive Behavioral Therapy+ Family Anxiety Management)	Barrett et al. (1996)
3. The STEPP Program (Strategies to Enhance Positive Parenting)	Chacko et al. (2008, 2009)
4. CBT+PAM (Cognitive Behavioral Therapy+ Parent Anxiety Management)	Cobham et al. (1998)
5. Trauma-Focused CBT (TF-CBT)	Cohen et al. (2004); Cohen and Mannarino (2008)
6. Maternal Stress Coping Group	Chronis et al. (2006)
7. Parent Counseling and Support (Parent Advisor Service)	Davis and Spurr (1998)
8. Cognitive Behavioral Group Therapy	Deblinger et al. (2001)
9. Supportive Group for Caregivers	Deblinger et al. (2001)
10. Project Team	Feinfeld and Baker (2004)
11. Individual and Multi-Family Psychoeducation Groups (IFP & MFPG)	Fristad et al. (2003)
12. Family Group Psychoeducation	Geist et al. (2000)
13. PMT+PPS (Parent Management Training+ Problem-Solving Intervention)	Kazdin and Whitley (2003)
14. (FCBT) Family Cognitive Behavioral Therapy	Kendall et al. (2008)
15. (FESA) Family-based Education, support, and attention	Kendall et al. (2008)
16. A Community-Based Aggression Mgmt Program	Lipman et al. (2006)
17. The Parent Education and Skills Training Group (for families of adolescents with ADHD)	McCleary and Ridley (1999)
18. Evidence-based Engagement Strategies	McKay et al. (1998)
19. Time for a Future	Melvin et al. (2006)
20. CFF+CBT—Child and Family Focused Cognitive Behavioral Therapy) for youth with bipolar disorder	Pavuluri et al. (2004)



**Table 1** continued

Intervention or program name	Source
21. Psychoeducation and Support Group Intervention for Bereavement	Pfeffer et al. (2002)
22. Parent Training+PTPS (Parent Social Problem-Solving Skills)	Pfiffner et al. (1990)
23. C-PERF (Psychoeducation Responsive to Families Coping with a Child with Emotional Disorders)	Pfiffner et al. (1990)
24. Enhanced Family Treatment	Prinz and Miller (1994)
25. Maudsley Model of Family-Based Treatment	Rhodes et al. (2008)
26. Cognitive Behavioral Family Intervention	Sanders and McFarland (2000)
27. Enhanced Triple P	Sanders et al. (2000)
28. Educational Support for Parents	Sheridan and Moore (1991)
29. FRIENDS Program (A Family-Based Group Cognitive Behavioral Treatment)	Shortt et al. (2001)
30. Parent Therapy for youth with ADHD	Sonuga-Barke et al. (2001)
31. Parent Stress Management (PSM) Training for AD/HD	Treacy et al. (2005)
32. FCBT for OCD	Valderhaug et al. (2007)
33. Incredible years Advanced Training	Webster-Stratton (1994)
<i>Team led</i>	
1. Vanderbilt Caregiver Empowerment	Bickman et al. (1998)
2. CMT+AST (Child Management Training+Ally Support Training)	Dadds and McHugh (1992)
3. Parent Connections	Ireys et al. (2002)
4. (CMAP) Children's Medication Algorithm Project for children with ADHD/Depression and their families	Lopez et al. (2005)
5. Multiple Family Group	McKay et al. (1999)
6. S.E.E. Group Intervention (Support, Empowerment, Education)	Ruffolo et al. (2005, 2006)

### Operational Definitions and Framework

A key aim of this review was also to develop clearer consistency in terminology about family support in children's mental health. We reviewed all relevant literatures including the Friesen (1996), Hogan et al. (2002), Ireys et al. (2002), and Robbins et al. (2008). To derive descriptive categories, codes, and typologies that would capture the range of models, two of the authors (Olin and Cavaleri) systematically reviewed the 50 interventions that met criteria (described earlier) in weekly meetings over a year. The same authors (SO and MC) then divided the 50 studies between themselves and used the coding scheme as a basis for coding the programs based on the descriptions provided in the published articles and/or relevant sources. The coding system was reviewed with all of the authors, including the leaders from the three national family advocacy organizations (ES, DG, RH). The two authors then simultaneously reviewed the programs in order to ensure inter-rater reliability. Any discrepancies were

discussed among all of the authors until consensus was reached. The coding system was refined until no additional codes were needed (Table 2).

### Results

As with the adult mental health literature, this review revealed similar variations in format, content emphasis, provider, or service context of family support services for caregivers of children with identified mental health needs. Because of the potential policy and research implications in light of the national rise in family-to-family support services, the programs were stratified and analyzed at the provider level. Within each level, the following aspects of the programs were highlighted. First, an overall description of the program with respect to target population (caregiver, child, specific disorder), format of support (e.g., individual, group, or mixed sessions, number of sessions), type of support (e.g., informational, instructional, emotional,

**Table 2** Definitions of family support components

Definitions of family support components	
1. Informational/Educational Support	Education about child behavior/development, course of mental illness and its impact, treatment options, child and family service systems, and other resources
2. Instructional/Skills Development Support	A. Skill building directed at coaching caregiver on effective ways to address their child’s illness or associated behaviors B. Skill building directed at addressing caregiver’s personal well-being (e.g., communication, problem-solving, crisis management, anger/anxiety/stress management skills)
3. Emotional and Affirmational Support	Shared communication among families and/or between providers and families to promote caregiver’s feelings of being affirmed, understood, and appreciated
4. Instrumental Support	Concrete services such as respite care, transportation, and flexible funds for emergencies
5. Advocacy Support	A. 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 B. Leadership skill building to develop caregiver as an advocate at policy and service system levels

instrumental, advocacy), and setting (e.g., community based, clinic, hospital). The program description also included information on the context within which family support is provided, such as whether or not such support was provided as part of the child’s overall treatment, or a separate intervention or program. Second, we focused on the components or specific activities or content provided to parents. This allowed us to compare the content emphasis of different program models. Third, we describe the study design and sample in order to assess the rigor of the evaluation. Finally, the impact of the programs was examined in terms of caregiver, child, and service-related outcomes.

Table 3 describes the primary typologies of support (e.g., family, peer, or team-delivered).

**Table 3** Comparison by program type

Type of support	Family led (n = 11)	Clinician led (n = 33)	Team led (n = 6)	Total programs (N = 50)
Information Education	n = 10, 91%	n = 22, 44%	n = 5, 83%	37 (74%)
Instructional Skills Development	n = 10, 91%	n = 26, 79%	n = 5, 83%	41 (86%)
Emotional	n = 6, 55%	n = 10, 30%	n = 6, 100%	22 (44%)
Instrumental	n = 3, 27%	n = 0	n = 3, 50%	6 (12%)
Advocacy	n = 11, 100%	n = 7, 21%	n = 5, 83%	23 (46%)

**Peer-to-Peer (Family-Led) Programs**

Out of the 50 programs that were included in this review, 11 programs (22%) were delivered using a peer-to-peer model (see Table 4 of Appendix). Eight of the 11 programs (73%) were affiliated with family-run organizations, including the National Alliance on Mental Illness (NAMI), Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), the National Federation of Families for Children’s Mental Health, Keys for Networking, Inc., and the New Jersey Parent’s Caucus. It should be noted that the three NAMI-based programs (NAMI Basics, Hand-to-Hand, and Visions for Tomorrow) represent adaptations or variations of the same basic family educational program, although they vary somewhat in which forms of support they offer.

The three programs that were not affiliated with family-run organizations were federally supported research projects led by university-based researchers in collaboration with family stakeholders. These programs were funded as pilot projects to develop peer-led programs that would increase access and activation of parents in mental health services (PEP, Hoagwood et al. 2009; Olin et al. 2009; Family Associate Program, Koroloff et al. 1996) or improve academic performance for children identified with eligible for special education services because of behavioral or emotional needs (Parent Connectors, Kutash et al. 2006; K. Kutash, personal communication, 2009).

**Provider Characteristics**

These programs were all led by parents who had experience navigating complex service systems for their own children who had mental illness. The use of veteran parents is a critical aspect of family-led programs; as such parents serve as important role models and partners for caregivers in order to facilitate their sense of empowerment and their ability to independently navigate service systems (Koroloff et al. 1996). In this review, only programs that included a structured format or curriculum were included; even so, the degree to which parents are paid, trained, or supported to provide peer-to-peer support was not always clear. Training and support for family advisors providing peer support

were more explicitly articulated in the three federally funded demonstration programs [Parent Empowerment Program (Hoagwood et al. 2009), EPSDT Family Associate Program (Koroloff et al. 1994), and Parent Connectors (Kutash et al. 2006)]. In all three programs, paid parent peers received formal training (ranging from 2 to 6 days), ongoing supervision, and support from research staff that included a mental health clinician. In these programs, family advisors met in individual and/or group supervision to share experiences, challenges, and strategies. Supervision by a trained mental health professional was considered a crucial support and backup to the role of family advisors in these programs (Koroloff et al. 1996).

### Program Characteristics

The programs represent a broad range including a set of workshops focused on topical areas relevant to caregivers of children with mental illness (e.g., NAMI Basics (<http://www.nami.org/>), Parent Empowerment classes (<http://www.ffcmmh.org/>), Parent to Parent (<http://www.chadd.org/>), Parent Empowerment Academy (<http://www.newjerseyparentscaucus.org/>) to individualized contacts based on caregiver needs (e.g., Adams et al. 2006; Koroloff et al. 1996). The workshop-based programs were typically highly structured with respect to content and time involvement; these programs tended to be delivered in a group format. The individualized programs tended to be more flexible or variable with respect to content and time. For example, the Targeted Parent Assistance program varied in length and was determined by the level of parent involvement on a continuum that ranged from parents as help-seekers to parents as system advocates (Adams et al. 2006), while caregiver participation in the Family Associate Program was determined by successful parent linkage to mental health services (Koroloff et al. 1996).

It should be noted that the workshop-based programs run by family organizations typically represented only one aspect of a broader array of caregiver support resources available to caregivers. For example, caregivers who accessed the NAMI programs (NAMI Basics, Family-to-Family, or Visions for Tomorrow), which were primarily informational or educational in nature, also had access to other support groups that focused on social and emotional support.

### Client Characteristics

All 11 family-led programs primarily targeted the needs of caregivers. With the exception of the Parent-to-Parent program run by CHADD, caregiver participation was typically not limited by the child's diagnosis or treatment condition. A couple of programs (both Passages-affiliated

programs) required that the child receive mental health treatment.

### Types of Support

Unlike clinician-led programs described below, a unique support component of all family-led programs is advocacy. All of the family-led programs included advocacy as a key component of the support program. Except for one program that explicitly described providing direct advocacy and action (Adams et al. 2006), advocacy support appeared to be primarily focused on empowering families with information about laws, entitlements, and strategies for advocacy. Few programs provided coaching on advocacy skills, with one program including the development of advocacy leadership skills as part of the continuum of family support components within a single program (Adams et al. 2006).

Informational and instructional types of support were almost unanimously represented among all the family-led programs as well ( $n = 10$ , 91%). Informational support was typically broadly focused on education about brain biology/mental illness or child psychiatric disorders, the mental health evaluation process, the impact of child disorder on the family, and about resources and options for available services and treatments. Importantly, a key function of the parent who led these programs was to provide information and/or to link families to community resources and services. Unlike clinician-led programs that tended to focus on family and parent-level barriers to the child's receipt of services (e.g., parental stress, Kazdin and Whitley 2003; Prinz and Miller 1994), family-led programs were more apt to recognize the significant impediments posed at the system level, such as the availability of accessible resources and services, basic information on the mental health care system and treatment options, and the nature of child mental disorders and their impact on the family. Among the family-led programs, instructional support was typically focused on caregiver coping, self-care, crisis management, problem-solving, and communication skills. Unlike the clinician and team-led programs, only one family-led program (Parent to Parent, Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) website; R. Hughes, S. Pickford-Schenke, personal communication, 2008) provided behavior management strategies or tips; such parenting skills were typically not a focus of family-led support programs. Instructional support in these programs was predominantly focused on caregiver's personal skill development, and not on parenting skills.

While emotional support may be implicit in the peer-to-peer context, only six of the 11 (55%) programs explicitly described emotional support as a key component of the program (Adams et al. 2006; both Passages-affiliated programs, B. Bates, personal communication, March 1, 2009;



Hoagwood et al. 2009; Koroloff et al. 1996; Kutash et al. 2006). The other programs tended to focus more on providing information and instruction. Where emotional support was a key component, such emotional support typically took the form of facilitated sharing of experiences and social connections to other families; the parent peer may also directly provide emotional support by sharing their own experiences and encouragement. Regardless of format, emotional support was aimed to decrease stigma, feelings of isolation, shame, guilt, and helplessness.

Instrumental support was the least common type of family support among the 11 programs reviewed. Only three programs provided such supports to families and consisted of childcare, respite, travel costs, and emergency funds (Adams et al. 2006; Koroloff et al. 1996; Kutash et al. 2006).

### Evaluation Designs

Compared to the clinician and team-led family support programs, the evidence base for family-led family support programs is thin. Not surprisingly, only the three federally funded projects employed a control group, two were randomized controlled trials (Hoagwood et al. 2009; Kutash et al. 2006), and one was a quasi-experimental design (Koroloff et al. 1996). All the other programs were based on pre–post evaluations, with no control groups.

### Outcomes

Outcomes examined by the family-led programs were all primarily focused on the caregiver. Caregiver satisfaction was the most commonly measured outcome. In the three experimental studies, caregiver outcomes that focused on caregiver empowerment produced mixed results. Koroloff et al. (1996) found that low-income families who had the support of a family associate to facilitate child mental health service use showed increased family and service empowerment and caregiver report of family well-being. Hoagwood et al. (2009) and Kutash et al. (2006) did not find differences in family empowerment, though pre–post differences on this measure was reported among families who were less empowered to begin with (Kutash et al. 2006). Taken together, these findings suggest that family support may be particularly beneficial for families who are less empowered, such as low-income families.

Outcomes related to service participation or access were also mixed. Koroloff et al. (1996) reported that caregivers who received support from family associates were more likely to initiate mental health services for their children but did not fare better than controls on treatment attendance or retention. Kutash et al. (2006) and Hoagwood et al. (2009) did not find an impact on caregiver access to or participation in services.

Among the same three studies that examined the impact of supporting caregivers on child outcomes, only one program, which specifically focused on child academic performance among seriously emotionally disturbed youth (Kutash et al. 2006), found positive changes in child academic achievement. The influence of caregiver support in these pilot demonstration studies on child behavioral and emotional outcomes were not discernable (Hoagwood et al. 2009; Koroloff et al. 1996; Kutash et al. 2006).

### Clinician-Led Programs

Two-thirds ( $n = 33$ , 66%) of the 50 programs included in this review were led by one or more clinicians (see Table 5 of Appendix). Unlike the family-led programs, none were connected to family-run organizations; instead, all of these programs were developed and studied by academic researchers affiliated with major universities in United States, Canada, England, and Australia. In addition, many received federal grants to support these programs and examine their impact (e.g., Cohen and Mannarino 2008; Deblinger et al. 2001; Fristad 2006; Kazdin and Whitley 2003; Prinz and Miller 1994; Treacy et al. 2005; Webster-Stratton 1994).

### Provider Characteristics

Consistent with their strong academic affiliation, most of the clinician-led programs were delivered by master's or doctoral-level clinicians, and predominantly, psychologists (e.g., CBT+FAM, Barrett et al. 1996; CMB+PAM; Cobham et al. 1998; Project Team, Feinfeld and Baker 2004; Individual and Multi-Family Psychoeducation, Fristad 2006; FCBT & FESA, Kendall et al. 2008; Parent Training+PTPS, Piffner et al. 1990; EFT, Prinz and Miller 1994; PSM, Treacy et al. 2005). Even among this set of providers with advanced educational qualifications, clinicians were extensively trained and supervised. For example, clinicians who delivered FCBT (Family Cognitive Behavioral Therapy) and FESA (Family-based Support, Education, and Attention), the comparison treatment to FCBT, took part in 2–3-h workshops consisting of didactic instruction, role-plays, and demonstrations. Additionally, therapists were supervised for 2 h weekly throughout the duration of the project (Kendall et al. 2008). In a similar vein, clinicians who delivered PMT+PPS studied manuals and participated in ongoing supervision in which videotaped sessions were reviewed (Kazdin 1987, 1999; Kazdin and Whitley 2003), while therapists who delivered the Community-based Aggression Management Program were required to participate in a 1½ day training, review the manual, videotape sessions, and weekly supervision (Lipman et al. 2006).

## Program Characteristics

### Settings

Of the clinician-led programs, eleven (33%) specifically identified the site of the program as a clinic or center nested within an academic setting. Less commonly, programs were offered at community-based clinics ( $n = 5$ , 15%) (Cohen et al. 2004; Cohen and Mannarino 2008; Lipman et al. 2006; McKay et al. 1998; Melvin et al. 2006; Valderhaug et al. 2007), or very infrequently, an inpatient psychiatric unit or a clinic within a children's hospital ( $n = 3$ , 9%) (Geist et al. 2000; McCleary and Ridley 1999; Sheridan and Moore 1991), the caregiver's home ( $n = 2$ , 6%) (Davis and Spurr 1998; Sonuga-Barke et al. 2001), a Child Abuse Diagnostic and Treatment Center ( $n = 2$ ) (Deblinger et al. 2001; both treatment arms), or the child's school ( $n = 1$ ) (Pollio et al. 2005). Notably, some programs were delivered across multiple settings, such as Fristad (2006) Individual and Multi-Family Psychoeducation, which was initially tested in a medical center and is currently being tested in the community (M. Fristad, personal communication, February 2, 2009).

### Format

Among the behavior parent training (BPT) programs in particular, the identified child typically did not directly receive services from the clinician (e.g., EFT, Prinz and Miller 1994; PT, Sonuga-Barke et al. 2001), or was seen intermittently (PT+PTPS, Piffner et al. 1990). The cognitive behaviorally based (CBT) programs often had a separate curriculum for the child, following or adapting the existing manualized treatments for childhood anxiety disorders (e.g., Barrett et al. 1996; Cobham et al. 1998; Kendall et al. 2008; Shortt et al. 2001). Aside from BPT programs that focused on the parents, interventions were typically conducted either in concurrent, separate sessions (e.g., Chacko et al. 2008, 2009; Fristad 2006; Pfeffer et al. 2002), conjointly (e.g., Kendall et al. 2008), or a combination of conjoined and separate sessions (e.g., Cohen et al. 2004; Cohen and Mannarino 2008; Deblinger et al. 2001; Geist et al. 2000). Parent support interventions were often offered in group formats for BPT/PT programs; while CBT groups were less common (e.g., Deblinger et al. 2001; Fristad 2006).

### Program Orientation

Over half of the clinician-led programs ( $n = 18$ , 55%) either focused on behavior parent training strategies (e.g., praise, positive reinforcement, planned ignoring, time out) or were enhancements of core BPT programs (e.g., Maternal Stress Coping Group, Chronis et al. 2006; Enhanced Triple

P, Sanders et al. 2000; Incredible years, Webster-Stratton 1994). The theoretical premise behind BPT-based programs is that negative interactions between the parent and child (e.g., reinforcing aggressive behavior by attention, compliance, or acquiescence) maintain problematic behaviors. Instructing caregivers to attend and reinforce prosocial and adaptive behaviors is the primary goal (Kazdin 1987; Kazdin and Whitley 2003). For example, the Enhanced Family Treatment program (Prinz and Miller 1994), and PMT+PPS (Kazdin and Whitley 2003), two programs for youth exhibiting aggressive and antisocial behaviors and their families, taught caregivers a set of techniques including praise, attention, and the provision of rewards to increase the frequency of positive behaviors, and planned ignoring and time out to withdraw attention in order to extinguish maladaptive behaviors.

While standard behavioral parent training programs have a long history of documented effectiveness largely demonstrated in randomized controlled designs, these approaches have not been as successful for more vulnerable populations (Chacko et al. 2008, 2009; Dadds and McHugh 1992; Mah and Johnston 2008; McKay et al. 1999). Studies to date have identified risk factors associated with poor treatment response, such as sociodemographic and mental health characteristics of families including single parent status, income and education level, parental stress, lack of social support, and logistical and concrete barriers to service use. Accordingly, augmentations or adaptations to existing BPT programs have sought to address some of these parent or family factors that could potentially interfere with the effectiveness of treatment (Chacko et al. 2008, 2009; Chronis et al. 2006; Kazdin and Whitley 2003; Piffner et al. 1990; Prinz and Miller 1994; Reyno and McGrath 2006; Sanders et al. 2000; Sanders and McFarland 2000). Several programs added enhancements to BPT by addressing personal parent issues such as stress (e.g., Kazdin and Whitley 2003; Prinz and Miller 1994), social supports (e.g., Chacko et al. 2008, 2009); marital discord, anger management, communications skills, and problem-solving skills (e.g., Chacko et al. 2008, 2009; Webster-Stratton 1994).

Most programs that augmented BPT interspersed the additional component throughout the program (e.g., PMT+PPS offered problem-solving sessions between every two to four sessions of BPT), although a few such as the Maternal Stress Coping Group (Chronis et al. 2006) and Enhanced Triple P (Sanders et al. 2000) offered the enhancement sequentially after caregivers completed BPT. Specifically, caregivers were eligible for the Maternal Stress Coping Group only after participating in an intensive Summer Treatment Program (STP) that taught BPT skills to caregivers of youth with ADHD, while parents were offered the option to participate in the Enhanced form of Triple P after completing one of several BPT-based programs.

Similarly, many of the CBT programs for parents were based on the assumption that parental issues, such as anxiety, can fuel children's anxiety. Consequently, these programs focused on assisting caregivers in learning to identify and modify their anxiety and model these skills for their child (Cobham et al. 1998; Deblinger et al. 2001). As an example, CBT+PAM (Cobham et al. 1998) instructed the caregiver to apply cognitive restructuring (identifying and altering faulty cognitions) and relaxation skills to decrease their own symptoms of anxiety.

Of the remaining programs that did not employ BPT or CBT or were an enhancement of a BPT program, all offered educational support (e.g., Supportive Group for Caregivers, Deblinger et al. 2001; Fristad et al. 2005; Geist et al. 2000; FESA, Kendall et al. 2008; Pfeffer et al. 2002; Rhodes et al. 2008; Sheridan and Moore 1991), and the focus of the educational component was not on alleviating the child's symptoms, but on the child's and/or parents' understanding of the disorder and its impact on the family. The objectives of the Individual Family Psychoeducation program and Multiple Family Psychoeducation Groups for families of youth with mood disorders, for instance, were to provide the parents with information in order to understand their child's mood disorders and decrease their anxiety, make an informed choice regarding treatment, and enable both the youth and their family to cope with the disorder (Fristad 2006).

Further, five of these programs (Supportive Group for Caregivers, Deblinger et al. 2001; Geist et al. 2000; FESA, Kendall et al. 2008; Pfeffer et al. 2002; Sheridan and Moore 1991) including two parent support programs used as comparison arms for CBT (Supportive Group for Caregivers, Deblinger et al. 2001; FESA, Kendall et al. 2008) focus on providing emotional support. All of these programs were offered in a group format to decrease isolation, express, and find ways to cope with their feelings, and/or draw support from other group members on topics such as sexual abuse, parental suicide, anorexia, and schizophrenia.

Finally, McKay et al. (1999) Evidence-Based Engagement Strategies is a unique program, different from the others in this category, because it focused on assisting providers to identify and problem-solve with parents obstacles that might interfere with intake appointments or initial service participation. This pretreatment intervention to increase service engagement utilized problem-solving skills and motivational interviewing strategies to directly address issues that might interfere with treatment service initiation.

#### Client Characteristics

Unlike family-led programs that are available to parents irrespective of the child's diagnosis or treatment status,

most of the clinician-led programs were only available to parents if the child was receiving services from the program or was the identified patient (e.g., CBT+PAM, Cobham et al. 1998; Cognitive Behavioral Group Therapy, Deblinger et al. 2001; PMT+PPS, Kazdin and Whitley 2003; EFT, Prinz and Miller 1994; Enhanced Triple P, Sanders et al. 2000). Also, many of the clinician-led programs had clearly specified criteria for participation, which were most often associated with the child's diagnosis, age, or treatment status.

#### Types of Support

The majority of clinician-led programs offered instructional or informational support to caregivers, with instructional support being the most frequently provided type of support ( $n = 26, 79\%$ ). Given that the majority of programs were BPT- or CBT-based, the primary focus of instructional support included building parenting skills (e.g., Barrett et al. 1996; Deblinger et al. 2001; Kazdin and Whitley 2003; McCleary and Ridley 1999; Pavuluri et al. 2004; Prinz and Miller 1994; Pffiffner et al. 1990), and/or addressing the caregiver's own symptoms of anxiety or distress through cognitive behavioral techniques such as cognitive restructuring and relaxation strategies (e.g., Barrett et al. 2004; Chronis et al. 2006; Cobham et al. 1998; Cohen et al. 2004; Cohen and Mannarino 2008; Kendall et al. 2008; Melvin et al. 2006; Sanders and McFarland 2000; Treacy et al. 2005). Additional instructional support skills focused on enhancing the caregiver's problem-solving, communication, and/or coping skills (e.g., Barrett et al. 1996; Chacko et al. 2008, 2009; Deblinger et al. 2001; Fristad et al. 2003; Geist et al. 2000; Pollio et al. 2005; Sanders et al. 2000; Treacy et al. 2005). For example, CBT+FAM aimed to develop problem-solving and communication skills in order to equip caregivers to handle child and family difficulties and decrease conflict and maintain treatment gains after the program ended (Barrett et al. 1996).

Moreover, the Strategies to Enhance Positive Parenting Program for youth with ADHD and their caregivers offered coping and problem solving skills in a group format so that caregivers could build these skills and learn from each other (Chacko et al. 2008, 2009). Programs such as the Enhanced Family Treatment program (Prinz and Miller 1994), PMT+PPS (Kazdin and Whitley 2003), Parent Training+Parent Social Problem-Solving Skills (PTPS) program (Pffiffner et al. 1990), and Advance Parent Training (Webster-Stratton 1994) offered problem-solving skills as an adjunctive component to standard BPT to identify and resolve parental factors that may impede the child's progress or engagement in treatment. Notably, those programs that aimed to treat oppositional, aggressive, and disruptive behaviors (e.g., Feinfeld and Baker 2004; Kazdin and

Whitley 2003; EFT, Prinz and Miller 1994) tended not to focus on information about the child's disorder but emphasized parent skill building. One exception is the Community-based Aggression Management Program, an aggression management group for youth and their caregivers, which provided information about appropriate forms of anger (Lipman et al. 2006).

Educational/informational support was the next most common component of parent support among the clinician-led programs ( $n = 22$ , 67%): Overwhelmingly, the main type of informational support was clinician-delivered education concerning the child's disorder, including their etiology, symptoms, course, and prognosis, treatment options, and the impact of the child's disorder on the caregiver and the family. One notable exception is the Maudsley Model of Family-Based Treatment, an outpatient family-based treatment for anorexia nervosa for adolescent girls, which offered information from a veteran parent consultant during a treatment session guided by the therapist. This veteran parent consultant shared their story about how they managed to facilitate their children's recovery (Rhodes et al. 2008).

Almost one-third of programs ( $n = 10$ , 30%) explicitly identified emotional support as a key component of the caregiver component, either on an individual basis through discussion of the caregiver's issues and difficulties with an empathic clinician (Davis and Spurr 1998; FESA, Kendall et al. 2008; Prinz and Miller 1994; Valderhaug et al. 2007) or in a group format, in which the group created an opportunity to share and process caregivers' feelings and experiences in order to decrease isolation and enhance social support (Chacko et al. 2008, 2009; Deblinger et al. 2001; Geist et al. 2000; Pfeffer et al. 2002; Sheridan and Moore 1991; Treacy et al. 2005).

Unlike the family-led programs, advocacy was not a main focus of parent support; only seven programs (21%) (Cohen and Mannarino 2008; Deblinger et al. 2001; Fristad et al. 2003; McCleary and Ridley 1999; Pavuluri et al. 2004; Pollio et al. 2005; Treacy et al. 2005) provided advocacy through the provision of information about special education services, individualized educational programs (IEP), and services systems (e.g., juvenile justice, mental health). TF-CBT (Cohen et al. 2004; Cohen and Mannarino 2008), a program for youth who were sexually abused and their caregivers, was unique in its provision of information about the criminal justice system and how to obtain victim's assistance (Cohen et al. 2004; Cohen and Mannarino 2008): Likewise, the Cognitive Behavioral Group Therapy program, which was also for caregivers of youth who were sexually abused, brought in a speaker from the Office of Victim Witness Advocacy for two of the 11 group sessions (Deblinger et al. 2001). Although most of the advocacy support was informational, one program

(Pavuluri et al. 2004) also provided direct advocacy by attending IEP meetings.

Finally, instrumental support was not identified as a component in any of these clinician-led programs; however, several noted that they offered on-site childcare and/or monetary incentives in order for caregivers to attend the program (e.g., Kazdin and Whitley 2003; Treacy et al. 2005).

#### Evaluation Design

The 31 studies involving 33 clinician-led programs (both Deblinger et al. 2001; Kendall et al. 2008, compared two treatments in one study) were unlike the family-led programs, as over three-fourths ( $n = 26$ , 84%) employed an experimental design, and specifically, random assignment to other treatment groups or wait-list control. Only one study was based on a quasi-experimental design, and the remaining programs utilized pre-post ( $n = 4$ , 13%) or post designs ( $n = 1$ ).

#### *Studies Designed to Test the Parent Support Component Alone*

Seven studies ( $n = 23%$ ) evaluated the impact of caregiver support on its own. The programs were not an augmentation of an existing therapy or an integrated component of the child's treatment (Davis and Spurr 1998; McCleary and Ridley 1999; McKay et al. 1999; Pollio et al. 2005; Sheridan and Moore 1991; Sonuga-Barke et al. 2001; Treacy et al. 2005). Thus, much like the family-led programs, the child was not a direct focus of the intervention (Davis and Spurr 1998; McKay et al. 1999; Treacy et al. 2005), the child was receiving separate services that were not directly connected to the program (e.g., Pollio et al. 2005; McCleary and Ridley 1999; Sheridan and Moore 1991), or the caregiver was the primary focus of the intervention that aimed to improve the child's mental health (Sonuga-Barke et al. 2001).

One of these studies in particular was a pretreatment program that aimed to link caregivers to services for the child (McKay et al. 1999); two other programs (Davis and Spurr 1998; Treacy et al. 2005), while providing some parenting skills, were primarily focused upon the caregiver's stress and well-being. Thus, this group of studies could provide some evidence for the value of parent support irrespective of the child's treatment.

#### *Studies That Tested the Parent Support Component as an Augmentation to Standard Treatment*

Twelve programs (36%) that were tested contained parent support as a separate but related component that augmented



an existing treatment for the child, such as BPT or CBT (Barrett et al. 1996; Chacko et al. 2008, 2009; Chronis et al. 2006; Cobham et al. 1998; Kazdin and Whitley 2003; FCBT, Kendall et al. 2008; Piffner et al. 1990; Prinz and Miller 1994; Rhodes et al. 2008; Sanders et al. 2000; Sanders and McFarland 2000; Webster-Stratton 1994).

#### *Studies Where the Parent Support Was Integrated into Child Treatment*

The remaining 14 programs (42%) that were included in our review were parent support programs that were an integrated part of the child's treatment (Barrett et al. 2004; Cohen and Mannarino 2008; [Cognitive Behavioral Group Therapy, Supportive Group for Caregivers] Deblinger et al. 2001; Feinfeld and Baker 2004; Fristad 2006; Geist et al. 2000; FESA, Kendall et al. 2008; Lipman et al. 2006; Melvin et al. 2006; Pavuluri et al. 2004; Pfeffer et al. 2002; Shortt et al. 2001; Valderhaug et al. 2007). The studies of these programs were not designed to test the impact of the parent support component by itself; thus, no clear conclusions about the impact of these family support programs separate from the child's treatment can be drawn.

#### Outcomes

Almost universally, the main outcomes examined in 24 of the 31 studies (77%) of clinician-led programs focused upon reduction in child's symptoms or improvement in functioning. Overall, results were favorable (e.g., Barrett et al. 2004; Cobham et al. 1998; Cohen and Mannarino 2008; Deblinger et al. 2001; Feinfeld and Baker 2004; Kazdin and Whitley 2003; Sanders et al. 2000; Sanders and McFarland 2000; Shortt et al. 2001). The remaining seven studies did not focus on child outcomes (Chronis et al. 2006; Feinfeld and Baker 2004; McKay et al. 1999; Pollio et al. 2005; Sheridan and Moore 1991; Treacy et al. 2005), or child outcomes were not the primary area of investigation (Prinz and Miller 1994).

Over two-thirds ( $n = 21$ , 64%) of studies focused on caregiver outcomes (not including treatment satisfaction) either solely or in addition to child or other factors. Among these outcomes, over half focused on parental mental health and/or stress ( $n = 15$ ), although for several studies, improvements in caregiver health and well-being were modest or unchanged (e.g., Barrett et al. 2004; Pfeffer et al. 2002).

Additional caregiver outcomes included factors that might influence the child's receipt of the program, such as parental satisfaction with the intervention, which was examined by almost one-half of the studies ( $n = 14$ , 45%) and was in general high (e.g., Supportive Group for Caregivers, Deblinger et al. 2001; Fristad et al. 2003; Pavuluri et al. 2004; Shortt et al. 2001), and the influence

of the parental component upon the child's treatment process (Pavuluri et al. 2004).

Other caregiver outcomes examined aspects directly related to the support that was provided, such as parenting skills (e.g., Chacko et al. 2008, 2009; McCleary and Ridley 1999; Prinz and Miller 1994; Sanders et al. 2000), knowledge about the child's illness (e.g., Fristad 2006; Sheridan and Moore 1991), and perceived social support (Sanders and McFarland 2000; Treacy et al. 2005), with results being favorable in general.

Several programs also measured service-related outcomes such as treatment attendance and premature termination (Chacko et al. 2008, 2009; Kazdin and Whitley 2003; McKay et al. 1999; Prinz and Miller 1994; Sanders and McFarland 2000), with mixed results. For example, two studies found significantly higher rates of attendance as a result of the intervention (Chacko et al. 2008, 2009; Prinz and Miller 1994), and two found no difference (Kazdin and Whitley 2003; Sanders and McFarland 2000) despite that participants in the former study reported fewer caregiver-reported barriers. McKay et al. (1999) found that the first engagement strategy employed at the time of initial contact was associated with significant increases in initial attendance, but engagement strategies at both the initial contact and follow-up appointment were necessary to impact ongoing use of services. Notably, one study found parent support to reduce demands on the health care system, as evidenced by reduced caregiver contacts with health visitors and general practitioners (Davis and Spurr 1998).

Several programs also measured the impact of the intervention upon family-level factors such as family dysfunction and conflict, with mixed results. Specifically, families in the Family Group Psychoeducation program showed an increase in family dysfunction from baseline (although it was still within normal range), Kazdin and Whitley (2003) and Melvin et al. (2006) saw no change in family functioning or the parent/child relationship, Lipman et al. (2006), found non-significant improvements in the quality of the parent/child relationship in both the treatment and control group from pre to posttest, although greater gains were obtained in the treatment group; and McCleary and Ridley (1999) found a significant decrease in the amount and intensity of conflict between the parent and child from pre to posttest.

#### *Studies That Tested the Parent Support Component Alone*

Of the seven studies (of the same number of programs) that examined the value of caregiver support as a distinct service or intervention, all but one (e.g., McKay et al. 1999) assessed caregiver outcomes. The impact of caregiver support tended to fall within three areas: (1) satisfaction (2) efficacy, and (3) mental health and stress. Satisfaction with



the parent support tended to be high across studies (Davis and Spurr 1998; McCleary and Ridley 1999; Pollio et al. 2005; Sheridan and Moore 1991; Treacy et al. 2005). Results for parent efficacy (i.e., skills and confidence) were mixed. Programs that targeted specific parenting skills found an impact on parenting efficacy (e.g., McCleary and Ridley 1999; Davis and Spurr 1998; Sonuga-Barke et al. 2001). In addition, three programs also impacted parental mental well-being, significantly reducing parental stress (Davis and Spurr 1998; Treacy et al. 2005) and symptoms of anxiety and depression (Davis and Spurr 1998; Sonuga-Barke et al. 2001). Parent support that focused on education and information was found to influence attitudes about managing child illness (Sheridan and Moore 1991).

Additionally, three studies also examined child outcomes with positive findings related to significant decreases in behavioral problems or symptoms (Davis and Spurr 1998; McCleary and Ridley 1999; Sonuga-Barke et al. 2001). Two programs that examined service-related outcomes found positive outcomes related to the caregiver support: specifically, McKay et al. (1999) found a positive effect of caregiver support on engagement in service initiation and continuation, while Davis and Spurr (1998) found that caregiver support reduced the level of contacts by caregivers with the health care system.

#### *Studies That Tested the Parent Support Component as an Augmentation of the Standard Intervention*

Of the twelve studies that tested the impact of the caregiver's supportive component as an augmentation to standard treatment (Barrett et al. 1996; Chacko et al. 2008, 2009; Chronis et al. 2006; Cobham et al. 1998; Kazdin and Whitley 2003; FCBT, Kendall et al. 2008; Piffner et al. 1990; Prinz and Miller 1994; Rhodes et al. 2008; Sanders and McFarland 2000; Sanders et al. 2000; Webster-Stratton 1994), seven examined the effectiveness of the augmented program upon caregiver outcomes beyond parenting (competence, skills, self-efficacy) (Chacko et al. 2008, 2009; Chronis et al. 2006; Kazdin and Whitley 2003; Kendall et al. 2008; Rhodes et al. 2008; Sanders and McFarland 2000; Webster-Stratton 1994). Findings from these studies, although mixed, suggest that the caregiver component was a valuable augmentation to standard treatment for the child, caregiver, and family.

#### *Interventions for Youth with Disruptive Disorders*

Because the majority of the studies among the clinician-led programs focused on youth with disruptive disorders and anxiety disorders, we also examined these programs by youth disorder targeted. Most studies of interventions that targeted caregivers of youth with disruptive disorders found

that the enhanced component was associated with greater outcomes for youth and their caregivers over standard BPT (e.g., Chacko et al. 2008, 2009; Kazdin and Whitley 2003; Piffner et al. 1990; Sanders et al. 2000; Sanders and McFarland 2000; Webster-Stratton 1994). Specifically, enhanced PMT+PPS was associated with decreased parental depression and stress, and fewer self-reported barriers to care in comparison with PMT alone (although there was no difference between groups concerning treatment attendance) (Kazdin and Whitley 2003). Youth in standard PMT and enhanced PMT+PPS improved.

Likewise, in the Chacko et al. (2008, 2009) study, which focused on providing intensive group supports for single mothers, youth of caregivers in both the standard BPT and the parent support enhancement (STEPP) showed improvements in symptoms of ODD when compared to a waitlist control, and greater improvements were found for STEPP compared to BPT. With respect to caregiver outcomes, STEPP resulted in improvements in parent and family impairment and stress when compared to the BPT condition. Furthermore, families in the STEPP condition were significantly more likely to attend treatment and comply with homework when compared to the BPT condition. Unfortunately, treatment gains were not maintained in either the STEPP or BPT conditions at 3-month follow-up. (STEPP, Chacko et al. 2008, 2009), suggesting that ongoing parent support may be critical for this vulnerable population.

Webster-Stratton (1994) found that the Advance Parent training program resulted in additional improvements for both the parent and the child compared to those parents who only received the Basic Parent Training. Specifically, parents in the Advance Parent Training demonstrated better communication and problem-solving skills, as well as better consumer satisfaction. Furthermore, their children demonstrated greater knowledge of prosocial solutions.

Similarly, results of a comparison between Enhanced Triple P, two programs that were primarily BPT-based but differ in format (Standard and Self-directed), and a wait-list control group indicated similar gains among preschool-aged youth and their caregivers (e.g., reductions in behavioral problems, improvements in parenting skills and competence) in the Enhanced and Standard groups comparative to the Self-directed and WLC groups at posttest, although youth who were in the Enhanced group evidenced the greatest decrease in behavioral problems. Further, although all three experimental group conditions showed similar treatment gains at 1-year follow-up based upon observation, the Enhanced and Triple P groups reported greater improvements via parent self-report. Finally, caregivers in the Enhanced and Standard Triple P groups rated the program more favorably than caregivers in the other two groups (Sanders et al. 2000).

Finally, Prinz and Miller (1994), who focused on treatment adherence, found that an enhancement to standard family therapy (BPT) focusing on the caregivers' issues had an impact on treatment adherence. Fewer families in the enhanced condition dropped out of treatment. This is significant because families who stayed in treatment (regardless of being in the basic Standard Family Therapy or the Enhanced Family Therapy) evidenced a significant decrease in child behavioral problems and greater improvements in the caregiver's parenting skills in comparison with families who dropped out.

Overall, the aforementioned studies demonstrate the added value of parent support to standard BPT treatments for youth with disruptive behaviors. While support focused on caregivers' personal skills and issues do not always produce superior child outcomes compared to standard BPT, such parent support demonstrated important benefits for parent mental health and well-being, improved family functioning, increased treatment engagement, and reduced barriers to care. Such family-level outcomes are critical in difficult to engage populations, as these factors help increase the likelihood that the most vulnerable populations stay in services and benefit from treatment.

#### *Interventions for Youth with Anxiety Disorders*

Added value was found for parent support in treatments for youth with anxiety. Results of Cobham and colleagues' (1998) study, which compared CBT with CBT+PAM, stratified youth into groups based upon their caregiver's mental health status, found the greatest benefit of parent support on child outcomes (being diagnosis-free) was for youth with a caregiver who suffered from an anxiety disorder (77% in CBT+PAM were diagnosis-free in comparison with 39% of youth who received CBT alone). Similarly, significantly more youth in CBT and CBT+FAM were diagnosis-free (69.8%) in comparison with WLC (26%) at posttest, and more youth maintained their treatment gains at 1-year follow-up in the enhanced condition (95.6% were diagnosis-free), in comparison with 70.3% of the CBT group (Barrett et al. 1996).

In another study focused on anxiety, Kendall and colleagues (2008) found child improvements across all treatment conditions regardless of whether the parent was involved in treatment. Parent support (the FCBT condition) focused on targeting parent's own anxiety symptoms had added value on child symptoms only among those children where both parents evidenced an anxiety disorder (Kendall et al. 2008).

#### *Interventions for Anorexia*

Rhodes and colleagues (2008) found that a single parent consultation session added to the Maudsley Model of

Family-Based Treatment, did not result in improvements in clinical outcomes for children with anorexia nervosa (though an immediate increase in weight restoration was noted) (Rhodes et al. 2008). Parent efficacy was not found to mediate ideal weight restoration in the adolescents. However, qualitatively, parents reported that this added component helped parents feel more hopeful and less isolated. The authors felt that a heavier dose of parent support may have yielded positive benefits.

#### *Studies That Included Parent Support as Part of the Child's Intervention*

Finally, while the specific impact of the caregiver component cannot be discerned from studies of 14 programs in which the caregiver component was integrated into the child's treatment (Barrett et al. 2004; Cohen and Mannarino 2008; Cognitive Behavioral Group Therapy, Supportive Group for Caregivers, Deblinger et al. 2001; Feinfeld and Baker 2004; Fristad 2006; Geist et al. 2000; Lipman et al. 2006; Melvin et al. 2006; Pavuluri et al. 2004; Pfeffer et al. 2002; Shortt et al. 2001; Valderhaug et al. 2007), four did not assess caregiver outcomes despite the inclusion of caregivers as an integral part of the child's treatment (Cohen and Mannarino 2008; Geist et al. 2000; Melvin et al. 2006; Valderhaug et al. 2007). However, two of these studies examined family functioning (Geist et al. 2000; Melvin et al. 2006), although they found no significant impact.

Of those that did assess caregiver outcomes, six studies focused on caregiver satisfaction (Barrett et al. 2004; Deblinger et al. 2001; Feinfeld and Baker 2004; Fristad 2006; Pavuluri et al. 2004; Shortt et al. 2001). The others found positive caregiver outcomes related to the parent's mental health (CBT and supportive group, Deblinger et al. 2001; Pfeffer et al. 2002), parenting stress (Feinfeld and Baker 2004; Lipman et al. 2006), increased knowledge (Fristad 2006), parenting practices, efficacy, and attitudes toward their child (Feinfeld and Baker 2004; Fristad 2006), intrusive thoughts, and emotional reactions to their child's abuse (CBT and supportive group, Deblinger et al. 2001).

All of these programs, in contrast, assessed child outcomes and many revealed highly favorable results, including significantly decreased symptoms and/or severity of illness (Barrett et al. 2004; Cohen and Mannarino 2008; Feinfeld and Baker 2004; Pavuluri et al. 2004; Pfeffer et al. 2002; Shortt et al. 2001; Valderhaug et al. 2007). Additional three studies also found benefit for the treatment, although this was not significantly different than the alternative treatment condition where support of parents' own well-being was not a component (e.g., Geist et al. 2000; Lipman et al. 2006; Melvin et al. 2006). FESA, the parent support condition (no cognitive skills provided to

parents) that was the active control to FCBT, yielded the weakest impact on the child. The impact of the parent component on caregiver outcomes was modest, with small improvements in parental anxiety (and specifically, the mother's anxiety) (Kendall et al. 2008).

Only four of these studies examined the impact on service-related outcomes. Fristad and colleagues (2004) and Lipman et al. (2006) reported that families when supported were more likely to obtain or use appropriate services. Pavuluri and colleagues (2004) found a positive effect on treatment adherence among families of bipolar youth. A hospital based family group psychoeducation program for adolescents with anorexia and their families was found to be equivalent to standard family therapy that was typically offered (Geist et al. 2000).

Notably, one study examined the impact of family support groups (with adjunctive child support groups) as typified by those generally found in community (Deblinger et al. 2001). This support group is notable because the authors manualized this supportive intervention based on information in the clinical and empirical literature on self-help groups as well as in consultation with community leaders of support groups. Using this supportive group counseling as a comparison condition for the active cognitive behavioral group treatment for non-offending mothers of children who have experience sexual abuse (Deblinger et al. 2001), the authors found that both types of interventions benefited participants, with the active CBT treatment resulting in greater benefits regarding child knowledge of body safety (but not PTSD symptoms) and greater reductions in parental level of distress and intrusive thoughts posttreatment. At 3 months follow-up, overall clinical improvements were sustained by participants in both groups, with parents in the supportive group showing additional decreases in negative parental reactions. Furthermore, parents in the support group condition were more likely to maintain contact with other parents and to obtain additional therapy for their child at follow-up, suggesting the potential benefits of typical community-based support groups for parent engagement.

Overall, programs that included caregiver support as part of the child treatment yielded positive benefits for the caregiver, the child, and service-related outcomes.

### Team-Led Programs

Out of the 50 programs that were included in this review, six (12%) were led by a clinician and family member team (see Table 6 of Appendix). All six programs were developed primarily by researchers and/or clinical professionals, who collaborated with (e.g., Ireys et al. 2002) or engaged family members (e.g., Dadds and McHugh 1992) as

co-leaders or facilitators of the parent support component. These programs were all funded through foundation and/or federal grants as interventions for children with serious emotional and behavioral disorders or psychiatric diagnoses.

### Provider Characteristics

Professionals who led these programs were primarily psychology or social work clinicians who partnered with family members. With the exception of the CMT+AST program (Dadds and McHugh 1992) that utilized allies identified by parents in treatment, the co-facilitators of these programs were typically veteran parents who have had experience navigating complex service systems for their own children who had mental illness. In the CMT-AST program, the allies who provided support were trained by therapists to perform specific tasks for the families (e.g., listen, discuss problems, encourage, provide babysitting, etc.). In other programs (e.g., Ireys et al. 2002 and Ruffolo et al. 2006), the collaboration between health professionals and parents was emphasized in the planning, implementation, and evaluation of the program.

Training requirements were not articulated for all programs. Where they were specified, regular meetings among the co-facilitators were considered critical in delineating roles and responsibilities of the partners. For example, Ruffolo et al. (2006) noted that fostering partnerships that valued the unique contributions of each facilitator required additional skills and training. Typical concerns of parents who partnered with mental health professionals related to concerns about parent blaming for child disorders; professional concerns related to boundary setting (e.g., sharing life experiences). Ireys et al. (2002) described the collaborative nature of such teams as being based on "different responsibilities, equal voice, and a common purpose." (p. 158). Bickman et al. (1998) noted that the parent advocate as a team member served as a credible source of information, as well as an important role model of parent-professional collaboration.

Where specified (e.g., in Dadds and McHugh 1992, Ireys et al. 2002, Ruffolo et al. 2005), the roles of the provider team appear to play to the strength of each member, with clinicians often primarily responsible for the informational and instructional components and the parent partner being primarily responsible for the emotional component or for facilitating linkages to information and resources. In programs that emphasized the collaborative nature of the programs providers, a key aspect of the collaborative teams was to serve as a model for participants on parent-professional collaboration and partnerships (e.g., Bickman et al. 1998; Ruffolo et al. 2005, 2006).

## Program Characteristics

The programs represented in Table 6 of Appendix range from brief workshops or topical groups (e.g., 11 h curriculum for the Vanderbilt model, Bickman et al. 1998; Lopez et al. 2005) to more individualized programs such as the Parent Connections (e.g., 15 months; Ireys et al. 2002). These programs were predominantly delivered in group-based formats. Two of these programs contained individual, one-on-one components, in which the parent partner of the team was responsible for personally establishing and providing emotional and instrumental supports to caregivers (Dadds and McHugh 1992; Ireys et al. 2002).

Two of these programs (Bickman et al. 1998; Ireys et al. 2002) can be considered independent parent support programs, in that they were not integrally tied to the child's treatment, even though the youth may be in treatment elsewhere. In the other four programs (Dadds and McHugh 1992; Lopez et al. 2005; McKay et al. 1999; Ruffolo et al. 2005), the parent support component was an adjunctive piece of a larger treatment program or service. For example, Ruffolo's S.E.E. group (2005, 2006) is an augmentation to intensive case management, targeted at providing key caregiver supports for families of children with serious emotional and behavioral problems with histories of out-of-home placements or inpatient hospitalizations. Similarly, Dadds and McHugh's caregiver support is an augmentation to a parenting program, targeted at socially disadvantaged parents of youth with conduct problems. In McKay's multifamily group (McKay et al. 1999), the child and siblings were seen concurrently as well as together with the parents for part of each session. Within CMAP (Lopez et al. 2005), the parent support component is only one piece of a larger array of services (e.g., medication, social skills training, etc.) for youth with ADHD or depression.

## Client Characteristics

Four of the six programs primarily targeted caregivers. Two programs included youth as part of the program, either in concurrent sessions or for some part of the treatment sessions (Lopez et al. 2005; McKay et al. 1999). These programs typically focused on specific populations, such as disadvantaged caregivers of youth with conduct problems (Dadds and McHugh 1992; McKay et al. 1999), and caregivers of youths with serious emotional and behavior problems who utilize intensive services (e.g., Ireys et al. 2002; Ruffolo et al. 2005).

## Types of Support

Emotional support was unanimously identified as a key component of these team-led programs. When provided in

group format, emotional support typically included the facilitation of shared experiences, insights, and peer support. In three programs (Dadds and McHugh 1992; Ireys et al. 2002; Ruffolo et al. 2005), parent partners also provided individual emotional support through emphatic understanding and affirmational support to encourage parent self-efficacy.

Instructional, informational, and advocacy were the next most commonly provided types of support, being present in five out of six programs. Instructional support typically included skill building around child management strategies, communication, problem-solving, and stress management. Informational support typically included education about the nature of child mental illness, the mental health care system or treatment options, or information about resources. McKay's MFG (1999) also provided education about core concepts related to family functioning (e.g., rules, roles, responsibilities). Advocacy support was primarily limited to the provision of information about parent rights or entitlements; coaching of negotiation skills was more limited (Ireys et al. 2002; McKay et al. 1999). Only one program discussed advocacy in terms of leadership, in the form of "giving back" to others (Ireys et al. 2002).

Instrumental support was only provided by three out of the six programs. Two programs (Ireys et al. 2002, Ruffolo et al. 2005) included onsite childcare and transportation to facilitate parent attendance in groups. The ally support component in Dadds and McHugh's program provided individual instrumental support, including babysitting, transportation, and outings (with or without the child).

## Evaluation Design

Five out of the six programs were tested using experimental designs, with four randomized controlled trials (Bickman et al. 1998; Dadds and McHugh 1992; Ireys et al. 2002; Ruffolo et al. 2005) and one quasi-experimental design (McKay et al. 1999). One study was a pilot feasibility evaluation of an algorithm-based medication project (Lopez et al. 2005). Of these programs, only four were designed to assess the impact of the parent support component. Bickman et al. (1998) and Ireys et al. (2002) were stand-alone parent programs, while Dadds and McHugh's (1992) and Ruffolo et al. (2005) were designed to test the parent component as augmentations to an existing treatment or service.

## Outcomes

Only five studies had published data (Ireys et al. 2002 did not publish final data); one of these five reported on implementation feasibility and not outcomes (Lopez et al. 2005). With respect to caregiver outcomes, only Bickman



et al. (1998) found a positive impact of a caregiver empowerment curriculum on caregiver's sense of services efficacy and knowledge but not actual change in caregiver behavior as it pertains to treatment involvement. In the two studies designed to assess the impact of the caregiver component as an augmentation to an existing treatment (Dadds and McHugh 1992) or service (Ruffolo et al. 2005), caregivers in both groups showed improvements in caregiver outcomes pertaining to caregiver symptoms (e.g., depression), perceived social support, and skills. No added gains were found for the caregivers with the additional caregiver support component in both these studies. However, Dadds and McHugh noted that responders from either group were more likely than non-responders to report high levels of perceived social support from friends. Ruffolo and colleagues (2005) also reported trends favoring the caregiver support group. In the Ruffolo study, qualitative data indicated that parents who had the added caregiver support component reported higher levels of social support, spoke more positively about their children, and felt less isolated and hopeless than their counterparts who received the intensive case management service only.

With respect to child outcomes, the three programs that contained a focus on child management or services (Dadds and McHugh 1992; McKay et al. 1999; Ruffolo et al. 2005) documented a positive impact on child behavior and symptoms. Bickman et al. (1998) program, which focused solely on caregiver empowerment, did not find the intervention to carry over to the child's mental health status.

Both Bickman et al. (1998) and McKay et al. (1999) also examined the impact of the program on service use. McKay et al. (1999) reported that the Multifamily Group intervention, which was targeted at youth with externalizing problems and included both caregiver, youth and siblings in the intervention, was associated with higher rates of mental health service use and lower dropout rates. Bickman et al. (1998), which focused solely on the caregivers' empowerment, found no impact on service use.

Overall, team-led parent support programs showed positive benefits on caregiver-related outcomes related to self-efficacy, symptoms, and perceived social supports and skills. Where the parent support also targeted the child (e.g., through intensive case management, child management training, or child participation in the intervention), positive benefits on child and service-related outcomes were also found. However, these gains could not always be solely attributed to the parent-focused support component.

## Discussion

This review highlights strengths and weaknesses in studies of family support services for parents of youth with mental

health problems. The purpose of the review is to provide conceptual consistency in the definition of this service, to identify typologies and core components of these services, and to assess the status of research on its impact. Three salient models characterized the 50 studies we evaluated; programs led by a clinician, the more traditional model; those led by a family member, a newer model; and those led by a team, the least developed but most recent model. We identified five core components and functions that captured (broadly) the range of services: information sharing (or education), skill development, emotional support, instrumental support (i.e., concrete services), and advocacy support. What is unique about family support services, as opposed to traditional clinical care, is that they are designed to assist parents in clarifying their *own* needs or concerns, reducing their sense of isolation, stress, or self-blame, and empowering them to take an active role in their children's services. We found that the specific functions and activities that constituted each of the five components of family support were quite similar irrespective of who provided the service or where it was provided. Differences were found in emphasis (mixture of components) and even more starkly, in the extent to which the program models had a research base.

We found substantial unevenness in the distribution of models (i.e., family led, clinician led, team led) and in the quality of evaluation data. Two-thirds of programs were led by clinicians; less than a quarter of programs were led by family members and only a handful represented a team-based collaboration between a mental health clinician and a family member. Despite the surge of interest in family-driven service models, few such models have been systematized and developed to the point that evaluations have been conducted. Instead, the bulk of the extant programs are clinician led.

## Key Findings: Program and Participant Characteristics

Almost unanimously, family and team-led programs were not delivered in clinical settings, but rather in community settings. In addition, the majority of the family-led programs were affiliated with national or local family-run organizations. Team-led programs were typically affiliated with universities and developed and delivered by researchers who collaborated with family members through federally funded research efforts. Almost all the clinician-led programs were based in clinical settings, with family support services almost always contingent on the child having a diagnosis, being an identified patient, or in concurrent treatment. In contrast, family and team-led programs were less likely to place constraints on eligibility for family support services, other than having a child with an identified mental health need.



### Key Findings: Types of Parent Support

Overall, similar types of functions or activities (i.e., education/information, emotional, skill building) were represented across the three different provider categories. However, the content and emphasis differed across providers. Thus, clinician-led programs were more likely to focus on skill building related to managing the child's mental health issues, while family-led programs emphasized parent cognitions about their experiences, with the goal of problem-solving child management issues. Clinician-led programs tended to be grounded in behavioral or cognitive behavioral theories, focusing primarily on parenting skill building to manage child symptoms. As noted in a recent review of parent engagement in the behavioral parent training literature, a key limitation of such programs is the exclusion of parent's emotional experiences and social cognitions related to the acceptability of these methods (Mah and Johnston 2008). Within family-led programs, skill building focused more on parents' own needs involving personal coping, stress, and anger management, communication and problem-solving skills, respite and self-care. Clinician-led programs tended to focus on the parents' own needs but in the service of increasing the parents' capacity to support the child's compliance with treatment (e.g., help parent manage own anxiety so parent can support child adherence to exposure exercises). Family-led programs were also more likely to emphasize advocacy supports, and more apt to recognize and discuss system level barriers rather than parent-level barriers to service access.

Advocacy and instrumental support were not a core component of the programs provided by clinicians, whereas they were more often included in family-led programs. In addition, family-led programs were more likely to emphasize emotional support through shared experiences, often with a goal of reducing parental isolation and stigma. Team-led programs appeared to be more comprehensive, with a more balanced emphasis across the various types of support: instructional, informational, advocacy, and emotional. Team-led programs were also more likely to provide instrumental supports than family-led or clinician-led programs.

### Key Findings: Strength of the Data

Programs led by clinician or clinician-family teams have been far more rigorously studied than family-led models. Clinician-led programs are more likely to have used experimental designs, most often with random assignment. Family-led programs have received much less federal research support and therefore have relied on weaker evaluation designs and consequently have a much thinner evidence base. Where evaluation data exist, pre-post

designs with weak or no comparison groups were the predominant design.

In terms of outcomes, family-led programs were more likely to focus on caregiver satisfaction or caregiver perceived support. This is in keeping with the primary focus of family-led programs on targeting caregiver isolation and providing information and education. Outcomes in clinician-led models tended to focus on reduction in child's symptoms, improvement in functioning, and parent mental health or stress reduction. Among clinician-led programs, the findings from the research clearly demonstrated the value of family support services. In general, support services for parents produced superior child outcomes to standard treatment alone. This held whether the program was an independent intervention, an augmentation to standardized child treatment, or an integrated component of child treatment. In addition to augmenting child outcomes, these studies found that parent support conferred important benefits for the parents, improving mental health and well-being, increasing self-efficacy, reducing stress, and improving perceived social supports and skills. It also improved family functioning, increased treatment engagement, and reduced barriers to care.

Families support services are likely to grow in the coming years in part because this type of service is adaptable to the needs of different families, can be individualized, is likely to be cost-effective (although that has not been established), and is a natural gate-way into mental health services for parents who might otherwise shun them. For example, family support is likely to be especially helpful for parents who have experienced blame stemming from the stigma of mental health, parents with different cultural frameworks, or parents who have had negative experiences with the system. In an important new development, this service model is becoming increasingly professionalized as states undertake the process of making it a billable service (NY) and create credentialing programs to certify peer parent providers to deliver this service. Given the growing workforce shortage, the availability of a cadre of highly trained professional family advisors delivering effective family support services may assist the mental health system as it is transformed under new paradigms of health care.

### Future Research

Despite its promise, and relative to other scientific sub-fields in children's mental health, family support has received limited research attention. This is due in part to sloppiness in defining either the parameters of "support," its core functions, the competencies needed to deliver it well, or the outcomes it is intended to effect. The field is awash in different terms, interpretations, and other verbal

debris that obfuscate the potential of this service. Such ambiguity has prevented the development of a clear framework for understanding and systematically studying family support and its impact. This review provides an important first step in operationalizing and characterizing key components of family support.

A clear conceptual framework is needed to guide future studies. This review provides some insight into components of family support and suggests what the contours of a framework might include. In our view, a comprehensive conceptualization could be drawn from theory and research on behavior change (Jaccard et al. 2002), patient activation (Alegria et al. 2008), self-efficacy (Bandura 1977, 1986), and empowerment (Sarason et al. 1990; Santelli et al. 1993). A comprehensive model will need to include attention to mediators of parent and child outcomes (e.g., does emotional support that reduces shame, self-blame, and isolation increase parent activation and self-efficacy that in turn positively impact child and family functioning?) The components of family support fit well within the Unified Theory of Behavior's (UTB) explanatory model (Jaccard et al. 2002). For instance, information and education may shape parents' expectancies, attitudes, and beliefs; emotional support is likely to influence perceptions of social norms; instrumental support and advocacy may address environmental constraints; skill building is likely to influence self-efficacy). Considerable work is needed to outline thoroughly the logic model underpinning family support, as well as the most salient outcome measures for assessing change, but this we believe is a necessary next step.

A range of studies is needed to fill this vacuum. These include mediator and moderator analyses of the impact of family support to identify what factors account for outcomes. It will not be sufficient to document evidence of effective family support interventions if concurrent attention is not paid to the mechanisms by which impact is

attained. There is a need for intervention enhancement studies (e.g., adding family support to other interventions) to assess its comparative effectiveness. To develop a science on individualized care, it will be necessary to launch studies that identify which components are most helpful to which types of parents or at what particular junctures in their personal journey.

The development of the evidence base in children's mental health has been largely driven by researchers who have historically focused on improving child outcomes, assessed in terms of psychiatric symptoms (e.g., CBCL scales, diagnoses or items from the DISC) or generalized functioning (e.g., CGAS). Even among those treatment studies that provide caregiver support, caregiver outcomes are often focused on parent pathology (e.g., depression/anxiety/psychiatric symptomatology), and more relevant caregiver measures (e.g., caregiver strain, parental stress) are often not measured. Asynchrony exists. Likewise, the limited evaluations that currently characterize most family-led services have failed to yield scientifically generalizable knowledge. To advance the science in this area and keep pace with its rapid emergence as a promising adjunctive service, new paradigms of scientific collaborations involving researchers and family advocates are essential.

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## Appendix

See Tables 4, 5 and 6.

**Table 4** Clinician led

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
<p>1. Individual or Group Cognitive Behavioral Family Therapy (CBFT) <i>Source:</i> Barrett et al. (2004)</p>	<p>A CBT-based program “Freedom from Obsessions and Compulsions Using Cognitive Behavioral Strategies” offered at a university-based clinic in Australia for childhood obsessive–compulsive disorder. Treatment was 14 weeks in length. Two booster sessions one and 3 months posttreatment were also included</p> <p>Total treatment time was 1.5 h weekly; the child was seen individually or in group-based CBT for 50 min, the parent received skills training for 30 min, and the remaining 10 min was for review. The program was open to siblings as well.</p>	<p><i>Informational:</i> Psychoeducation about OCD and anxiety, the impact of OCD upon siblings; and information about the child’s treatment (exposure and response prevention)</p> <p><i>Instructional:</i> Parent anxiety management (cognitive skills); problem-solving skills; parent management of child anxiety and behavioral difficulties; strategies to decrease the child’s OCD and support the treatment in the home.</p>	<p><i>RCT Sample:</i> 77 youth between 7 and 17 years of age randomized to individual CBFT, group CBFT, or waitlist control (WLC) Pre/post/3 and 6 months follow-up.</p>	<p><i>Child:</i> Youth in both individual and group CBFT evidenced significant decreases in OCD (symptoms and severity) at posttest compared to pretest; no significant differences between individual and group modalities. Gains were maintained up to 6-months follow-up</p> <p><i>Caregiver:</i> (1) No change in caregiver distress (depression, stress) across experimental groups</p> <p>(2) High caregiver satisfaction</p> <p><i>Other:</i> (1) Significant reductions in sibling depression and reinforcing child’s OCD across all three groups (no difference between the experimental and WLC groups; (2) Sibling satisfaction with treatment high</p>
<p>2. Cognitive Behavioral Therapy+Family Anxiety Management (CBT+FAM) <i>Source:</i> Barrett et al. (1996)</p>	<p>A CBT-based program for children with anxiety disorders and their caregivers offered at a university-based clinic in Australia. Treatment is delivered in 12 weekly sessions: the child receives CBT for 30 min based upon the Coping Koala workbook (Barrett et al. 1991), and then joins the caregiver for a 40 min Family Anxiety Management session. The total duration of each session is 60–80 min</p>	<p><i>Instructional:</i> BPT to decrease the child’s anxiety (e.g., praise, rewards, planned ignoring); skills to manage the caregiver’s symptoms of anxiety and upset; communication and listening skills; problem-solving skills (to model for child during fearful situations)</p>	<p><i>RCT sample:</i> 79 children with 7–14 years of age randomized to (CBT, CBT+FAM, or WLC) Pre/post/6 and 12 months follow-up.</p>	<p><i>Child:</i> Youth in both experimental arms were diagnosis-free at posttreatment and follow-up in comparison with WLC, and youth in the CBT+FAM condition evidenced greater gains than CBT group. Females and younger children evidenced the greatest gains in the CBT+FAM condition</p>
<p>3. Strategies to Enhance Positive Parenting (STEPP) Program <i>Source:</i> Chacko et al. (2008, 2009)</p>	<p>A skills-building, university-based parent training program for single mothers of youth between 5 and 12 years of age with ADHD. Children participate in a separate social skills group (derived from Cunningham et al. 1998). The program is delivered over nine 2.5 h sessions</p>	<p><i>Instructional:</i> Parent training; coping and problem-solving skills</p> <p><i>Emotional:</i> Group process addresses parent’s issues and facilitates social support</p>	<p><i>RCT sample:</i> 120 children with ADHD children and their mothers were randomly assigned to Behavioral Parent Training, STEPP, or WLC</p>	<p><i>Child:</i> Youth in the STEPP condition evidenced significant decreases in ODD in comparison with WLC, and STEPP comparative to BPT</p> <p>Children in the STEPP intervention were significantly more likely to attend treatment compared to BPT</p>

Table 4 continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
4. Child Behavioral Therapy+Parent Anxiety Management (CBT+PAM) <i>Source:</i> Cobham et al. (1998)	<p>A CBT-based program for childhood anxiety disorders based out of a university-based clinic in Australia. Parents participate in four PAM sessions, and the child is seen for ten CBT sessions</p> <p>The child's treatment is based on the Coping Koala workbook (Barrett et al. 1991), a derivative of the Coping Cat program (Kendall et al. 1990). Total time for treatment was 1 h</p>	<p><i>Informational:</i> Psychoeducation about the etiology of anxiety and the caregiver's impact upon their child's illness (i.e., maintaining the child's disorder)</p> <p><i>Instructional:</i> Cognitive skills training (e.g., cognitive restructuring, relaxation training, contingency management)</p>	<p><i>RCT sample:</i> 67 children between 7 and 14 years of age. Children grouped by parent anxiety level (Child Anxiety vs. Child+Parent Anxiety) and subsequently randomly assigned to either child-focused CBT or CBT+PAM</p> <p>Pre/post/12 month follow-up</p>	<p><i>Parent:</i> (1) Parents in STEPP evidenced significant improvements in stress and impairment compared to WLC and BPT. (2) Caregivers in STEPP were significantly more likely to attend treatment and complete assignments compared to parents receiving BPT. (3) High satisfaction with treatment compared to BPT</p> <p>However, gains not maintained for either STEPP or BPT at 3-months follow-up, and youth in STEPP did not evidence significant reductions in ADHD, impairment with peers, and maternal depression comparative to WLC</p> <p><i>Child:</i> The Child Anxiety group was more likely to be diagnosis-free at posttreatment than the Child+Parent anxiety group regardless of condition (82% CBT, 80% CBT+PAM). Among the Child+Parent Anxiety group, more youth were diagnosis-free (77%) in the CBT+PAM group than in CBT alone (39%) were diagnosis-free in CBT compared to 77% in the CBT+PAM</p> <p>At 12 months follow-up, gains were maintained, and youth in the Child Anxiety group evidenced higher rates of being diagnosis-free, but these results were not significant</p>

**Table 4** continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
<p>5. Trauma-focused cognitive behavioral therapy (TF-CBT)  <i>Source:</i> Cohen et al. (2004); Cohen and Mannarino (2008)</p>	<p>A 12-week, educational and skills-building program based upon PTSD programs that was offered at a university clinic for children who have been sexually abused and their caregivers. Youth and caregivers are seen sequentially and separately in individual sessions (45 min per individual) except for three 30-min joint sessions to facilitate communication, provide information about issues pertaining to sexuality and safety, and to discuss the child's experience. During joint sessions, caregivers and youth were seen individually for 30 min each</p>	<p><i>Informational:</i> Psychoeducation re: symptoms and diagnosis, sexual abuse and its effects upon child and family, information about the justice system  <i>Instructional:</i> BPT (praise, attention, time out); cognitive skills (e.g., relaxation and cognitive coping skills, identifying and correcting inaccurate thoughts)  <i>Advocacy:</i> Information and resources about how to obtain assistance for victims</p>	<p><i>RCT sample:</i> 229 youth with 8–14 years of age and their parents were randomly assigned to TF-CBT or child-centered therapy (CCT)                      Pre/post/6- and 12-month follow-up</p>	<p><i>Child:</i> Youth receiving TF-CBT evidenced significant decreases in symptoms of PTSD depression, behavioral problems, shame and cognitions related to abuse compared to youth in CCT  <i>Parent:</i> Caregivers in the TF-CBT group reported improved symptoms of depression, trauma-related distress, and parenting skills</p>
<p>6. Maternal stress coping group  <i>Source:</i> Chronis et al. (2006)</p>	<p>The Maternal Stress Coping Group is a derivative of the Coping with Depression Course. This group is a 12-week, university-based, group program for parents of youth with ADHD who are at risk of or are suffering from depression. Consists of four modules targeting skills building in areas such as social skills, assertiveness, relaxation training and engaging in activities. Caregivers participated following their child's involvement in an 8-week, BPT-based Summer Treatment Program (STP), to decrease their child's ADHD, during which caregivers participated in a weekly group on parenting derived from the Community Parenting Education program (COPE; Cunningham, Bremner, and Second-Gilbert, 1994)</p>	<p><i>Informational:</i> Psychoeducation (i.e., information about the relationship between thoughts and one's feelings and behaviors)  <i>Instructional:</i> Relaxation skills, social skills and assertiveness, cognitive restructuring. Skills to increase activities</p>	<p><i>RCT sample:</i> 62 mothers received the coping group or WLC following completion of the ADHD Summer Treatment Program                      Pre/post, 5-month follow-up</p>	<p><i>Parent:</i> (1) Significant decrease in sx's of depression and improvement in self-esteem compared to WLC, (2) Significantly greater decrease in negative cognitions about child in the tx group; (3) Significantly less impairment among tx group in comparison with WLC; (4) Treatment satisfaction; Parents rate the program favorably (helpful and applicable)                      Treatment gains were maintained at follow-up</p>



Table 4 continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
7. Parent Advisor Service <i>Source:</i> Davis and Spurr (1998)	<p>A parent advisory service based in the United Kingdom for caregivers of preschool children residing in poor and stressful environments and experiencing parenting difficulties, psychosocial problems, or have youth evidencing emotional and behavioral problems</p> <p>Provision of home-based, mental health services including individual support on a weekly basis to the parent with a gradual tapering off depending upon identified need; no set number of sessions (mean number of sessions was six). Usually 1 h in length. Services delivered by health visitors (registered nurses or midwives) and pediatricians, who are trained and supervised by a clinical psychologist</p>	<p><i>Instructional:</i> Behavioral strategies and problem-solving skills</p> <p><i>Emotional:</i> Provision of emotional support to augment their self-esteem</p>	<p>Quasi-experimental study of 60 families in experimental condition and 38 in the comparison condition, who had usual contact with existing services</p>	<p><i>Child:</i> Decreased behavior sxs and severity of problems</p> <p><i>Parent:</i> (1) Increased self-esteem; (2) decreased parental stress and emotional difficulties (anxiety and depression); (3) more positive constructions of their children; (4) Satisfaction with treatment. Social support also measured (no changes due to intervention)</p> <p><i>Other:</i> Referrers found the service highly valued; improvements in the home environment; reduced contacts with health visitors/GPs</p>
8. Cognitive Behavioral Group Therapy <i>Source:</i> Deblinger et al. (2001)	<p>A group program consisting of 11 sessions for mothers of youth with 2–8 years of age who have been sexually victimized. Children were seen concurrently in their own group. Groups met for 2 h; the last 15 min were reserved for an activity to be completed by the caregiver and child</p> <p>Compared to the Supportive Group for Caregivers (see #9)</p>	<p><i>Informational:</i> provision of education about sexual abuse to reduce distorted parental cognitions</p> <p><i>Instructional:</i> BPT for behavioral difficulties, enhancing coping strategies, communication skills</p> <p><i>Advocacy:</i> The Office of Victim Witness Advocacy spoke to caregivers during two of the 11 sessions</p>	<p><i>RCT sample:</i> 44 mothers and youth were randomly assigned to the cognitive or supportive group</p> <p>Pre/post/3 month follow-up</p>	<p><i>Child:</i> Youth in the cognitive group evidenced more safe body knowledge than youth in the supportive group at posttest</p> <p><i>Parent:</i> (1) The cognitive group was associated with greater decreases in adverse emotions concerning the abuse and intrusive thoughts compared to mothers in the supportive group. (2) Parents in the cognitive behavioral group rated the program more favorably than those in the supportive intervention</p> <p>Child and parent-level gains were significantly more likely to be maintained at follow-up among those who participated in the cognitive group vs. the supportive group</p>

**Table 4** continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
<p>9. Supportive Group for Caregivers  <i>Source:</i> Deblinger et al. (2001)</p>	<p>The active comparison to Cognitive Behavioral Group Therapy (see #8) consisting of a supportive group for youth 2–8 years of age who have been sexually victimized and their mothers. 11 sessions, 1 h 45 min in length. The child was seen concurrently in a separate group</p>	<p>Informational (topics decided by group, etc.)  <i>Emotional:</i> Facilitating a supportive atmosphere in which caregivers expressed their concerns and feelings about their child's abuse. Peers enhanced the caregiver's support</p>	<p><i>RCT sample:</i> 44 mothers and youth between 2 and 8 years of age were randomly assigned to the cognitive or supportive group                      Pre/post/3 month follow-up</p>	<p><i>Child:</i> Youth in the cognitive group evidenced more safe body knowledge than youth in the supportive group at posttest  <i>Parent:</i> The cognitive group was associated with greater decreases in adverse emotions concerning the abuse and intrusive thoughts compared to mothers in the supportive group                      Child and parent-level gains were significantly more likely to be maintained at follow-up among those who participated in the cognitive group vs. the supportive group</p>
<p>10. Project Team  <i>Source:</i> Feinfeld and Baker (2004)</p>	<p>A 12-week treatment, BPT-based program for youth evidencing externalizing behavioral problems and their caregivers. Children are seen in 8 weekly group sessions lasting 1.5 h and three 40-min sessions with pairs of youth. The child's treatment runs concurrent to the parent group, which is delivered over nine group sessions lasting 1.5 h and three individual sessions lasting 40 min in length                      The program also includes "together time," in which children and parents practice new skills and participate in tasks and relationship-building exercises for 30 min before each group session</p>	<p><i>Instructional:</i> BPT, communication skills; problem-solving and anger management skills; strategies to increase consistency; cognitive skills training (e.g., strategies to decrease the caregiver's maladaptive and distorted thoughts)</p>	<p><i>RCT sample</i> of 47 youth between 4 and 8 years of age and their caregivers were randomized to the experimental (<math>n = 24</math>) or delayed treatment condition (<math>n = 23</math>), condition                      Pre/post/5 month follow-up</p>	<p>Parents in the cognitive behavioral group rated the program more favorably than those in the supportive intervention  <i>Child:</i> Youth in the treatment group evidenced statistically significant improvements in behavior compared to delayed treatment. Treatment gains were maintained at follow-up based upon caregiver report (and significantly improved based on teacher report)  <i>Caregiver:</i> (1) Parents in the treatment condition evidenced significant improvements in parenting practices, efficacy, and decreased parenting stress and adverse parenting strategies (e.g., power assertiveness); (2) increased knowledge about BPT; (3) High satisfaction with program                      Decrease in parenting stress maintained at follow-up                      Other: Treatment attendance</p>

Table 4 continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
<p>11. Individual and Multi-Family Psychoeducation  <i>Source:</i> Fristad et al. (2003)</p>	<p>A psychoeducational program for caregivers of children and adolescents with mood disorders (bipolar and depressive spectrum illnesses). MFPG consists of eight group-based, 90 min sessions</p> <p>Also available in individual (IFP) formats consisting of 8, 16, and 24 50-min sessions and 24 sessions. In the MFPG program, youth and their families meet together at the beginning and end of the session and separately during the middle portion of the session</p> <p>Children may receive other services in addition to IFP or MFPG</p>	<p><i>Informational:</i> Education about mood disorders, treatment options, and negative family cycles</p> <p><i>Instructional:</i> Problem-solving, coping and communication skills, symptom management</p> <p><i>Advocacy:</i> Provision of informational about how to work with the mental health and school system</p>	<p>Multiple studies including (1) an evaluation of the 1½ h workshops (<math>n = 25</math> parents of 20 youth); (2) Two RCTs of the six-session MFPG with a sample of (a) nine parents/youth in the first study, and (b) 35 families of youth ages 8–11 in the second RCT (active treatment condition compared to delayed treatment)</p>	<p>(1) Evaluation results  <i>Caregivers:</i> Both caregivers, but particularly fathers, evidenced significant increases in knowledge about mood disorders post workshop; both parents evidenced significantly decreased EE post intervention</p> <p>(2) RCT #1  <i>Child:</i> High satisfaction with program</p> <p><i>Caregivers:</i> (1) Both parents evidenced improvements in EE levels and more favorable views of their children posttest; (2) High treatment satisfaction; (3) RCT#2</p> <p><i>Child:</i> Youth in the experimental intervention reported significantly greater levels of parental social support (support from peers approached significance)</p> <p><i>Caregivers:</i> (1) Compared to WLC, parents evidenced significant improvements in mood disorder knowledge. Treatment gains maintained at 6-month follow-up</p> <p><i>Other:</i> Greater improvements in service seeking compared to WLC. No difference in knowledge or decreased EE between MFPG and WLC once WLC group participated in the program</p>

**Table 4** continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
<p>12. Family Group Psychoeducation  <i>Source:</i> Geist et al. (2000)</p>	<p>A psychoeducation group for families of female adolescents with newly diagnosed anorexia nervosa in an inpatient setting. The goal was to foster attitudinal and behavior change. Eight sessions every 2 weeks over 4 months. Each session consists of joint 45-min family group sessions and 45-min separate adolescent and parent groups. Parents were also integrated into standard psychosocial treatment to address feelings associated with illness.</p>	<p><i>Information:</i> Education about eating disorders and its physical and psychological impact; coping with change  <i>Emotional:</i> Help both adolescent and family deal with intense feelings associated with weight gain</p>	<p><i>RCT sample:</i> 25 adolescents and their parents randomized to FGP or Family Therapy</p>	<p><i>Child:</i>                      (1) Weight gain equivalent in both treatments; (2) No change in psychological symptoms; (3) No change in length of hospital stay;  <i>Family:</i> Increase in family dysfunction from baseline, although still within normal range</p>
<p>13. Parent Management Training + Problem-Solving Intervention (PMT+PPS)  <i>Source:</i> Kazdin and Whitley (2003)</p>	<p>A BPT-based program for youth with behavioral problems and their caregivers at an outpatient urban clinic nested within a university setting. Parents participate in 16 weekly sessions lasting 1 h. Problem-solving sessions (PPS) are interspersed with BPT every 2–4 weeks. Treatment offered in an individual format: The child is either not directly seen, or is in a parallel form of therapy (Problem-Solving Skills Training (PSST) for 16 weeks) depending on age</p>	<p><i>Instructional:</i> BPT (e.g., praise, positive reinforcement, shaping, planned ignoring, time out); problem-solving skills for stress</p>	<p><i>RCT sample</i> consists of 127 children ages 6–14 and their caregivers assigned to either PMT or PMT+PPS. All of the youth in this study received PSST</p>	<p><i>Child:</i> Youth across both conditions improved; however, greater improvements in behavior were evidenced in the PMT+PPS condition  <i>Caregiver:</i> Both groups evidenced improvements; however, caregivers in the enhanced condition evidenced significantly lower levels of parenting stress, decreased symptoms of depression, and fewer barriers to service use in comparison with PMT  <i>Family:</i> No difference among groups regarding family relationships  <i>Other:</i> No difference between groups regarding treatment attendance</p>

Table 4 continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
14. Family Cognitive Behavioral Therapy (FCBT) <i>Source:</i> Kendall et al. (2008)	A CBT-based program for children with anxiety disorders based at a university-based clinic. Sixteen weekly sessions lasting 1 h in duration. Children and their caregivers are seen jointly except for two sessions, in which they meet separately with the therapist. The child's treatment is based upon the Coping Cat Workbook (Kendall and Hedtke, 2006)	<i>Informational:</i> Psychoeducation about anxiety disorders <i>Instructional:</i> Communication skills; cognitive skills (cognitive restructuring (modifying irrational thoughts) to decrease the caregiver's anxiety and appropriately respond to the child's symptoms)	<i>RCT sample:</i> 161 children between 7 and 14 years of age; 56 received family FCBT, 55 received individual CBT (ICBT), and 50 received FESA (an active comparison-see program #15) Pre/post/1-year follow-up	<i>Child:</i> All groups evidenced, but more youth in the ICBT and FCBT groups (64%, 64%) were diagnosis-free in comparison with FESA (42%), which was statistically significant. Treatment gains were maintained, and again, more youth in the CBT-based groups were diagnosis-free at follow-up in comparison with FESA Teacher reports supported greater benefits for ICBT over FCBT for child anxiety, while FCBT was associated with greater treatment gains over ICBT when both parents also evidenced anxiety disorders <i>Caregiver:</i> Maternal anxiety (modest improvements at posttest and follow-up, but no significant difference between the CBT groups and FESA. Sample size precluded analysis of father anxiety from pre to post)
15. Family-based Support, Education, and Attention (FESA) <i>Source:</i> Kendall et al. (2008)	A 16-week child and caregiver treatment program for children with anxiety disorders based at a university-based clinic; this was the active control to FCBT (see #14). Treatment consisted of 16 weekly sessions, 1 h in duration. The main component of this program was the provision of psychoeducation. Children and caregivers were seen jointly for all but two sessions	<i>Informational:</i> Psychoeducation about anxiety, etiology, and theoretical perspectives <i>Emotional:</i> Support from a clinician, who provided a forum for caregivers to discuss their child's symptoms	Same sample and research design as described for FCBT (program #14)	Same findings as described for FCBT (program #14)



**Table 4** continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
<p>16. A Community-based Aggression Management Program  <i>Source:</i> Lipman et al. (2006)</p>	<p>An aggression management group for youth based in a Canadian community clinic. Caregivers participated in three group sessions held prior to the child's group and three individual sessions in the home. Children were seen in separate, problem-solving group based upon the kNOW Problem Pathway to enable youth to control their anger/aggression. The total intervention consisted of 16 sessions (3 parent group sessions, 10 child group sessions, and 3 in home practice sessions)</p>	<p><i>Informational:</i> Information about normal expressions of anger and aggression  <i>Instructional:</i> parenting techniques; strategies used in the child's program</p>	<p><i>RCT sample:</i> 123 families of youth 7–11 years of age contributed pretest data, 99 contributed posttest</p>	<p><i>Child:</i> Both groups showed a decrease in behavioral problems, and the intervention group made greater gains than the control condition although these differences were not significant  <i>Caregiver:</i> Improvement from pre to post for both groups, and greater gains in the treatment group, but no significant differences in parental stress between groups  <i>Family:</i> Improvement from pre to post regarding the quality of the parent/child relationship among families in both groups, and greater gains in the treatment group, but no significant differences between groups  <i>Other:</i> Use of child mental health services (use of support worker; use of social worker other than child welfare, and medication) increased in both groups, but no significant changes between groups</p>
<p>17. The Parent Education and Skills Training Group  <i>Source:</i> McCleary and Ridley (1999)</p>	<p>Group program for caregivers of adolescents with ADHD offered in a child's mental health center that is part of a Canadian teaching hospital. Ten weekly group sessions lasting 2 h in duration. The child is seen separately in outpatient sessions at the same center</p>	<p><i>Informational:</i> Psychoeducation about ADHD and treatment (e.g., pharmacotherapy)  <i>Instructional:</i> Communication, problem-solving, and parenting skills (e.g., planned ignoring, time out)  <i>Advocacy:</i> Discussion about educational system and how parents can work with the schools</p>	<p>Pre/post evaluative design  <i>Sample</i> 163 caregivers of 103 youth between 12 and 17 years of age</p>	<p><i>Child:</i> Significant decrease in problem behavior from pre to post base upon caregiver report  <i>Caregiver:</i> (1) Self-reported improvements in parenting skills and confidence. (2) High program satisfaction  <i>Family:</i> Significant reduction in parent/child conflict</p>

Table 4 continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
18. Evidence-based Engagement Strategies <i>Source:</i> McKay et al. (1998)	A telephone and first-interview pretreatment engagement intervention delivered to predominantly low-income caregivers of color to facilitate attendance in child mental health services. Two contacts (telephone and first interview) delivered individually; the telephone intervention lasts approximately 30 min in length, and the subsequent intervention lasts approximately 1 h. The child is not seen for this program	<i>Informational:</i> Clarification of child's need for services, the role of the provider, agency, intake process and treatment options <i>Instructional:</i> Problem-solving skills re: barriers to child mental health services	<i>RCT sample:</i> 109 caregivers randomly assigned to the telephone intervention alone ( $n = 35$ ), both components ( $n = 35$ ), or intake as usual (IAU) ( $n = 39$ )	<i>Other:</i> Both experimental groups evidenced significant increases in initial attendance in comparison with IAU, but only the group that received both interventions was associated with ongoing service use
19. Time for a Future <i>Source:</i> Melvin et al. (2006)	A CBT-based treatment for adolescents with depression offered in a community clinic. The program consisted of 12 50-min weekly individual sessions for the adolescents; concurrent sessions for the parents available. Two family sessions were included. The adolescent CBT was derived from the Adolescent Coping with Depression Course (Clarke et al. 1990)	<i>Informational:</i> Psychoeducation about depression <i>Instructional:</i> Goal setting; cognitive skills (e.g., relaxation training and cognitive therapy)	<i>RCT Sample</i> of 73 adolescents and their parents randomized to CBT, medication or CBT+medication	<i>Child:</i> All treatments demonstrated significant improvements in adolescent depression, anxiety and suicidal ideation, which were maintained 6 months later. Improvement in clinician reported adolescent functioning at post-treatment but not at follow-up. No change in parent-reported internalizing symptoms <i>Family:</i> No change in parent-reported family functioning
20. Child and Family Focused Cognitive Behavioral Therapy, AKA The Rainbow Program (CFF+CBT) <i>Source:</i> Pavuluri et al. (2004)	A treatment program for pediatric bipolar disorder based upon the RAINBOW principles: Routine, Affect Regulation, I Can Do It (positive statements), No Negative Thoughts/Living in the Present, Being a Good Friend/Encouraging a Balanced Lifestyle for parents, Oh How Can We Solve this Problem (problem-solving skills), and Ways to Get Support. Treatment delivered weekly over the course of 12 sessions, 60 min in length, individually with youth. Children and their families are either seen separately, together, or with siblings depending on the session. Treatment optimally suited for children 8–12 years of age	<i>Informational:</i> Psychoeducational (e.g., etiology, treatment). Also, provided education to teachers about bipolar disorder <i>Instructional:</i> Self-care (finding balance); problem-solving and communication skills; instructing caregivers on reinforce children's treatment (e.g., to generate positive self-statements, validate child's feelings, skills to monitoring the child's mood, etc.) <i>Advocacy:</i> An optional component in which caregivers are provided with information about special education services, an Individualized Education Plan, or possibly attend an IEP conference on behalf of the caregiver	Exploratory pre/post feasibility study <i>Sample:</i> 34 children between 5 and 12 years of age with PBD treated with CFF+CBT plus medication in a specialty clinic	<i>Child:</i> Significant reductions in symptoms and severity from pre to posttest <i>Caregiver:</i> High Satisfaction with program <i>Other:</i> Treatment integrity and adherence to the intervention (high)

**Table 4** continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
21. Psychoeducation and Support Group Intervention for Bereavement Source: Pfeiffer et al. (2002)	A bereavement group intervention (BGI) for children between 6 and 15 years of age, their siblings and their parents after the suicide of a parent. The parent component focused on educating parents so they can assist their bereaved children. The children and parents were seen separately but concurrently in ten 1.5 h sessions	<i>Informational:</i> Psychoeducation on childhood bereavement and how to foster child's expressions of grief, discuss suicide, identify morbid reactions, and promote child's emotional and social functioning <i>Emotional:</i> Support provided for parents to express their own grief	<i>RCT sample:</i> 52 families (75 children) were randomly assigned to BGI or no BGI	<i>Child:</i> BGI children showed reduced anxiety and depression. Posttraumatic stress symptoms and social maladjustment persisted <i>Caregiver:</i> No change in parent depression
22. Parent Training+Parent Social Problem-Solving Skills Source: Pfiffner et al. (1990)	An augmented, BPT-based, program for single mothers of children with conduct disorder. The program consisted of eight sessions lasting 1.5 h each week delivered in an individual format Treatment consisted of problem-solving skills addressing non-child related difficulties in addition to BPT. The child was seen for three of the sessions	<i>Instructional:</i> BPT (e.g., positive attention, praise, rewards, planned ignoring, time out); problem-solving skills for additional difficulties	<i>RCT sample:</i> 11 single mothers of youth between 4 and 9 years of age of children were randomized to either Intensive Parent Training without the problem-solving component or (IPT) or PTSP Pre/post/4-month follow-up	<i>Child:</i> Both groups evidenced significant reductions in behavioral problems posttest and at 4-month follow-up based upon maternal report. Youth in the PTSP condition had a significantly greater decrease in comparison with IPT at follow-up
23. Psychoeducation Responsive to Families Coping with a Child with Emotional Disorders (C-PERF) Source: Pollio et al. (2005)	A school-based psychoeducational program for parents of youth with emotional and/or behavioral disorders offered in either twice a week sessions for 8 weeks or 12 weekly sessions. Both options meet for 90 min per session. Topics to be discussed are decided upon by caregivers; children must be engaged in school social work or other services (the child's treatment is not related to the caregiver's program)	<i>Informational:</i> Psychoeducation (child and adolescent disorders, treatment such as medication), education about adolescent development <i>Instructional:</i> BPT, relaxation, problem-solving, coping, communication, and social skills are some skills that caregivers can elect to receive <i>Advocacy:</i> Juvenile justice and zero tolerance policies, special education services and individualized education programs	Evaluation (post). Sample of 15	<i>Caregiver:</i> Reported satisfaction with program
24. Enhanced Family Treatment (EFT) Source: Prinz and Miller (1994)	An enhanced parent training program for caregivers of youth with aggression that provides BPT (standard family treatment=SFT) and additional discussions of non-child related issues. Twelve sessions of SFT; 11 sessions were interspersed with discussions of other issues. The child is not directly seen for services	<i>Instructional:</i> BPT (e.g., praise, rewards, time out, shaping, planned ignoring) Problem-solving skills, communication skills, trouble-shooting skills <i>Emotional:</i> Supportive sessions with a clinician who established an open, collaborative relationship. Discussion focused on topics not directly related to the child (e.g., job stress, personal worries)	<i>RCT sample</i> consisted of 147 caregivers of boys between 4 and 9 years of age who were randomly assigned to either SFT or EFT	<i>Other:</i> Rate of dropout was the primary outcome under investigation, and was significantly lower in the EFT group over SFT, particularly among families at high risk (e.g., low SES, single caregivers, substance abuse) <i>Child:</i> Youth evidenced reductions in child behavior problems, compared with dropouts <i>Parent:</i> Caregivers who completed treatment in both conditions evidenced greater improvements in parenting skills

Table 4 continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
25. Maudsley Model of Family-Based Treatment <i>Source:</i> Rhodes et al. (2008)	An outpatient, family-based treatment for anorexia nervosa for adolescent girls (12–16 years old). Standard family treatment consisted to 20 h-long sessions; parent-to-parent consultation was conducted once early in the treatment in conjunction with two therapists who structured the involvement of the veteran parent. Parents were given 10 min at the end of the session to talk without the therapists	<i>Informational:</i> The parent consultant described their life and how they managed to facilitate their children's recovery	<i>RCT sample:</i> Random assignment of 20 families into two groups: Standard treatment vs. Treatment augmented with Parent-to-parent consultation. Study sought to specifically test the parent-to-parent component	<i>Child:</i> No difference in clinical outcomes <i>Caregiver:</i> Parent efficacy not found to mediate ideal weight restoration. However, qualitative findings suggest that the consultations allowed parents to develop an immediate and intense bond with consultants. Parents felt less isolated and more hopefulness
26. Cognitive Behavioral Family Intervention (CBFI) <i>Source:</i> Sanders and McFarland (2000)	A 12-week, BPT and CBT-based program offered at a university-based clinic in Australia that derived from the Coping With Depression Course (Sanders and Dadd, 1993) for depressed mothers of youth with a primary diagnosis of ODD or CD. Both the child and caregiver participated. Eight of the sessions were offered weekly on an individual basis with families, and four sessions (two times per week) were conducted in the home for the purposes of observation and feedback	<i>Instructional:</i> BPT (e.g., praise, attention, time out), cognitive techniques (e.g., identifying negative thoughts, cognitive restructuring), relaxation training, coping skills	<i>RCT sample:</i> 47 caregivers of youth 3–9 years of age were randomly assigned to BFI or CBFI Pre/post/6-month follow-up	<i>Child:</i> Disruptive sx's decreased across both groups which were maintained at follow-up, but no significant difference in gains across groups <i>Parent:</i> Both treatments were associated with significant reductions in depression, but gains were maintained among more families in CBFI than BFI at 6-month follow-up. No difference between groups regarding negative cognitions, sense of competence and social support (both groups evidenced improvements from pre to post) <i>Other:</i> No significant difference between groups re: dropout

**Table 4** continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
<p>27. Enhanced Triple P (Positive Parenting Program)  <i>Source:</i> (1) <a href="http://www.triplep.net">www.triplep.net</a>; (2) Sanders et al. (2000)</p>	<p>The fifth level of a multi-tiered prevention and intervention program (Positive Parenting Program, Triple P) for caregivers of youth with behavioral problems enhanced Triple P (the fifth level) is for caregivers of youth evidencing behavioral problems who are experiencing their own mental health difficulties (e.g., depression, stress), or partner/marital discord. Families must have already completed one of several Level Four programs (which are primarily BPT), to be considered for Enhanced Triple P. Caregivers are offered three modules (Practice, Coping Skills, Partner Support) consisting of up to three session each, 90 min in duration except the Practice module, which is 40 min in length. Total sessions typically do not exceed 11 sessions</p>	<p>Module-dependent  <i>Instructional:</i> (a) Practice Module: refine BPT skills learned in Level 4; (b) Coping Skills Module: Identify and modify dysfunctional cognitions, coping skills (i.e., relaxation techniques) self-statements; (c) Partner Support Module: Communication and listening skills, develop strategies to support partners, problem-solving skills</p>	<p><i>RCT sample:</i> 305 preschool-aged youth and their caregivers were randomly assigned to either Enhanced, Standard, Self-Directed Triple P or WLC                      Pre/post, 1 year follow-up</p>	<p><i>Child:</i> Youth of caregivers receiving Enhanced and Standard Triple P evidenced greater decreases in disruptive behaviors compared to Self-Directed and WLC youth                      Youth receiving Enhanced Triple P evidenced the greatest gains at post. At one-year follow-up, all three experimental groups evidenced similar treatment gains (via observation), but the Enhanced and Standard Triple P groups reported greater improvements in the child's behavior as reported by parent  <i>Parent:</i> Caregivers receiving Enhanced and Standard Triple P evidenced greater gains in parenting, parenting competence, and satisfaction in comparison with Self-Directed and WLC conditions</p>
<p>28. Educational and support group for parents with schizophrenic adolescents  <i>Source:</i> Sheridan and Moore (1991)</p>	<p>A group intervention for parents of adolescents with schizophrenia in a community private psychiatric in-patient or day hospital. Parents were at different stages of adjustment and knowledge of the illness. Six weekly 1.5 h sessions were led by a team of social worker, psychologist and psychiatrist</p>	<p><i>Informational:</i> Increase knowledge about schizophrenia to boost parental confidence in handling adolescent. Topics included diagnosis, medication, family issues, prognosis  <i>Emotional:</i> Support to help parents feel less isolated in dealing with disorder; parents set personal goals (e.g., respite, hobby)</p>	<p>Pre-post evaluation of 32 parents of 17 adolescents; qualitative analysis of questionnaires</p>	<p><i>Caregivers:</i> Attitudinal changes on impact of managing adolescent illness; no significant change knowledge about schizophrenia; caregiver satisfaction. Anecdotal reports from treatment team that parents made fewer distress phone calls during and after group compared to pre group</p>



Table 4 continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
29. FRIENDS (A Family-based group Cognitive Behavioral Treatment) <i>Source:</i> Shorrt et al. (2001)	An Australian, CBT-based child and parent treatment program for caregivers of youth with anxiety disorders. The FRIENDS program (an acronym for the strategies, which consist of Feeling Worried, Relax and feel good, Inner thoughts, Explore plans, Nice work so reward yourself, Don't forget to practice, and Stay calm, you know how to cope now) consists of 10 weekly sessions and 2 booster sessions. The caregiver skills component is 6 h (either four 1 1/2 h sessions or 10 40-min sessions), and dovetails with the child's treatment in content. The child's component is based upon the Coping Koala Group Workbook (Barrett, 1995)	<i>Informational:</i> Psychoeducation about anxiety (symptoms), cognitive, learned, and physiological facets of anxiety <i>Instructional:</i> Cognitive restructuring, relaxation skills (deep breathing, muscle relaxation, creating a calm "time"), parent training skills (praise, reinforcement, positive reinforcement, planned ignoring) communication, partner support, and problem-solving skills	<i>RCT sample:</i> 71 youth between 6½ and 10 years of age were randomized to either FRIENDS ( $n = 54$ ) or WLC ( $n = 17$ )	<i>Child:</i> Youth in the treatment group were significantly more likely to be diagnosis-free (69%) at posttreatment than WLC (6%). Gains were maintained at 12 month follow-up High treatment satisfaction <i>Caregiver:</i> High treatment satisfaction
30. Parent Training (PT) <i>Source:</i> Sonuga-Barke et al. (2001)	An 8-week program based in England for caregivers of preschoolers with ADHD delivered in an individual format. This program is provided for the caregiver who is seen by a trained health visitor therapist in the client's home. The child is not directly seen for services except for an observational period to assess the interaction between the child and caregiver	<i>Informational:</i> Education about ADHD <i>Instructional:</i> BPT (praise, setting limits and boundaries, establishing routines, time out, and managing tantrums)	<i>RCT</i> Three groups (total sample of 78 caregivers of 3-year old youth); parent training (PT) ( $n = 30$ ), parent counseling and support (PC&S) ( $n = 28$ ), waiting list control ( $n = 20$ )	<i>Child:</i> Significantly decreased symptoms of ADHD posttreatment comparative to PC&S and WLC. Youth in PC&S approached significance Treatment gains maintained at 15 week follow-up <i>Caregiver:</i> Significant improvement in maternal adjustment (mental health, efficacy) and parenting satisfaction) compared to PC&S and WLC
31. Parent Stress Management Program (PSM) <i>Source:</i> Treacy et al. (2005)	A group program for caregivers of youth with ADHD for 2 h weekly over 9 weeks that met at a research center	<i>Informational:</i> Education about (1) stress, impact of stress on caregivers and parenting, management; (2) ADHD (etiology, symptoms, treatment) <i>Instructional:</i> Problem-solving, communication, self-care, and parenting skills (BPT), cognitive restructuring <i>Emotional Support:</i> provided via the group function <i>Advocacy:</i> Provision of information about community resources and entitlements (e.g., educational and financial)	<i>RCT sample:</i> 63 caregivers (40 mothers, 23 fathers, 27 families) were randomly assigned to either the PSM or the WLC Pre/post/6 and 12 month follow-up	Parent: (1) PSM was significantly associated with decreased parenting stress and improvements in parenting (e.g., reductions in overreactions, verbosity, and lenience) for mothers, and a decrease in verbosity among fathers; (2) High program satisfaction

**Table 4** continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
<p>32. Family Cognitive Behavioral Therapy for OCD  <i>Source:</i> Valderhaug et al. (2007)</p>	<p>CBT treatment for children and adolescents with OCD, conducted in non-academic, outpatient urban and rural child psychiatric clinics. Treatment conducted over 12 sessions; two joint sessions with the child, and 10 sessions with parents being seen with or without their child as developmentally appropriate for 15–30 min. The child was seen for 45 min individually                      Family interventions were linked to the child's treatment</p>	<p><i>Informational:</i> Education about OCD and its treatment  <i>Instructional:</i> Teach parents re: ways to disengage from child's OCD behavior  <i>Emotional:</i> Address parental feelings of blame, frustration and anger, family and parent well-being, and ways to build support for parent and child</p>	<p>Open trial of 28 youngsters (age 8–17). Pre–post evaluation, 3 and 6-month follow-up</p>	<p><i>Child:</i> Reduction in OCD symptoms and illness severity  <i>Caregiver:</i> None</p>
<p>33. Incredible Years Advance Parent  <i>Source:</i> Webster-Stratton (1994) see also <a href="http://www.incredibleyears.com">www.incredibleyears.com</a></p>	<p>Part of a comprehensive array of programs for parents, teacher and children aimed at reducing disruptive behaviors and promoting emotional regulation, prosocial behaviors and problem-solving in children ages 2 to 12. The Advance Parent training builds on the BASIC parenting program by focusing on parent's own interpersonal issues. This program can be delivered in 9–11 weekly 2 h group sessions</p>	<p><i>Instructional:</i> Teaches communication skills, problem-solving skills, anger, stress and depression management, strengthening social support</p>	<p><i>RCT sample:</i> 78 families with children between three and eight years of age were randomly assigned to BASIC vs. Advance Parent Training</p>	<p><i>Child:</i> (1) Both groups showed significant improvements at short term follow-up on child adjustment, parent distress, child knowledge of social skills and communication and problem-solving between parents. Advance Training showed added improvements in: (2) Increased knowledge of prosocial solutions  <i>Parent:</i> (1) Communication and problems solving skills; (2) Better consumer satisfaction</p>

**Table 5** Family led

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
1. Keys for Networking: Targeted Parent Assistance <i>Source:</i> Adams et al. (2006). See also, <a href="http://www.keys.org/">http://www.keys.org/</a>	A peer-to-peer support model for other parents with children who have or are at risk for emotional and/or behavioral problems. This Kansas family-run organization is based on a ten-level continuum that helps parents move from family to system advocacy (i.e., from help-seekers to help-givers). Parents are engaged at their level of experience and interest, and their level of involvement and progress through the continuum varies	<i>Informational:</i> Information and linkages to Keys' trainings related to parent interests <i>Instructional:</i> Training related to parent interest <i>Emotional:</i> Connection to mentors and other families <i>Instrumental:</i> Mileage, childcare, lodging and travel connections with other parents <i>Advocacy:</i> Information and skills through trainings about legislation and other services, as well as direct advocacy and action. Parents at the final stage in the continuum are trained to provide peer support and systems advocacy	Pre-post and benchmarking according to ten-level continuum Sample size not reported	<i>Outcomes measured:</i> Results not published <i>Child:</i> Educational outcomes (attendance, reading and math) and mental health measures <i>Caregiver:</i> Progress along the ten-level continuum of parent movement from help seeking to giving; parent participation in meetings and function, parent satisfaction
2. Parent to Parent <i>Source:</i> R. Hughes, S. Prickford-Schenke, personal communication (2008)	A CHADD-affiliated program that provides state of the art information about treatment, day-to-day symptom management, effective educational interventions, and living with AD/HD in the family. Developed for caregivers of children and adolescents. Seven group-based sessions consisting of 2-h modules	<i>Informational:</i> Education about the nature and course of AD/HD and its impact upon the family <i>Instructional:</i> Behavior management and strategies to strengthen family relationships <i>Advocacy:</i> Information about laws and entitlement, strategies about how to develop an effective education team	Three Evaluations (post) Unknown sample size	<i>Caregiver:</i> Attitudes and commitment to treatment, and educational management Unpublished data
3. Parent Empowerment Program* <i>Source:</i> Hoagwood et al. (2009)	A 40-h training program for family support workers who provide parent-to-parent support to parents of children with mental health needs. This training is co-led by a parent advocate and a mental health clinician. PEP is based on principles of parent support and a theory-based behavior change model to help providers activate and empower caregivers of children with mental health needs. Six-month bi-weekly consultation calls are provided to hone application of knowledge and skills from training PEP is in part adapted from Bickman et al.'s (1998) Vanderbilt Caregiver Empowerment (see team-led section)	<i>Informational:</i> Education about common childhood disorders and their treatments, the mental health system of care, and basic educational laws <i>Instructional:</i> Listening, engagement, need assessment, and goal setting skills. Skills on problem-solving, partnering and negotiating with various professionals involved in child's care <i>Emotional:</i> Self-care and boundary setting in with caregivers in a professional capacity <i>Advocacy:</i> Help parents create linkages and negotiate on behalf of their child's mental health and educational needs. Use of knowledge about educational laws to advocate	New York State studies: 2 pilot trials using experimental-waitlist control (Usual treatment) design, and state wide evaluation (Community, School, and Statewide samples) Community-based study: $N = 32$ parents; 127 families; School-based study: $N = 19$ parent coordinators, 37 families. Statewide evaluation: $N = 60$	<i>Child:</i> No impact on emotional and behavior functioning found when measured <i>Caregiver:</i> No significant differences found on services efficacy, empowerment, mental health status, caregiver strain, working alliance, or parent satisfaction with provider services <i>Other (Parent advisor):</i> 1. Knowledge improved post-training, but not maintained at follow-up

**Table 5** continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
<p>4. EPSDT Family Associate Program  <i>Source:</i> Koroloff et al. (1996)</p>	<p>A pretreatment component of Oregon's <i>Early and Periodic Screening, Diagnosis, and Treatment Program</i> (EPSDT) to facilitate access and use of child mental health services via the provision of parental support and tangible services. Family associates (FA) serve as role models and partners to facilitate caregiver empowerment and independent navigational skills within service systems. This program targets low-income caregivers of youth between 4 and 18 years of age. Length of services varies; associates work with caregivers in the home until the child participates in three mental health appointments. FA are supervised by mental health providers</p>	<p><i>Information:</i> Provides information about EPSDT and mental health evaluations and child psychiatric disorders  <i>Emotional:</i> Provision of social and emotional support  <i>Instrumental:</i> Flexible cash fund for childcare, transportation costs, clothing, respite care, etc.  <i>Advocacy:</i> Education concerning the rights and responsibilities of the caregiver and child, facilitate connections with resources</p>	<p>Quasi-experiment 96 families from three Oregon counties with FAs were compared to 143 families from four Oregon counties with no equivalent intervention</p>	<p>2. Provider Mental Health Services Self-Efficacy improved in two trial                      3. High levels of training satisfaction  <i>Child:</i> no differences in child symptoms  <i>Caregiver:</i> increased family and service system empowerment and family well-being based on interview; no impact on family functioning  <i>Other:</i> Caregivers more likely to initiate children's mental health services, but no impact on treatment attendance or retention</p>
<p>5. Parent Connectors  <i>Source:</i> Kutash et al. 2006; K. Kutash, personal communication, 2008</p>	<p>A school-based, parent support program for parents of children who are educated in a public school special education program and identified as emotionally disturbed. Regular telephone-based parent support is delivered over 9 months by a peer from the Federation of Families who is paid, trained, and supervised by a clinician. A primary focus was on improving child academic performance rather than child mental health. Three Educational Dinners were held throughout the school year                      This model is adapted from Parent Connections, another program described in the Team-Led section (Ireys et al. 2002)</p>	<p><i>Informational:</i> Information and linkages to resources provided through phone contact and educational dinners  <i>Instructional:</i> Problem-solving and skill building, particularly around child's academic success  <i>Emotional:</i> Support for parents' own issues (e.g., coping and finding support)  <i>Instrumental:</i> Transportation and childcare to allow attendance at educational dinners  <i>Advocacy:</i> Coach parents on advocacy skills, especially around child's academic success</p>	<p><i>RCT</i>                      Teacher Training Group (<math>N = 55</math>) (to increase parent involvement) vs. Teacher Training plus Parent Connectors group (<math>N = 60</math>)</p>	<p><i>Child:</i> Improved reading achievement; no change in emotional and behavioral functioning  <i>Caregiver:</i> Pre-post changes noted only among those highly strained, those with low mental health services efficacy and low family empowerment  <i>Other:</i> No change in family participation in educational planning; No impact on child receipt of MH services</p>

Table 5 continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
6. NAMI Basics Program <i>Source</i> : T. Brister (personal communication, 2007)	A NAMI-affiliated, trauma-based model of education to help heal, raise consciousness and empower families. This program is an outgrowth of NAMI Visions for Tomorrow. Developed for caregivers of children and adolescents with mental illness  Six group-based sessions consisting of 2.5-h modules. The child does not need to be in treatment for the caregiver to participate  NAMI Basics is an outgrowth of NAMI Visions, which is described below	<i>Informational</i> : Education about mental illness, treatment options, family burden, and systems involved  <i>Instructional</i> : Collaborative problem-solving skills for day-to-day communication, crisis and safety management  <i>Advocacy</i> : Information and resources on how to advocate for their child	In progress. Pre-post evaluation. For the pilot test, 176 pretests and 135 post tests completed (93 matched pairs)	Under evaluation. Measures include: <i>Caregiver</i> : Stress, self-care, empowerment, and self-description. Also, knowledge about mental illness, assessment and intervention, and advocacy  <i>Family</i> : Family problem-solving and communication
7. NAMI Hand to Hand <i>Source</i> : (1) NAMI ( <a href="http://www.nami.org/">http://www.nami.org/</a> ); (2) Personal correspondence with S. Robinson of NAMI (director of programs for NAMI Ohio) (2008)	A NAMI-affiliated program designed to foster learning, healing and empowerment among parents and families of children with emotional-mental-neurobiological disorders. Nine group-based sessions consisting of 2 h modules. The child does not need to be in treatment for the caregiver to participate	<i>Informational</i> : Information about ADHD, major depression, childhood schizophrenia, etc. and their biological basis; medications management; treatment options, and recovery  <i>Instructional</i> : Coping skills, crisis and relapse management  <i>Advocacy</i> : Working with the juvenile justice system, guidance on locating or obtaining appropriate support and better services within the community and obtaining; advocacy for appropriate federal and state policies	Evaluation (post)  Sample size unknown	Results not published. Measure includes: <i>Caregiver</i> : Parent Satisfaction
8. NAMI Visions for Tomorrow <i>Source</i> : (1) NAMI website (accessed 2008), <a href="http://www.nami.org/">http://www.nami.org/</a> 2) T. Brister (personal communication, 2008)	A NAMI-affiliated, family support program consisting of group workshops for primary caregivers of children and adolescents with brain disorders. Twelve sessions can be completed over 12 weeks or a 3-day program. The child does not need to be in treatment for the caregiver to participate	<i>Informational</i> : Education about brain biology/mental illness, types of therapies  <i>Instructional</i> : Coping and self-care skills, problem management, communication skills  <i>Advocacy</i> : Advocacy skills and education about the juvenile justice system	Evaluation (pre/post)  Sample size unknown	Based on Dissertation: <i>Caregiver</i> Knowledge; perceptions of themselves as caregivers  Unpublished manuscript



**Table 5** continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
<p>9. Parents' Empowerment Academy  <i>Source:</i> New Jersey Parents' Caucus website <a href="http://www.newjerseyparentscaucus.org/index.asp">http://www.newjerseyparentscaucus.org/index.asp</a> (accessed 2008).                      K. Wright (personal communication, 2008)</p>	<p>A comprehensive training and education program for caregivers of youth with emotional and behavioral challenges to aid in collaboratively negotiating with government agencies and other systems. This program is part of the New Jersey Parent's Caucus, an organization that provides group-based workshops, trainings, and certifications to caregivers. The program meets for 5 weeks, with classes ranging from 2 to 6 h each. The child does not need to be in treatment for the caregiver to participate</p>	<p><i>Informational:</i> Education about mental illness, education for fathers  <i>Instructional:</i> Conflict resolution skills, communication skills  <i>Advocacy:</i> Navigating the special education system and the IEP process, professional-parent advocacy training program</p>	<p>Evaluation (pre/post)                      Unknown sample size</p>	<p>Results not published. Measures include:  <i>Child:</i> Satisfaction  <i>Caregiver:</i> Satisfaction, systems involvement, relationship with case mgrs and mental health, child welfare, special ed and juvenile justice system  <i>Other:</i> How training impacted child's services</p>
<p>10. Parent Empowerment Classes  <i>Source:</i> B. Bates (personal communication, 2009)</p>	<p>A Passages-affiliated series of psychoeducational workshops for caregivers of youth with serious mental illnesses. Ten group-based sessions consisting of 1-h modules. The youth must be receiving their own separate treatment</p>	<p><i>Informational:</i> Education about brain biology, mental illnesses (e.g., early onset schizophrenia, anxiety disorders, ADHD)  <i>Instructional:</i> Coping, self-care, communication and problem-solving skills  <i>Emotional:</i> Via the group process  <i>Advocacy:</i> IDEA legislation and the juvenile justice system</p>	<p>Evaluation (post)                      Unknown sample size</p>	<p><i>Caregiver:</i> Parent satisfaction                      Unpublished data</p>
<p>11. Partnership to Support Families  <i>Source:</i> B. Bates (personal communication, 2008)</p>	<p>A Passages-affiliated series of parenting courses. Developed for caregivers of youth in treatment for serious mental illnesses. Ten group-based sessions consisting of 1-h modules. The child must be in separate treatment</p>	<p><i>Informational:</i> Helping parents have a better relationship with their children and to write their child's treatment plans  <i>Advocacy:</i> Provides education about language used by mental health system so that parents can advocate for child and have an "active voice"  <i>Emotional:</i> Via the group process</p>	<p>Evaluation (post)                      Unknown sample size</p>	<p><i>Caregiver:</i> Parent Satisfaction                      Unpublished data</p>

**Table 6** Team led

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
1. Vanderbilt Caregiver Empowerment <i>Source:</i> Bickman et al. (1998)	An 11-h parent training curriculum aimed at empowering parents and increasing their involvement in their child's mental health treatment. The training is co-led by a parent advocate and a clinician and is delivered over three days during a 2-week period. Parent advocates serve as models for caregivers	<i>Informational:</i> Information about the nature of the mental health care system and other resources, diagnostic process, assessing child and family needs <i>Instructional:</i> Assertiveness and communication skill training; goal setting; problem-solving parent-professional relationship, building information files <i>Emotional:</i> Promote and encourage caregiver sense of self-efficacy re: decision making, collaborative relationships between parents and parents and professionals <i>Advocacy:</i> Information about parent rights	<i>RCT sample:</i> 250 caregivers assigned to receive training ( $N = 127$ ) or control condition ( $N = 123$ ); 3 and 12-month follow-up	<i>Child:</i> No change in child mental health status <i>Caregiver:</i> (1) Mental health service knowledge; (2) mental health services self-efficacy; (3) no change in treatment involvement <i>Other:</i> No change in child service use
2. Child Management Training+Ally Support Training (CMT+AST) <i>Source:</i> Dadds and McHugh (1992)	An adjunctive parent support component for socially isolated, disadvantaged single parents of youth with conduct problems. The six-session program, which emphasizes clinician-led skill building and emotional support via a family-chosen ally Parents receive CMT in a group setting, and AST is provided individually. The ally performs specific tasks that are outlined and modeled by the therapist The child is not seen for services	<i>Instructional:</i> child management training (provided by clinician), problem-solving (provided by ally) <i>Emotional:</i> Provided by ally (listening and discussing problems), encouraging and supporting the caregiver <i>Instrumental:</i> Babysitting, transportation, going on outings (provided by ally)	<i>Pre/post/6-month follow-up.</i> Random assignments to group 1 (CMT+AST) or group 2 (CMT only) Sample consisted of 22 single parents (21 mothers and 1 father)	<i>Child:</i> Deviant behavior <i>Caregiver:</i> Both groups CMT and CMT+AST showed gains in depression, perceived social support, aversive parent behavior, implementation of skills, and changes maintained at follow-up. AST produced no extra gains. Responders from either group were more likely than non-responders to report high perceived levels of social support from friends

**Table 6** continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
3. Parent Connections <i>Source</i> : Ireys et al. (2002)	A 15-month family support and education program aimed at promoting psychological and social functioning of nine to fourteen years old children who are in treatment for serious emotional or behavioral disorders. Parent partners provide support through phone contact and face-to-face meetings. Mental health professionals provide three educational workshops with parent partners engaging and facilitating parent participation (each workshop consists of 6 weekly 3-h-long meetings)	<p><i>Informational</i>: Educational workshops to increase mental health and parenting knowledge on child behavior, development, and coping. This information is aimed at facilitating parent access to relevant information, professional advice and services</p> <p><i>Instructional</i>: Coping, stress management skills, and listening skills; collaborating with MH professionals, managing child behavior at home</p> <p><i>Emotional</i>: Opportunities for families to gather in social atmosphere to exchange ideas, experiences, and insights; self-care. Parent partners provide affirmation, facilitate parent sense of efficacy and provide empathy for parents' feelings and concerns</p> <p><i>Instrumental</i>: Childcare and transportation</p>	Evaluation: results not published	Results not published
4. (CMAP) Children's Medication Algorithm Project <i>Source</i> : Lopez et al. (2005)	A multilevel program for families of youth with ADHD or depression consisting of four major components including the provision of medication treatment algorithms, support for treating physicians, a psychoeducational program for youth and their caregivers, and standardized documentation of treatment decisions and patient outcomes. The family component includes a psychoeducation program for caregivers, including a one session video group and topical groups consisting of between 5 and 7 sessions. The topical group is run by a clinical assistant and trained parent	<p><i>Information</i>: Includes handouts that provide education about the child's diagnosis, treatment options, medication, family, and school impact</p> <p><i>Instructional</i>: Setting limits, problem-solving and social skills</p> <p><i>Emotional</i>: The topical group aims to foster peer support</p> <p><i>Advocacy</i>: Working with the school system</p>	Pilot feasibility study involving 90 children between 6 and 17 years of age and their caregivers.	<p>Feasibility of program implementation:</p> <p><i>Child</i>: Estimates of clinical outcomes, child satisfaction</p> <p><i>Caregiver</i>: Parent satisfaction</p> <p><i>Other</i>: To determine whether medication algorithms can be effectively implemented within public mental health systems (good overall satisfaction with amount of educational information, all information rated as helpful or very helpful)</p>

Table 6 continued

Name of program, source	Overall program description including setting, target population, format	Family support components	Study design and sample	Outcomes
5. Multiple Family Group <i>Source:</i> (1) McKay et al. (1999); (2) A. Chacko and L. Franco (personal communication, 2008)	A team-led (2 therapists; ongoing evaluation led by therapist and family advocate), 16 week group program consisting of 1.5 h modules for urban, inner-city families of youth with externalizing behavioral problems	<i>Informational:</i> Provision of education regarding the core concepts of MFG (establishing family rules, roles, responsibilities, and respectful communication), information about resources <i>Instructional:</i> Some practice of respectful communication skills; specific exercises to help parents clarify rules, consequences and rewards about rules <i>Emotional:</i> Provision of emotional support from staff and other group members; addresses family stressors and social supports to help family maintain gains <i>Advocacy:</i> Provide information or coaching on ways to effectively negotiate for services, and identification of resources for direct advocacy to obtain services	Child and family assigned to one of three types of services according to availability: MFG ( $n = 34$ ) vs. traditional services (individual child or family therapy; $n = 54$ )	<i>Child:</i> Decrease in disruptive behavior in MFG <i>Caregiver:</i> None measured <i>Other:</i> MFG associated with higher rates of mental health service use and lower rates of dropout
6. Support, Empowerment, Education (S.E.E.) Group Intervention <i>Source:</i> Ruffolo et al. (2005, 2006)	A multifamily psychoeducation group intervention that serves as an augmentation to intensive case management (ICM) for families of children with serious emotional and behavioral problems with histories of multiple out-of-home placements or inpatient hospitalizations. Groups were led by a parent and mental health professional team and delivered in an open format with families leaving and entering based on their involvement with the mental health program. Families participated from 6 to 9 months, with structured groups meeting twice a month for 2 h each. The team model provided a role model for participants of professional–parent collaboration and partnership	<i>Informational:</i> Education about child mental illness and medication, parenting strategies (e.g., rules, communication), stress management, discipline and negotiation skills. Focus on parents discussing ways to obtain needed skills and information to help child <i>Emotional:</i> Parents engaged through individual meetings and phone contacts to minimized dropout; parents encouraged to build social support to help decrease feelings of stigma and isolation <i>Instrumental:</i> Onsite childcare and transportation <i>Advocacy:</i> Parents were taught ways to obtain information and skills to advocate for their child	Ninety-four parents randomized to ICM plus SEE ( $n = 58$ ) or ICM only ( $n = 36$ )	No statistically significant findings between groups, but some trends favoring ICM plus SEE group over time <i>Child:</i> Internalizing and externalizing problem behaviors Qualitative data indicated that ICM plus SEE parents reported higher levels of social support, spoke more positively about their children with SED, and felt less isolated and hopeless than their ICM only counterparts <i>Caregiver:</i> perception of social support; problem-solving, coping skills

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