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It Takes a Village to Deliver and Test Child and Family-Focused Services

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Abstract

Objectives—The purpose of this article is to highlight the benefits of collaboration in child focused mental health services research.

Method—Three unique research projects are described. These projects address the mental health needs of vulnerable, urban, minority children and their families. In each one, service delivery was codesigned, interventions were co-delivered and a team of stakeholders collaboratively tested the impact of each one.

Results—The results indicate that the three interventions designed, delivered, and tested are associated with reductions in youth mental health symptoms.

Conclusion—These interventions are feasible alternatives to traditional individualized outpatient treatment.

Keywords

collaborative research; mental health services; prevention programs; urban families; children and youth

Youth of color living within communities impacted by poverty face enormous challenges and exposure to a wide range of social ills including community violence, substance abuse, crime, HIV infection, school dropout, early pregnancy, and homelessness (Attar, Guerra, & Tolan, 1994; Brooks-Gunn & Duncan, 1997; Horowitz, McKay, Marshall, 2005). Although all inner-city youth risk being impacted by these urban “toxins,” a subset of children are more severely affected (Brooks-Gunn, Duncan, & Aber, 1997). These youth often experience compounded trauma (Horowitz et al., 2005) and have families who must navigate chronic stressors (Bell, Flay, & Paikoff, 2002). This subset of children and their

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families are likely to present with the most complex mental health difficulties, yet research studies abound that these are the same youth who are least likely to have appropriate contact with the child mental health system (U.S. Public Health Service, 2000, 2001) and even if they become involved with an outpatient child mental health clinic, they are the most likely to be lost to “no shows” and early dropouts (McKay & Bannon, 2004).

The complexity of inner-city mental health service delivery appears to be increasing as the number of urban youth of color presenting with serious, multifaceted mental health difficulties grows over time (Albus, Weist, & Perez-Smith, 2004; Donenberg, Emerson, Bryant, Wilson, & Weber-Shifrin, 2001; Ruchkin, Sukhodolsky, Vermeiren, Koposov, & Schwab-Stone, 2006; Salazar et al., 2005; Sionean et al., 2002). For example, nationally, 5–10% of youth, ages of 10–17 years, evidence conduct difficulties (Angold & Costello, 2000), however, as many as 24–40% of African American and Latino youth who reside in urban, low-income communities evidence externalizing behavioral difficulties (Bannon et al., 2006; Tolan & Henry, 1996). Rates of internalizing child mental health difficulties appear to be equally as problematic for inner-city youth with 35–65% of urban community samples of youth reporting struggles with symptoms related to depression, anxiety, and/or post-traumatic stress disorder (PTSD) (Horowitz et al., 2005). Such mental health difficulties can be especially problematic for children of color living within urban environments, as the consequences of behavioral missteps can place their safety and well-being in serious jeopardy, and internalizing symptoms can notably impact risk for substance use and academic failure (Tolan, Guerra, & Kendall, 1995; Tolan, Gorman-Smith, & Henry, 2004).

Rates of mental health needs for subpopulations of vulnerable inner-city youth can far exceed even the concerning figures associated with urban community contexts. For example, nationally, over 1 million youth are homeless each year (National Center on Family Homelessness, 2010). In November 2008 there were 9,720 homeless families with children in NYC shelters (Coalition for the Homeless, 2009) about 75% of homeless residents (Coalition for the Homeless, 2009). Severe shortages of affordable housing within urban areas can extend periods of displacement, with the average length of stay in a family shelter in NYC being 1 year (NYC Department of Homeless Services, 2010). The detrimental effects of homelessness on youth development have been examined previously with disruption in housing associated with youth mental health difficulties, educational underachievement, substance abuse, and numerous other health-related problems (Buckner, Beardslee, & Bassuk, 2004). Further, homeless youth may be at higher risk for exposures to violence and family separation (Buckner, Beardslee, & Bassuk, 2004).

In order to increase the engagement of highly vulnerable youth in needed mental health services and to create multifaceted services with sufficient intensity, flexibility, and relevance to serve inner-city youth and their families, new models of service development, delivery, and research are needed. Within the field of child mental health services research, there is a growing trend toward collaborating closely with family members and service providers as a means of overcoming barriers experienced by the most vulnerable youth and their families to help seeking (Collins & Collins, 1990; DeChillo, 1993; McKay & Paikoff, 2007).

More specifically, there is a range of ways that collaboration with families can occur within child mental health. An important example of the critical role that family members can play is provided by Koroloff and Friesen (1991) in their highly successful test of family members as research associates and linkers to services for youth and families in need. The family associate was a parent, without formal mental health training, who provided information, support, linkage to resources and direct assistance, such as help with transportation and child

care. The presence of a family associate was associated with significantly enhanced engagement and outcomes for low-income youth and their families (Koroloff & Friesen, 1991).

In relation to collaboration with mental health care providers, Weisz, Weiss, and Donenberg (1992) and Weisz, Hawley, Pilkonis, Woody, and Follette (2000) have emphasized the important differences between providers who deliver services within tightly controlled clinical trials and those who provide services within “real-world” settings. Further, there is increasing recognition that if we want evidence-based services to be applied in “real-world” settings, then providers within these settings must be capable of delivering them to their client populations within the constraints of their agencies’ policies and procedures. Therefore, there are increasing calls that whenever innovative service delivery strategies are being developed, providers need to participate in that development to increase chances of transportability.

However, collaboration with providers in previous research studies has not always gone smoothly. For example, field researchers frequently note ongoing conflict with provider staff. In addition, just as is the case when collaborating with consumers and family members, providers may lack research training and not appreciate research, therefore, creating obstacles to collaboration. Further, when research and service endeavors are brought together, there may be some inherent clashes of values that need to be dealt with prior to collaborative partnerships moving forward. Finally, for many provider staff, research activities often have an evaluative feel that is feared. Trust between research staff and providers is frequently an issue. Providers may feel protective of clients and question competency and sensitivity of researchers. For example, concerns may be raised that research activities will interfere with the clinical relationship or that clients may experience anxiety or discomfort as a result of participating in research interviews (Lundy, Gottheil, McLellan, Weinstein, Sterling, & Serot, 1997). Given the obstacles to collaborating with providers, time, communication, and trust building need to occur in order to effect productive research collaboration.

Although calls for increasing the number of collaborative child mental health–focused research efforts have been made, there is still relatively little guidance available to researchers interested in increasing the level of collaboration within their research studies. Thus, the purpose of this article is to highlight the collaborative processes and potential benefits of collaboration with youth, families, and providers by describing three unique research projects, where service delivery has been codesigned, interventions have been co-delivered, and the impact of each of the programs or services has been collaboratively tested and examined.

More specifically, research studies referred to as (a) MFG (multiple family groups for youth with disruptive behavioral difficulties); (b) HOPE (homeless outreach for parents and early adolescents, a family-based HIV prevention and mental health promotion program) and; (c) Step-Up (a multi-level, school-based mental health service for youth evidencing academic failure and mental health difficulties) are described.

MFG

The multiple family group service delivery model targets inner-city youth with serious conduct difficulties and their families who approach urban outpatient child mental health clinics. The MFG is defined as (a) a mental health service that involves six to eight families; (b) an intervention that is facilitated by trained clinicians and parent advocates; (c) a treatment where at least two generations of a family are present in each session; and (d) psychoeducation and practice activities that foster both within family and between family

learning and interaction. The MFG was designed to address conduct difficulties among children and youth through a family-based and mutual support service delivery model.

Research consistently points to family-level processes as the most powerful predictors in the development of disruptive behavioral difficulties, such as parental child management skills, discipline practices, family communication, and interactional difficulties. Based on empirical literature and strong collaboration with family consumers and mental health providers, four broad conceptual categories related to parenting skills and family processes formed the bases for the MFG service delivery strategy: rules, responsibilities, relationships, and respectful communication. The MFG consist of 16 weekly group meetings that focus on these four conceptual categories in order to increase parents' understanding about the importance of specific aspects of family life in the remediation of childhood behavioral difficulties. Focusing on these conceptual categories further enhances the relevance of addressing parenting and family processes while simultaneously reducing parental or family blame for youth behavioral difficulties.

Moreover, the MFG service delivery model targets substantial weaknesses exhibited by the child mental health service system in inner-city communities: (a) low rates of engagement in mental health service use among children residing in low-income urban communities and (b) the large number of children in need of mental health treatment in urban communities that far outstrips the availability of services and providers. The MFG further address factors that impact the engagement and retention of minority children and families, specifically (a) families of color often associate seeking mental health services with stigma; (b) parents of children with mental health difficulties have reported fears of being blamed for their child's problems and these fears may in turn influence decisions to continue in services over time; and (c) mutual support, help from peers, and normalization of family struggles with child mental health needs could create more receptivity to treatment and could potentially offer encouragement for family-level change needed to reduce youth behavioral difficulties.

Consequently, the MFG utilizes a family group format where six to eight families participate in sessions that also target factors (e.g., parental stress, use of emotional and parenting support, family involvement with the child in context, and stigma associated with mental health care) which potentially affect service use among and outcomes for children and families from inner-city, urban communities.

Currently, the MFG service delivery model is being rigorously evaluated in a large-scale, randomized clinical trial funded by the National Institute of Mental Health (NIMH). Preliminary rates of engagement for the first 190 families randomly assigned to either MFG versus comparison individualized or family therapy services offered with 10 outpatient mental health clinics are summarized in Figure 1.

In addition, there is emerging preliminary evidence that the MFG is associated with significant reductions in youth symptoms related to oppositional behavior and inattention and improvement in social skills relative to those youth enrolled in comparison services (see Tables 1 and 2).

HOPE

The HOPE family program, a family-based HIV prevention and mental health promotion program, was created through collaboration between an urban community collaborative board, a working group of inner-city parents, school staff members, and university-based research staff. Board members were also responsible for delivering the program in family homeless shelters, once the intervention protocol was completed. Core program components were drawn from existing evidence-based interventions.

The primary task of the collaborative board was to integrate existing evidence-based prevention and mental health service components, tailoring content/activities to perceived needs within inner-city communities and to the realities of shelter life. The program's development was guided by (a) a careful consideration of the relevance of the various components to the target population and (b) issues of retention for this transient population. The final product was an eight-session's curriculum in which parents and youth met separately and also together to discuss a range of topics, including family communication, monitoring and supervision, self-respect, peer pressure, puberty, and domestic violence. Concepts such as self-efficacy and comfort surrounding health protective sexual communication are integrated into each meeting.

The curriculum draws on a variety of methods to engage participants, including games, discussions, role-plays, scenarios, and visual aids. In order to conduct these family workshops, community board members received training and support from clinically trained research staff.

HOPE targets pre- and early adolescents, ages 11–14 years old, and their care giver who reside in family homeless shelters. Each session is divided into three parts: welcome, parents and youth groups, and the family discussion. Sessions begin with a warm-up period, which provides an opportunity for the families to connect with each other and to share updates about the previous topics and issues that have come up in their families since the previous group meeting. Each parent and youth group allows the participant to discuss issues at their age level. During family discussions, activities are used to facilitate communication between the parents and youth. The family discussion also serves as a wrap-up of the session.

Currently, the HOPE family program is being rigorously evaluated in a large-scale, randomized clinical trial funded by the National Institute for Drug Abuse (NIDA). Preliminary rates of engagement for the first 208 families randomly assigned to the HOPE family program are summarized in Figure 2.

In addition, there is emerging preliminary evidence that HOPE is associated with significant reductions in youth mental health symptoms (see Table 3).

Step-Up

Project Step-Up, a school-based mental health service delivery model, has been developed to bolster key family and youth processes related to youth mental health and risk-taking behaviors. Project Step-Up (a) intervenes with urban minority adolescents across inner-city ecological domains; (b) addresses multiple ecological levels (school, family, and community) in order to target youth behavioral difficulties; and (c) provides opportunities for increasing youth social problem-solving and life skills. Further, Step-Up integrates existing theory-driven, evidence-based interventions at a critical developmental juncture with a strong family and community preventative focus (McKay & Paikoff, 2007).

The goals of Project Step-Up are to (a) deliver a school, family, and community-based mental health intervention for adolescents (14–17 years of age) with serious impairments in behavioral and educational functioning due to complex and unmet mental health difficulties; (b) provide Project Step-Up within urban high school programs and neighboring inner-city communities; and (c) examine the process of mental health service delivery and the impact of Project Step-Up on youth mental health, impairment, and functioning across inner-city ecological contexts.

Project Step-Up is informed by several theoretical perspectives. Social action theory (SAT; Ewart, 1991) has been applied to guide understanding of youth mental health and

functioning within families and multiple inner-city ecological contexts. Asset theory (Sherraden, 1990, 1991) states that assets (e.g., savings and educational opportunities) have important psychological, social, and economic benefits for youth. Asset building involves efforts that enable people with limited financial and economic resources or opportunities to acquire and accumulate long-term productive assets. Asset building is increasingly viewed as a critical factor for reducing poverty, positively impacting attitudes and behaviors, and improving one's psychosocial functioning (Page-Adams & Sherraden, 1997; Yadama & Sherraden, 1996; Zhan & Sherraden, 2003). Project Step-Up incorporates asset theory in order to enable highly vulnerable youth to envision the future with optimism and improve their mental health functioning. Moreover, it is anticipated that incorporating asset theory is likely to promote future planning, educational goal-setting, and behavioral change among youth who might otherwise engage in harmful risk behaviors.

The process of developing the service delivery model involved convening a collaborative planning group consisting of forty 14–17-year-old adolescents attending two inner-city high schools in East Harlem and Bronx, New York. These groups were charged with making decisions regarding the specific content and service delivery processes.

Project Step-Up intervention components collaborative design include (a) youth board ongoing planning meetings, where youth become the recipients of mental health services and also the planners of these services for their high school; (b) study group sessions; (c) one-on-one contact with mental health and peer specialists; (d) summer internships/jobs; (e) incentive-based asset structure (includes stipends and savings accounts); (f) family outreach and mental health intervention; and (g) collaboration with school staff.

Project Step-up program delivery includes facilitation and mentoring by prosocial adult mentors of color, peer parent advocates, trained youth specialists, public health practitioners, and social work clinicians.

Currently, Step-Up is being examined with funding from the Robin Hood Foundation. Preliminary rates of engagement for the first 45 students assigned to the Step-Up are shown in Figure 3.

In addition, there is emerging preliminary evidence that Step-Up is associated with significant reductions in youth mental health symptoms (see Table 4).

Conclusion

This article illustrates that collaborative work between consumers, providers, and researchers is feasible and effective in the design, delivery, and evaluation of child and adolescent mental health and preventive services. In each one of the projects described and approved by the Institutional Review Board of the Mount Sinai School of Medicine, service delivery interventions have been codesigned, co-delivered, as well as collaboratively tested and examined. Preliminary results for each project indicate significant reductions in youth mental health symptoms and illustrate that these interventions are a feasible alternative to traditional individualized outpatient psychotherapy. Furthermore, these projects illustrate that effective services can be delivered not only in urban outpatient child mental health clinics, where the MFG program has been integrated into standard care, but also in a variety of settings such as schools and shelters serving homeless families.

The results also support the notion that collaborative efforts lead to “building bridges” that link vulnerable youth and their families to much needed mental health care (Collins & Collins, 1990; DeChillo, 1993; McKay & Paikoff, 2007); therefore, IT TAKES A VILLAGE (of youth, parent advocates, peers, clinicians, and services researchers) to create,

deliver, and test child- and family-focused prevention programs and services. Why do we need a village? The concept of a village normalizes struggles across the life cycle, enhances receptivity to programs and services, decreases stigma, and brings “real life” expertise into service delivery teams.

Implications for Practice

In “real-world” community agencies, a significant proportion of clients experience psychiatric disorders, and in these settings, social workers constitute the largest professional group available to address their needs (Proctor, McMillen, Haywood, & Dove, 2008). A program of research that aims to advance the understanding of what constitutes quality mental health for urban families will be more likely to succeed if it is located where services are delivered, that is in settings where families seek care. Engaging stakeholders and consumers (youth, parents, providers, and communities) in collaborative processes, as described earlier, can lead to the development and implementation of “user-friendly” services and prevention programs. Collaboratively developed and delivered services, as illustrated by the projects described earlier, are not only more acceptable and relevant to the consumer’s context, but more likely to be sustainable.

This method of inquiry and approach to research provides practitioners with an opportunity to emphasize the importance of knowledge generated from peoples’ “lived” experiences. Furthermore, it complements social work practice and responds to the challenges and limitations of traditional research. Collaborative research promotes inclusion, maximizes community resources and strengths, and creates opportunities for new social networks (Jacobsen & Rugeley, 2007) that can endure beyond the life of a given project.

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Figure 1. Multiple family group attendance (in comparison to rates of retention in outpatient urban individualized mental health services).

Figure 2.
HOPE rates of attendance. Note: HOPE = homeless outreach for parents and early adolescents.

Figure 3.
Percentage attendance at spring 2008 Step-Up sessions.

Table 1

Group Receiving MFG Intervention Showed Significant Improvement From Baseline to Posttest Using Paired Sample *t*-Test Whereas the Control Group did not

	MFG		Control	
	Baseline <i>M (SD)</i>	Post <i>M (SD)</i>	Baseline <i>M (SD)</i>	Post <i>M (SD)</i>
ODD	2.84 (0.68)	2.45*** (0.91)	2.54 (0.77)	2.86 (0.94)
Inattention	2.83 (0.75)	2.40*** (0.70)	2.73 (0.84)	2.73 (0.71)
Social skills	76.84 (10.62)	83.02*** (10.48)	81.95 (13.64)	78.05 (11.24)

Notes: MFG = multiple family groups for youth with disruptive behavioral difficulties.

ODD = oppositional defiant disorder.

 $p < .001$.

Table 2

The Differences Shown in Table 1 Were Confirmed by Significant Between-Group Interactions in Repeated Measures ANOVAs

<i>F Test of Between-Group Interaction</i>	
ODD	14.73 ***
Inattention	6.43 *
Social skills	14.84 ***

Notes: ANOVA = analysis of variance.

ODD = oppositional defiant disorder.

*
 $p < .05$.

 $p < .001$.

Table 3**Preliminary Outcomes Associated With HOPE**

Mental Health (Childhood Depression Inventory/Strengths and Difficulties Questionnaire)
40% of youth evidence clinically elevated depressive symptoms
19% of youth reported suicidal ideation
39% of youth were described by their adult caregivers as having noteworthy conduct difficulties
44% of youth were described by their adult caregivers as having significant peer problems

Notes: HOPE = homeless outreach for parents and early adolescents.

Table 4**Preliminary Outcomes of Step-Up**

Of the 45 students initially enrolled, only 4 students dropped out of services prematurely ($<10\%$ drop off vs. 50–90% drop out in traditional services) After 4 months of service, 22 students and their service providers agreed that academic and mental health issues had improved sufficiently to end involvement Approximately 50% agreed success vs. rare event in services as usual Of the 19 students remaining, an additional 8 students continued involvement in Step-Up for two additional months with a successful termination Two thirds reached, served, and successfully completed care 11 students continue in Step-Up currently
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