

Parent-to-Parent Peer Support

Goals

Parent-to-parent support involves either the provision of support from an experienced and knowledgeable parent to a parent experiencing stress or other psychological distress associated with the birth and rearing of a child with a condition that is considered atypical^{i, ii, iii} or parent-to-parent support groups where parents of young children and other family members engage in supportive and mutually beneficial exchanges based on common interests or concerns.^{iv} The majority of these types of experiences typically involve support exchanges in response to parents' needs associated with child conditions leading to poor outcomes.^v These child-related conditions include, but are not limited to, a developmental disability, a special health care need, a health impairment, a mental health issue, or a rare childhood disease.^{vi, vii, viii} Parent-to-parent support also includes the provision of support to women experiencing difficult pregnancies, teenage and first-time parents, and parents needing advice or guidance with parenting and child rearing.^{iv} Parent-to-parent programs are often called parent support networks, peer support programs, family support networks, or family-to-family support programs.^{ii, viii, ix, x, xi}

Program Features

Parent-to-parent programs and practices are based on social support theory which includes the tenet that emotional, informational, instrumentation, and other types of advice and assistance (social supports) provided in response to either stress-related incidents (e.g., birth of a child with a condition placing him or her at-risk for poor health or developmental outcomes) or the need for resources to address family or child-related concerns (e.g., information on child intervention options) lessen the negative psychological effects associated with difficult life events.^{xii, xiii} The support(s) provided by parents that are responsive to other parents' individual needs, concerns, priorities, etc., are expected to decrease stress, enhance positive adaptations, and enhance and promote positive child, parent, and family functioning.^{vii}

Parent-to-parent programs typically have a parent coordinator who "takes" referrals for a parent or from another family member on behalf of a parent and who uses information obtained during a referral to match the parent with a more-experienced parent knowledgeable about parents' concerns or requests. In larger parent-to-parent programs, other parents, in addition to the program coordinator, obtain information about parents' concerns and match the parent with another more-experienced parent. The parent-to-parent coordinator at the time of referral obtains information about the reason for referral and information about the parents' child, child condition, diagnosis, or special challenges, the types of support needed or requested, the characteristics of the parent with whom the parent will be matched, and any specific preferences or concerns to be taken into consideration as part of a parent-to-parent match. Formal training for parents who will provide support to other parents is considered both essential and necessary for parent-to-parent programs to be effective.^{xiv, xv, xvi} The same is the case for parent-to-parent support group facilitators.^{xvii}

Parent-to-parent support groups typically involve the exchange of information, advice, guidance, etc., and other types of social supports among parents with similar needs, concerns, or preferences.ⁱⁱⁱ These groups are most often conducted at regularly scheduled times and often include supportive exchanges during special events or those offered on special topics at parent meetings or workshops (e.g., parents night out). Parent-to-parent support groups are generally run

by parents with experience in the purpose of the groups or by professionals who have personal experience with the main focus of a support group.^{v, xviii}

The program features generally considered the defining characteristics of a well-developed and operated parent-to-parent program and parent-to-parent support groups include mutually beneficial exchanges between parents, parents who are respectful of one another, parents who are good listeners and who offer or provide support in response to other parents' concerns and requests, and parents who are nonjudgmental and accepting of parents' unique family situations.^{xix, xx, xxi} The benefits of these features are expected to include, but are not limited to, enhanced coping, psychological health, family adaptations, family functioning, and advocacy.^{i, viii, xi, xxi, xxii}

Target Audience

The target audience of parent-to-parent support as part of early childhood intervention includes mothers, fathers, and other family members in households with young children birth to 5 years of age where the children have conditions that cause psychological disturbances, stress, or other problems related to poor or maladaptive coping. Most parent-to-parent programs, however, work with parents with children of any age, although those funded by Smart Start are for children birth to 5 years of age.

Overall Research Evidence for Parent to Parent Peer Support

- Parent-to-parent support and parent support groups have a wide range of positive effects, including changes and improvements in parent psychological health; family functioning, coping, empowerment, and enhanced perception of family well-being; positive parent and family adaptations to each child and family's unique circumstances; improved willingness to engage in appropriate services; improved positive parenting practices; higher rates and duration of breastfeeding; and improved child development.^{x, xi, xxii, xxiii, xxiv, xxv, xxvi, xxvii}
- Results are positive for both parents receiving support as well as parents providing support to others. However, due to the lack of differences between parent-to-parent and nonintervention group parents, most investigators have concluded that parent-to-parent is promising but is not yet a practice that has sufficient research to claim that it is evidence-based.^{vii, xxviii, xxix, xxx, xxxi}

Peer Support for Parents of Children with Disabilities and Chronic Illness



Target Audience

Parents of young children who have disabilities or chronic illnesses

Documented Outcomes

	Type of Study	Parent Outcomes			
		Increased social support*	Improved family empowerment, functioning, coping, and adaptation to disability	Reduced parental anxiety	Increased parental confidence and self-esteem
Singer et.al. (1999) ^{xxxii}	Experimental	✓	✓		
Ireys et.al. (2001) ^{xxxiii}	Meta-Synthesis	✓		✓	
Schilling et.al. (2013) ^{xxxiv}	Meta-Synthesis	✓	✓	✓	✓

This table contains outcomes found to be associated with the program or approach. Individual studies may contain additional outcomes that were tested and not found to be associated with the program or approach.

*Aligned with Smart Start outcome *Increase in parent's social support*

Peer Support for Parents of Children with Disabilities and Chronic Illness Snapshot

- **EC Profile Indicator:** FS30 - Rate of investigated reports of child abuse/neglect per 1000 children ages 0-5
- **Clearinghouse Rating:** None
- **Research supports** use with parents of children, birth through five, who have disabilities or chronic illnesses
- **Related Smart Start outcomes:**
 - Increase in parent's social support
- **Training required:** Yes
- **Staff qualifications:** Parent of grown child with disability or chronic illness
- **Frequency:** Approximately bi-weekly
- **Suggested Assessments:** Protective Factors Survey

Research Evidence for Peer Support for Parents of Children with Disabilities and Chronic Illness

- There is evidence that parent-to-parent peer support can contribute to improved social support, improved family functioning, improved parent confidence, and reduced parental anxiety.

Review of Experimental and Quasi-Experimental Studies

Citation	Singer, G. H. S., Marquis, J., Powers, L. K., Blanchard, L., Divenere, N., Santelli, B., Ainbinder, J. G., Sharp, M. (1999). A multi-site evaluation of parent to parent programs for parents of children with disabilities. <i>Journal of Early Intervention, 22</i> , pp. 217-229.
Population and Sample	<ul style="list-style-type: none"> • 128 parents of children with disabilities assigned to treatment (n=56) or control groups (n=72). <ul style="list-style-type: none"> ○ 45% of children were 5 years of age and younger and receiving early intervention services • Selection criteria consisted of (a) being parents, foster parents, or grandparents of children with a disability or chronic health condition, (b) having access to a telephone, and (c) willing to wait up to 2 months for support from Parent to Parent if selected for the waiting list comparison group. <ul style="list-style-type: none"> ○ The treatment group participated in Parent to Parent for 2 months; control group parents were moved to a support group after 2 months.
Methodology	Experimental, with pre/post assessments and a qualitative component with a subsample
Purpose	This study was an experimental evaluation of Parent to Parent Programs in five states: Kansas, New Hampshire, North Carolina, South Carolina, and Vermont. Expected changes included an increase in parents' estimates of their a) ability to cope with a child's disability, b) sense of empowerment to effect change or obtain services for their children, and c) general acceptance of their family's life circumstances.
Measures & Assessments	<ul style="list-style-type: none"> • Source of Strength and Family Closeness subscale of the Kansas Inventory of Parental Perceptions (KIPP) • The Family Empowerment Scale • Parent Coping Efficacy Scale • Parent survey • Telephone interview
Study Implementation	<ul style="list-style-type: none"> • Eight weeks prior to random group assignment, pre-test measures were mailed to parents. • Parent mentors were asked to make four calls over the 2-month program period to the parents in the intervention group. • At the end of the 2 months, post-test measures were mailed to parents in the intervention and the control groups. • Following completion of the intervention by both the waiting list and treatment groups, parents were divided into two groups based on their responses to a survey: those who rated Parent to Parent as helpful and those who did not. From these two groups, 12 participants were randomly assigned to two groups for participation in a telephone interview to collect additional qualitative information about the program.
Staff Qualifications	<ul style="list-style-type: none"> • Parent mentors received an average of 8 to 10 hours of training.
Key Findings	<ul style="list-style-type: none"> • There were statistically significant gains for the intervention group on the family and disability measure, which is a measure of attitudes thought to be a primary component of parental cognitive adaptation to disability. • There were significant differences on post-test scores between the groups, in favor of the intervention group, for parents who began the study with lower levels of perceived coping skills. • There were no significant changes on the measure of empowerment. • The intervention group made statistically significantly greater progress in meeting their needs than the control group. • 89% of intervention group parents rated the program as helpful. • Qualitative interviews suggest that parents who rated the program as helpful and reported feeling isolated before participating in the program reported feeling supported by discovering that there are "really people out here that understand me." Parents who reported that the program was not helpful reported that the differences between the participating parent and the parent mentor impeded the participating parents' sense of being understood. These findings suggest that the perception of "sameness" is key to the success of the intervention.

Review of Meta-Syntheses

Citation	Ireys, H. T., Chernoff, R., Stein, R. E. K., DeVet, K. A., & Silver, E. J. (2001). Outcomes of community-based family-to-family support: Lessons learned from a decade of randomized trials. <i>Children's Services: Social Policy, Research, and Practice</i> , 4(4), pp. 203-216.							
Population and Sample	<ul style="list-style-type: none"> 3 randomized controlled trials of community-based support programs for parents of children with chronic illnesses; 78% to 92% of mothers had at least a high school education and mean age ranged from mid to late 30s; racial composition reflected the site of the study and the illnesses/conditions of the children in the groups. Mothers were randomly assigned to experimental and control groups (This article did not provide group sizes but noted that the information was reported elsewhere). <ul style="list-style-type: none"> Study 1: 365 children with a range of conditions; 37% African American, 48% Hispanic mothers; 42% of mothers worked outside of the home Study 2: 53 children with arthritis; 92% White mothers; 65% of mothers worked outside of the home Study 3: 193 children with diabetes, cystic fibrosis, sickle cell anemia, and moderate to severe asthma; 42% African American, 6% Hispanic mothers; 70% of mothers worked outside of the home 							
Methodology	Experimental, with repeated measures							
Purpose	A review of the results and lessons learned from 3 randomized controlled trials of 12- to 15-month community-based support programs for parents of school-aged children with chronic illnesses. Support was provided by trained mothers who were raising or had raised children with similar health conditions.							
Measures & Assessments	<ul style="list-style-type: none"> Psychiatric Symptom Index 							
Study Implementation	<ul style="list-style-type: none"> All three programs were based on the same conceptual framework and implemented through pediatric tertiary care centers. <table border="1" data-bbox="386 890 1427 1304"> <tr> <td>Study 1</td> <td>In Study 1, three parents of children with chronic health conditions were hired part time as support partners. Assignments were made on the basis of geographical proximity. Because we employed only three support partners and a large group of participating parents, no attempt was made to link support partners with parents on the basis of diagnosis.</td> </tr> <tr> <td>Study 2</td> <td rowspan="2">In Studies 2 and 3, the intervention was specifically designed to make this link; thus, all of the support partners had children with the same condition as the participating parents. In addition, we selected support partners with children who were at least young adults to convey the concept that the support partners "had been there, had survived, and are still going."</td> </tr> <tr> <td>Study 3</td> </tr> <tr> <td colspan="2">In all three studies, support partners were asked to make telephone calls every two weeks with assigned parents and to meet with them about six times during the course of the program. In addition, three special events (e.g., picnics or bowling parties) were held for all of the families during each of the intervention periods.</td> </tr> </table> <ul style="list-style-type: none"> Support partners included parents whose children were at least young adults. Three parents of children with chronic health conditions were hired as support partners in Study 1 and were not linked with parents whose children had the same or similar conditions. Studies 2 and 3 were specifically designed to link support partners who had children with the same condition as participating parents. Support partners were asked to make telephone calls to their assigned parents every two weeks and meet with them about six times throughout the period of the program. Three special family events (e.g., picnics or bowling parties) also were held during each program period. The Psychiatric Symptom Index was completed pre and post intervention by all participants. Posttest interviews were conducted 12 months after program enrollment. The intervention team met with a health and/or mental health professional every week throughout the programs. 	Study 1	In Study 1, three parents of children with chronic health conditions were hired part time as support partners. Assignments were made on the basis of geographical proximity. Because we employed only three support partners and a large group of participating parents, no attempt was made to link support partners with parents on the basis of diagnosis.	Study 2	In Studies 2 and 3, the intervention was specifically designed to make this link; thus, all of the support partners had children with the same condition as the participating parents. In addition, we selected support partners with children who were at least young adults to convey the concept that the support partners "had been there, had survived, and are still going."	Study 3	In all three studies, support partners were asked to make telephone calls every two weeks with assigned parents and to meet with them about six times during the course of the program. In addition, three special events (e.g., picnics or bowling parties) were held for all of the families during each of the intervention periods.	
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Staff Qualifications	<ul style="list-style-type: none"> After being nominated by specialty and general pediatric clinics, mothers participated in a 30- to 40-hour training program. Graduates thought to be most capable of serving as effective support partners were selected from the group and participated in a 10-hour intensive training program. 							
Key Findings	<ul style="list-style-type: none"> Mean anxiety scores were lower following intervention for the experimental groups than for the comparison groups in all three studies. This difference was significant for Studies 2 and 3. There were no significant effects on any other measure of maternal mental health for any of the studies. Although Study 2 found evidence of enhanced perceptions of social support, there was no evidence that this was the pathway for the effect on maternal anxiety. There was no evidence of a relationship between dosage of intervention and response. 							

Citation	Shilling, V., Morris, C., Thompson-Coon, J., Ukoumunne, O., Rogers, M., & Logan, S. (2013). Peer support of parents of children with chronic disabling conditions: A systematic review of quantitative and qualitative studies. <i>Developmental Medicine & Child Neurology</i> , 55(7), pp. 602-609.
Population and Sample	<ul style="list-style-type: none"> • Seventeen papers were included in the review: <ul style="list-style-type: none"> ○ 9 qualitative studies ○ 7 experimental studies ○ 1 mixed-methods evaluation
Methodology	Meta-study
Purpose	To review the quantitative and qualitative evidence of the effectiveness of peer support for parents of children with long-term health conditions.
Measures & Assessments	<ul style="list-style-type: none"> • Sources of Strength and Family Closeness • Impact on Family Scales
Study Implementation	<ul style="list-style-type: none"> • To be included in the analysis a study must involve: a) parents and caregivers of children with chronic disabling conditions (i.e., disabled, chronically, seriously ill children and young people); 2) informal or formal in-person parent support provided by parents either one-on-one or in group meetings; and 3) outcomes related to parental psychological health, experience of the person providing or receiving peer support, economic implications of peer support programs, family functioning, accessing services or information, relationships with health professionals, and long-term impact of peer support • Two reviewers independently assessed qualitative studies based on five criteria of quality; disagreements were resolved through discussion. • One reviewer assessed quantitative studies using criteria based on the National Health Service Centre for Reviews and Dissemination and the Cochran Collaboration. Scores were checked by a second reviewer.
Staff Qualifications	<ul style="list-style-type: none"> • Not addressed
Key Findings	<ul style="list-style-type: none"> • Eight studies contributed quantitative data based on the outcomes they assessed (i.e., psychological health, family function, experience of parents receiving support, accessing services and information). <ul style="list-style-type: none"> ○ There were consistent effects on anxiety, anger, cognitive disturbance, concern, confidence, coping, depression, empowerment, illness intrusion, overall mental health. ○ Evidence was weak regarding increased use of community resources by parents or the number of emergency room or acute care visits or number of calls made to specialists. • Ten papers contributed qualitative data across five themes (i.e., shared social identity, learning from the experience of others, personal growth, supporting others, when peer support does not work). <ul style="list-style-type: none"> ○ The most common theme across studies related to benefits of finding a shared social identity with other parents, which fostered a sense of belonging, support, and empowerment. This helped parents to feel better able to cope and reduced feelings of isolation, loneliness, and guilt. ○ Many parents described learning from the expertise and experience of other parents. ○ Parents reported a sense of empowerment, confidence, and control, enabling them to develop new skills, motivation, and affirmation of their expertise as parents. ○ Parents in several studies reported feeling that giving support was as important as receiving it. ○ Some parents reported no benefit from peer support, which was attributed to the lack of a shared identity. Parents with high levels of stress or who felt pressured by a professional to participate were less satisfied with the support they received.

Review of Descriptive and Non-Experimental Studies

None

Peer Support for Parents of Young Children with Mental Health Issues



Target Audience

Parents of young children who have concerns about the mental health of the parent, child, or family.

Documented Outcomes

	Type of Study	Parent Outcomes			Child Outcomes	
		Improved parenting competencies and practices*	Perceived parenting style	Improved family empowerment, functioning, coping, and adaptation to disability	Reduced child behavior problems**	Child academic performance**
Day et.al. (2012) ^{xxxv}	Experimental	✓			✓	
Lennon et.al. (1997) ^{xxxvi}	Non-experimental with comparison groups		✓			
Hoagwood et.al. (2009) ^{xxxvii}	Meta-synthesis					✓

This table contains outcomes found to be associated with the program or approach. Individual studies may contain additional outcomes that were tested and not found to be associated with the program or approach.

*Aligned with Smart Start outcome *Increase in positive parenting practices*

**Aligned with Smart Start outcome *More children on track for typical and/or enhanced development*

Parent-to-Parent Peer Support for Mental Health Issues Snapshot

- **EC Profile Indicator:** FS30 - Rate of investigated reports of child abuse/neglect per 1000 children ages 0-5
- **Clearinghouse Rating:** None
- **Research supports** use with parents of children, birth through five, who have concerns about parent, child, or family mental health
- **Related Smart Start outcomes:**
 - Increase in positive parenting practices
 - More children on track for typical and/or enhanced development
- **Training required:** Yes
- **Suggested Assessments:**
 - Eyberg Child Behavior Inventory
 - Protective Factors Survey

Research Evidence Peer Support for Parents of Young Children with Mental Health Issues

- The evidence in support of parent-to-parent peer support is varied, with some studies supporting peer support's effectiveness while other studies fail to find statistically significant associations between peer support and parent or child outcomes.

Review of Experimental and Quasi-Experimental Studies

Citation	Day, C., Michelson, D., Thomson, S., Penney, C., & Draper L. (2012). Evaluation of a peer led parenting intervention for disruptive behaviour problems in children: community based randomised controlled trial. <i>BMJ</i> , 344, pp. 1-10.
Population and Sample	<ul style="list-style-type: none"> • 116 children 2-11 years of age randomly assigned to groups; families reported difficulties in managing children's behavior: <ul style="list-style-type: none"> ○ Intervention group = 59 ○ Waitlist group = 57
Methodology	Experimental
Purpose	To evaluate the effectiveness of peer parent group program called, Empowering Parents, Empowering Communities, delivered to socially disadvantaged families at six sites located in schools and children's centers in inner London, UK. The goals of the parenting groups were to improve parent-child relationships and interactions, reduce child behavioral problems, and increase parents' confidence in their parenting abilities.
Measures & Assessments	<ul style="list-style-type: none"> • Eyberg Child Behavior Inventory • Concerns About My Child Measure • Arnold-O'Leary Parenting Scale • Parenting Stress Index-Short Form • Strengths and Difficulties Questionnaire
Study Implementation	<ul style="list-style-type: none"> • Trained peer facilitators worked in pairs to deliver the intervention program to groups of 7-14 parents over 8 weekly 2-hour sessions. Intervention sessions involved information sharing, group discussion, demonstration, role play activities, reflection, and planning and review of homework tasks. • Measures were administered to both groups one week before and immediately after the intervention ended. • Peer facilitators received regular supervision to ensure fidelity of the intervention, skill development, and personal support. Supervisors were available by telephone to manage potential safety issues, such as recognizing and reporting abusive parenting practices.
Staff Qualifications	Peer facilitators included 12 parents from the local community who completed an accredited training program. The training consisted of 60 hours of workshops, submission of a written portfolio, and a period of supervised practice.
Key Findings	<ul style="list-style-type: none"> • 91.5% of the peer-led intervention group had high treatment retention and user satisfaction. • Child behavior problems were significantly reduced for the intervention group. • Parenting competencies and practices significantly improved for the intervention group, with no differences in parental stress between the intervention and waitlist groups.

Review of Meta-Analyses

Citation	Hoagwood, K. E., Cavaleri, M. A., Olin, S. S., Burns, B. J., Slaton, E., Gruttadaro, D., & Hughes, R. (2009). Family support in children's mental health: A review and synthesis. <i>Clinical Child and Family Psychology Review</i> , 13(1), pp. 1-45.
Population and Sample	50 distinct programs and their major family support components
Methodology	Meta-study
Purpose	A review of structured family support programs in children's mental health to identify typologies of family support services and identify research gaps.
Measures & Assessments	Varied across study
Study Implementation	<ul style="list-style-type: none"> • To be included in the review, family services, interventions, or programs were expected to meet the following criteria: a) provide information, skills building, concrete help, or advocacy skill training support specifically for caregivers of children or adolescents with mental health conditions (as opposed to other health or developmental conditions); b) published between 1990 and 2008; c) provide more than a didactic workshop; d) be part of a child's treatment and include a separate caregiver support component that did not focus on improving the child's outcome; e) have a formal curriculum or structure; and f) have some evaluative data or be currently under study. • Two of the authors reviewed the 50 interventions meeting the selection criteria to determine categories, codes and typologies. The coding system was reviewed and approved by all of the authors and the two authors then coded the interventions, discussing any discrepancies until consensus was reached.

- Of the 50 programs reviewed, 11 (22%) used a peer-to-peer model, with 8 (73%) of these being affiliated with family-run organizations; 33 (66%) were clinician-led programs; and 6 (12%) were team led. Peer-to-peer programs were led by parents with experience navigating services systems for their own children with mental illness.
- *Only the peer-to-peer model studies are included in this review.*
- The two authors coded all 50 interventions together to ensure inter-rater reliability.

Staff Qualifications

- Not addressed

Key Findings

- There were only three experimental (n=2) or quasi-experimental (n=1) studies of the 11 peer-to-peer programs included in the review.
 - Overall, the findings suggest that family support may be most beneficial for less empowered families, such as low-income families.
 - Although families with support were more likely to initiate mental health services for their children, there was no difference between treatment and control groups for treatment attendance or retention.
 - One study focusing on child academic performance among seriously emotionally disturbed youth found positive changes in child academic performance.

Hoagwood et.al.	<p>NYS PEP Program: 40-hour training for family advisors/advocates working with parents/caregivers of youth with mental health needs (Jensen & Hoagwood, 2008) Followed by 6 month small group telephone consultation (12 hrs) Co-led by experienced parent advocate and MH professional to model collaboration Goals: – Enhance family advisors’ knowledge of evidence-based practices in children’s mental health – Enhance family advisors’ skills and competencies in working with parents (engaging, boundary setting, priority setting, questioning, group management) – Improve parent activation and youth mental health Theory-based targeting principles of behavior change (Jaccard et al., 2002) Manualized</p>
Kutash et.al. 2006	The article cited is a manual on school-based mental health interventions
Koroloff et.al. 1996	<p>The purpose of using paraprofessionals in this study was (a) to increase the number of families who, once referred for children's mental health services, actually initiated those services, and (b) to encourage service continuance. The Family Associate role was created to address the major problems associated with children's mental health service initiation and continuance, particularly those that low-income families might encounter. The Family Associates were employed by their respective county mental health programs and received referrals through the EPSDT process. In order to intervene early in the service initiation process—when dropout was most likely (Baekeland & Lundwall, 1975; Larsen, Attkisson, Hargreaves, & Nguyen, 1979; Sirls, 1990)—the Family Associates contacted the parents or other family members soon after the referral for mental health services was made. The most common Family Associate services were (a) providing families with information, (b) providing caregivers with social and emotional support, and (c) linking families to community resources and services. An innovative feature of this intervention was the availability of a flexible cash fund.</p>

Review of Descriptive and Non-Experimental Studies

Citation	Lennon, L., Maloney, C., Miller, J., Underwood, M., Walker, J., Wright, C., & Chambilss, C. (1997). An evaluation of informal parent support groups. Retrieved from: http://www.eric.ed.gov/ERICWebPortal/contentdelivery/servlet/ERICServlet?accno=ED408078 .
Population and Sample	<ul style="list-style-type: none"> • 75 parent participating without random assignment in intervention (n=38) and comparison (n=37) groups <ul style="list-style-type: none"> ○ Intervention group parents met regularly with other parents to discuss parenting concerns and experiences, but no explicit parental support was provided. ○ Comparison group parents had not previously participated in any formal or informal parent education programs.
Methodology	Non-experimental, pre/post with comparison group
Purpose	The purpose of this study was review the effects of informal parent support networks on perceptions of child behavior, styles of discipline, and satisfaction in parenting.
Measures & Assessments	<ul style="list-style-type: none"> • Eyberg Child Behavior Inventory • Cleminshaw- Guidubaldi Parent Satisfaction Scale • Parenting Self Appraisal Scale • Daily Behavioral Responses
Study Implementation	<ul style="list-style-type: none"> • Pre and post-tests were administered anonymously to all participants over a five week period. Post-test response rate was 35% for the intervention group and 54% for the comparison group.
Staff Qualifications	<ul style="list-style-type: none"> • Not addressed
Key Findings	<ul style="list-style-type: none"> • There were no significant differences between the groups on most measures of perception of children's problems and parenting or use of disciplinary strategies. • There was a significant difference between the intervention and comparison groups for perceived parenting styles, with intervention groups seeing their parenting as more permissive.

End Notes

ⁱ Kerr, S. M., & McIntosh, J. B. (2000). Coping when a child has a disability: Exploring the impact of parent-to-parent support. *Child: Care, Health and Development*, 26(4), pp. 309-321.

ⁱⁱ Mathiesen, A. M. (2012). Parental needs among children with birth defects: Defining a parent-to-parent support network. *Journal of Genetic Counseling*, 21, pp. 862-872.

ⁱⁱⁱ Santelli, B., et al. (1995). Parent to parent programs: A unique form of mutual support. *Infants and Young Children*, 8(2), pp. 48-57.

^{iv} Pizzo, P. (1987). Parent-to-parent support groups: Advocates for social change, in America's family support programs: Perspectives and prospects, S.L. Kagan, et al., Editors. Yale University Press: New Haven, CT. pp. 228-242.

^v Solomon, M., Pistrang, N., & Barker, C. (2001). The benefits of mutual support groups for parents of children with disabilities. *American Journal of Community Psychology*, 29, pp. 113-132.

^{vi} Roman, L. A., et al. (1995). Parent-to-parent support initiated in the neonatal intensive care unit. *Research in Health and Nursing*, 18, pp. 385-394.

^{vii} Silver, E. J., et al. (1997). Psychological outcomes of a support intervention in mothers of children with ongoing health conditions: The parent-to-parent network. *Journal of Community Psychology*, 25(3), pp. 249-264.

^{viii} Wilton, G., & Plane, M. B. (2006). The family empowerment network: A service model to address the needs of children and families affected by fetal alcohol spectrum disorders. *Pediatric Nursing*, 32(4), pp. 299-306.

^{ix} Dunst, C. J., et al. (1989). Building and mobilizing informal family support networks, in Support for caregiving families: Enabling positive adaptation to disability, G.H. Singer and L. Irvin, Editors. Brookes: Baltimore, MD. pp. 121-141.

^x Hoagwood, K. E., Cavaleri, M. A., Olin, S. S., Burns, B. J., Slaton, E., Gruttadaro, D., & Hughes, R. (2010). Family support in children's mental health: A review and synthesis. *Clinical Child and Family Psychology Review*, 13(1), pp. 1-45.

^{xi} Ireys, H. T., Chernoff, R., Stein, R. E. K., DeVet, K. A., & Silver, E. J. (2001). Outcomes of community-based family-to-family support: Lessons learned from a decade of randomized trials. *Children's Services*, 4, pp. 203-216.

^{xii} Jones, L., Rowe, J., & Becker, T. (2009). Appraisal, coping, and social support as predictors of psychological distress and parenting efficacy in parents of premature infants. *Children's Health Care*, 38, pp. 245-262.

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