

# The Society for Clinical Child and Adolescent Psychology (SCCAP): Initiative for Dissemination of Evidence-based Treatments for Childhood and Adolescent Mental Health Problems

With additional support from Florida International University and The Children's Trust.



# Keynote

## Engaging Urban Families in Child Mental Health Care: What Does the Evidence Suggest?

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# Acknowledgements

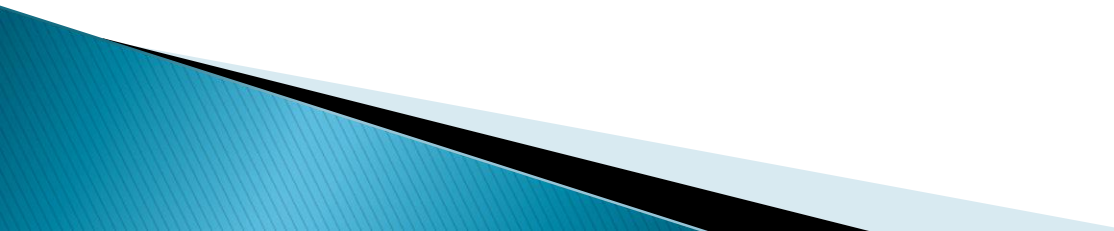
## Bronx Community Collaborative Board

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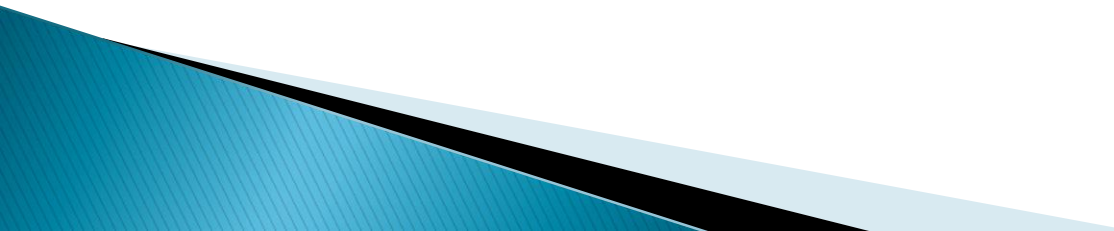
# Urban Child Mental Health Crisis

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- *Two thirds* of children in need of mental health care do not receive services
  - Rates of service use are at their *lowest* in low income, urban communities
  - No show rates can be as high as *50%*
  - Drop outs occurring after *two or three sessions* are common
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# Barriers to Engagement

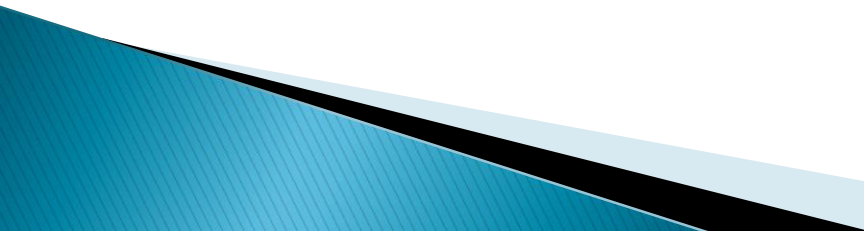
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- ▶ Ecological perspective locates barriers to initial and ongoing engagement within the family, the provider, and/or the system
  - ▶ Triple threat: poverty, single parent status, stress
  - ▶ Concrete obstacles: time, competing priorities, transportation, child care
  - ▶ Perceptual obstacles: attitudes about mental health, stigma, negative experiences, parents' own stress and needs
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# Research Findings on Barriers to Engagement

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- ▶ Not all barriers are “equal.”
  - ▶ Perceptual barriers (e.g., stigma) and prior negative experiences have been shown to have the greatest influence on initial and ongoing engagement
  - ▶ Addressing perceptual barriers may be more important than focusing only on concrete obstacles
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# Early experimental work aimed at increasing initial and ongoing engagement

- ▶ Brief, evidence–informed, targeted interventions focused on enhancing attendance
  - During initial telephone or first meeting (closing the gap between referral/initial telephone contact and keeping a first appointment)
  - During first intake evaluation (closing the gap between evaluation and ongoing services)

# Initial Engagement Interventions

(at point of telephone contact or referral)

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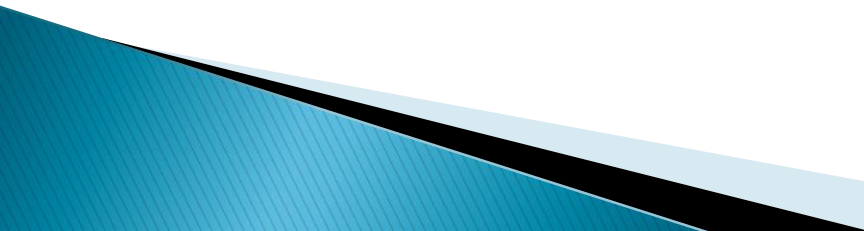
## ▶ Goals:

1. Clarify the need
2. Increase youth and caregiver investment and efficacy
3. Identify attitudes about previous experiences with care and institutions
4. **PROBLEM SOLVE! PROBLEM SOLVE! PROBLEM SOLVE!** around concrete obstacles to care

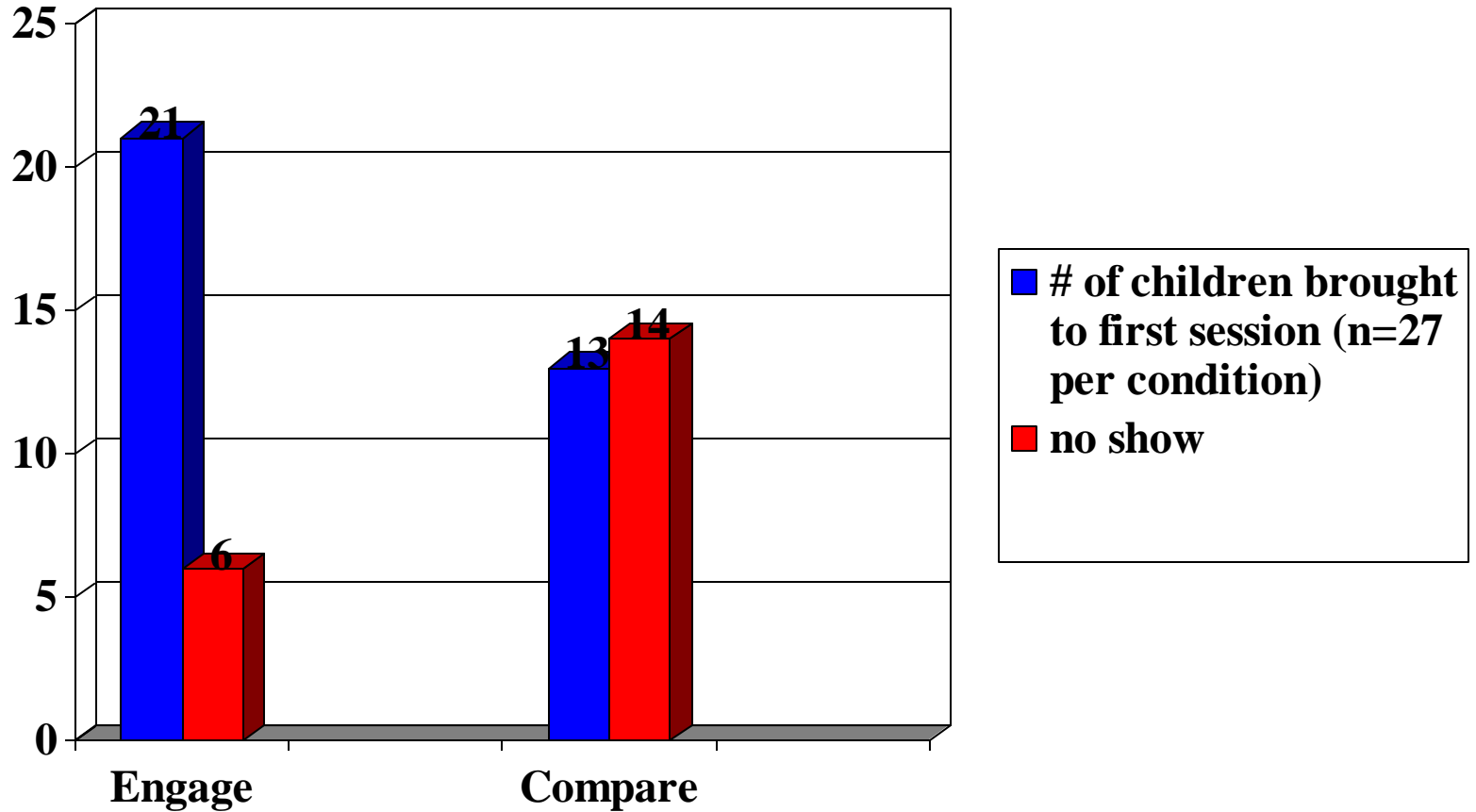


# Study #1 Methods

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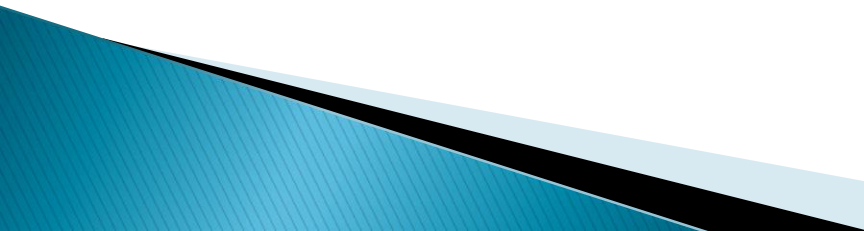
- ▶ Outcome of interest: # of families that brought their child to an initial appointment
  - ▶ Setting: urban outpatient clinic
  - ▶ Sample:  $\underline{n}=54$
  - ▶ Design: Matched comparison of consecutive referrals in one month
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# Study #1 Results



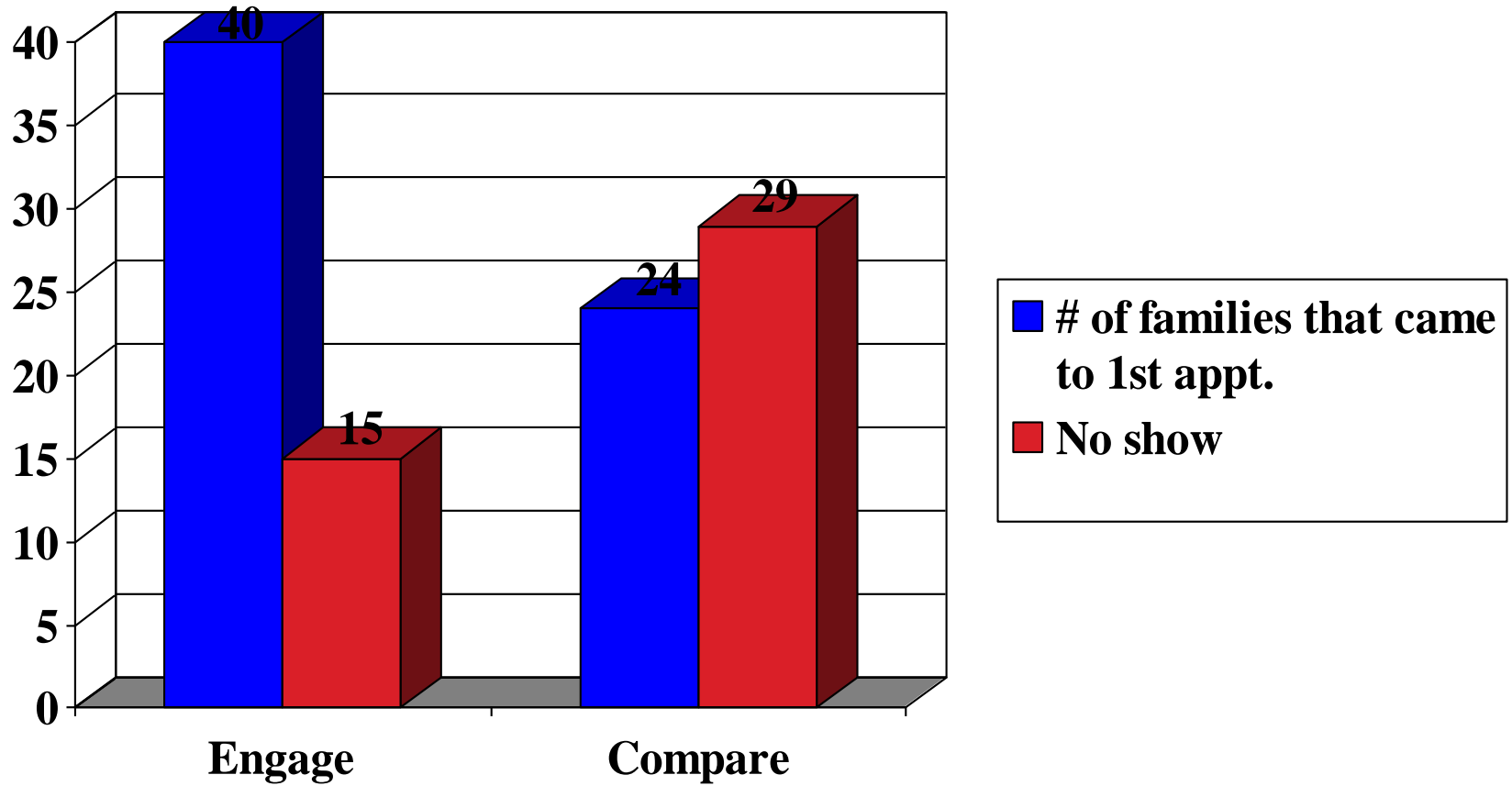
# Study #2 Methods

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- ▶ Outcome of interest: # of families that brought their child to an initial appointment
  - ▶ Setting: Outpatient clinic
  - ▶ Sample:  $n=108$
  - ▶ Design: random assignment to condition
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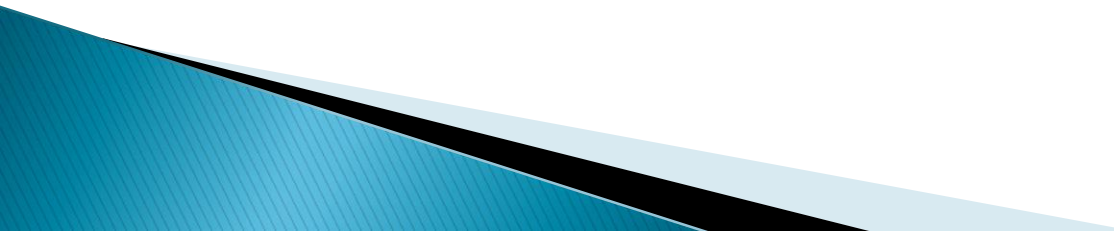
# Study #2 Results

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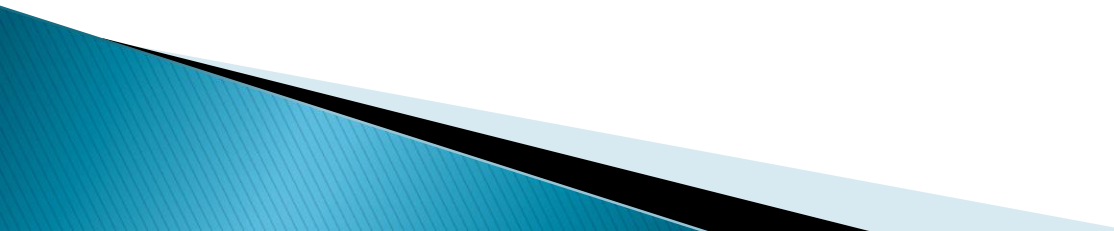
# Importance of First Evaluation Interview

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- ▶ Families are 49% less likely to return after a first appointment if parents are skeptical about possible service helpfulness.
  - ▶ The first evaluation interview is the point at which many families decide if the clinic they are visiting is a good fit.
  - ▶ If families are leave first appointment dissatisfied or with significant questions/concern, they are not likely to return.
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# Study #3 focused on orientating providers to the engagement purposes of the first evaluation meeting

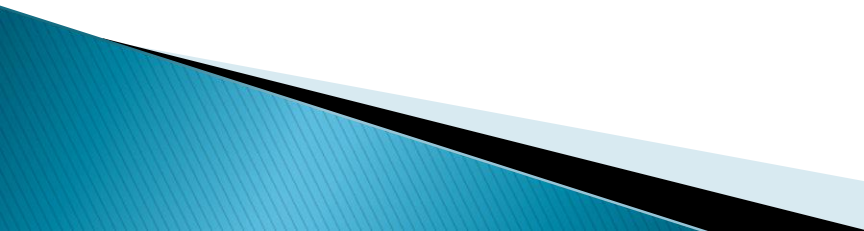
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- ▶ Two primary purposes:
    - To understand why a youth and family want help from provider.
    - To engage the youth and family in a helping process, if appropriate.
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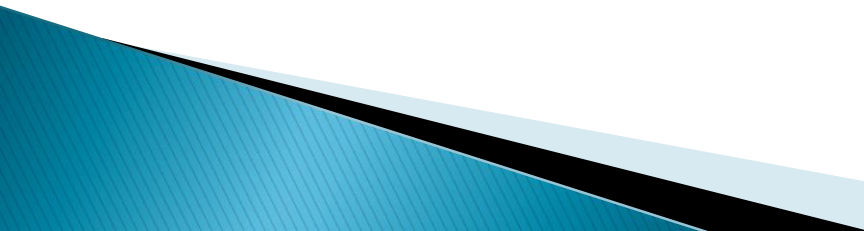
# Four Critical Elements of the Engagement Process

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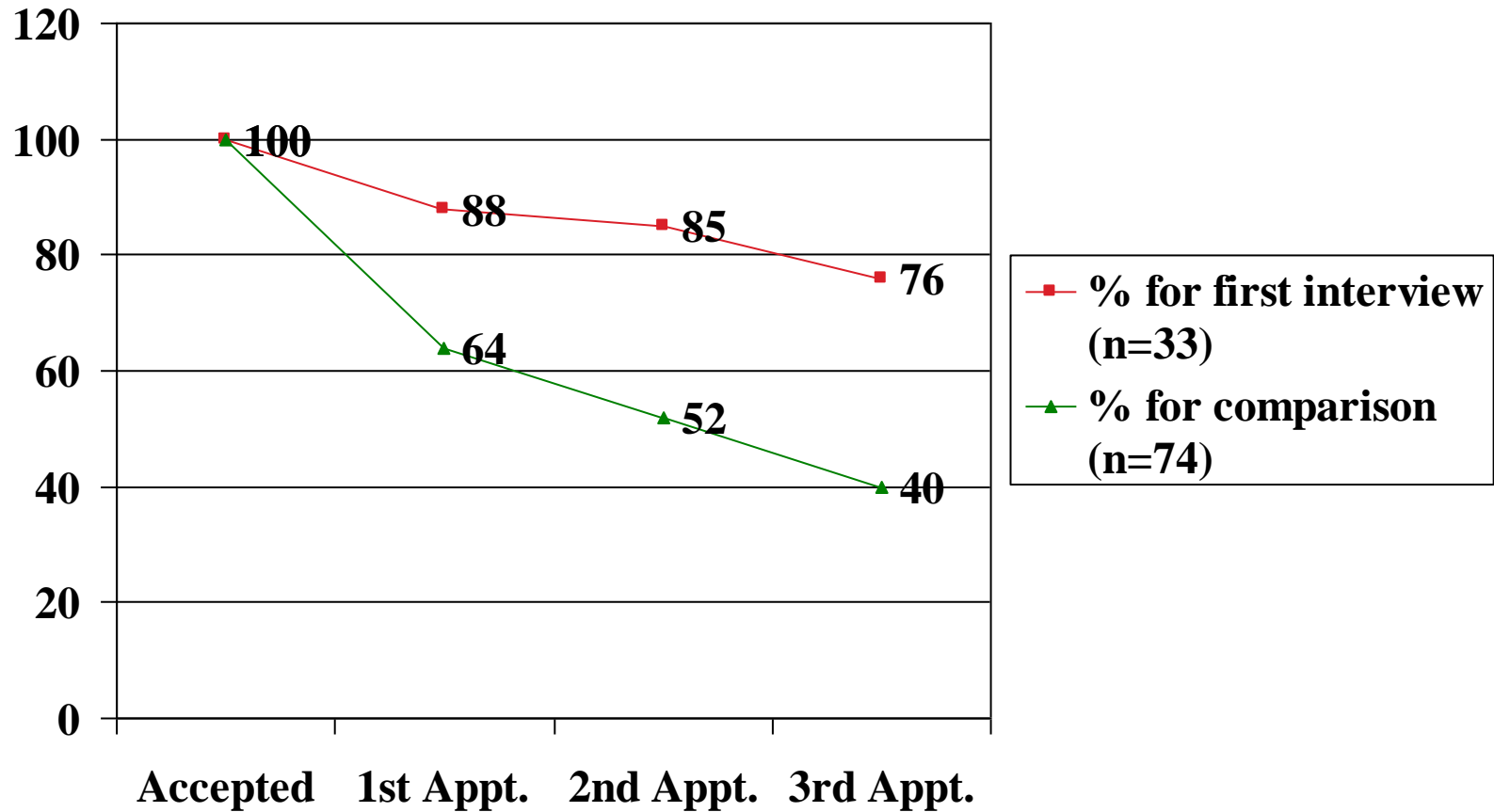
- ▶ Clarify the helping process for the client
  - ▶ Develop the foundation for a collaborative working relationship
  - ▶ Focus on immediate, practical concerns
  - ▶ Identify and problem solve around barriers to help seeking
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# Study #3 Methods

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- ▶ Outcome of interest: # of families that came to initial and ongoing appointments
  - ▶ Setting: Outpatient clinic
  - ▶ Sample:  $\underline{n}=107$
  - ▶ Design: Random assignment to condition
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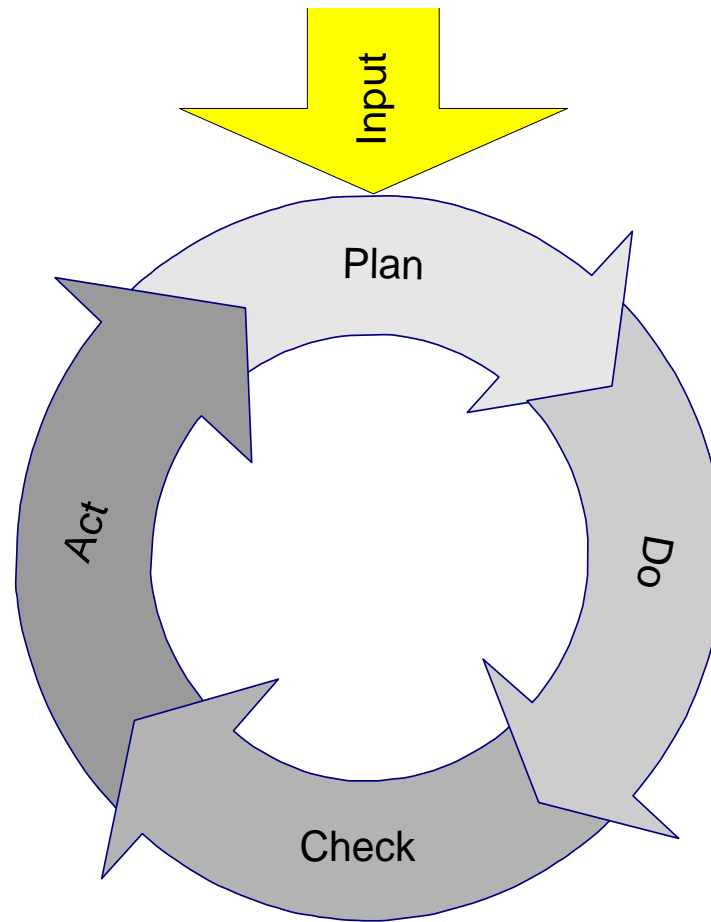
# First Interview Results



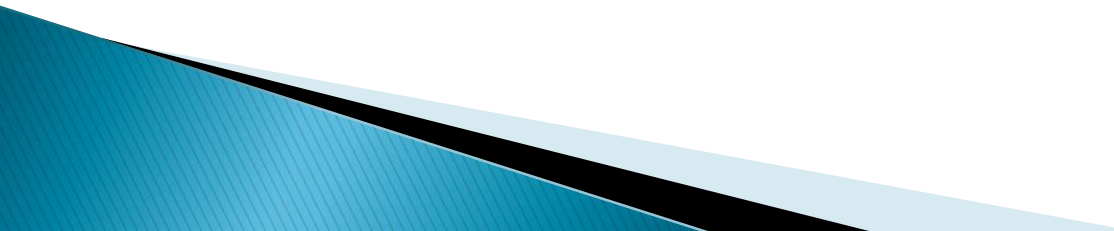
# Learning Collaborative: Enhancing Engagement of Youth & Families in Mental Health Care in New York City

New York State Office of Mental Health  
New York City Department of Health & Mental Hygiene  
Citizen's Committee for Children  
Mount Sinai School of Medicine

# The continuous quality improvement cycle



# CQI cycle

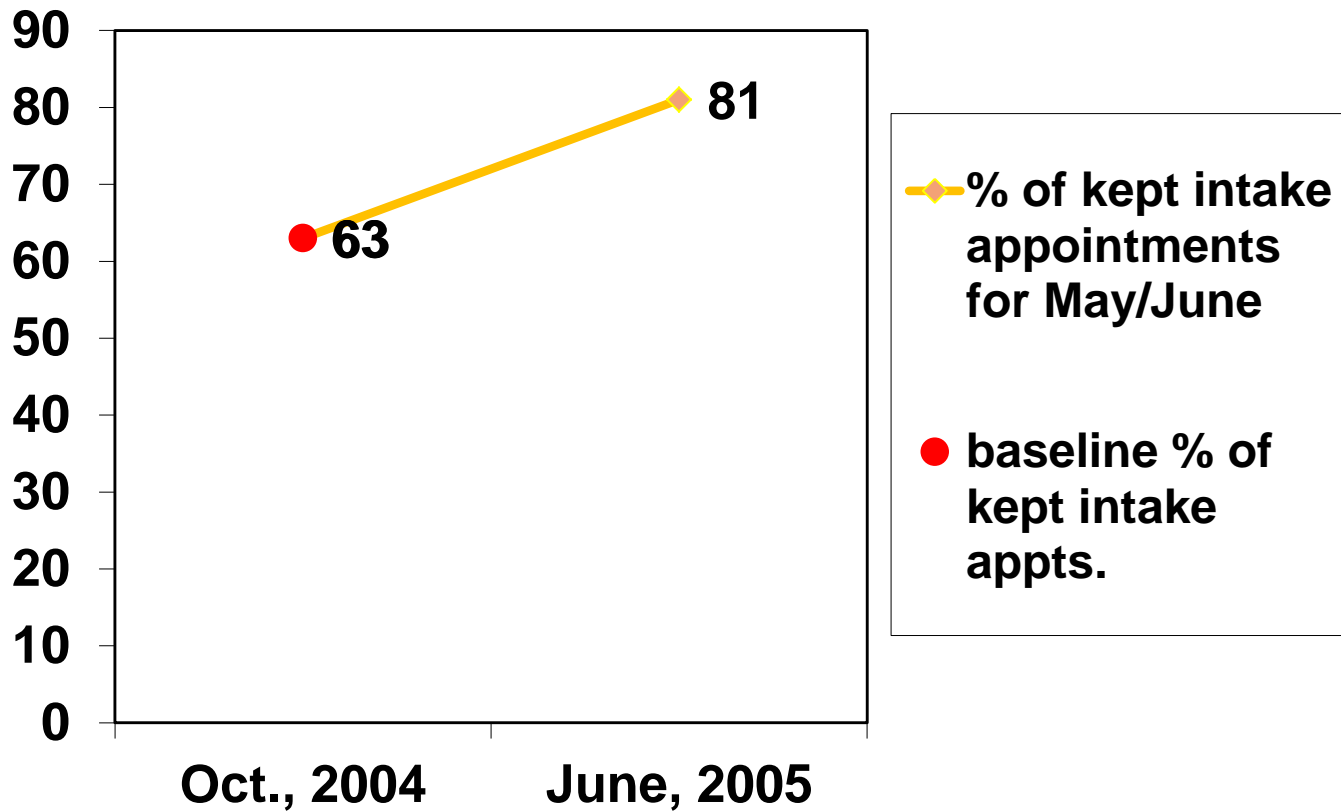
- ▶ Plan – define organizational plan for quality tied to customer needs.
  - ▶ Do – improve organizational performance on key indicators.
  - ▶ Check – assess how well the services delivered in “DO” phase accomplished the objectives in “PLAN” phase.
  - ▶ Act – evaluate and refine quality plan.
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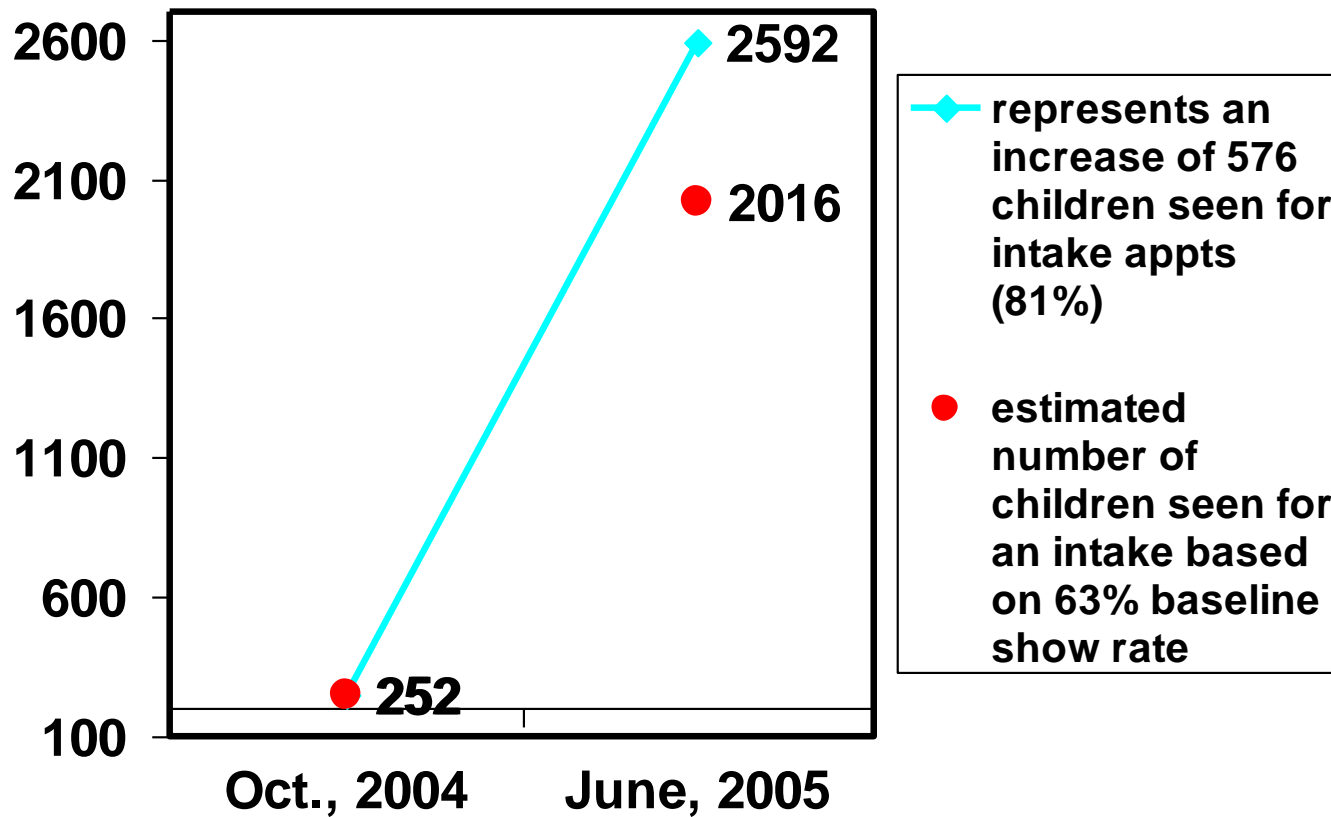
# Performance Indicator #1

- ▶ Show-rate for intake appointments for all new evaluations of children and adolescents
- ▶ Baseline in October, 2004
- ▶ Measured by:
  - # kept intake appointments
  - # scheduled intake appointments

# Performance Indicator #1 (unweighted end point across 14 agencies)



# Estimates of number of children completing an intake over time (using unweighted endpoint rate of change across 14 agencies)



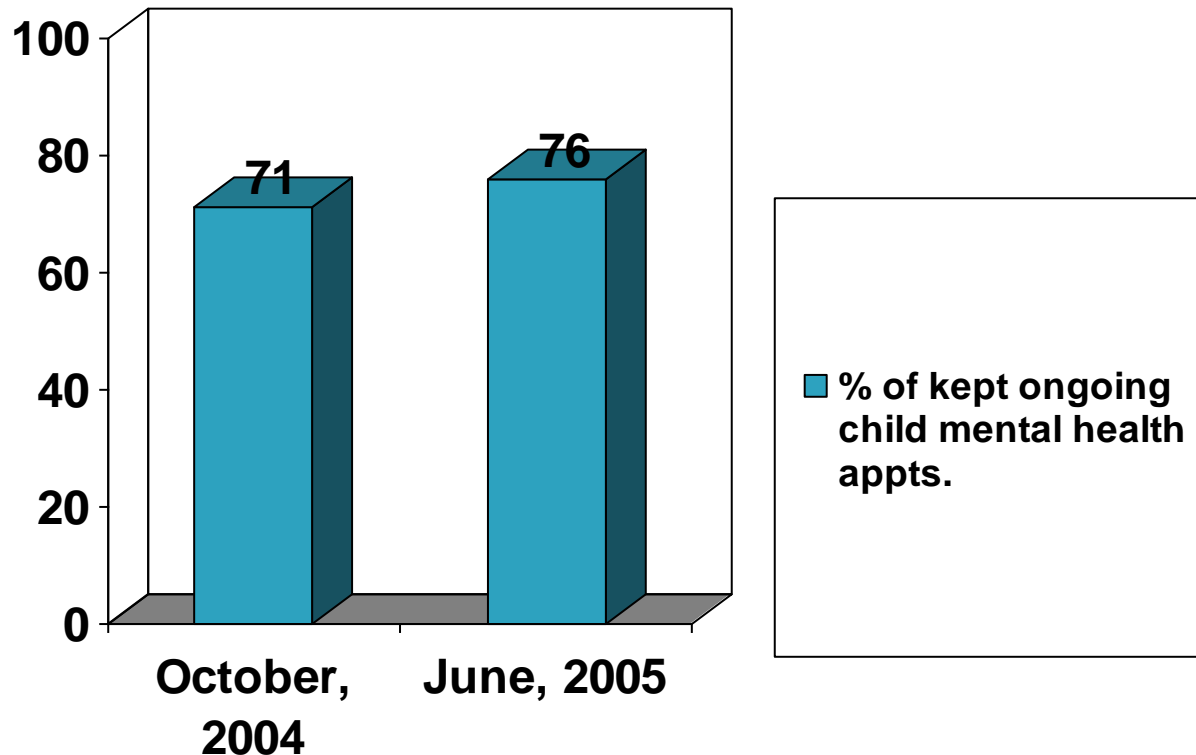
# Performance Indicator #2

- ▶ Attendance rate for any scheduled clinic appointment subsequent to the first intake appointment.
- ▶ As measured by:
  - # attended clinic appointments\*
  - # scheduled clinic appointments\*

\*Exclude the first kept intake appointment

# Performance Indicator #2

(unweighted endpoint across 12 agencies)



# Performance indicator #3

- ▶ Increase the total # of children who attend 8 or more clinic appointments, measured every 3 months for all new evaluations:

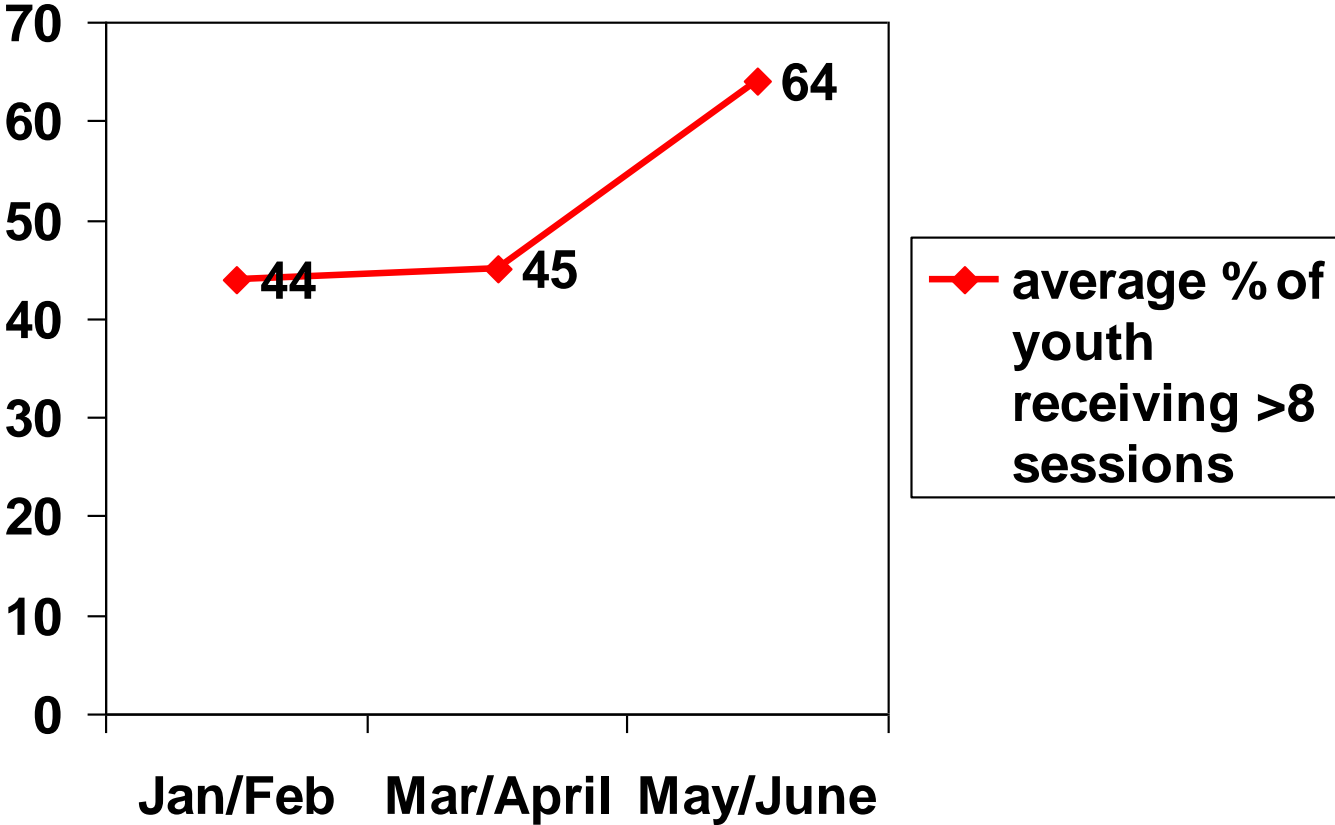
# children attending 8 or more clinic appointments

# children in treatment



# Performance Indicator #3 (unweighted)

trend across 5 agencies)



# Performance indicator #4

- ▶ Improve parents' and caregivers' perceptions of mental health care as measured by a survey:

Perception of care survey is administered to the parents and caregivers of all children and adolescents attending the clinic during a 1 week period every 3 months.

# Performance indicator #4

- ▶ Seven of the agencies completed at least one survey of satisfaction during the 9-month Learning Collaborative

# Next steps: Engaging service delivery models


Multiple family groups (MFG) for youth with disruptive behavioral difficulties



# MFG Research Study

- Multiple Family Group (MFG) is a service delivery strategy meant to enhance child mental health service use and mental health outcomes for urban, low-income children of color.
- NIMH-funded, randomized effectiveness trial of MFG vs. services as usual in 10 outpatient clinics across NYC
  - Youth 7–11 and their families
  - Met criteria for ODD or CD
  - Majority of families with low household income and of African American and/or Latino descent
- MFG content and process was designed in collaboration with parents & providers

# What is a MFG?

- A clinical service meant to enhance child mental health service use and reduce serious conduct difficulties for urban, low-income children
  - Developed from previous research involving urban parents and their children
  - Provides an opportunity for parents and children to share information, address common concerns, and develop supportive networks
  - Involves 6 to 8 families
  - At least two generations of a family are present in each session
  - Knowledge sharing and practice activities foster both within family and between family learning/interaction
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# MFG Evidence Informed Targets

- ▶ Strengthens parenting skills and family relationship processes
  - child management skills
  - family communication
  - within family support
  - parent/child interaction
- ▶ Addresses factors affecting service use and outcomes
  - parental stress
  - use of emotional and parenting support
  - stigma associated with mental health care




# In the words of families...

Multiple family groups should focus on: (4Rs)

- Rules
  - Roles and Responsibilities
  - Respectful communication
  - Relationships
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- As well as the 2Ss:
  - Stress and Support



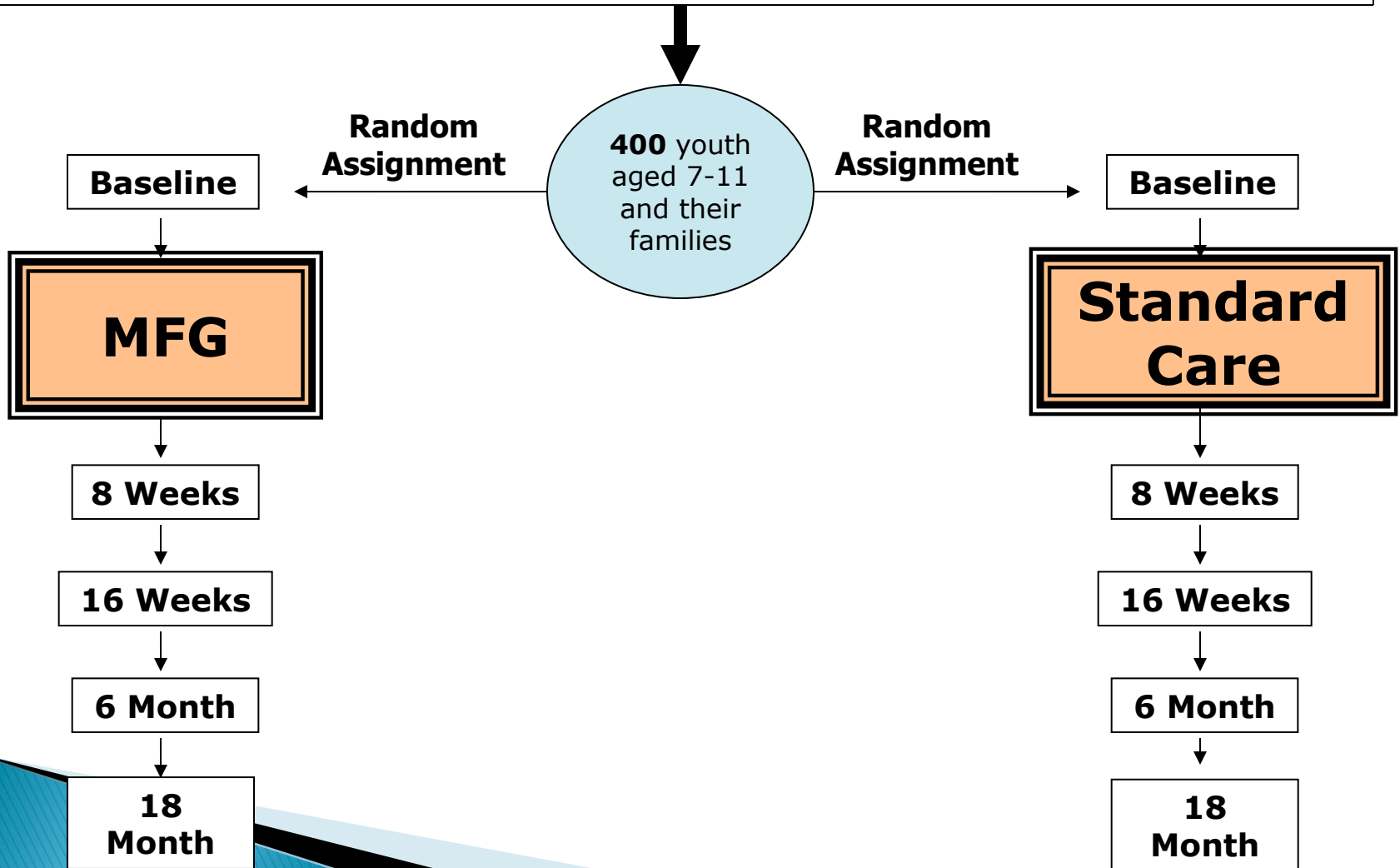
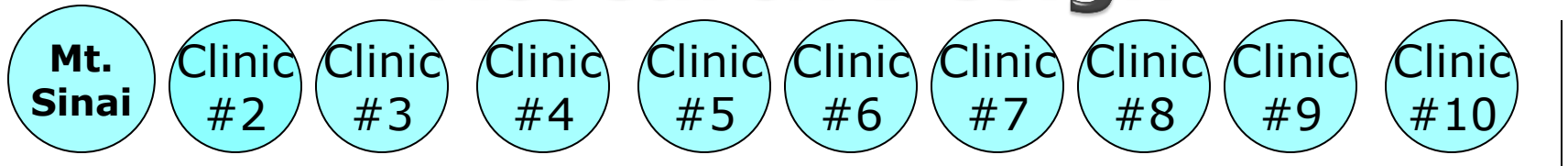
# MFG Collaborative Development & Service Delivery

- ▶ Clinician and parent advocate co-facilitate
  - ▶ Clinicians provide professional expertise
  - ▶ Parent advocates provide support and practical information
  - ▶ Sessions guided by a manual characterized by flexibility, choice of activities, discussion questions
  - ▶ Parent consumers made substantive contributions to the development of the intervention guide based on their experience and existing literature (e.g., brought stress to the forefront)
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# MFG Methods

- Randomized effectiveness trial of MFG vs. services as usual (SAU) in 10 outpatient clinics across NYC
  - Youth 7–11 and their families
  - ODD or CD
  - low-income African American and Latino families

# Research Design



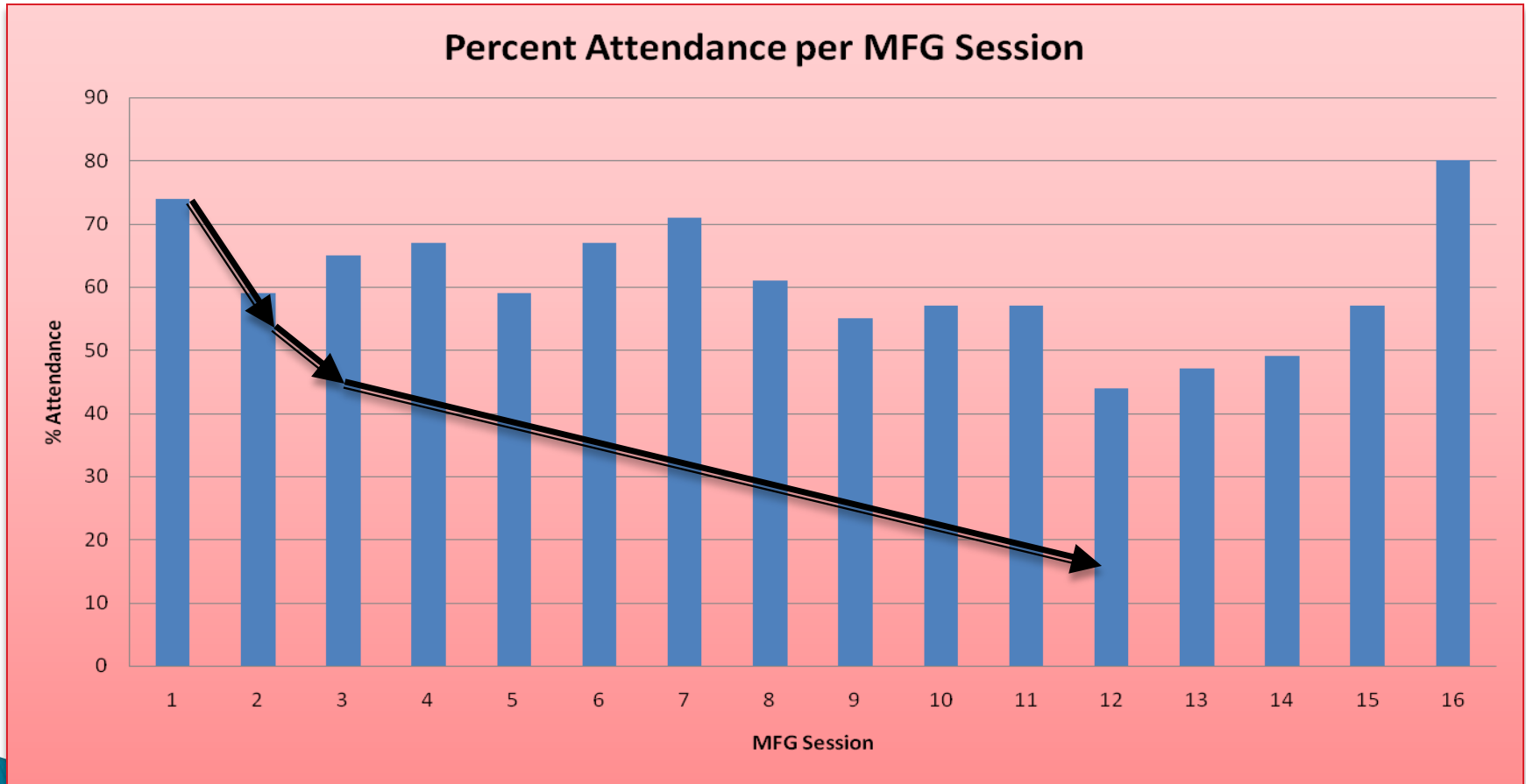
# To date....

Emerging findings from 408 youth and their families involved in the study

# Study Participants

- ✓ Adult caregivers were 87% female
- ✓ A third of parents were born outside the US
- ✓ Half of parents completed high school
- ✓ 45% were employed
- ✓ Racial/ethnic backgrounds were:
  - 47% African American; 42% Latinos
- ✓ Families had an average of 3 children living with them.
- ✓ Youth were evenly split by gender with an average age of 9.5 years.

# MFG Attendance (in comparison to rates of retention in comparison services)



# Further steps: Evidence on Family Support & Engagement

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- ▶ Reduces stigma and distrust by improving communication (Linhorst & Eckert, 2003)
- ▶ Improves activation in seeking care (Alegria et al., 2008)
- ▶ Improves self-efficacy– i.e., active participation in decision-making (Heflinger & Bickman, 1997; Bickman et al., 1998)
- ▶ Improves knowledge and beliefs about children's mental health and this is associated with use of higher quality services for children (Fristad et al., 2003; 2008)



# Resources

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- ▶ **McSilver Institute for Poverty, Policy, & Research:** [www.mcsilver.org](http://www.mcsilver.org)
  - ▶ **Families Together in New York State:** [www.ftnys.org](http://www.ftnys.org)
  - ▶ **Clinic Technical Assistance Center (CTAC):** [www.ctac.com](http://www.ctac.com)
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For more information, please go to the main website and browse for more videos on this topic or check out our additional resources.

## Additional Resources

### Online resources:

1. McSilver Institute for Poverty, Policy, & Research: [www.mcsilver.org](http://www.mcsilver.org)
2. Society of Clinical Child and Adolescent Psychology website: <http://effectivechildtherapy.com>
3. Families Together in New York State: [www.ftnys.org](http://www.ftnys.org)
4. Clinic Technical Assistance Center (CTAC): [www.ctac.com](http://www.ctac.com)

### Peer-reviewed Journal Articles:

1. Alegría, M., Polo, A., Gao, S., Santana, L., Rothstein, D., Jimenez, A., ... & Normand, S. L. (2008). Evaluation of a patient activation and empowerment intervention in mental health care. *Medical care*, 46(3), 247.
2. Bickman, L., Heflinger, C. A., Northrup, D., Sonnichsen, S., & Schilling, S. (1998). Long term outcomes to family caregiver empowerment. *Journal of Child and Family Studies*, 7(3), 269-282.
3. Cavaleri, M., Franco, L., & McKay, M., Appel, A., Bannon, W., Bigley, M., Fazio, M. Harrison, M., Nayowith, G., Salerno, A., Sher, T., & Thakor, S. (2007). The sustainability of a learning collaborative to improve mental health service use among low-income, urban youth and families. *Best Practices in Mental Health*, 3, 52-61.
4. McKay, M. M., Gopalan, G., Franco, L., Dean-Assael, K., Chacko, A., Jackson, J. M., & Fuss, A. (2011). A collaboratively designed child mental health service model multiple family groups for urban children with conduct difficulties. *Research on Social Work Practice*, 21(6), 664-674.
5. McKay, M. M., Hibbert, R., Hoagwood, K., Rodriguez, J., Murray, L., Legerski, J., & Fernandez, D. (2004). Integrating evidence-based engagement interventions into "real world" child mental health settings. *Brief Treatment and Crisis Intervention*, 4(2), 177.

