Strengthening Components and Processes of Family Involvement in School Mental Health

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Involving families in youth mental health services is foundational to achieving positive youth outcomes (for review, see Hoagwood et al., 2010). Unfortunately, this can be a particularly challenging process, and families are often not meaningfully involved in services. In studies of engagement in community mental health services, youth and family no-show rates at initial appointments range from 28 % to 62 % (Harrison, McKay, & Bannon, 2004; McKay, Lynn, & Bannon, 2005; McKay, McCadam, & Gonzales, 1996). Thus, at a basic level of involvement, some families are not being engaged in services. This has the potential to compromise the delivery of evidence-based interventions given that family involvement may be an essential factor in obtaining and maintaining positive outcomes for youth (National Institute of Mental Health [NIMH], 2001). As national mental health policy calls for families to become active consumers of mental health services, and for children and youth to receive more comprehensive services (New Freedom Commission on Mental Health [NFCMH], 2003), it is increasingly important to review empirically supported strategies for effectively involving families in mental health services so that these approaches can be consistently integrated into practice.

Despite the call for and importance of incorporating families in youth mental health services, community-based locations, such as schools, bring unique challenges to engaging families in youth mental health services (Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007). These include the inability of the family to get to the school during school hours, variability in behavior and attitudes of school staff toward families, and negative experiences family members may have had with their own schooling (Bickham, Pizarro, Warner, Rosenthal, & Weist, 1998). Thus, it is important to examine effective family involvement strategies specifically within the context of SMH.

Family Involvement in School Mental Health

The President's New Freedom Commission on Mental Health (2003) calls for involving "consumers and families fully in orienting the mental health system towards recovery." In addition, the President's New Freedom Commission (2003), the Surgeon General's Report on Mental Health

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(U.S. Department of Health and Human Services, 1999), and the No Child Left Behind Act (2002) call for the expansion of mental health services for youth in schools. Expanded SMH involves the provision of a full continuum of effective mental health promotion; prevention of social, emotional, and behavioral problems; and intervention for students in general and special education through a shared agenda involving school-family-community partnerships (Weist, 1997). As indicated in this emphasis on a shared agenda (see Andis et al., 2002), families play a key role in collaborating with SMH staff in improving their child's emotional, behavioral, and school functioning. Additionally, families should help to guide and continuously inform mental health programming. Although such family involvement is central to high-quality SMH, often such involvement is not at an optimal level (see Weist et al., 2007; Lever et al., 2006). In this chapter, we will review evidence-based strategies which enable the successful engagement of families with schools and in SMH programs and services. Issues related to family involvement are further illustrated through experiences from a research study that focuses on achievable strategies for high-quality, evidence-based practice in SMH, with a major emphasis of this study placed on family engagement and empowerment[1].

School-Wide Family Involvement

Family, school, and community factors are believed to operate in concert to influence children's learning (Epstein, 1987). When families are actively involved in the school, there are many benefits for students, including earning higher grades and test scores, increased likelihood of grade-level promotion, having more positive attitudes about school, and graduating and pursuing higher education (Catsambis, 1998; Epstein, Clark, Salinas, & Sanders, 1997; Miedel & Reynolds, 1999; Shaver & Walls, 1998; Shumow & Miller, 2001; Trusty, 1999; Westat and Policy Studies Associates, 2001; for review see Henderson & Mapp, 2002). Various factors influence levels of caregiver involvement in their children's education. Family involvement is influenced by the child's age, with involvement decreasing as age increases (Epstein & Connors, 1994). Other demographic characteristics include socioeconomic status, ethnicity, and cultural background (for review see Hill & Taylor, 2004). In general, families of higher socioeconomic status are more involved, given less time constraints from work, as well as fewer barriers to transportation and resources (Hill & Taylor, 2004). Factors that support caregiver involvement and are more malleable include caregiver perception of their role in their youth's education, whether the caregiver feels efficacious in helping their student learn, and invitations from the school to be involved (Hoover-Dempsey & Sandler, 1995, 1997; Walker, Wilkins, Dallaire, Sandler, & Hoover-Dempsey, 2005). LaParo, Kraft-Sayre, and Pianta (2003) found that a significant majority of families were willing to participate in school-initiated kindergarten transition activities, when offered the opportunity. Additionally, those who participated in these activities were more likely to be involved across subsequent school years. This underscores the crucial role of teachers in reaching out to caregivers, inviting them to play an active role in the school from an early stage.

At the administrative level, the principal sets the tone for family involvement in the school (Hiatt-Michael, 2006). For example, as the on-site administrator, a principal can promote family involvement activities by building time for these activities into staff schedules and role descriptions. For teachers and staff, the most significant barriers are related to lack of adequate preparation and training (Morris & Taylor, 1998). When provided with foundational courses in family involvement in education, teachers reported greater comfort and competence in planning and implementing programs emphasizing this theme (Morris & Taylor, 1998). In addition to teachers and school administrators,

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school-employed mental health staff, such as school psychologists, counselors, and social workers, also play a critical role in promoting family involvement in the school (Bryan & Holcomb-McCoy, 2004).

Targeted Family Involvement in School Mental Health Programs and Services

In contrast to the aforementioned school approach which targets parents, guardians, and family members of all students, this section focuses on enhancing family involvement among students receiving SMH services. Currently, the need for family involvement in youth mental health services is fairly well accepted. This may be due to various factors such high levels of caregiver stress that are consistently reported when raising a child with mental health needs and accessing suitable services (Weisz, 2004). However, while familial involvement is critical to effective child and adolescent therapy (Weisz, 2004), attention to caregiver support in children's mental health services has been minimal (Hoagwood et al., 2010). A lack of research and attention to development of programs of this sort has resulted in few program models that can be examined and replicated. Thus, in this section, commonly used models of family support will be discussed, followed by key processes of family involvement and related interventions.

Models of Targeted Family Involvement

Families can be involved in services in a variety of manners, and here we will specifically discuss family supports. Family supports can be defined as "services, interventions, or programs targeted at the needs of parents or caregivers of children or adolescents with identified mental health needs" (Hoagwood et al., 2010). There are three primary delivery models of family supports: clinician led, family led, and team led. Clinician-led supports are led by a mental health clinician, with most at the masters or doctoral level, while family-led supports are led by a caregiver of a youth with a mental health problem who has already navigated the complexities of the mental health service system. Team-led family supports are led by a team that consists of a clinician and an experienced family member. In a meta-analysis of clinician-led, family-led, and team-led supports for families, Hoagwood and colleagues (2010) identified 50 programs that were targeted to the needs of families of youth presenting emotional/behavioral challenges. Specifically, services, interventions, or programs were included if they provided informational/educational support, instructional/skill development support, emotional or affirmational support, instrumental support, or advocacy support to families.

Clinician Led

In the Hoagwood et al. (2010) review, supportive services led by the clinician were the most common (33 of the 50 programs). Most of the supports provided by clinicians focused on providing instructional (n = 26, 79 %) and informational (n = 22, 67 %) support; however, 30 % also identified emotional support as a key component. Instructional support was commonly provided through building parenting skills or addressing caregiver mental health problems. Informational support was most frequently presented as clinicians providing psychoeducation to the families. And, emotional support included one-on-one discussions between clinicians and family members. Almost all of these clinician-led supportive services were based in a clinical (i.e., non-community) setting, and eligibility to participate was based on the child's diagnosis or treatment status. Results from clinician-led supportive services included reductions in symptoms and improvement in functioning for youth, high caregiver satisfaction, improvement in parenting skills, improved treatment attendance, and reduced premature case closure (see Hoagwood et al.).

Family Led

Family-led supportive programs were the next most common type of programs (11 of the 50 programs). Peer-to-peer family services have

evolved to develop new family supports and help with management of the stressors associated with raising a child with mental health needs. In peer-led delivery systems, services are provided by parents or caregivers with experience navigating systems for their children with identified emotional/behavioral problems to parents or caregivers without such experience (Hoagwood et al., 2008). Evidence suggests these programs are beneficial both to peer leaders and the group members (Koroloff, Elliott, Koren, & Friesen, 1996). Due to personal experience with managing barriers to services and dealing with caregiver stress, these experienced family members have been reported as more credible and trustworthy by caregivers, making them able to encourage the active engagement of families in mental health services (Gyamfi et al., 2010; Hoagwood, 2005; Osher, Penn, & Spencer, 2008).

The popularity of caregiver-led supportive programs has stimulated advocacy organizations, such as the National Alliance on Mental Illness (NAMI), Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), and the National Federation of Families for Children's Mental Health, to develop training programs for peer leaders. Typical types of support provided in these family-led supportive services are advocacy, instructional supports, informational supports, and emotional supports (Hoagwood et al., 2010). However, research on the content of these services and their impact on families is quite limited (Hoagwood, 2005). As peer-delivered family support has recently become a billable mental health service in a number of states (e.g., New York, Maryland, South Carolina; Cavaleri, Olin, Kim, Hoagwood, & Burns, 2011), it is hoped that increased emphasis will be placed on the development of evidence-based, supportive programs that can be implemented in a variety of healthcare settings.

Team Led

The team-led supportive programs, programs led by a clinician and an experienced family advocate, were the least frequent (6 of the 50 programs) in the Hoagwood et al. (2010) review. These programs involve more of a collaborative process among families and professionals, with each team being characterized by "different responsibilities, equal voice, and a common purpose" (Ireys, Devet, & Sakwa, 2002; p. 158). As opposed to clinician- and peer-led supportive services, team-led programs are generally conducted in a group-based format (Hoagwood et al., 2008) and are not necessarily dependent on the child's receipt of services. Across these types of programs, such as the Vanderbilt Empowerment Project (Bickman, 1987) and Parent Connections (Ireys et al., 2002), it has been found that much emphasis is placed on provision of emotional support. Families are encouraged to share experiences and insights and are met with affirmational listening (i.e., communication intended to promote a caregiver's feelings of being supported, valued, and affirmed), intended to enhance well-being and self-efficacy (Hoagwood et al., 2008). Additionally, these programs place emphasis on instructional support through building parenting skills, informational support through providing information on the nature of emotional and behavioral problems in children and youth and navigating the healthcare system, and strategies for families to become advocates for themselves. Studies of the effectiveness of such team-led programs have reported enhanced caregiver empowerment, increased access to services, and improved youth functioning (Bickman, 1987; McKay, Quintana, Kim, Gonzales, & Adil, 1999; Ruffolo, Kuhn, & Evans, 2005).

Key Processes in Targeted Family Involvement

As described above, family support services, which are intended to bolster family involvement and support families in youth mental health services, can be provided in various modes. In the following section, key processes involved in support services will be examined. It is important to recognize that many of these constructs may be overlapping and are complimentary. These key processes are important in understanding how and why interventions work and are also important for the development of new strategies to enhance family involvement in schools and in SMH programs.

Engagement

Low family engagement and family retention in treatment are problematic in youth mental health services and are significant threats to evidence-based interventions (NIMH, 2001). McKay and Bannon (2004) conceptualize engagement in services as beginning with the recognition of a child's mental health issue, connecting to relevant services through referral, and then completing with the child receiving services. In the literature, engagement has also been broken down into two steps: initial attendance at services and ongoing retention in services (McKay, Stoewe, McCadam, & Gonzales, 1998). However, in certain high-risk populations, youth and family no-show rates at initial intake for community mental health appointments are alarmingly high (Harrison et al., 2004; McKay et al., 2005; McKay et al., 1996). This underscores the critical need for strategies to bolster families' initial and ongoing engagement in SMH.

While treatment attendance is important, it cannot be the only variable considered when discussing engagement (Staudt, 2007). There are both behavioral and attitudinal components of engagement (Staudt, 2007). For example, a fully engaged client may desire therapy, understand its importance, be committed to it, and actively participate (e.g., complete homework, respond to the requests of the therapist; see Karver, Handelsman, Fields, & Bickman, 2005). In a similar manner, caregiver engagement in therapeutic services could also be expanded to include these same constructs outlined above (Karver et al., 2005). However, the literature has focused more on behavioral than attitudinal or emotional aspects of family engagement in services, pointing to an important area of future research (Staudt, 2007).

Factors Related to Family Engagement

Relatedly, there are numerous process variables that have been identified that affect family and youth engagement in youth mental health services (for reviews, see Gopalan et al., 2010; McKay & Bannon, 2004). Here, specific factors at the student, family, and clinician levels that are pertinent to family engagement in SMH services will be reviewed. At the student level, adolescents may be particularly resistant to involving family members, as adolescence is a period marked by a desire for independence and self-determination. Additionally, students may be resistant to involving family members if they fear familial disapproval for seeking SMH services or if they wish to conceal the presenting problems for which they are seeking services (Bickham et al., 1998; Center for School Mental Health Assistance [CSMH], 2002).

Families have identified concrete barriers to involvement in SMH services, across socioeconomic status, ethnicity, and religion, including lack of transportation or childcare and inflexible scheduling (Bickham et al., 1998; CSMH, 2002; Koroloff, Hunter, & Gordon, 1994). Ideological barriers include concerns about confidentiality, stigma related to mental health services and problems, and concern that the clinician may talk down to or blame family members for the student's problems (Bickham et al., 1998; CSMH, 2002; Federation of Families for Children's Mental Health [FFCMH], 1998; Koroloff et al., 1994).

And finally, at the clinician level, there may be concern that involving the family could slow down or unnecessarily complicate the treatment process (Bickham et al., 1998; CSMH, 2002). For instance, the clinician may worry that balancing the involvement of additional family members could jeopardize the clinician's alliance with the student. Alternatively, the clinician may not have training or experiences in providing services to families (CSMH, 2002).

Strategies for Engaging Families

Strategies have been developed to enhance family engagement in SMH. A critical first step for the SMH program is to establish the importance of family involvement, as well as to create a philosophy about how families will be involved in the program (Bickham et al., 1998; CSMH, 2002). Central to the importance of family involvement is the recognition that the family is the primary and most influential system in which the child belongs. Additionally, by involving the family, more information can be acquired about the child, and the family can assist with promoting change in the home environment (CSMH,

2002). Caregivers can be involved in various capacities, such as a recipient of services, parent advocate, or otherwise. The roles in which families can be involved should be determined before presenting an invitation to participate in the SMH program (Bickham et al., 1998). Once this has been ascertained, more tangible strategies can be employed to include families in the SMH program.

An important engagement strategy for clinicians and other professionals is to utilize a collaborative style with families. Unfortunately, there has been an emphasis on the "professional-centered" model in mental health, in which the clinician serves as the expert, and this approach can lead to professionals treating families in a patronizing manner (Bickham et al., 1998). While the clinician brings a breadth of clinical expertise to the table, families bring substantial expertise as well (FFCMH, 1998). Families have the most information about their child(ren) and their family and can provide details about the strengths and difficulties associated with both. Additionally, caregivers have more time to work with the child and to monitor progress than does the clinician, making caregivers important partners in the change process. Therefore, clinicians should actively request family input and guidance, demonstrating respect for their ideas and refraining from assuming a stance as "expert."

In an important study by McKay and colleagues (1996) of family engagement, social workers at a mental health center were trained in engagement strategies specifically for the initial interview with families. Focal elements of this training were to clarify processes associated with mental health services as well as to provide service options, to begin the collaborative relationship between the client and the worker, to focus on concrete and practical concerns of families, and to assess potential barriers to services. Results indicate that clients that participated in the engagement strategies were significantly more likely to attend the first appointment.

Empowerment

It is believed that engagement is an antecedent to empowerment (Itzhaky & York, 2000). Family empowerment has been characterized as "helping families become active and competent agents of change" (Hoagwood, 2005, p. 701). Empowerment and the related construct, self-efficacy (i.e., beliefs about personal efficacy in a given situation), are based on Bandura's social learning theory (1977). It is believed that empowerment and self-efficacy are fostered when caregiver strain is reduced and skills and knowledge are increased (Hoagwood, 2005). Skills for empowerment of caregivers in relation to their student's mental health problems could include assertiveness, communication, goal setting, problem solving, and how to navigate resources (Bickman, 1987; Hoagwood, 2005). Relatedly, knowledge around the youth mental health service system and community resources could be targeted in addition to understanding about assessment and treatment procedures and caregiver rights (Bickman, 1987; Hoagwood, 2005). Family empowerment over time has been found to be predictive of positive change in youth with externalizing problems, as well as youth functioning and satisfaction with services (Resendez, Quist, & Matshazi, 2000; Taub, Tighe, & Burchard, 2001).

Strategies for Empowering Families

Bickman (1987) conducted a study on empowering caregivers of youth receiving mental health services. The study was based upon a logic model that suggested that the empowerment intervention would increase knowledge of the mental health services system and mental health services self-efficacy. Increases in knowledge and self-efficacy were then hypothesized to lead to increased family involvement in youth mental health services, leading to increased service utilization and finally to better clinical outcomes for the youth (Bickman, 1987). The Caregiver Empowerment Project was an 11-h training for caregivers held over 3 days. The training focused on building caregiver knowledge about the mental health system, available resources, and assessment and treatment procedures in mental health services, along with discussion of caregiver rights in receiving these services. Caregivers were also taught tangible skills such as assertiveness, communication, goal setting, assessing professional relationships, problem solving, finding relevant community resources, and creating files

for personal records. Finally, caregivers were encouraged to actively participate in decision making and to build collaborative working relationships with mental health professionals, with appropriate participation in caregiver support groups modeled for them. The Caregiver Empowerment Project significantly predicted caregiver knowledge about mental health services and self-efficacy about acquiring and participating in mental health services for their children. However, other hypotheses on increased knowledge and self-efficacy leading to increased involvement in services and improved outcomes were not supported.

Based on the work of Bickman (1987), a recently developed and piloted program, the Parent Empowerment Program (PEP), was developed through a community-based participatory research approach and targeted at family advocates (Olin et al., 2010b). PEP is a 40-h, manualized training based upon the book *Improving Children's Mental Health through Parent Empowerment: A Guide to Assisting Parents* (Jensen & Hoagwood, 2008) and is aimed at family advocates new to the field (Olin et al., 2010a). There was significant change in advocates' perceptions of their overall professional skills. Specifically, the advocates presented more advanced skills such as priority setting, problem solving, group management, and application of knowledge in the areas of child mental health problems and treatment, the mental health services system, and services in the school system (Olin et al.). Although more research is warranted, this program shows promise in enhancing family advocates' competencies, as family advocates become more prominent in children's mental health services (Hoagwood et al., 2008).

Alliance

The therapeutic alliance, also referred to as the therapeutic relationship, alliance, helping alliance, working alliance, and others, is a significant construct that has been discussed since the infancy of psychotherapy and is very related to the constructs discussed above. Alliance has been commonly conceptualized as a relational connection with the clinician (Karver et al., 2005). Bordin (1979) further conceptualizes the construct as the assignment of tasks and agreement on goals in therapy, as well as the development of a bond. Alliance has been shown to be a predictor of outcomes (Shirk & Karver, 2003); however, different alliances (i.e., youth-clinician alliance, caregiver-clinician alliance) are predictive of different outcomes. Youth alliance is significantly associated with greater improvement in youth- and caregiver-reported symptom severity, as well as predictive of engagement in therapeutic tasks (Hawley & Weisz, 2005; Karver, Handelsman, Fields, & Bickman, 2006). Caregiver-clinician alliance is positively related to family participation in treatment and agreement with their clinician on when to end services and negatively related to session cancellation rates (Hawley & Weisz, 2005). Additionally, caregivers of youth who did not complete treatment indicate higher levels of therapeutic relationship problems than caregivers of youth who completed treatment (Garcia & Weisz, 2002). Given these findings, it will be important to use alliance-building skills to engage and retain families in SMH services as well as reach positive outcomes for students.

Alliance-Building Strategies

Although more research is needed, some alliance-building and alliance-diminishing behaviors have been identified. Creed and Kendall (2005) examined clinician behaviors that contribute to youth's perceptions of the therapeutic alliance within the context of cognitive-behavioral treatment for anxiety disorders. Collaboration between the clinician and youth was predictive of higher youth ratings of alliance. Collaboration was defined as the therapist characterizing therapy as a team effort, including mutual goal setting and the therapist encouraging the child to be involved and give feedback about treatment. Alternatively, finding common ground, or emphasizing commonalities with the child, and pushing the child to talk, pressuring the child to talk about their anxiety beyond the point that the youth was interested or comfortable, were predictive of lower youth ratings of alliance. While utilization of these skills in session could be advantageous in forming stronger alliances with the youth client, more research is needed in the area of building and maintaining alliances with families.

Application of Family Involvement Strategies in SMH Services

A large project underway entitled "Strengthening the Quality of School Mental Health Services" and funded by the National Institute of Mental Health focuses on implementation of a school mental health quality assessment and improvement intervention that emphasizes family engagement and empowerment and evidence-based practices. Participants in the study are school mental health clinicians employed by a community mental health center and based in approximately 30 elementary, middle, and high schools. Students and families served by clinicians are also participants in the study. The study is a randomized controlled trial with staff assigned to the target condition referred to as Clinical Services Support (CSS), or a comparison condition emphasizing Personal and Staff Wellness (PSW). In the CSS condition, clinicians are receiving significant and ongoing training and coaching in systematic quality assessment and improvement (Weist et al., 2007), modular evidence-based practice for disruptive behavior problems (Chorpita & Daleiden, 2007), and family engagement and empowerment (FEE) strategies (Hoagwood, 2005; Jensen & Hoagwood, 2008; McKay et al., 2004; Olin, Saka, Crowe, Forman, & Hoagwood, 2009; Rones & Hoagwood, 2000), which are all reinforced through implementation support (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005).

The strategies employed for FEE are based on the work of Hoagwood and colleagues (Hoagwood, 2005; Jensen & Hoagwood, 2008; Olin et al., 2009; Rones & Hoagwood, 2000), building from the work by McKay and Bannon (2004), which aims to improve engagement and retention of families in community mental health services. More specifically, clinician participants are trained and supported on how to assess and prioritize family needs; how to engage, listen to, and set appropriate boundaries with families; how to assist families in accessing appropriate services; and helping caregivers become their child's case manager to ensure the receipt of appropriate and effective services.

Fidelity of FEE strategies is being assessed with the *Family Engagement/Empowerment Observation System* (*FEEOS*; Weist, 2009), which is an eight-item, observational measure that has been created to assess factors (1 = poor to 6 = superior) pertinent to family engagement and empowerment such as general (e.g., empathy, sincerity, warmth, humor), agreement, trust, engagement, collaboration, support, and empowerment strategies as employed by mental health clinicians. In on-site implementation support, senior trainers are using the FEEOS to assess and give collegial feedback to clinicians on their family engagement and empowerment strategies.

Preliminary findings drawn from FEE data have interesting implications. These data indicate growth in the number of family sessions by CSS clinicians over time and can be used to identify "model clinicians" (i.e., clinicians who have the most success in engaging and empowering families), with model clinicians as potential mentors for those struggling with FEE skill development. Notably, the infrastructure supports of having senior trainers providing intensive bimonthly training on FEE and at least monthly on-site coaching support have led to significant increases in family involvement by clinicians in the CSS condition (specific results cannot be reported since at the time of this writing, there is an additional year of data collection).

However, even with these supports, clinicians have discussed the tension of implementing FEE and evidence-based strategies while negotiating significant bureaucracy associated with fee-for-service billing (see Staudt, 2007). For example, clinicians required to see a minimum of seven clients a day may try to maximize their time catching up on phone calls or paperwork when a client misses an appointment, rather than contacting the family and keeping them engaged. Thus, it is believed that this project will not only add significantly to this critical research area and to knowledge of best practices but will also provide noteworthy lessons to impact policy.

Conclusions and Future Directions

When families are actively involved in the school, there are many benefits for students (Catsambis, 1998; Epstein et al., 1997; Miedel & Reynolds, 1999; Shaver & Walls, 1998; Shumow & Miller, 2001; Trusty, 1999; Westat and Policy Studies Associates, 2001; for review see Henderson & Mapp, 2002). Factors that support this caregiver involvement in schools include caregiver perception of their role in their youth's education, whether the caregiver feels efficacious in helping their student learn, and invitations from the school to be involved (Hoover-Dempsey, & Sandler, 1995, 1997; LaParo, Kraft-Sayre, & Pianta, 2003; Walker et al., 2005). Similarly, family involvement is critical to effective child and adolescent therapy (Weisz, 2004). While supportive services led by clinicians seem to be the most common method of supportive services delivery, the popularity of caregiver-led supportive programs has stimulated the development of training programs for peer leaders as family advisors. Family advisors have been reported as more credible and trustworthy by caregivers, making them able to encourage the active engagement of families in mental health services (Gyamfi et al., 2010; Hoagwood, 2005; Hoagwood et al., 2010; Osher et al., 2008).

Research has supported a number of key processes that contribute to family involvement in their child's mental health treatment including engagement, empowerment, and alliance. Supporting school-based mental health clinicians with strategies to promote these processes has the potential to bolster family involvement in SMH services. And, current research aimed at improving the quality of SMH services is targeting strategies to build family engagement, empowerment, and alliance in SMH services.

While much great work has been done in the area of family involvement, there are several ways to conceptualize engagement and empowerment and multiple interpretations of their operationalization. This, taken together with their overlap with related constructs such as alliance (Dearing, Barrick, Dermen, & Walitzer, 2005; Yatchmenoff, 2005), makes it difficult to define and develop standardized measures of engagement and empowerment. Variability in the conceptualization and operationalization of family engagement and empowerment impacts empirical investigation of these constructs, as well as the investigation of their relationship to treatment processes and outcomes. This has led some intervention researchers to implicate poor FEE construct clarity as a unique contributor to the development of gaps within the knowledge base (Dearing et al., 2005; Staudt, 2007). Multiple interpretations of their operationalization taken together with overlap with related constructs such as alliance (Dearing et al., 2005; Yatchmenoff, 2005) makes it difficult to define and develop standardized measures of engagement and empowerment. This lack of clarity is a notable limitation given that consistent assessment and feedback of clinician FEE skills, and of family perceptions and responsiveness to these skills, can facilitate intervention success.

Poor construct clarity is compounded by the empirical trend toward examining concrete (i.e., transportation or childcare as barriers to engagement) and behavioral (i.e., attendance, homework completion) factors influencing FEE, with less attention focused upon differentiating behavioral and attitudinal factors (see Staudt, 2007). Attitudinal components have been conceptualized as the factors driving engagement behaviors and largely contributing to family outcomes (see Staudt, 2007). For example, caregiver characteristics, including attitudes about programming and psychological distress, in conjunction with concrete barriers can play an important role in successfully engaging families in intervention programming influence behavioral factors such as attendance (Mendez, Carpenter, LaForett, & Cohen, 2009). However, the exploration of attitudinal components whether in isolation or in conjunction with concrete barriers relative to FEE skill usage remains a noted deficiency in the knowledge base and contributes to incomplete conceptualization and operationalization of FEE as a construct (e.g., Staudt, 2007).

Potential implications and future directions of these findings suggest the benefit of further investigation of FEE through idiographic, in contrast to nomothetic, approaches. For example, an

idiographic approach, such as a single-case design, could be used to assess and isolate sources of intersubject variability in attitudinal components of caregiver engagement and isolate factors responsible for this variability (see Barlow & Nock, 2009). Given that idiographic methodologies, such as the single-case experimental design (see Barlow et al., 2008), can be implemented in practical settings with flexibility and efficiency; require minimal time, resources, and participants, respectively; and can provide strong evidence of causal relations between variables (Barlow & Nock, 2009), the execution of these types of experimental designs may be the next logical step in determining attitudinal components that influence caregiver engagement in intervention, thus further inform conceptualization and operationalization of the FEE construct. Similarly, use of single-case designs could further elucidate and identify FEE skills that clinicians can use to enhance practices with families.

There is a legitimate argument that low FEE skill usage among clinicians will be associated with poorer outcomes and thus should be viewed as a performance/accountability issue. Strategies to enhance not only the delivery but the accountability in delivery of FEE strategies and evidence-based practice in SMH are an important and under-explored research area, beginning to be pursued by the research team at the University of South Carolina. As the implementation of evidence-based practices (EBPs) becomes increasingly connected to policies mandating dissemination of state and federal grant monies (see the New Freedom Commission, 2003), and the importance of family-driven services is further emphasized in the success of EBPs, the operationalization of FEE skills and their translation into policies at the agency level could have lasting impacts.

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