

BARRIERS TO ENGAGEMENT AND RETENTION OF CHILDREN'S MENTAL
HEALTH SERVICES

A Project

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by

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Division of Social Work

Abstract
of
BARRIERS TO ENGAGEMENT AND RETENTION OF CHILDREN'S MENTAL
HEALTH SERVICES

by
Christine Ruiz & Viviana Nevarez

When trying to understand why children and families in need of mental health services do not access their benefits it is important to understand the barriers faced when attempting to utilize services. The purpose of this project was to identify the barriers of engagement and retention that children and their parents face when accessing mental health services in the county of Sacramento. This qualitative survey research study asked 41 professionals of a local, Medi-Cal funded agency to identify what barriers they believed families encountered when attempting to access mental health services. The study found among financial stress being the most significant barrier, cultural barriers, and transportation were also identified. In addition, this study found the areas in which agencies could improve engagement techniques and training among mental health clinicians and other related staff. Implications for social work practice and policy are also discussed in this study.

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Date

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To my dearest Heavenly Father- thank you for never leaving my side. Thank you for Your unconditional and unfailing love. Mom and dad- I have felt your constant prayers in my life. Thank you for always listening, supporting, and pushing me to be the best I could be. I would of never been able to complete this season of my life without you. I love you! Alim- Thank you for the constant push to continue on when I felt I most wanted to give up. I love you. Adriana and Manpreet- The journey with you ladies has been one filled with constant love and support. Thank you for being the sisters I never had. I love you both dearly!

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For our beautiful children Zachary, Liam, Elliot, Sylvan, and Talia.

For my best friend and life partner Peter Quady.

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Chapter 1

INTRODUCTION

The barriers of engagement and retention of children's mental health services are a growing concern in the mental health field. It is estimated that of families that receive services, 20-80% drop out prematurely with many receiving less than half of the prescribed interventions (Ingoldsby, 2010). According to Sanitago, Kaltman, and Miranda (2012), these interventions are seen to broken into three major categories: logistical, attitudinal, and systemic. These barriers block the engagement and retention of families who are the most in need of such services for their children especially when low-income individuals do receive evidence-based mental health healthcare, they respond well to treatment. Ingoldsby adds that the consequences to the inability to engage and retain within this population are seen to be significant which include public health benefits being diluted and frequent no-shows and cancelations being costly for service providers. This is shown to only increase the low-income family's stressors and places them at a higher risk for mental health disorders. Further, mental illness can interfere with educational and occupational attainment, and increase risk for poverty and as authors suggest, high-quality and evidence-based interventions are needed to successfully reduce mental health problems and promote healthy functioning (Sanitago, Kaltman, & Miranda, 2012).

Statement of Collaboration

This project was written through the collaboration of both researchers, Christine Ruiz and Viviana Nevarez. Both researchers worked equally on chapters and all the subsequent revisions of the five chapters.

Background of the Problem

The National Survey of American Families (NSAF) reported that of the high numbers of children ages 6-17 in need of mental health services, only 21% will actually receive them; leaving 79%, or roughly 7.5 million children ages of 6 and 17, in need of mental health without care (Bringewatt & Gershoff, 2010). The troubling statistics become additionally disturbing when one begins to think that the current need for mental health services children have remains as high today as it was 20-49 years ago and not just in the United States but also internationally. It has been estimated by the World Health Organization that by 2020 psychiatric disorders in children will increase by over 50% and will become one of five most common causes of morbidity, mortality, and impairment in children (González, 2005).

It is predicted that families of single-parent status homes, socioeconomic disadvantage, parent psychopathology, ethnic minority status, and coming from a low-resource neighborhood demonstrate lower rates of engagements in clinical services and quality of participation in prevention programs (Ingoldsby, 2010). Such parents are not always fully engaged in treatment but research suggests that “engaged clients are more likely to bond with therapist and counselors, endorse treatment goals, participate to a greater degree, remain in treatment longer, and report higher levels of satisfaction”

(Thompson, Bender, Lantry, & Flynn, 2007). An average, 80 percent of therapists indicate routine inclusion of children and parents in treatment (Dowell & Ogles, 2010). Rates for older children, teens, is similar with an estimated 50-75% referred to treatment not initiating or completing the full course of treatment (Dowell & Ogles). For example, Thompson et al., (2007) states that creating a therapeutic alliance with adolescents is particularly challenging due to youths' inherent demand for developing independence and constant striving to differentiate themselves from authority. Adolescents are often involuntarily referred by parents and other caregivers and see limited value or need for treatment.

Statement of the Research Problem

The authors identified barriers faced by children and families seeking to access and retain mental health services. The authors also identified challenges faced by mental health professionals in engaging children and families in services. Data of reported challenges faced by families and professionals and data of evidence based engagement techniques to increase client success was analyzed in the conduction of this study.

Purpose of the Study

Families in search of mental health services for their children daily face barriers that contribute to children not obtaining services or the adequate amount of services. The primary purpose of this research was to quantitatively identify barriers to engagement and retention of youth and families receiving Medi-Cal funded mental health services in Sacramento County. The secondary purpose of this research was that it will inform mental health agencies in Sacramento County about the barriers that were found in hopes

that agencies could be better informed on the subject and find ways to appropriately minimize found barriers. Findings from the research project can be used to either create curriculum module or training session to health and human services professionals in Sacramento County so that they are better prepared to provide effective services to their future clients.

Theoretical Framework. It can be said that with families in need of mental health services are motivated to be a part of their treatment and make a greater effort to engage in services when individuals feel they are obtaining rewards. Relational cultural theory emphasizes human growth and strength in relationship with others and deemphasizes strength in isolation (Comstock, 2005). Isolation is seen as the source of most suffering, while the process of creating mutual empathy and mutual empowerment is seen as a route out of isolation” (Comstock, 2005). Isolation is significantly different than being alone or having moments of solitude. Isolation is the disconnection from others that may be accompanies with feelings of worthlessness and shame. The theory proposes that individuals who live in isolation are vulnerable to depression and self-destructive behaviors when they feel invisible, unheard, and undervalued (Comstock, 2005). Researchers have noted that clients and providers hold a level of power that is negotiated at all levels of engagement. According to this theory, “the process of moving through connections, disconnections, and back into new, transformative, and enhanced connections” leading to better quality of life (Comstock, 2005).

Roots of this theory are traced back the publication of *Toward a New Psychology of Women* (Miller, 1976). Jean Baker Miller, Alexander Kaplan, Irene Stiver, Janet

Surrey, and Judy Jordan were the individuals who conceptualized Relational- Cultural theory (Comstock, 2005). The emphasis of Relational- Cultural is the development of self within the context of relationships with others. Forming healthy relationships leads to resilience, better self-esteem, and enhanced empathy.

Another theory, relational theory, is a combination of psychoanalytic, interpersonal, and object relation perspectives. It is believed that human behavior is learned through personal interactions. “In relational theory, as with object relations, the basic human tendency (or drive) is relationships with others, and our personalities are structured through ongoing interactions with others in our environment” (Huchinson, 2013). Healthy relationship patterns provide individuals with a stronger foundation for navigating new or potentially threatening experiences. Unhealthy relationship patterns undermine an individuals’ natural ability to navigate new or potentially threatening experiences in a health manner. When unhealthy patterns of interactions are repeated outside of the relationship they were learned, in it can create conflict for the individual. In this theory “there is strong value of recognizing and supporting human diversity in human experience, avoiding the pathologizing of differences, and enlarging traditional conceptions of gender and identity” (Huchinson, 2013). Relational theory is very similar to the social work practice of focusing on the person in their environment.

Definition of Terms

The following terms are used throughout this project and are relevant to identifying the barriers and engagement of children’s mental health.

Family Advocate: A para-professional, with lived experience parenting a child who has navigated mental health systems of care that offers support and advocacy to parents or caregivers of children receiving mental health services.

Youth Peer Mentor: A para-professional, with lived experience as a youth navigating mental health systems of care that offers support and advocacy to youth receiving mental health services.

Clinician: A mental health professional, with a Master's degree or higher and Board of Behavior Sciences license eligible, providing mental health services to children and families in the Sacramento County region.

Engagement :The level of connection between a clinician and individual receiving mental health services. Engagement can be defined as the level of trust and confidence in the professional relationship.

Retention: Effective engagement with a mental health professional in a clinical setting that result in a beneficial relationship that fosters change and growth for the individual receiving mental health services.

Youth: A child between the ages of 0-18 receiving mental health services.

Caregiver: A parent, foster parent, family member responsible for the caretaking of the youth receiving mental health services.

Assumptions

Both researchers have established a list of assumptions to be considered in this study. These assumptions are as follows: 1) Professionals are aware and are able to identify the population they serve; 2) Professionals work with children whose mental

health services are Medi-Cal funded; 3) Parents, or caregivers, are Sacramento County residents attempting to access services for at least one child in their family ; 4) Sacramento County requires yearly satisfaction surveys to be conducted by children and caregivers receiving Medi-Cal funded mental health services. Medi-Cal based mental health agencies have satisfaction surveys used to track client's satisfaction of services provided.

Justifications

This study will aim at benefiting families and children that face barriers when attempting to access mental health services. It is important to invest in children because they are the future generation and one that society desires to empower and equip with the necessary resources to succeed. One of the ways in which this is done is by attending to their pending mental health needs. Agencies and professionals have a responsibility of providing suitable mental health services for their consumers. In order to provide their consumers with appropriate care, providers and professionals must be aware of the barriers families face when they are approaching them for care. For those providers who are aware, there must be a manner in which professionals are aware of ways in which to improve existing services in addition to making services more accessible.

Chapter 2

REVIEW OF THE LITERATURE

The review of the literature for this Master's Project is being organized as:

(1) History, (2) Barriers, (3) Clinical Practice.

History of Medi-Cal

In 1965 Medicaid was enacted to provide health care services to low income and disabled citizens. Many of the funds allocated for Medicaid mental health services were used to pay for institutionalized care of the mentally ill. Cynthia Shirk (2008) states that in 1986, Medicaid contributed approximately 7.5 billion, or 16%. This was less than consumers, state or local government, or private health insurance companies. Today, Medicaid is the single largest funding source for both institutionalized and community based mental health services in the United States. A shift to providing mental health services in the community, rather than relying primarily on institutionalized care of the mentally ill has proven a more cost effective way of providing mental health services and allowed a greater number of low income individuals access to those services. Medicaid provides funding for community based mental health services treating individuals with a wide range of mental health needs. Medicaid is the single largest funding source for mental health benefits in the United States. According to Cynthia Shirk (2008), Medicaid spends over \$26 billion on mental health service. This accounted for 26% of total national mental health expenditures in 2003. Medicaid has become the most important funding source for mental health treatment for adults and children.

Medicaid is the only health care plan to cover home-based mental health services to children. States use Medicaid funds to provide services to children through child welfare, juvenile justice and mental health services. According the U.S Department of Health and Human Services in 2011, there were 400,540 children in foster care in the United States (Adoption and Foster Care Analysis and Reporting System, 2011). Wight, Chau, and Aratani (2010) of the National Center for Children in Poverty, report that nearly 16 million children in the United States live in households with incomes less than \$23,550. Hanson, Mawjee, Barton, Metcalf, Joye (2004) found that children in the foster care system and those living in poverty have a higher rate of emotional and behavioral disturbances that necessitate the services of mental health providers.

California Budget Project, in 2013, estimated that California's Medi-Cal covered over 7 million low-income children. The number of children eligible for coverage is expected to increase significantly with the implementation of the Affordable Care Act. Each county oversees medicaid-funded services through the California Medi-Cal managed care plan. Sacramento County provides a wide range of mental health services to low-income children and their families through community-based mental health agencies. Medi-Cal coverage includes services such as Early and Periodic Screening, Diagnosing, and Treatment (EPSDT) services. Some EPSDT services include: individual therapy, family therapy, group therapy, case management, crisis counseling, special day treatment programs, medication management, drug and alcohol treatment (Protections & Advocacy, Inc., 2002).

With the EPSDT model, families experience multiple barriers to obtaining treatment. These barriers also increase the risk for dropping out. These barriers include stressors and obstacles that compete with treatment participation (such as conflict with a family member about coming to treatment), treatment demands and issues (such as treatment being too costly or too long), perceived relevance of treatment (such as the perception that treatment is of little relevance to the child's problems), and the relationship with the therapist (such as little perceived support from the therapist). Additionally, specific critical events may lead to sudden treatment termination (such as moving to another city or death of a close relative). Although such events might be more common in families who drop out, these events are not seen as the typical barriers that account for the high dropout rates in child and adolescent therapy. The absence of barriers might serve as a protective factor (i.e. for families with a high risk for dropping out, the perception of few barriers might attenuate the risk), while the presence of barriers could serve as a mediator by explaining how other (static) predictors operate to produce dropping out (Kazdin, Holland, Crowley et al., 1997).

THE PROBLEM

Children, especially those of early childhood and school age years, rely heavily on caregivers to meet their physical and mental healthcare needs. When caregivers are unable to provide the child with appropriate physical and emotional care, children are particularly vulnerable. According to Lopez, Bergren, and Painter (2008), in 1999 the former United States Surgeon General, David Satche, called the problem of mental illness in children a national public health crisis, in which consequences of the problem greatly

increase with inadequate or nonexistent treatment. Such consequences can lead to complications in the school setting affecting the child's learning, causing attention difficulties and behavioral issues, placing them at greater risk for additional mental health problems including violence, suicide, and homicide.

Access to and retention in children's mental health treatment has several unique characteristics, especially when compared to childhood medical treatment. Owens, Hoagwood, Horwitz, et al. (2002), state that professionals may be discouraged by the low rate of client retention in mental health services due to the lack of consensus on the causes, identification, and long-term treatment effect on children mental health. The ever-changing array of federally funded programs for children's mental health is complex and relies heavily on the political climate.

Similarly, Owens and colleagues state that mental health stigma is associated with seeking, accessing, and retaining mental health services and often cause a person with mental health needs to delay seeking professional help.

Identifying and treating childhood mental illness has improved over the past thirty years. The variety of services available to meet the mental health needs of vulnerable populations has increased over time. In their report, Mennen and Trickett (2007) state that 42% of boys and 31% of girls have a psychiatric disorder that is typically discovered between the ages of 9 and 10. They estimated that children in the child welfare system have a higher need for services, with up to 82% displaying mental health problems. They are more than 23% more likely to receive services than a child with similar symptoms not in the child welfare system. These two researchers added that children who have suffered

from abuse, specifically physical or sexual abuse, have been found to obtain more services than those children who reported being neglected. Over 50% of children who have been identified as victims of abuse and neglect reported feeling they were not able to obtain the mental health services they felt they needed.

Of the children who do obtain mental health treatment, it is estimated that 28% to 75% of them terminate services prematurely and are left with untreated mental health problems that may continue into adulthood. Such children display a number of untreated behavioral problems and account for a high number of high school dropouts. Haan, Boon, Jong, Hoeve, and Vermeiren, (2013) report that those children engage in higher risk delinquent activities, abuse drugs and alcohol, and are more likely to become unemployed as an adult. It is important to note that unlike adults, in most cases, children do not seek mental health treatment for themselves. Therefore much of their treatment and progress lies in the motivation of others, such as parents or guardians (Kazdin et al., 1997).

Mendez et al. (2009) report that although many view the barriers families and children face as structural and attitudinal barriers, of which parents report most challenging, there are social-ecological barriers one must also consider. Such barriers, which are based on the both the developmental ecological theory and the ecological-transactional models, are represented through a multitude of levels. Barriers may stem from the individual (ontogenetic), the setting in which the individual lives (family, school; microsystemic), the community with which they associate (exosystemic), and the culture to which they identify with (macrosystemic).

In direct practice, social workers and therapists use various intervention models to work with clients. For example, some of these practitioners use the relational theory enabling clients to recognize the connections they have with their biological, psychological, and social domains. According to Hutchinson (2013), the relational approach enriches the concept of practitioner empathy by adding the notion of mutuality. It encourages a variety of activities familiar to social workers including brief interventions, case management, environmental development, and advocacy. Based on this definition, the practitioner utilizes this mutual empathy to foster trust and build rapport with the client as they work toward goal achievement in the therapeutic setting. In their practice setting, the practitioner builds a relationship with the client in an effort to engage and motivate the individual toward change.

Barriers

Furthermore, research indicates that low socioeconomic status is the strongest predictor of early childhood emotional problems and account for the racial disparities in rates of low socioeconomic childhood social emotional behavioral problems. Children growing up in low socioeconomic households may experience increased exposure to additional risk factors such as violence, parental distress or substance abuse that may adversely affect their behavior and mental development. For example, Bringewatt and Gershoff (2010) found that among low income children, ages 6 to 17, about 21% have mental health problems and are able to access appropriate services; it is estimated that 7.5 million children in need of services are not obtaining them. Gonzales (cited in Bringewatt & Gershoff, 2010) noted that children exposed to ongoing poverty appear to present with

higher levels of depression, anxiety, social withdrawal, peer conflict, and aggression yet these children are often unable to obtain the adequate help due to the multiple barriers children and their families face when seeking care.

Since 2007, Santiago, Kaltman, and Miranda (2012) found that the percentage of children living below the federal poverty line has steadily increased to 22%, of which 75%-80% do not get mental health treatment; appearing higher for children of ethnic minority backgrounds and an added risk of psychological disorders to develop which in turn increases the likelihood of additional poverty. It is reported that 20-50% of children from low socioeconomic status families are critically in need of psychological help due to added risk of exposure to trauma and violence in their homes, schools, and communities, post-traumatic stress disorder (PTSD), anxiety, and depression.

Santiago, Kaltman, and Miranda (2012) suggest that low-income families respond well when they are able to access evidence-based services. A research by Cook, Barry, and Busch, (2013) showed that economic barriers are due to the inability for low-income families to navigate the health care system or pay for their children's mental health care. Many families, that are low income but do not qualify for Medi-Cal, experience physical and mental health disparities and face large out-of-pocket costs for mental health care as an obstacle to treatment (Gonza'lez, 2005). In addition to being the group of children who have the highest rates of need and greatest rates of underutilization of services, low-income children are also more likely to terminate services or receive services for shorter periods of time. For example, research has shown that African American and Hispanic children are most likely to have unmet mental health needs with Hispanic children having

the highest percentage of unmet mental health needs. Bringewatt and Gershoff (2010) found that children of color are 2.6 times less likely to have their medical and mental health needs met and less likely to access specialty care than non-Hispanic white children.

Another barrier to children accessing services is the parent's time required to take children to and from treatment, and this barrier is especially high for parents working multiple jobs, as many low-income families do. Such parents may hold jobs in work settings that do not allow them the flexibility to access mental health services during regular working hours. In addition many of the provided services have been found to service families outside of a convenient geographic location. If services are accessed, however, obtaining on-going transportation to and from these services can be financially and emotionally taxing for many low-income urban families. Mendez, Carpenter, LaForett, and Cohen (2009) found that mothers who had a child in a low-income Head Start program most frequently reported their reason for not having their child participate in mental health services was having a schedule conflict with other activities and other time constraints.

Children from disadvantaged neighborhoods, also known as economically disadvantaged areas, have higher rates of internalizing their problems. Gonza'lez (2005), states that children living in disadvantaged areas have also been found to be the population with the most amount of maltreatment. The type of maltreatment has also been found to be a predictor in the level of impairment they have yet only about half of children with clinical levels of symptoms receive services.

Although African American and Hispanic families are in greater need of mental health services than white families, barriers to accessing services are typically higher. Gonza'lez (2005) reported that children who come from families living in urban areas, particularly low-income children of color, are at a higher risk of developing mental health problems and are less likely to access appropriate and effective mental health care. Snowden, Masland, Fawley, and Wallace, (2009) found that of the children in non-foster care placements utilizing Medi-Cal funded California mental health services, African American, Latino, and Asian American children were less likely to have had successful contact with a mental health treatment system than their non-Hispanic whites of a similar age.

Meyer and Zane (2013) report that parents of African American, Hispanic, and Asian American children are most likely to report dissatisfaction with those providing therapeutic services to their children and are most likely to perceive poorer quality of care although providers report being culturally competent and sensitive. For example, Ali, Jackson, Foster, Pecora, et al., (2013), explain that due to parental expectations about mental health treatment for children of African Americans appear to be influenced by past experiences of the quality of services and autonomy felt in the therapeutic relationship. Thompson et al. (2012) also found that the negative experiences of African American parents are linked with the expectation of future negative interactions with mental health providers. Such disparities demonstrate that people of color in the United States do not benefit from community-based mental health services to the same degree as whites (Gonza'lez, 2005).

Over the last decade, progress within the field of mental health for children of color has been shown to be slow (Center, 2007). In a counseling situation, Meyer and Zane (2013) report that a therapist's ethnicity may be one of the most important features a client will take into account when choosing to attend the initial visit. It is during this time clients report assessing the race and ethnicity of their counselor above anything else. In a meta-analysis of seven studies Gonza'lez (2005) found that when clients were matched with therapist of the same ethnicity they were less likely to drop out of therapy, utilize more community resources, have favorable treatment outcomes, and report greater therapeutic satisfaction. This disparity may be due to the diverse cultural beliefs, language barriers, and help-seeking patterns of families of color that are not always taken into account by service providers.

Lesbian Gay Bisexual Transgender and Questioning (LGBTQ) youth face significant barriers to accessing appropriate mental health services. Allen, Hammack, and Himes (2012), found that LGBTQ youth experience an increased risk of depression, victimization, suicidal ideation and self-harm, and substance use compared to heterosexual identifying peers. They also indicated that many LGBTQ youth face discrimination, complex family dynamics, fear of coming out to family and friends, and social challenges living as an openly sexual minority. LGBTQ individuals may be negatively impacted by the prejudice of and discriminatory actions by health care professionals. In a report by Alessi (2013), the negative impact of covert or overt discrimination had a negative impact on service utilization and treatment outcomes in the LGBTQ community. Alessi discusses that areas that are important include sexual identity

confusion, family understanding and acceptance. Alessi adds that mental health providers can reduce real or perceived barriers for LGBTQ youth seeking treatment by requiring clinicians and therapists to have specialized training to increase knowledge of LGBTQ specific issues.

Snowden et al. (2009) state that some families avoid seeking mental health treatment due to social stigma, mistrust of mental health clinicians, lack of culturally preferred alternatives, and language barriers. The stigma many families associate with their involvement in mental health services appears to be greater for children of color and their families due to society-sanctioned discrimination, such as racism and oppression (Gonza'lez, 2005). Parents often feel uneasy about bringing the social and psychological difficulties of their children to the attention of mental health professionals out of fear that they will be blamed for their children's problems (Gonza'lez, 2005). Snowden et al., 2009 surmised that caretakers in some ethnic minority communities mistrust treatment programs and personnel. According to Cook et al. (2013), many individuals never obtain proper information on diagnoses of mental illness or simply do not utilize available mental health services. Larson, DosReis, Stewart, Kushner, et al., (2011) identified stigma, distrust in the mental health system, and cultural beliefs about mental illness as contributing factors that add to the challenges low income families face in accessing mental health services.

Although parental characteristics, such as mental health challenges of parents, have not been proven to directly affect their child's access to mental health services, Mendez and colleagues (2009) report that higher levels of parental psychopathology,

along with lower quality of life, predicted greater perception of barriers. Parents who were dealing with their own personal mental health issues were less able to competently look after of their child's mental health treatment. In addition, such parents may perceive that they are not able to positively influence or effect change in their children thus leading them to limited engagement in their child's mental health treatment or interventions.

School districts often attempt to help families access mental health services through referral and school based Educationally Related Mental Health Services (ERMHS), yet it has been shown that there are often more challenges that families then have to navigate within the special education system. Screening in schools often leads to children being labeled and misdiagnosed due to inadequate training and supervision of staff in school sites. Parents also find that their children are being tested without their consent and that they are misinformed by school districts about screening programs, which often are characterized as mandatory when, in fact they are not. Although many families could benefit from services being provided by the school, the schools have insufficient funding, inadequate funding and supervision of staff, limited evaluation of programs and outcomes for policy improvement, and environmental factors such as lack of facility use (Center, 2007).

Clinical Practices

For many families, the initial contact with the mental health system is during times of intense crisis. When families are unable to obtain community-based mental health services they are often forced to utilize emergency rooms, emergency mental

health services, law enforcement, and other mental health crisis programs during times of crisis.

Researchers found that in order to have the greatest outcomes in children's psychotherapy, the family must be engaged. Miller, Blau, Christopher, and Jordan (2012) concluded that commitment to treatment by both the child and family increases based on the roles they have in making important treatment decisions about their clinical services and can result in a higher retention rate.

A child's symptoms and the assessment by the parent is a great predictor of the referral the child will obtain. The parent's evaluation and report of their child's problematic behavior have been shown to strongly influence whether a child obtains services. If children are exhibiting significant problems, but their parents or caregivers are not aware, they will likely not obtain appropriate services. Mennen and Trickett (2007) state that this may become difficult to assess and often will occur to children who internalize their problems and feelings, which results in parents being unable to observe, evaluate and seek treatment.

The literature reviewed by the authors of this Master's Project identifies several key factors that affect accessing and retaining mental health services for children and families. It is widely recognized that one of the most challenging barriers to effective therapy is parent or caregiver engagement. Take for example, Thompson and colleagues (2007) who identified the capacity of a therapist to engage and retain a family in mental health treatment as a key component to successful family therapy. Thompson et al., also add that retention of services include, but are not limited to: clearly defined expectations

of treatment, the bond between the client and therapist, attendance, and client satisfaction with treatment progress and outcomes.

The process of engaging individuals in the therapeutic process requires the building of a trusting relationship between the clinician, family partner or youth peer mentor, and the client. Research shows that the strongest predictors of positive mental health treatment outcomes were therapists' interpersonal skills, direct influence skills, and the active participation of clients in their own treatment (Thompson et al., 2007). Creating a relationship alliance allows the client and therapist to collaborate on the treatment goals and plan. Ingoldsby (2010) reports that providers who successfully engage families in treatment report utilizing a wide array of interpersonal communication styles that include empathy and validation of the client's feelings about interventions and communicating with families with respect for their unique cultural backgrounds and religious beliefs. This trust and rapport empowers clients to take an active interest in their own treatment, thus building engagement in the process and the outcome.

Teens can be especially challenging to engage in therapeutic treatment. Children and teens who are referred for services by their parents are considered involuntary clients. Cultivating a therapeutic relationship with a reluctant youth requires therapists to engage clients in their own treatment and empowering them to create their own solutions. Research indicates that adolescent clients' perception of their therapist is especially important. Thompson et al. (2007) identified respect, time shared, openness, role differentiation, guidance, identification, familiarity with the therapist, trust, and taking

responsibility as characteristics that led to a positive therapeutic relationship between clients and clinicians.

Adolescents, who view their feelings as concrete links to particular situations, experience difficulty in understanding the long-term lasting nature of their feelings and behaviors. When the relationship with their service provider is fostered and strong, adolescents are more empowered to overcome barriers to treatment. O'Reilly and Parker (2013) found that teens disengaged from therapy by passively resisting, actively disengaging, and by asserting their own autonomy. Bender, Kapp, and Hahn (2011) show that when parents and caregivers of adolescents build a strong alliance with their child's therapist, their child is more likely to engage with their therapist and remain in treatment. Active engagement in mental health treatment requires a commitment by youth and their parents. O'Reilly and Parker (2013), assert that youth receiving services have a higher likelihood of sustaining therapeutic change when parents are actively involved to support the progress being made.

The ability of clients to attend regular therapy sessions can impact their engagement and retention in services. Ingoldsby (2010) found that appointment reminders are a simple strategy that can be implemented to increase attendance. Santiago, Kaltman, and Miranda (2012) found that families of low socioeconomic status identified lack of transportation, childcare, health insurance, and difficult work hours as barriers to accessing community-base mental health services for their children. Mental health providers can increase regular attendance by meeting families in the community, or at the clients' school, and by being flexible in the session scheduling to accommodate work

schedules. Ingoldsby (2010) reported that providers find that families engage in treatment more often if they acknowledge and address barriers such as scheduling, transportation, and financial concerns. Community-based service providers can increase attendance and engagement by meeting families in their homes. Providing services to clients in their homes removes the barrier of transportation and alleviates financial concerns associated with using public transportation for clients and families. Additionally, the financial repercussions to providers for missed appointments can be an unintended consequence of the ignoring client limitations and barriers. Ingoldsby (2010) also found that adjunctive family support such as family advocates and youth peer mentors integrated into treatment support parents and caregivers in addressing life stressors, such as job and financial concerns, relationship conflicts, health problems, accessing community resources and special education services, and reducing anxiety when navigating multiple systems of care with families.

A risk of ineffective engagement with clients in mental health services results in the premature ending of services. Service providers run the risk of having families drop out of services prematurely when expectations about goals and the course of treatment are not clearly communicated and agreed upon. Premature termination of services can have consequences that affect more than just the child and family. The community the individual lives in may experience negative consequences when mental health services are terminated prematurely. The agency providing services loses money when clients habitually missed or reschedule appointments. Effective engagement strategies lead to positive treatment outcomes, higher client satisfaction, and increased provider

productivity. Evidence-based mental health treatment has been shown to be effectiveness among children and families when combined with engagement and retention strategies (Santiago et al, 2012).

Once families are able to obtain services, many professionals find that they are unable to keep families engaged. According to authors Bender, Kapp, and Hahn (2011), continued effort by the clinician to engage families is the strongest predictor of a positive mental health outcome. Families who are under high levels of stress have a higher risk of terminating services prior to the completion of services. When engagement during the treatment process is displayed and the children, along with their parents or caregivers, are participating, invested and involved, the result become enhanced and greater opportunity exists to create lasting change. A study that analyzed treatment among youth and their level of participation concluded that there is a major link between level of participation and the outcome of positive mental health outcome. The study showed that youth who participated in their mental health treatment inconsistently or terminated treatment prematurely were least likely to reach their treatment goals or show clinical gains. In addition Bender, Kapp, and Hahn (2011) reported that 40-75% of adolescents who had been referred to clinical treatment do not begin services and/or terminate prematurely. Children who suffer from severe and lingering problems such as aggressive or antisocial behavior, academic failure, and social difficulties and children who come from families with young, single parents are most likely to drop out of treatment (Bender, Kapp, & Hahn, 2011).

Families with a child that has a disability face additional barriers due to their situation. Children with special needs are generally considered as having one or more chronic behavioral or emotional condition that affects their ability to function to their greatest capacity and can require an array of services to be provided from multiple systems. Many such children have a difficult time obtaining services due to the conflict professionals have in formulating a correct diagnosis due to the behaviors they display, which may be related to an underlying physiological condition. They may also present their psychological symptoms in somatic ways, which often leads providers to misdiagnose when children are seen by primary care doctors for treatment instead of appropriately trained mental health services (Zimmerman et al, 2001).

According to Mennen and Trickett (2007), children who are a part of the child welfare system, regardless of racial background, are also at higher risk of needing mental health services, as are children that live in disadvantaged neighborhoods. Children entering the foster care system are assessed through a functional assessment to identify severe emotional and behavioral disorders. Unfortunately, these children may never receive follow-up assessments. The initial emotional and behavioral assessments are often inadequate in identifying trauma and objectively evaluating incoming foster youth for appropriate mental health referrals. Several barriers faced by foster youth in need of appropriate mental health services include, but are not limited to, failure to refer youth to services in a timely manner, gaps in insurance coverage, and lack of professionals trained in appropriately assessing and providing mental health services (Ali, Jackson Foster, Pecora, Delaney, & Rodriguez, 2013). The gatekeepers to mental health services for

foster youth often represent a barrier due to the high caseloads they carry, insufficient training in identifying needs of the youth, and lack of follow-through in coordination with appropriate service providers.

Family and Youth Advocates

Slaton, Cecil, Lambert, King, and Pearson (2012) stated that a nationwide advocacy movement emphasizing the importance of the family and youth voice in an effort to promote meaningful participation and engagement in mental health services began thirty years ago due to the Children's Mental Health Initiative. Family-driven mental health services can be defined as the family and youth having the primary decision-making role in the mental health treatment being provided. Family-driven mental health services incorporate family advocates and youth peer mentors. These professionals support caregivers and youth in navigating mental health service systems. Behrens, Lear, and Price (2013) found that including parents in treatment planning and services is based on the belief that the parents' knowledge of the child is valuable to the treatment team. They advocate for family-driven services for youth, reducing communication barriers with providers and within mental health agencies. Slaton, Cecil, Lambert, King, and Pearson (2012) also found that family advocates and youth peer mentors ensure family-friendly language in policy creation and implementation.

System of Care Approach

New approaches, such as the System of Care concept have been put into place in an attempt to eliminate programs aimed at treatment with only a single program mentality. This new concept, which has been adopted by mental health systems as well as

by child welfare, juvenile justice, education, and substance abuse systems aims to coordinate services and supports across community agencies to meet the multiple and complex needs of their youth. Miller et al. (2012) states that this collaboration allows for a transformation in how mental health care is provided by community-based mental health service providers toward a more family-driven and youth-guided model. Encouraging families to be the primary decision makers regarding the mental healthcare of their children and allowing them to choose support, services, providers, goals, and evaluation of services, and having a family and youth voice in policies and procedures governing mental health care for all children in their community are the primary transformative concepts embodied in the System of Care approach.

The System of Care approach has been found to positively impact the structure, organization, and availability of services and has proven to be a cost-effective way to invest resources by redirecting resources from restrictive services to home-based and community-based services and supports. Miller et al. (2012) found that the success and advancement of children's mental health must include an examination of the roles that a number of partners play, including early childcare providers, child welfare, juvenile justice, recreation programs, and faith-based organizations.

Chapter 3

METHODOLOGY

This chapter's purpose is to describe the methodology and research design the researchers used in process of this study. Throughout this chapter, the researchers described the sampled population along with how the sample was obtained. Chapter 3 is also to include an explanation of the data and how the data was analyzed. Lastly, the chapter discussed the steps the researchers took to protect human subjects.

Research Question

This study examined the following research question: What barriers do parents face when attempting to obtain mental health services for their children? And once services were received, what are the factors that contribute to retention of their mental health services?

Research Design

The design of this Master's Project was exploratory-quantitative in nature. Mental health professionals, including clinicians, family advocates, and youth peer mentors working with children and families at a community-based agency in Sacramento County, California, completed a confidential survey. The data collected from the survey resulted in a mixed methods data collection.

A closed-ended survey instrument containing 22 questions was developed. A quantitative design is appropriate to describe the population being examined as it emphasizes the production of generalizable statistical findings when there is a need to verify whether a cause produces an effect in general (Rubin & Babbie, 2011).

Variables

This research study explored two research questions: what barriers do parents face when attempting to obtain mental health services for their children and what are the factors that contribute to retention of their mental health services? The independent variables of the respondents were: gender, number of years working in the mental health profession, working in Sacramento County, clinical role in the agency surveyed, and participation in engagement trainings through the agency surveyed. The dependent variables of the respondents were: the perception of how helpful the agency-provided engagement training was, the perception of how helpful sharing the results of the Client Satisfaction Survey was, when building engagement was most important in treatment, the utilization of family advocates to engage families in mental health treatment, and whether community resources had been provided to families receiving services.

Instrumentation

The focus of this study was to explore the barriers that parents face when attempting to obtain mental health services for their children along with the factors that contribute to the retention of their child's mental health services (See appendix A: Survey Instrument). The researchers developed the questionnaire for the study project, which aimed at identifying barriers to engagement and retention of services through the lens of local mental health professionals. The questionnaire contained two major sections. The first section gathered demographic variables such as gender, job title, and years of working in the mental health profession. The second section of the questionnaire targeted

the professional's training and knowledge about the barriers families face when attempting to access mental health services according to their experiences.

Testing for reliability of the research instrument was not conducted. The population of study does, however, have knowledge of engagement techniques in working with children and families within the mental health field. The questionnaire was self-administered to consenting participants without the researchers present. This resulted in a reduction of influence researchers may have had on the participant's survey responses. Researchers ensured that the measured concepts were clearly written and participants were able to easily understand and answer the questions. Because this survey was based on professionals' perceptions, measures of validity could be validated when looking at this instrument.

Data Gathering Procedures

Sample Population

The sample for the research study included 41 mental health professionals working for a non-profit provider of both mental and behavioral health services in Sacramento County. Participants included 33 clinicians, 3 family advocates, and 2 youth peer mentors. Three (n= 3) participants declined to identify their position with the agency. All participants have had experiences working with children and families who receive Medi-Cal benefits.

Professionals that were surveyed identified the length of their experience within the mental health system as varying from less than a year to longer than six years. Two

participants have been working in children's mental health for less than a year, 5 for a year to two years, 8 for three to five years, and 26 for six years or longer.

Researching the perceptions of all mental health professionals in Sacramento County could result in an increase of reliability and validity for the research, but it was not feasible to sample them all. The professionals at the agency surveyed, made themselves available to the researchers and represent a significantly large sample of data to study and give an idea of what mental health professionals believe are the barriers families in the Sacramento Region face when attempting to access mental health services.

Mental health professionals at the agency surveyed were the informers for the researchers due to the knowledge about the research population and research topic. They were also willing to share their knowledge with researchers. Evaluation of informers was based on a number of factors, which included: 1) employees of the agency, 2) provided Medi-Cal funded Mental Health services to Sacramento families, 3) knowledge about the barriers families they have worked with face.

On January 7, 2014, researchers were allowed to explain and conduct their study at an all staff meeting. A total of 41 staff personnel, which included 33 Clinicians, 3 Family Advocates, and 2 Youth Peer Mentors were in attendance and all agreed to participate in the study. Researchers explained the purpose of their study and distributed the consent form. After the consent form was explained, staff members were asked to sign the consent form if they agreed with the information provided to them. Staff members were given a copy of the questionnaire and an envelope in which they were to place their completed survey. The participant placed the questionnaire (either completed

or incomplete) in an envelope and returned it to the researchers along with their signed consent form. Sealed questionnaires were placed in large envelope and consent forms in another large envelope.

Protection of Human Subjects

Researchers aimed to create a research instrument that would best allow respondents to identify their perceived barriers of engagement and retention within children's mental health. A survey questionnaire containing 22 questions was created between the two and soon after the researchers met with the agency's Chief Privacy Officer to request permission to conduct the study with current clinicians, family partners, and youth peer mentors.

During the meeting , the researchers explained the reasons for the research, how the survey would be conducted, the human subjects approval process, and discussed the voluntary nature of the study for the participants. The researchers requested a letter of approval from the agency to access a sample population of clinicians, family partners and youth peer mentors to participate in the study. The researchers provided the agency with a copy of the questionnaire for review and approval purposes. After the Chief Privacy Officer reviewed the survey materials and the study procedures, researchers were given permission and a signed letter of consent to conduct the study with clinicians, family advocates and youth peer mentors employed at the studied agency.

The researchers submitted an application to the Division of Social Work Human Subjects Committee for approval. The application was approved by the Division of Social Work Human Subjects Committee as "Exempt". Researchers explained in the

application that any information obtained and recorded by the researchers would be done a manner where human subject participants would not be individually identified. Lastly, there were no risks of criminal or civil liability, financial gain, employment, or reputation associated with the participation in the study. The researchers instructed the human subject participants that they were not obligated to answer any or all of the questions on the questionnaire and could decline to continue participation at any time.

The researchers ensured the privacy of the participants in the study by guaranteeing the use of a confidential survey format. The questionnaire for the study did not include any identifying information of the participants. Human subject study participants were requested to not write their names or any other identifying information on the questionnaires to further protect their privacy. The researchers provided the human subject participants with a consent form, a copy of the survey, and a sealable envelope for the completed survey. The completed surveys were submitted to the researchers in sealed envelopes with no identifying information of the human subject participants. Once all surveys had been submitted to the researchers, the surveys, in sealed envelope were placed in a larger sealed envelope to be analyzed after leaving the agency.

After all elements of research were taken into consideration, the study was considered “exempt” because the questionnaire was given to professionals to seek their perceptions and opinions on barriers of Children’s Mental Health, which had no known risks associated with their participation. Furthermore, study participants remained anonymous to the researchers due to them not knowing who chose to participate in the

research project and who did not, as well as the lack of personally identifying information on each survey.

Data Analysis Plan

Once the researchers received the questionnaires, they entered the information into the SPSS computer database and the variables were statistically analyzed.

Researchers utilized descriptive statistics, frequencies, means scores, and multiple response analysis when analyzing the data.

Summary

The purpose of this chapter was to define how this study was a quantitative exploratory research design. A discussion of the sampled population and methods utilized in the process of obtaining proper consent and approval was also discussed in this chapter along with the administration of the questionnaire and how the data was received. . The chapter concluded with a discussion of how human subjects were not harmed in the process of participation of this research and why researchers obtained a status of exempt in conducting their research. The chapter that is to follow will further present the data that was obtained by research in addition to an analysis of the findings.

Chapter 4

STUDY FINDINGS AND DISCUSSIONS

This chapter examines the results of the survey. The demographics of the clinicians, family advocates, and youth peer mentors of a mental health agency in Sacramento County as well as the responses of the participants regarding their perceptions of barriers to engagement and retention of children's mental health services. Additional variables included in the survey are: gender of respondent, number of years respondent has worked in the mental health profession, whether the respondent works in Sacramento County, whether the respondent participated in engagement trainings provided by the agency surveyed, the perception of how helpful the agency-provided engagement training was, the perception of how helpful sharing the results of the Client Satisfaction Survey was, the respondent's perception of when building engagement was most important in treatment, whether respondent's utilized family advocates to engage families in mental health treatment, and whether community resources had been provided to families receiving services.

Table 1

Gender of the respondents.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 Female	36	87.8	87.8	87.8
2 Male	5	12.2	12.2	100.0
Total	41	100.0	100.0	

One of the purposes of this research Project is to understand background of the respondents. Among the background information are gender and place of residency. Of the total respondents, 36 (87.8%) of them indicated that they were female. The remaining 5 (12.2%) were male (see Table 1). Gender composition of service providers is helpful in understanding service utilization among social services clients.

Table 2

Respondents Working in Sacramento County.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 Yes	39	95.1	95.1	95.1
2 No	2	4.9	4.9	100.0
Total	41	100.0	100.0	

For the purpose of this research study, researchers wished to identify the county in which respondents worked in. When asked, 95.1% (n=39) of the 41 indicated that they work in Sacramento County and the remaining 4.9% (n=2) reported they did not work in Sacramento County (see Table 2).

Table 3

Mental Health Provider Role within the Agency.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 0 Decline	3	7.3	7.3	7.3
1 Clinician	33	80.5	80.5	87.8
2 Family Advocate	3	7.3	7.3	95.1
3 Youth Peer Mentor	2	4.9	4.9	100.0
Total	41	100.0	100.0	

The researchers wished to identify the role of the respondents within the agency surveyed. Of the 41 participants, 33 (80.5 %) identified themselves as a clinician, 3 (7.3%) identified as family advocates, 2 (4.9%) identified as youth peer mentors, and 3 (7.8%) decline to state their role within the agency (see Table 3). Identification of the clinical roles is helpful in understanding perceptions of barriers to engagement and retention for clients.

Table 4

Duration of Years Working in the Field of Children's Mental Health.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 Less than one year	2	4.9	4.9	4.9
2 1 - 2 Years	5	12.2	12.2	17.1
3 3 - 5 Years	8	19.5	19.5	36.6
4 6 Years or Longer	26	63.4	63.4	100.0
Total	41	100.0	100.0	

Once researchers were aware of the roles represented within the sample population, researchers aimed to identify the length of time participants have been working in the field. When participants were asked about how long they have worked in the field of children's mental health (Table 4), 63.4 % (n=26) have had 6 or longer years, followed by 19.5% (n=8) have been working 3-5 years, 12.2% (n=5) 1-2 years, and 4.9% (n=2) less than one year.

Table 5

Training on Engagement Techniques.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 Yes	39	95.1	95.1	95.1
2 No	2	4.9	4.9	100.0
Total	41	100.0	100.0	

The researchers wished to evaluate if clinical staff received engagement training through the agency surveyed. Participants were asked if they have received training on engagement techniques when working with children and families in mental health. Of the 41 respondents, 39 (95.1%) indicated they have and the remaining 2 (4.9%) reported not to have received training (see Table 5). Engagement training for agency and staff improves the quality of survives to clients and families.

Table 6

Training effectiveness in development of engagement skills when working with children and families.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Very Helpful	6	14.6	15.4	15.4
	2 Helpful	11	26.8	28.2	43.6
	3 Somewhat Helpful	22	53.7	56.4	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

When participants were asked how effective the training they have received has been in developing engagement skills, 53.7 (n=22) reported their training to be somewhat helpful, followed by 26.8% (n=11) reported training to be helpful, and 14.6% (n=6) reported training to be very helpful. It should be noted that 4.9% (n=2) did not indicate the use of the trainings (see Table 6).

Table 7

Point in treatment process where engagement is most important.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 At the first point of contact with a family	13	31.7	31.7	31.7
2 At the intake appointment	4	9.8	9.8	41.5
3 During assessment phase of treatment	1	2.4	2.4	43.9
4 Throughout treatment services	23	56.1	56.1	100.0
Total	41	100.0	100.0	

One of the purposes of this research Project is to understand mental health clinician's perceptions of when engagement begins with clients and their families. Of the clinical staff surveyed, 56.1% (n=23) of the participants reported that engagement is most important throughout the entire duration of treatment while 31.7% (n=13) reported it to be most important at the first point of contact with the family. An additional 9.8% (n=4) reported it to be at the intake appointment and 2.4% (n=1) during the assessment phase of treatment (see Table 7).

Table 8

Community resources provided to families having difficulties accessing mental health services.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 Yes	36	87.8	87.8	87.8
2 No	2	4.9	4.9	92.7
3 Unsure	3	7.3	7.3	100.0
Total	41	100.0	100.0	

The researchers wished to evaluate if clinical staff found it necessary to utilize additional community resources to support families in meeting basic needs such as: low-income housing, food, assistance with utility payments, and welfare benefits. Among the 41 respondents, 36 (87.8%) indicated they have provided community resources to families, 2 (4.9%) reported they had not, and 3 (7.3%) reported they were unsure (see Table 9). Clinical staff overwhelmingly utilizing referrals to community resources to support families meeting their basic needs, thus removing barriers to engaging in therapeutic services.

Table 9

Perception of importance of providing basic mental health services to children and families.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 Yes	39	95.1	95.1	95.1
2 Unsure	2	4.9	4.9	100.0
Total	41	100.0	100.0	

The authors of this research Project evaluated the respondent's perception of importance to providing basic mental health treatment to the identified population. 95.1% (n=39) of the 41 respondents believe it is important to provide mental health services to families and children, while 4.9% (n=2) reported to be unsure (see Table 10). The majority of respondents surveyed agreed that providing basic mental health services was important and beneficial to the population of clients served within their agency.

Table 10

Utilization of family advocates to engage parents in child's treatment.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes, I have had	34	82.9	100.0	100.0
Missing	System	7	17.1		
Total		41	100.0		

The agency surveyed requires the utilization of family advocate support engaging children and families at risk of dropping out of treatment. When asked if participants utilize the support of family advocates in engaging parents in their child's mental health treatment, 82.9% (n=34) reported having utilized the support of family advocates in engaging parents in their child's mental health treatment, while 17.1% (n=7) did not respond (see Table 11). Increasing the number of clinical staff utilization the services provided by family advocates may improve retention rates of the clients referred to services.

Table 11

Requirement of agency to conduct yearly satisfaction survey.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes, it does	36	87.8	92.3	92.3
	2 No, it does not	3	7.3	7.7	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

The agency the authors surveyed is required to conduct a yearly client satisfaction survey for Sacramento County Department of Health and Human Services. Participants were surveyed regarding their knowledge of the agency's requirement to conduct a client satisfaction survey. Of the respondents, 87.8% (n=36) reported they are required to conduct the survey, while 7.3% (n=3) reported they were not. It should be noted that 4.9% (n=2) did not respond (see Table 12).

Table 12

Agency provided the results of satisfaction survey.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Yes, it does	35	85.4	89.7	89.7
	2 No, it does not	4	9.8	10.3	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

Among the 41 professionals that were asked if their agency provided them with the results of the satisfaction survey, 85.4% (n=35) reported the results were provided while, 9.8% (n=4) reported they were not. It should be noted that 4.9% (n=2) did not respond (see Table 13). The results of the client satisfaction survey inform clinical staff with valuable client feedback regarding services being provided. Client feedback is helpful in identifying agency strengths and areas of service that may need improvement.

Table 13

Helpfulness of client satisfaction survey results in relation to professional development.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Very Helpful	9	22.0	23.1	23.1
	2 Helpful	10	24.4	25.6	48.7
	3 Somewhat Helpful	16	39.0	41.0	89.7
	4 Not Helpful	4	9.8	10.3	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

Participants were asked about the helpfulness of the client satisfaction survey in relation to their professional development. 39% (n=16) reported the survey to be somewhat helpful, followed by 24.4% (n=10) reported results to be helpful, and 22 % (n=9) reported results to be very helpful, 9.8% (n=4) reported it to not be helpful. It should be noted that 4.9% (n=2) did not respond (see Table 14). The client's feedback is important to clinical staff and the agency. In addition, it improves the quality of mental health services.

Table 14

Most significant barrier to engagement children in mental health treatment.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1 Transportation barriers	3	7.3	7.3	7.3
2 Financial stress	9	22.0	22.0	29.3
3 Cultural barriers	7	17.1	17.1	46.3
4 Other	22	53.7	53.7	100.0
Total	41	100.0	100.0	

Participants were asked to identify what they believed was the most significant barrier to engagement of children in mental health treatment. Of the 41 participants, 22.0% (n=9) believed financial stress to be the most significant barrier, 17.1% (n=7) believed cultural barriers are the most significant barriers, and 7.3% (n=3) identified transportation barriers to be the most significant (see Table 14). 53.7% of the participants (n=22) identified other barriers they believed were the most significant to engagement children in mental health treatment. Participants responses included but were not limited to: “Child or family does not want to participate; Engaging parents in being part of treatment as a team, not just the child’s problem; Lack of trust in the ‘system’ and mental health professionals being seen as part of the system; Meeting children where they are at (not location) versus putting our own beliefs onto them; Multiple years in system, wanting services to "fix" problems immediately; Too much clinical terminology used through assessments that are not client friendly”.

Table 15

Most used intervention when developing child's mental health treatment plan.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Partnering with parents	17	41.5	42.5	42.5
	2 Collaborate with other Mental Health Professionals	1	2.4	2.5	45.0
	3 Focus on Child and their own work ahead	9	22.0	22.5	67.5
	4 Other	13	31.7	32.5	100.0
	Total	40	97.6	100.0	
Missing	System	1	2.4		
Total		41	100.0		

When asked what intervention the participant most utilizes when developing a child's mental health treatment plan, 17 (41.5%) identified their most used intervention to be partnering with parents, 9 (22.0%) identified their focus on child and their own work ahead to be the most utilized intervention, and 1 (2.4%) believed collaborating with other Mental Health Professionals to be their most used intervention (see Table 15). 13 (31.7%) of participants indicated that they utilize other techniques and interventions. Interventions included but were not limited to: "Collaborating with parents, children and other mental health professionals; Working to discuss treatment goals that fit in line with family's culture and preference using and entire systems; Assisting with child what needs/goals are needed and wanted; Using FFT (Functional Family Therapy)".

Chapter 5

DISCUSSION

The purpose of this chapter is to summarize the significant findings that were obtained from the research study. The chapter included a summary of the findings that were presented in chapter four, a discussion on the conclusions that was be drawn from the study, and how the findings related with the literature that was reviewed in chapter two. The chapter also described the limitations of the study, in addition to providing implications for social work practice. In conclusion, this chapter provided suggestions for future research on the barriers children and their families face when accessing mental health services.

Summary of Study

Many studies have been conducted that aim to understand the barriers of various forms of engagement and retention of children's utilization of mental health services, yet, there has been no studies dedicated to understanding the barriers within Sacramento county. After completing this research project, researchers summarized major findings on the data collected of mental health providers' perceptions of barriers to engaging children and families in mental health services. On the review of the data, the authors recommend improving engagement training opportunities for social workers, especially mental health clinicians and service administrators.

Upon completion of the study, researchers found that although training on engagement techniques when working with children and families in mental health was provided to professionals working in the field, most found the training to only be

somewhat helpful and some even reporting the training to not be helpful. Professionals also reported utilizing support from family advocates in engaging their client and utilizing the results from yearly client satisfaction surveys with 22% who believed the results were very helpful to their professional development. Other responses included 39% of respondents who reported the survey responses to be somewhat helpful, 24% reporting them to be helpful, and almost 10% who believed the client surveys were not helpful.

The barriers mental health professionals identified to be the most significant in families attempting to access mental health services for their children, or in maintaining mental health services, included a the financial stress a family is experiencing at the time of services and cultural barriers between the family engaging in services and the mental health professional. Respondents also identified a number of additional barriers they preserve to be prevalent in the families they have worked closely with.

Respondents listed inconsistencies of the working professional to be an identified barrier. At times, professionals believed they utilized clinical terminology, or jargon, that was not “client friendly”. In addition, professionals believed at times they would not meet child, or clients, “where they were at” in their therapeutic journey, and instead would place their own beliefs onto them.

Other barriers were identified to come from the child directly. Barriers such as the lack of motivation of the client to participate and engage in therapeutic service, along with the desire of wanting to change were perceived barriers. In addition, the lack of trust the child may have in the mental health field, or as respondents stated, “the system”, and

the mental health professional being linked by the child as part of that system.

According to findings from the study, parents and family members also play a significant part in the barriers that are faced. Many children face blame from parents and perceive themselves to bring negativity to their family. Professionals reported that engaging parents, who at times are also dealing with their own mental health issues, to be a part of their child's treatment and work collaboratively with mental health professionals, along with remaining constant with treatment and follow through was among the challenges faced for families. Other families struggle with supporting the therapeutic process, do not "buy in" to the work that is at hand, or at times do not believe the services are of need to their children. Contrary, other families have unrealistic expectations of the mental health services provided to them and believe that services should aid to "fix" their child's problems immediately.

When asked what interventions techniques professionals most utilize when developing a child's mental health treatment plan, most respondents reported to utilize the partnership between themselves and the child's parents. Others believed it was a combination of the partnership with parents, collaboration with other mental health professionals, and the focus on the child and their own work ahead. Other interventions reported included talking with the family and the child in hopes of obtaining their views on their needs and goals of treatment along with discussing how those needs and wants fit in line with their culture and preference. Family Functional Therapy was also listed as an intervention technique.

Implications for Social Work

From the findings of the research, there are implications for social work practice and policy, which can be identified at a micro, macro, and mezzo level. At the micro level, professionals can be provided with improved trainings that aim at training professionals about techniques and manners in which they are able to properly identify barriers and further engage clients along the journey. Agencies should be supporting and encouraging the professionals that work for their agencies to seek out the areas of their individual professional work in engagement techniques and identify which areas they feel must be improved. In addition, agencies could allocate, collaborate, or unify with local donors, or community resources, to assist in the funding to best assist in meeting the needs of families.

At a macro level, policies could be outlined with the purpose of funding quality engagement techniques and guidelines for those providing mental health services for children and their families. Counties, at the mezzo level, could require the utilization of family advocates and youth peer mentors when engaging the families in their mental health agencies, especially those families where barriers of engagement are identified.

Discussions

Researchers created the study with the intention of discovering an understanding of the barriers to engagement and retention of mental health services from children and families in Sacramento County. This study was created to further understand the perceptions barriers to engagement by clinicians, family partners, and youth peer mentors. In the creation of this study, the researchers looked to identify what clinicians,

family partners, and youth peer mentors believed to be most important times in the treatment process to effectively engage clients in services. Additionally, in the creation of this study, the researchers looked to identify the effectiveness of engagement trainings provided within the agency surveyed.

Participants were asked to identify what they believed was the most significant barrier to engagement of children in mental health treatment. Of the 41 participants, 22.0% (n=9) believed financial stress to be the most significant barrier, 17.1% (n=7) believed cultural barriers are the most significant barriers, and 7.3% (n=3) identified transportation barriers to be the most significant (see Table 14). A large percentage of the participants (53.7% or n=22) identified other barriers they believed were the most significant to engagement children in mental health treatment. Participants responses included but were not limited to: “Child or family does not want to participate; Engaging parents in being part of treatment as a team, not just the child’s problem; Lack of trust in the ‘system’ and mental health professionals being seen as part of the system; Meeting children where they are at (not location) versus putting our own beliefs onto them; Multiple years in system, wanting services to “fix” problems immediately; Too much clinical terminology used through assessments that are not client friendly”. The researched found that over half of the participants identified additional barriers not previously reported.

When asked what intervention the participant most utilizes when developing a child’s mental health treatment plan, 17 (41.5%) identified their most used intervention to be partnering with parents, 9 (22.0%) identified their focus on the child and their own

work ahead to be the most utilized intervention, and 1 (2.4%) believed collaborating with other Mental Health Professionals to be their most used intervention (see Table 15).

Thirteen (31.7%) of participants indicated that they utilize other techniques and interventions. The participants that identified other interventions included but were not limited to: “Collaborating with parents, children and other mental health professionals; Working to discuss treatment goals that fit in line with family's culture and preference using and entire systems; Assisting with child what needs/goals are needed and wanted; Using FFT (Functional Family Therapy)”.

The researchers found that 82.9% of clinicians utilized the support of family advocates to engage parents in their child’s mental health treatment (see Table 11). The high rate of utilization of family advocates by participants, indicate that support from family advocates and youth peer mentors is a valuable asset to the treatment team. Utilizing the services of family advocates and youth peer mentors alone could also contribute to reducing barriers such as housing stabilization, accessing community resources to ensure that basic needs in the home are met, supporting communication with clinician and other community services provider to ensure family friendly services are being provided, and supporting parent and youth voice advocacy in mental health systems.

The researcher asked participants to identify in what stage of the therapeutic process they felt engagement was the most important. Twenty-three (56.1%) of the participants reported that engagement is most important throughout the entire duration of treatment while 31.7% (n=13) reported it to be most important at the first point of contact

with the family. An additional 9.8% (n=4) reported it to be at the intake appointment and 2.4% (n=1) during the assessment phase of treatment (see Table 7). More than half of the participants agreed that engaging children and families in treatment is an ongoing process. The findings are concurrent with the research previously reported.

Suggestions for Future Research

Suggestions for future research include the effect of utilizing Family Advocates and Youth Peer Mentors to increase rates of engagement with mental health providers in the private insurance sector and the effect mental health service provider location flexibility and the rate of family and youth engagement in mental health services. Additionally, authors suggest further study exploring the correlation of community based services provided outside traditional office locations, transportation support to and from appointments, and trainings on engagement/retention of children and families in mental health services.

Recommendations for Future Research

The purpose of this study was to advance the knowledge of the barriers of engagement and retention in children's mental health. The section below includes a list of recommendations for upcoming research and how this study could have obtained better results. The list will also include recommendations for professionals and agencies who serve children and their families for mental health needs.

- In the survey instrument, the researchers could have surveyed clinicians, family partners, and youth peer mentors from more than one agency. By doing this, the researchers could have looked for trends based individual agencies.

- The researchers could have allotted for a longer collection period for the surveys to ensure that more clinicians, family partners, and youth peer mentors were given the opportunity to complete the survey.
- The researchers could have surveyed the number of years a professional had been working in the field of mental health and correlated with perceptions of barriers to engagement and retention of services.
- At the end of the survey instrument, the researchers could have included an open-ended question to see if there were any additional identified barriers to engagement and retention of services by clinicians, family partners, and youth peer mentors.
- Social workers could work closer with mental health agencies to better understand the barriers children and families face in accessing mental health services.
- Further research studies could examine and explore whether clinicians, family partners, and your peer mentors could utilize the information gathered to improve engagement and retention children and families in mental health services.

Limitations

This research project does not include qualitative data to further explore barriers to accessing mental health services and retention of services for children and families. Information retrieved is limited to the clinicians, family advocates, and youth peer mentors working in children's mental health agencies in Sacramento County. As evidenced in the literature, there are many factors that contribute to challenges in engaging children and families in mental health services and retaining their engagement

in treatment. The researchers, only included four barriers of engagement, created the survey questionnaire, thus many other barriers that may contribute to engagement were not included in the questionnaire. Example of barriers may include: lack of family buy in, lack of parent and family participation, lack of trust from parents in the mental health and child welfare systems, and clinicians inability to understand the family's perspective and tailoring treatment to meet the individual's needs.

APPENDICES

APPENDIX A

Survey Questionnaire

Instructions. Please complete the following questions to the best of your ability. Please do not put your name anywhere in the questionnaire. Thanks for your time.

1. Please circle your gender
 - A. Female
 - B. Male
 - C. Decline

2. Do you work in Sacramento County?
 - A. Yes
 - B. No

3. Please check your position in your agency
 - A. Clinician
 - B. Family Advocate
 - C. Youth Peer Mentor
 - D. Decline

4. If you are a mental health clinician, are you currently licensed?
 - A. Yes
 - B. No
 - C. Decline

5. How long have you been working in the field of children's mental health?
 - A. Less than one year
 - B. 1-2 years
 - C. 3-5 years
 - D. 6 years or longer

6. Does your agency provide mental health services to children and families who receive MediCal benefits?
 - A. Yes
 - B. No

7. Does your agency provide training for staff to develop engagement techniques?
 - A. Yes
 - B. No
 - C. I don't know

8. Have you ever participated in a training on engagement techniques when working with children and families in mental health? If No, skip question #9
 - A. Yes
 - B. No
 - C. Decline

9. If yes, how effective do you feel the training was in helping you develop engagement skills in your current position?
 - A. Not very helpful
 - B. Somewhat helpful
 - C. Helpful
 - D. Very helpful.

10. At what point in the treatment process do you feel engagement the most important?
 - A. At the first point of contact with a family
 - B. At the intake appointment
 - C. During assessment phase of treatment
 - D. Throughout treatment services

11. How important do you feel parental involvement is in a child's mental health treatment?
 - A. Not important
 - B. Somewhat important
 - C. Important
 - D. Very important

12. Please identify the most significant barrier to engaging children in the mental health treatment you are providing?
 - A. Transportation barriers
 - B. Language barriers
 - C. Financial stress
 - D. Cultural barriers
 - E. Other. Please specify_____

13. Please identify the most significant barrier to engaging children in the mental health treatment you are providing?
 - A. Transportation barriers
 - B. Language barriers
 - C. Financial barriers
 - D. Cultural barriers
 - E. Other. Please specify_____

14. Have you provided community resources to families who indicated that they were having difficulties accessing mental health services?
- A. Yes
 - B. No
 - C. Unsure
15. Do you think your agency has the capability of providing mental health resources to meet basic needs of children and families in Sacramento County?
- A. Yes, I do
 - B. No, I do not
 - C. Unsure
16. In your views, is it important to provide basic mental health services to families and children in Sacramento County?
- A. Yes,
 - B. No
 - C. Unsure
- Skip Questions # 17 and 18 if you are not a children mental health clinician.
17. In your service to children mental health, do you utilize the support of family advocates to engage parents in their child's treatment?
- A. Yes, I have had
 - B. No, I had not
18. In your service to children mental health, do you utilize the support of youth peer mentors to engage youth in mental health treatment?
- A. Yes, I have had
 - B. No, I had not
19. Overall, does your agency require you to conduct a yearly satisfaction survey?
- A. Yes, it does
 - B. No, it does not
20. Does your agency provide you with the results of the satisfaction survey?
- A. Yes, it does
 - B. No, it does not
21. How helpful do you find reviewing the results of client satisfaction survey in relationship to your professional development?
- A. Not helpful
 - B. Somewhat helpful
 - C. Helpful
 - D. Very helpful

22. What intervention would you say is the intervention you used most often in developing a treatment plan for the children you work with?

- A. Partnering with parents
- B. Collaborate with other Mental Health Professionals
- C. Focus on Child and their own work ahead
- D.

Other: _____

APPENDIX B

Human Subjects Approval



CALIFORNIA STATE UNIVERSITY, SACRAMENTO
DIVISION OF SOCIAL WORK

To: Viviana Nevarez & Christine Ruiz Date: December 11, 2013

From: Research Review Committee

RE: HUMAN SUBJECTS APPLICATION

Your Human Subjects application for your proposed study, “Barriers of Engagement and Retention of Children's Mental Health”, is **Approved as Exempt**. Discuss your next steps with your thesis/project Advisor.

Your human subjects Protocol # is: **13-14-056**. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Research Review Committee members Professors Maria Dinis, Jude Antonyappan, Serge Lee, Francis Yuen, Kisun Nam, Dale Russell

Cc: Lee

REFERENCES

- Alessi, E. J. (2013). Acknowledging the impact of social forces on sexual minority clients: introduction to the special issue on clinical practice with LGBTQ populations. *Clinical Social Work Practice, 41*, 223–227. doi:10.1007/s10615-013-0458-x
- Ali, A. L., Jackson Foster, L. J., Pecora, P. J., Delaney, N., & Rodriguez, W. (2013). Reshaping Child Welfare's Response to Trauma: Assessment, Evidence-Based Intervention, and New Research Perspectives. *Research on Social Work Practice, 23*(6651668), 651-668. doi:10.1177/1049731513491835
- Allen, K. D., Hammack, P. L., & Himes, H. L. (2012). Analysis of GLBTQ youth community- based programs in the united states. *Journal of Homosexuality, 59*(9), 1289-1306. doi:10.1080/00918369.2012.720529
- Behrens, D., Learn, J.G., & Price, O.A. (2013). Improving access to children's mental health care: Lessons from a study of eleven states. Washington, DC: Center for Health and Health Care in Schools. Chicago
- Bender, K., Kapp, S., & Hahn, S.A. (2011). Are case management services associated with increased utilization of adolescent mental health treatment?. *Children and Youth Services Review, 33*(1), 134-138. Chicago

- Bringewatt, E. H., & Gershoff, E. T. (2010). Falling through the cracks: Gaps and barriers in the mental health system for America's disadvantaged children. *Children and Youth Services Review*, 32, 1291-1299
DOI:10.1016/j.chilyouth.2010.04.021
- California Budget Project (2013). *Expanding horizons: key facts about Medi-Cal programs as California implements health care reform*. Retrieved from http://www.cbp.org/pdfs/2013/130402_Expanding_Horizons.pdf
- Center, M. A. (2007). An Overview of Multicultural Issues in Children's Mental Health
- Cook, B., Barry, C. L., & Busch, S. H. (2013). Racial/Ethnic disparity trends in children's mental health care access and expenditures from 2002 to 2007. *Health Services Research*, 48, 129-149. DOI:10.1111/j.1475-6773.2012.01439
- Disability Rights California (2002). *A Guide To Children's Mental Health Services Under Medi-Cal* (5188.01). Retrieved from <http://A Guide To Children's Mental Health Services Under Medi-Cal>
- Dowell, K. A., & Ogles. B. M., (2010). The effects of parent participation on child psychotherapy outcome: a meta-analytic review. *Journal of Clinical Child & Adolescent Psychology*, 39(2) 151-162. DOI: 10.1080/15374410903532585
- Gonza'lez, M. J. (2005). Access to mental health services: The struggle of poverty affected urban children of color. *Child and Adolescent Social Work Journal*, 22, 3-4. DOI: 10.1007/s10560-005-0036-3

- Haan, A.M. , Boon , A.E. , Jong, J.T.V.M. , Hoeve, M., Vermeiren, R.R.J.M. (2013)
Clinical Psychology Review, Volume 33, Issue 5, July 2013, Pages 698–711
<http://dx.doi.org/10.1016/j.cpr.2013.04.005>
- Hansen, R. L., Mawjee, F., Barton, K., Metcalf, M. B., & Joye, N. R. (2004). Comparing the Health Status of Low-Income Children in and out of Foster Care. *Child Welfare*, 83(4), 367-380
- Hutchison, E. D. (2013). Essentials of human behavior: Integrating person, environment, and the life course. Thousand Oaks, CA. SAGE Publications, Inc.
- Ingoldsby, E. M. (2010). Review of interventions to improve family engagement and retention in parent and child mental health programs. *Journal of Child and Family Studies*, 19(5), 629-645
- Kazdin, A. E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of consulting and clinical psychology*, 65(3), 453
- Larson, J., DosReis, S., Stewart, M., Kushner, R., Frosch, E., & Solomon, B. (2011). Barriers to mental health care for the urban, lower income families referred from pediatric primary care. *Administration and Policy in Mental Health and Mental Health Services Reserch*, 40(3), 159-167
- Lopez, C., Bergren, M.D., & Painter, S.G. (2008). Latino disparities in child mental health services. *Journal of Child & Adolescent Psychiatric Nursing*, 21(3), 137-145. DOI:10.1111/j.1744-6171.2008.00146.x

- Mendez, J. L., Carpenter, J. L., LaForett, D. R., & Cohen, J. S. (2009). Parental engagement and barriers to participation in a community-based preventive intervention. *American journal of community psychology*, 44(1-2), 1-14
- Mennen, F. E., & Trickett, P. K. (2007). Mental health needs of urban children. *Children and Youth Services Review*, 29(9), 1220-1234
- Meyer, O. L. & Zane, N. (2013). The influence of race and ethnicity in clients' experiences of mental health treatment. *Journal of Community Psychology*, 41(7), 884-901. DOI: 10.1002/jcop.21580
- Miller, B. D., Blau, G. M., Christopher, O. T., & Jordan, P. E. (2012). Sustaining and expanding systems of care to provide mental health services for children, youth, and families across America. *Am J Community Psychology*, 49, 566–579. DOI:10.1007/s10464-012-9517-7
- O'Reilly, M. , & Parker, N. (2013). You can take a horse to water but you can't make it drink: Exploring children's engagement and resistance in family therapy. *Contemporary Family Therapy: An International Journal*, 35(3), 491-507
- Owens, P. L., Hoagwood, K., Horwitz, S. M., Leaf, P. J., Poduska, J. M., Kellam, S. G., & Ialongo, N. S. (2002). Barriers to children's mental health services. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41(6), 731-738
- Santiago, C.D., Kaltman, S., & Miranda, J. (2012). Poverty and mental health: How do low-income adults and children fare in psychotherapy? *Journal of Clinical Psychology: In Session*, 69(2), 115-126. DOI: 10.1002/jclp.21951

Shirk, C. (2008, October). Medicaid and mental health services. In National Health Policy Forum Background Paper

Slaton, A. , Cecil, C. , Lambert, L. , King, T. , & Pearson, M. (2012). What a difference family-driven makes: Stories of success and lessons learned. *American Journal of Community Psychology, 49*(3/4), 538-545

Snowden, L., Masland, M., Fawley, K., & Wallace, N. (2009). Ethnic differences in children's entry into public mental health care via emergency mental health services. *Journal Of Child & Family Studies, 18*, 512-519. DOI:10.1007/s10826-008-9253-7

Thompson, R., Dancy, B. L., Wiley, T. R., Najdowski, C. J., Perry, S. P., Wallis, J., Mekawi, Y., & Knafl, K. A. (2012). African american families expectations and intentions for mental health services. *Administration and Policy in Mental Health and Mental Health Services Research, 40*(5), 371-383. doi:10.1007/s10488-012-0429-5

Thompson, S. J., Bender, K., Lantry, J., Flynn, P. M., (2007). Treatment Engagement: building therapeutic alliance in home based treatment with adolescents and their families. DOI 10.1007/s10591-007-9030-6

Wight, V. R., Chau, M., & Aratani, Y. (2010). *Who Are America's Poor Children? The Official Story*. Retrieved from The National Center for Children in Poverty website: http://www.nccp.org/publications/pdf/text_912.pdf

United States. Administration for Children and Families (2011). *Adoption and Foster Care Analysis and Reporting System* (19). Retrieved from U.S. Department of Health and Human Services website:

<http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport19.pdf>

Zimmerman, B., Schwalberg, R., Botsko, C., Gallagher, J., & Borzsak, D. (2001). Mental and physical health: Barriers to and strategies for improved integration. *Rockville: Health Resources and Services Administration, Maternal and Child Health Bureau*