

# **Best Practices in Children's Mental Health**

A Series of Reports Summarizing the Empirical Research and other  
Pertinent Literature on Selected Topics

## **Report # 22**

### **Best Practices to Engage Parents of Children Receiving Mental Health Services**

**January, 2008**

**Produced by the University of Kansas**

School of Social Welfare

Twente Hall

Lawrence, Kansas

In conjunction with

Kansas Department of Social and Rehabilitation Services

Author: Tara McLendon, LSCSW

Project Supervisor: Chris Petr, PhD, LSCSW

## Table of Contents

Executive Summary.....	3
Introduction.....	5
Search Methodology.....	7
Consumer Perspective.....	8
Professional Perspective.....	9
Research Perspective.....	11
Summary Conclusions of Current Best Practices.....	15
Summary of Best Practices.....	17
Critique of Current Best Practices.....	18
Recommendations to Improve Current Best Practices.....	20
References.....	23

## **Best Practices to Engage Parents of Children Receiving Mental Health Services**

### Executive Summary

It has been well-documented that parental involvement in children's mental health treatment is a crucial component to positive outcomes and lasting change (Cunningham & Henggeler, 1999; Liddle, 1995; Szapocznik et al., 1988; Coatsworth, Santisteban, McBride, & Szapocznik, 2001; Hogue, Liddle, Dauber, and Samuolis, 2004). This best practices report examines consumer, professional, and research perspectives regarding ways to engage parents in the provision of children's mental health services. The research perspective includes high quality, experimentally designed studies. Each of the three perspectives is considered, practices identified by each perspective are compared and contrasted with the other two perspectives, and current best practices are identified. Finally, recommendations for potential improvements are made.

In summary, there is little agreement across all three perspectives regarding what would be considered best practices to involve parents in the provision of children's mental health services. There were, however, six distinct practices identified by at least two of the three perspectives examined:

- providing culturally competent services;
- showing respect and concern to parents;
- increasing consumer knowledge of resources and treatment options (including increasing knowledge of the educational system);
- utilizing a framework for the initial phone call/first session/ongoing sessions
- facilitating interagency collaboration;

- providing hope to parents that the problematic situation can improve.

There are at least three recommendations that could enhance currently identified best practices. First, a more consistent emphasis on identifying parent and child strengths in the engagement process could help facilitate parental involvement. Secondly, more clearly articulating program costs and how this impacts family accessibility, as well as developing effective no or low-cost models to facilitate parental engagement in children's mental health services could potentially improve involvement. Lastly, within the context of what is already known about the consumer, professional, and research perspectives, improvement could be made by incorporating all of the six identified best practices together into a structured, organized, and focused program of family involvement. In doing so, this would provide a model based on current best practices which could then be evaluated and continually developed. This would enhance development of a model in a rural setting, as this is one area of research regarding parental engagement that appears to be non-existent.

## **Best Practices to Engage Parents of Children Receiving Mental Health Services**

This Best Practices Report is adapted from McLendon, T. (2008). Best practices to engage parents of children receiving mental health services. In C.G. Petr (Ed.), *Multidimensional Evidence-Based Practice: Synthesizing Knowledge, Research, and Values*. New York: Routledge.

### **Introduction**

This inquiry focuses on better understanding how to engage parents in the provision of children’s mental health services. As a point of clarification, the term “parents” is infrequently utilized in the literature. Instead, “family” involvement is commonly the way in which participation in a child’s treatment is conceptualized. For the purpose of this inquiry, the term “parents” will be utilized, with the understanding that it is consistent with the terms “family”, “caretaker”, or terms implying any person(s) functioning in the parent role. Furthermore, while the role and needs of the entire family are important considerations, the specific focus of the conclusions and recommendations of this inquiry will focus on parental involvement.

Parents of children with SED have many strengths, as well as clearly identified needs. Strengths of this population can include well-developed advocacy skills, perseverance, knowledge of mental health and social services, willingness to provide support to other parents of SED children, and wisdom about the needs of their children and themselves (Ditrano & Bordeaux, 2006; Spencer & Powell, 2000). Needs of these people can include the desire for a family-centered approach, cohesive and coordinated care that involves structured communication between service providers, being treated

with respect by service providers, geographically accessible services, and culturally competent care (Ditrano & Bordeaux, 2006; Spencer & Powell, 2000; Kruzich, Jivanjee, Robinson, & Friesen, 2003; Williams Adams, 2006).

There are several desired outcomes that increased parental engagement in the provision of children's mental health services could produce. Primary effects potentially include increased parental investment in the helping process, improved information exchange between the parent(s) and service provider(s), greater potential for reinforcement of treatment goals in the home, and enhanced parent/service provider alliance. Secondary outcomes of these primary effects could prospectively include more children avoiding out-of home placement home, as well as addressing concerns outlined above by Davis and Vander Stoep (1997).

It has been documented that parents who are engaged in the treatment of their child(ren) are a crucial component to positive outcomes and lasting change (Cunningham & Henggeler, 1999; Liddle, 1995; Szapocznik et al., 1988; Coatsworth, Santisteban, McBride, & Szapocznik, 2001). Hogue, Liddle, Dauber, and Samuolis (2004) point out,

Rigorous empirical studies have shown that family-based therapy can produce engagement and retention of drug users and their families in treatment (Henggeler et al., 1991); reduction or elimination of drug use (Liddle et al., 2001; Waldron, Slesnick, Brody, Turner, & Peterson, 2001); decreased involvement in delinquent activities (Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993); improvement in multiple domains of psychosocial functioning such as school grades, school attendance, and family functioning (Liddle et al., 2000); and increased quality of

parenting behavior (Mann, Bourdin, Henggeler, & Blaske, 1990; Schmidt, Liddle, & Dakof, 1996). (p.84)

This best practice inquiry incorporates consumer, professional, and research perspectives regarding the best practices to engage parents in the provision of children's mental health services. Each perspective is considered separately and best practices are summarized from each perspective. Finally, using a value framework, gaps in service delivery are identified and recommendations for improvement are made.

#### Search Methodology

A search of the literature regarding parental engagement in the provision of children's mental health services was conducted to identify consumer, professional, and research perspectives. Databases searched included: Expanded Academic ASAP, PsychINFO, Social Work Abstracts, and Lexus/Nexis Academic. Key terms included: children's mental health, Seriously Emotionally Disturbed (SED), family-centered practice, family-centered care, family involvement, family empowerment, family engagement, parent management training, parent(al) involvement, parent support, parent(al) engagement, barriers to mental health service provision, and system(s) of care. Finally, websites for Keys for Networking ([www.keys.org](http://www.keys.org)), The Research and Training Center on Family Support and Children's Mental Health at Portland State University ([www.rtc.pdx.edu](http://www.rtc.pdx.edu)), The Federation of Families for Children's Mental Health ([www.ffcmh.org](http://www.ffcmh.org)), Family Voices [www.familyvoices.org](http://www.familyvoices.org), and the University of Wisconsin Library ([www.library.wisc.edu](http://www.library.wisc.edu)) were searched for relevant information.

### Consumer Perspective: Sources

In an effort to include a consumer perspective regarding best practices to engage parents in the provision of children's mental health services, studies and articles incorporating this viewpoint were examined. The sources included were selected because they incorporate consumer thoughts and opinions, and this "voice" is clearly evident. The two empirically-based studies have an unambiguous research design and systematic data collection. The third article is an interview of a mother of an SED child, and speaks to parental involvement in short-term and long-term placement. Finally, the newspaper article expresses the voice of parents of SED children as articulated via a summit sponsored by the National Alliance for the Mentally Ill (NAMI).

Ditrano & Silverstein (2006) (C1) utilized a participatory action research (PAR) design to identify ways schools and parents can work together to more effectively to meet the needs of children with emotional disturbances. Although this study took place in an educational setting, because of the population studied and the goal of increasing parent engagement and involvement, it is reasonable to assume the findings are applicable to mental health service provision. A group of nine parents met seven times and a theoretical narrative was created by the researchers. This narrative described the parents' stories, their action projects, and conclusions reached regarding their need to become more effectively involved in their child's educational experience.

In Spencer and Powell (2000) (C2), the author (John Powell) interviewed Sandra Spencer, who is a parent of a child with SED and Executive Director of the Federation of Families for Children's Mental Health, a national advocacy organization. Her son was

placed in a residential treatment setting for one-and-one-half years, and later in an inpatient psychiatric unit for 30 days. Throughout the interview, Ms. Spencer spoke of staff behaviors or institutional policies she saw as barriers to her involvement in her son's care, as well as behaviors and policies she perceived to engender parental engagement and ongoing involvement in care.

A survey of 102 family caregivers in 31 states examined perceptions of barriers to and supports of their participation in their children's out-of-home treatment (Kruzich, Jivanjee, Robinson, & Friesen, 2003) (C3). The data were gathered via a questionnaire mailed to parents of children who had received at least three months of in-home treatment or at least 30 continuous days of out-of-home treatment for emotional, behavioral, or mental disorders from September 1, 1996 and August 31, 1998. Finally, a NAMI sponsored summit held in January 2006, the Children's Mental Health Voice of Florida Summit, produced recommendations to fill service gaps and better involve parents in service delivery to SED children (C4).

#### Professional Perspective: Sources

In addition to consumer perspectives, professional perspectives of best practices to involve parents in the provision of children's mental health services were examined. Criteria for selection included rigorous research design and/or significant study and implementation of the particular model or paradigm. One of the articles represents the perceived needs of service providers to more effectively involve families in service delivery (P1). Articles two, three, and four are conceptual papers based on well-

developed and thoroughly studied models of service delivery, all of which include a framework for engaging/involving parents.

Craft-Rosenberg, Kelley, and Schnoll (2006) (P1) conducted four focus group interviews with the purpose of describing service provider views of family-centered practice. Seventy-six service providers from social work, nursing, and other helping professions participated. Pre and post meeting questionnaires were utilized.

Liddle (1995) (P2) describes engagement strategies specific to Multidimensional Family Therapy (MDFT). The author conceptualizes engagement not as an event which takes place at the beginning of therapy, but as an ongoing therapeutic process. Strategies and methods to engage parents in their child's treatment include providing hope, looking for parent strengths, and attending to transportation and childcare barriers, among others.

Santisteban and Szapocznik (1994) (P3) provide strategies to engage families of substance abusing and emotionally/behaviorally troubled youth. This framework is the result of thirty years of service provision and study at the Spanish Family Guidance Center at the University of Miami. This approach to family involvement is based on Brief Strategic Family Therapy and specifically aims to address family interactional patterns that prevent families from engaging in services.

Through the development of Multisystemic Therapy, Cunningham and Henegler (1999), identify ways in which multi-problem families can be engaged in the therapy process (P4). Multisystemic Therapy is a home-based services approach that provides integrative, family-centered treatment. It was specifically designed to respond to the needs of adolescents who exhibit serious anti-social behavior and conduct disorder. The

authors discuss universal engagement strategies, as well as those specific to MST.

#### Research Perspective: Sources

A research perspective of parental involvement in children's mental health service delivery to was also considered. Each selection criteria was worth ten points, with a possible total of 100 points. Selection criteria included: design type (Lyness, Walsh, & Sprenkle, 2005); length of study; sample size (Lyness, Walsh, & Sprenkle, 2005); quality of instruments (e.g., reliability, validity) (Lyness, Walsh, & Sprenkle, 2005); intervention fidelity (Schoenwald, Sheidow, & Letourneau, 2004); thoroughness of data analysis/reporting; consistency with inquiry; strength of conceptual/theoretical base; transportability of practices/findings (Schoenwald & Hoagwood, 2001); and acknowledgement of inquiry limitations/researcher bias. A thorough literature review revealed eleven quantitative studies that specifically examined *means by which* to engage parents in children's mental health service provision. The five which scored the highest on the selection criteria were included, with scores ranging from 72 to 89.

McKay, McCadam, and Gonzalez (1996) (R1) report the effects of a engagement intervention delivered during the initial parent telephone contact that was designed to increase attendance at intake assessment. One hundred-eight inner-city families requesting child mental health services were randomly assigned to one of two conditions. The first condition (n=55) involved a 30 minute intensive telephone engagement intervention. It was designed to clearly identify the child's needs, help the caretaker to take steps to address situation prior to the initial appointment, and examine and address barriers to service (e.g. negative experience with previous helping

experiences, problems with transportation and/or childcare). This service was provided by two master level social workers. The second condition (n=53 families) consisted of a routine telephone screening, lasting approximately thirty minutes. This screening, provided by a Master level social worker, specifically related to the child's functioning and the need for service. Forty of the fifty-five intervention families (72.7%) attended the first appointment or called at least one day in advance to reschedule. Conversely, only 45.3% of comparison families attended the first appointment or called to reschedule.

Santisteban et al., (1996) (R2) utilized Strategic Structural Systems Engagement (SSSE) with 193 Latino families that were randomly assigned to experimental or control conditions. The experimental condition consisted of SSSE, which is based on concepts of Brief Strategic Family Therapy and purports that a family's resistance to therapy will manifest itself during the intake process, and as such, can be more effectively addressed within that context. Control families received usual intake services. The study found that 81% of the experimental group was successfully engaged (attending at least two sessions), while only 60% of the control families attended at least two sessions.

McKay, Nudelman, McCadam, and Gonzalez (1996) (R3) report the effects of an engagement model designed to be delivered during the initial session. One hundred-seven inner-city families requesting child mental health services were randomly assigned to one of two conditions. The first condition (n=33) involved an interview protocol designed to involve families in mental health care. This condition had the purpose of engaging the child and family in the helping process, focusing on immediate and practical

concerns, and identifying and addressing barriers to engaging in the helping process, among others.

In this study, 107 new families were randomly assigned to first interviewers trained in the above method, or a comparison group of therapists who did not receive this specific training. Of the 33 families assigned to the intervention provided by trained interviewers, 29 families (88%) attended their first session, and 28 (97%) returned for a second session. In comparison, of the 74 families assigned to the routine first interview condition, 47 (64%) attended the first session, and 39 (83%) returned for a second session. Over the 18 week study period, the intervention group attended an average of 7.1 sessions, while the second group attended an average of 5.4 sessions.

McKay, Stowe, McCadam, and Gonzalez (1998) (R4) studied the effects of two different engagement interventions and their impact on attendance at the initial appointment, as well as retention in ongoing services. One-hundred nine families participated in the inquiry, being randomly assigned to one of three conditions: combined intake procedure (n=35); telephone intervention alone (n=35); and usual intake procedure (n=39). Briefly, the telephone intervention alone consisted of a thirty minute intervention which was designed to assist the primary caretakers to invest in the helping process, explore barriers to seeking help, as well as encourage participants to take concrete steps to improve the situation before the first session. The combined intervention consisted of the telephone intervention, as well as assignment to a therapist specifically trained to focus on engagement during the first session. Finally, the comparison procedure consisted of usual techniques (e.g. assessing the child's need for service, obtaining

demographic information).

In summary, the combined intervention and telephone only intervention were associated with increased attendance at the initial appointment, as compared to usual techniques. This difference, however, was not statistically significant. Families in the combined condition attended an average of 7.3 sessions during the 18 week study, while those receiving only the telephone intervention attended an average of 5 sessions during this time. Finally, the usual intake group attended an average of 5.9 sessions within the course of the study.

The Family Associate Intervention was examined by Elliot, Koroloff, Doren, and Friesen (1998) (R5). This approach utilizes trained paraprofessionals, who have a child that has utilized community mental health services, as “Family Associates” (FA). In this study, 239 families were assigned to either a group that received usual community mental health services and the Family Associate Intervention (n=96) or a group only receiving usual services (n=143). At the time of referral and before a family’s first appointment, the FA contacted the parents to provide information about services, emotional support, and link families to community resources, and remained in contact with the parents for three months or until the child/family had completed three sessions. Follow-up information was collected four months after the three month/three session criteria were met. Each family also had access to \$250 to assist with barriers to service (e.g. child care, transportation, and respite). It is important to note it appears the \$250 was only made available to the families who received the FA Intervention. Moreover, the authors never speculate as to the influence of the money on the study outcomes (e.g., the

influence of the money on families who had access to it, versus comparison families who did not have access to the funds), nor do they discuss limitations in general.

Results indicate that FA involvement increased parent/caretaker initiation of services (attending the first session) to a statistically significant degree. At the four month follow-up, however, the two groups were relatively similar in continuation of services. Specifically, approximately 25% of each group had dropped out of services and approximately 30% of each group had missed at least one appointment.

### Summary Conclusions of Current Best Practices

#### Similarities and Differences

There is little agreement across all three perspectives regarding what would be considered best practices to involve parents in the provision of children's mental health services. This is likely due to the limited research base specific to this issue (Hoagwood, 2005). There are, however, six distinct practices identified by at least two of the three perspectives examined. Table 4 summarizes similarities and differences across the three perspectives.

Within the context of the consumer and professional perspectives, current best practices are identified. In addition, "recommended" practices are identified as well. These recommended practices are based on practices which consumers and professionals think might facilitate parental engagement in the provision of mental health services to children, or are interventions based on positive past experience(s) which involved parents in service provision. The purpose of this inclusion of "recommended" practices is to interface practices to which consumers and professionals would like to have

access/utilize, with best practices identified by the research community.

The two most commonly cited practices across all three perspectives are the provision of culturally competent services (C2, C3, C4[R], P1[R], P3, P4, R1, R2, R3, and R4) and showing respect and concern to families (C1[R], C2, C3, P2, P3, P4, R1, R2, R3, and R4). The next most frequently cited practice is the provision of a general framework for the initial phone call/first session/ongoing sessions (P1[R], P2, P4, R2, R3, and R4). Increasing consumer knowledge of resources and treatment options (including increasing knowledge of the educational system) follows (C1, C2, R3, R4, and R5). The facilitation of interagency collaboration (C2[R], C4[R], P1[R], and P2) is cited four times. Finally, providing hope to parents that their family's situation can improve is also noted four times (C1, C2, P2, and P4).

There are several practices referred to in one of the perspectives, but not in the other two. Specifically, consumers articulate the need for support from other parents/consumers to help them navigate and be more effectively involved in the system (C1 and C2[R]), as well as having the opportunity to contribute to the design of the treatment utilized with their children (C2 and C4[R]). Consumer perspectives two and three also make reference to the importance of communication with service providers as a practice to more effectively involve them in the care of their children.

Practices cited only within the professional perspective include the need for administrative support and allowance of adequate time to involve parents in the treatment process (P1[R], P2, and P4), as well as the importance of identifying parent and family strengths (P1[R], P2, and P4). Finally, there are practices cited by one source,

including building skills to work with multi-need families (P1[R]), addressing parental problems which may interfere with engagement (e.g., substance abuse, mental illness) (P4), and establishing therapist credibility as ways to effectively engage parents in the provision of mental health services to their children (P4).

Practices noted only in the research perspective, include the use of the initial phone call for services as a way to facilitate increased parent investment and involvement in their child’s care (R1, R2, R4, and R5). In addition, immediately addressing concrete parental concerns is cited three times (R1, R3, and R4).

**Table 4 Summary of Best Practices Across Consumer, Professional, and Research Perspectives**

<b>Best Practice</b>	<b>Consumer</b>	<b>Professional</b>	<b>Research</b>
<b>Interagency Collaboration</b>	<b>2R,3,4R</b>	<b>1R,2</b>	
<b>Culturally Competent Services</b>	<b>2,3,4R</b>	<b>1R,3,4</b>	<b>1,2,3,4</b>
<b>Showing Respect to/ Concern for Families</b>	<b>1R,2,3</b>	<b>2,3,4</b>	<b>1,2,3,4</b>
<b>Increasing Consumer Knowledge of Resources/ Treatment Options (Including Educational System)</b>	<b>1,2</b>		<b>3,4,5</b>
<b>General Framework of Engagement/Framework for 1st Session/Ongoing Sessions</b>		<b>2,3,4</b>	<b>1,2,3,4</b>
<b>Developing Consumer Advocacy Skills/ Increasing Family Self-Efficacy/Empowerment</b>	<b>1,2R</b>		<b>5</b>
<b>Providing/Instilling “Hope” for Families</b>	<b>1,2</b>	<b>2,4</b>	

X=Current Best Practice

R=Recommended Best Practice (based on theory of what might work or positive past experience)

### Summary of Best Practices

Through the inquiry outlined above, six practices were identified in response to the question, “What are the best practices to engage parents of children receiving mental health services?” These practices include: providing culturally competent services; showing respect and concern to parents; increasing consumer knowledge of resources and treatment options (including increasing knowledge of the educational system); utilizing a framework for the initial phone call/first session/ongoing sessions; facilitating

interagency collaboration; and providing hope to parents that the problematic situation can improve.

#### Critique of Current Best Practices

All of the studies were particularly strong in reference to sample size, as all of them had more than 100 participants. Transferability of findings to other settings, however, was the weakest of the criteria. The dynamic that restricts transferability is that much of the research base regarding parental engagement has been built with Latino and African American families living in urban areas with low socio-economic status. Thus, the applicability of findings to rural families of other racial and ethnic backgrounds is yet to be understood. Perhaps another weakness of the research perspective that affects its potency is that three of the five research articles come from the same group (McKay and colleagues). This section may have been strengthened by a greater diversity of authors, however, McKay and colleagues present the most rigorously studied methods and most promising outcomes.

While the quality of sources included in the inquiry are relatively high and there is some well-established research (Santisteban et al., 1996; Liddle, 1995; Cunningham & Henggeler, 1999), the study of specific ways to engage parents in the provision of mental health services to their children is not particularly well-developed, generally speaking (Hoagwood, 2005). Moreover, in reference to agreement across perspectives, the existing literature does not appear to have a consistent focus. It is important to note that there is not *disagreement*, per se, across perspectives, but the emphasis varies from author to author and group to group. For example, parents consistently voice that

communication with service providers and support from other parents helps to engage them in service delivery. The research literature, on the other hand, emphasizes specific techniques and strategies to involve parents, which may or may not be consistent with these consumer wishes. Furthermore, despite the fact a particular research author does not explicitly state parents should be treated with respect while utilizing specific engagement techniques, it is reasonable to assume that the author would not *disagree* that this is an important practice that engenders parental engagement.

These inconsistencies impact the strength of the identified best practices in that there is only some consistency across, and even within, perspectives. Specifically, because of a lack of predictable focus within the consumer perspective, only one practice is identified by three sources (no practice was identified by all four), thus necessitating the consideration of practices cited by only two sources. For the purpose of consistency, all professional practices with only two citations were also considered. While all of these factors bring into question the overall quality of “best” practices identified in this inquiry, there is some agreement across and among perspectives (e.g., culturally competent care, showing respect and concern to families), and all these dynamics should be considered while bearing in mind the limited amount of research in this area (Hoagwood, 2005).

Within a value-based context, the identified best practices to engage parents of children receiving mental health services are generally consistent with a System of Care and family-centered service provision model. The best practices also reflect an ecological understanding of families and are consistent with the NASW Code of Ethics. While the specific practices are commensurate with a strengths perspective,

the research base contributing to the identification of best practices is lacking in this regard. Finally, in reference to affordability, the cost/benefit of these particular practices is unexplored at this point.

#### Recommendations to Improve Current Best Practices

One weakness of the research base that was reflected in the articles' respective research scores is that most work has been done with Latino and African American families in inner city areas. Ways in which to facilitate the engagement of parents from other racial and ethnic groups, as well as parents from rural areas, is not yet understood. Therefore, the potency of this area of inquiry could be strengthened considerably by better understanding the needs of consumers and parents that have not been the subject of inquiry, and incorporating these perspectives in program design and evaluation.

Bearing in mind the value-critical analysis, there are at least three recommendations that could enhance currently identified best practices. First, there is not a consistent emphasis on identifying parent and child strengths in the engagement process. It has been documented that this can be an essential part of the helping process when working with families (Early & GlenMaye, 2000; Werrbach, 1996). Simple steps could be taken in the engagement process to utilize specific strengths-based questions such as, "What is one thing that is going well in your family?" or "When things were going better in your family, what was different?" (Saleebey, 2002).

Within the context of family strengths, the best practice of providing hope to parents that the problematic situation with their child can be improved, could also be more clearly operationalized. Saleebey (2002) states, "Often forgotten, but truly

important in promoting beneficial change are hope (and) positive expectations” (p. 81). The concept of hope seems to be a rather nebulous concept which could benefit from being more clearly elucidated, perhaps via strengths-based inquiries like, “What are your hopes for your child and your family?” or “Tell me about a time when you were optimistic and your child’s and family’s future.”

In reference to accessibility and agency affordability, three models (Cunningham & Henggeler, 1999; Santisteban et al., 1996; Liddle, 1995) appear to have more limited accessibility because of cost of agency utilization (Leschied, 2002; Szapocznik, 1999). The cost of McKay and colleagues’ models was not discussed, however, it appears as if a similar model using components consistent with those discussed could be implemented at most any Community Mental Health Center. Therefore, a way in which best practices could be improved is to more clearly articulate program cost and how that impacts family accessibility. Moreover, improvement could also be facilitated in this area by an increased emphasis on the development of effective no or low-cost models to facilitate parental engagement in children’s mental health services.

Within the context of what is already known about the three perspectives, improvement could be made by incorporating all of the identified best practices together, as well as including the recommendations for enhancements. In doing so, this would provide a model based on current best practices which could then be evaluated and continually developed. For example, consistent with the work of McKay et al. (2004), a clear model for the initial phone call, as well as the intake session could be designed. In this model, parents would be encouraged to share their experience of their child’s mental

health difficulties; problem-solving around barriers to service delivery would be facilitated; knowledge about the treatment process, options for care, and community resources would be shared in a clear, respectful, and culturally sensitive manner; and interagency collaboration would be facilitated. An emphasis on parent and child strengths, as well as an optimistic service provider attitude, would be included throughout the process. Finally, development of this model in a rural setting would be valuable, as this is one area of research that appears to be non-existent.

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