Chapter 10
Future Directions

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Many infant and early childhood mental health treatments are effective and offer a good return on our investments (Oppenheim & Bartlett, 2023), but children do not reap the full benefits of treatment when their families are not engaged in and committed to the process (Waid & Kelly, 2020). As we reviewed the information in our book, we noted that there is a broad-brush stroke portrait of family engagement. Similar to Halgunseth (2009), who focused on school engagement, we define family engagement in mental health services for young children broadly. As such, family engagement involves connection, advocacy, and shared decision-making. In order to allow connection, family advocacy should be encouraged, and family input for formulating diagnoses and making decisions about treatment planning and implementation should be a standard of care for mental health practitioners. Treatment planning and intervention should encompass the classroom/school, the agency and program, the home setting, and other entities working with the family to improve their overall well-being, including but not limited to mental health. Moreover, interventions can extend to family and service contexts that are most important and culturally relevant to the child and family, including school, early childhood education, and community services settings. To extend family engagement throughout the child's treatment – beginning with the very first contact with a family – an atmosphere of collaboration, with parents and family as partners and team members, promotes strong family engagement. To enhance collaboration, mental health professionals can borrow tenants from social work, psychology, and other social sciences by fostering an atmosphere of "meeting them where they are" when

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engaging parents and other caregivers and family members in all aspects of treatment planning, engagement, and assessment of progress. This approach necessarily involves a deep appreciation for and responsiveness to family race, ethnicity, socioeconomic conditions, beliefs, worldviews, and values, as well as the cultural reference group(s) for the child and family members (Halgunseth, 2009).

Accordingly, in recent years, program, state, territory, tribal, and federal leaders have begun to make the important distinction between *family involvement* and *family engagement*. Family involvement comprises traditional methods of interacting with families in service settings, including focusing primarily on presenting problems, providing information on parenting and child development, sharing updates on the child's progress in treatment, inviting families to program-led events, and other means of interacting with families that reinforce current program and organizational values and practices. Although these strategies may be well intended, they often lead to a top-down, deficits-based approach that limits a family's voice and choice in their treatment. The absence of shared power and focus on family deficits also undermines a family's confidence, self-efficacy, and trust in the treatment process, particularly among historically minoritized families (Baquedano-Lopez et al., 2013; Ishimaru et al., 2019; Robles-Ramamurthy et al., 2022).

King et al. (2014) assert that there are many definitions of family engagement in the mental health literature and many different ways to assess or measure engagement, which leads to different theoretical orientations and a myriad of findings addressing factors related to engagement in children's mental health services. We agree that this is true, but in taking a strengths-based, trauma-informed stance (King et al., 2014; Substance Abuse and Mental Health Service Administration [SAMHSA], 2014), we view the term family engagement as expanding early approaches to include a wider array of approaches to partnering with families in their child's mental health care. The efforts of providers, and the capability for outreach of the mental health organization and policy, play a vital role in engaging families (Jose et al., 2020). For example, when discussing engagement in school processes, Williams and Baber (2007) highlight the critical nature of trust when engaging African American families. The chapters in this book, which summarize extant literature across young children's developmental stages, race and ethnicity, socioeconomic status, and service settings, clearly show that trust and respect are critical aspects of strong provider-family relationships and the foundation for effective family engagement in mental health services for young children.

Establishing Trust and Collaboration Are Critical to Family Engagement

Family engagement emphasizes shared power between the mental health provider/program and family by positioning the provider as a facilitator rather than leader of treatment. That is, "the goal of family engagement is not to serve clients but to gain

partners" (Ferlazzo, 2011, pp. 10–11). Thus, family engagement requires a fundamental shift in the field away from traditional mental health treatment aimed at ameliorating problems toward a strengths-based approach in which treatment goals, activities, and desired outcomes are codeveloped with families, and services are responsive to the racial and ethnic background, gender identity, sexual orientation, assets, and challenges of each family member and the family system. Family engagement also highlights the importance of partnering with families to overcome barriers to accessing treatment, whether due to challenges meeting concrete needs (e.g., health insurance, childcare, transportation), stigma, lack of alignment between family culture and the treatment modality, or personal and cultural beliefs and values that prevent parents and other caregivers from seeking help for their child. As defined by the US Department of Health and Human Services (2018):

> Family engagement is an interactive process through which program staff and families, family members, and their children build positive and goal-oriented relationships. It is a shared responsibility of families and professionals that requires mutual respect for the roles and strengths each has to offer. Family engagement means doing with – not doing to or for – families. At the program level, family engagement involves parents' engagement with their children and with staff as they work together toward the goals that families choose for themselves and their children. It also involves families and staff working toward goals to improve the program…staff work together with families, other professionals, and community partners in ways that promote equity, inclusiveness, and cultural and linguistic responsiveness. (p. 2)

In a scoping review of key literature, King et al. (2014) reported that mental health providers must also support each family's self-efficacy in the treatment process. Maybery et al. (2021) identified seven practices associated with motivating and engaging families: "(1) identify and acknowledge family and carers; (2) engage and communicate with family and carers; (3) involve family and carers in planning/collaboration in consumer's treatment; (4) assess vulnerable family member or carer's needs; (5) provide or offer ongoing support to family and carers; (6) provide psychoeducation to family and carers; and (7) provide or recommend referrals for family and carers" (p. 4). These seven practices show overlap with the steps mentioned by Turnbull et al. (2021) for establishing a trust between the provider and parents or family. In Chapter 4, Malone and her colleagues highlighted Turnbull's principles of respect, fairness (equity), communication, advocacy, and commitment as provider behaviors which are cornerstones for establishing trust in the therapeutic relationship between provider and family. In fact, we believe that combining the aforementioned behaviors with the seven steps for engaging families establishes a family-centered care environment which will promote positive outcomes for the child and promote well-being at the family level.

As Staudt's (2007) framework for family engagement suggests, the attitudes held by providers and their organizations are as consequential as their behaviors. For example, valuing parents, other primary caregivers, and family members (i.e., carers) for what they are – the most important influences in their child's life – is at the heart of family engagement. Relatedly, a provider's expressed interest in and respect for each family's cultural beliefs, values, goals, strengths, and needs is an essential

step in making a successful connection or forming a “therapeutic alliance” (Ardito & Rabellino, 2011). Making a commitment to involving and, more than that, engaging them in care through shared decision-making with providers is another key step in engagement. Collaboration to determine the course of interventions is a feature of the shared decision-making that will help tailor interventions to child needs and what parents and family members can do to support the intervention. Providing sufficient, clear, linguistically and culturally appropriate information so that parents and families can make educated choices about their child’s treatment and advocate for their needs is another pillar of family engagement.

This relationship-based approach differs considerably from traditional approaches to parent education, in which the “expert” provider offers information and advice to parents, who may be treated as if they are empty vessels awaiting direction rather than as the true experts on their child. Of course, no single intervention can fully address young children’s mental health needs, and thus, providing referrals and connecting families to community resources are part of the logistics that can help families overcome barriers and further connect families and mental health providers. All of these beliefs and attitudes must also be aligned with a trauma-informed approach in which the principles upheld include safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues (SAMHSA, 2014).

This is a tall task for many reasons, not the least of which is that mental health providers are usually committed to family engagement approaches that reflect the policy and culture of the mental health organization in which they work, for better or worse. The organization itself must be flexible and committed to learning about families from backgrounds that are both similar to and different from their own, ongoing communication with caregivers, and sharing power in decision-making. Other provider qualities include receptivity to feedback, transparency in providing information about child progress and functioning, empathy for the needs and barriers faced by families and the child, and being friendly and approachable should family members have concerns (Jacques & Villegas, 2018).

Connection and Communication to Foster Family Engagement in Mental Health Services

There are many studies examining engagement, and we encourage readers to review research and find what fits for meeting families where they are for their specific services, given the culture of the families they serve. For those in primary care, it may be that a “navigator” will help families to enter the web of mental health services. Godoy et al. (2019) reflected that many children do not receive needed mental health services. They recommended finding a way “in” to services from primary care, proposing that a family navigator could assist parents in traversing the complex and overloaded mental health system. The family navigator is well positioned

to address the perceived barriers (e.g., stigma about mental health services, financial concerns) the family has to seeking care and then engaging in the child's therapy and then help the family make appointments and wade through long "wait times" for a child to access a mental health provider and make a first appointment. Similarly, family service workers and infant and early childhood mental health consultants in two-generational programs such as Head Start/Early Head Start serve a key role in helping families navigate the complex and challenging landscape of services related to infant and early childhood mental health. For instance, they link families to community-based resources, refer them to mental health and other services, and support families in crisis (Warren et al., 2023).

Langley et al. (2013) conducted research using focus groups to understand parent perspectives on ways to engage them in trauma-related mental health services offered at schools. Critical factors included education about services and their potential outcomes for youth. Also, providers need to be aware of and committed to communication with parents throughout the course of service provision. Communication also was a critical factor in Halgunseth's (2009) perspectives on key factors defining engagement. Understanding family culture and needs can improve communication and guide providers so that they can provide education that counts and can be absorbed by families (Halgunseth, 2009). Considering family needs and concerns and their values can assist providers in meeting the families' needs and in meeting the care needs of the service user, which we define as meeting them where they are.

As highlighted by Hornstein, in his chapter on fathers (in this volume), establishing connections, care, and trust improves engagement of fathers in treatment, and fathers are essential to child development in many ways, such as providing social support through sensitive and critical play with the child (Grossmann et al., 2002). Fathers also teach the child structure and social rules as they provide discipline and transmit cultural mores to their children even while they are working to actively disrupt gender stereotypes associated with parenting (Miller, 2011; O'Connell, 2005). Dr. Hornstein provides several strategies for enhancing trust to engage fathers, including a commitment to involving fathers, scheduling sessions after work or on weekends, and targeting fathers' ideas for care during treatment (Tully et al., 2017). His treatment recommendations including finding opportunities for fathers to spend quality time engaging with their child at home can also promote the child's functioning and contribute to the success of therapeutic interventions (Ellis et al., 2014).

Understanding what factors facilitate communication in different circumstances for children of different ages also may foster family engagement and positive outcomes for the child. For instance, in terms of engaging families of children with chronic illnesses, Nabors and her colleagues (this volume) mention using a family systems approach (e.g., Balling & McCubbin, 2001) to communication with the family and key players in the child's life. At the same time, it is important to understand the interconnections among family members to match recommendations to the needs of the family members and the child, with these interconnections in mind (Knafl et al., 2017). There are several areas for related future research, including

determining what communication works in different contexts and with intervention goals for the child. For instance, if the goal is improving academic performance, then factors enhancing communication between the family, medical team, and teachers, such as having regular meetings to discuss the child's medical and academic progress, become important. Considering the illness type, course, and treatment is important as well. For example, it may be critical to assess academic performance to determine if cognitive changes are influencing the academic performance of young children with different types of cancer with varying treatment courses, who were diagnosed at different ages, who are experiencing late effects related to chemotherapy treatments (Armstrong et al., 1999; Erdmann et al., 2021).

On the other hand, aspects of communication that influence adherence to medical recommendations, such as interventions to improve parent health literacy, may be critical to engaging families, especially when parents are having difficulty understanding instructions provided by the medical team (DiMatteo, 2004). Adherence to medical recommendations could also be impacted by misreading interconnections among family members – if a child has diabetes and must test herself, which involves needle sticks, and has a fear of needles shared by her mother, it may not be advantageous to ask her mother to help with these checks, especially if her father is comfortable with taking on this role and has a strong connection with his child to help him soothe her fears. At the same time, health and mental health professionals need to consider the developmental stage of the child (Berk & Meyers, 2016). In the case of the youngster with diabetes, coaching might be very different for a young preschooler, using the "Tell, Show, Do" method, which involves telling the child about the procedure, demonstrating it, and then conducting the procedure (Dahlquist, 1997). Conversely, a child in early elementary school may benefit from learning relaxation skills and could discuss the procedure with her father, and he would not necessarily have to demonstrate the procedure to the child (dos Santos Felix et al., 2019). Health and mental health professionals need to be aware of factors impacting communication to engage families and children. The same factors could influence teachers' recommendations – family interconnections determine who the child turns to for advice on homework or for listening about how to improve classroom behaviors. Conducting research to increase knowledge about factors impacting communication and family engagement will advance the field, spurring better connections to engage families and children in clinical practice.

Family Engagement Leads to Successful Outcomes

Family engagement in mental health interventions for young children and their caregivers is critical to successful treatment outcomes in both generations (Walter et al., 2019). Research has firmly established the importance of family engagement in a range of service settings for young children, their families, and the programs with whom they work, including but not limited to behavioral health, early childhood education, schools, Head Start/Early Head Start, early

intervention, child welfare, home visiting, medical settings, and parenting/fatherhood programs (Henderson & Mapp, 2002; Ingoldsby, 2010). For example, high-quality family engagement is associated with improved social, behavioral, and emotional functioning for children and their families (Podell & Kendall, 2011) and higher student achievement and fewer child behavior problems in school (Smith et al., 2013; Van Voorhis et al., 2013). In addition, when respectfully and actively engaged, families develop more self-efficacy, confidence, and skills (Green et al., 2007; Hoover-Dempsey et al., 2005) and are better positioned to help providers and programs identify new ways to build safe and welcoming environments (Powell et al., 2010; Reedy & McGrath, 2010). Conversely, low-quality family engagement limits the success of prevention and intervention programs. This is especially concerning given that many infants, toddlers, and preschoolers never receive the mental health care they need, and 20–80% of families drop out of treatment prematurely (Armbruster & Kazdin, 1994; Gomby, 2000; Masi et al., 2003).

One of the many areas in which engagement is critical is the treatment of young children who have experienced trauma as a result of exposure to adversity (Bartlett et al., 2017). By extension, mental health providers and professionals are also treating the indirect trauma the family experiences or intergenerational trauma, which encompasses the family history of trauma (American Psychological Association, n.d.). It is important to engage the family in treatment to understand and address their own trauma and to partner with them to develop the skills they need for working with the young child who reexperiences and reenacts trauma at home (Child Welfare Information Gateway, 2017). Bartlett also points to the importance of considering family socioeconomic status and health disparities when treating children and families for trauma, which disproportionally affects historically marginalized families due to historical and structural racism and discrimination (Bartlett & Sacks, 2019). Encouraging trust may be especially important for engaging families where the experience of trauma impacts parents and the family unit (Nicholson et al., 2022). In her chapter, Bartlett provides examples of evidence-based treatments, such as Parent-Child Interaction Therapy (Eyberg et al., 1995) and Trauma-Focused Cognitive Behavioral Therapy (Cohen & Mannarino, 2015). When parents and families are engaged in two-generational treatments, children can begin to heal, return to their typical levels of functioning, gain motivation, improve school readiness, increase their social and self-regulation skills, and exhibit higher levels of positive, prosocial behaviors (see Dowell & Ogles, 2010 for a review). Parents learn to understand their young child's challenging behavior as symptoms of trauma exposure ("What's wrong with you versus what happened to you?"), along with skills for successfully managing these behaviors at home, which in turn leads to improved child functioning and well-being, as well as improved parent morale and psychological well-being (Child Welfare Information Gateway, 2017).

In their chapter on children with intellectual and developmental disabilities, Malone and colleagues (this volume) discuss the importance of parents as partners

on the treatment team. They write that parents and caregivers of children with special needs in early education programs typically are perceived as active contributors and decision-makers – both during initial assessment and treatment planning processes and throughout the child's intervention processes (Division for Early Childhood, 2014). Malone and colleagues promoted the Sunshine Model (Turnbull et al., 2021; Turnbull & Turnbull, 2022), which identifies parents, siblings, and extended family as partners in the child's care, who help to co-construct interventions and care of the child. For instance, their Sunshine Model is fluid in nature, which helps ensure a family-friendly partnership, allowing for critical team players or members to shift over time according to child and family needs (Turnbull & Turnbull, 2022). The notion of parents and all team members as partners, in the different systems of the young child's life, ensures care of the child in multiple contexts that influence development. As the partners, including professionals, work as a team, their partnership is transdisciplinary, and this team can integrate the many services young children with special needs may need, thereby engaging families and team members as key players facilitating the young child's growth and development (Hernandez, 2013).

Successful outcomes are data for change in policy that will lead to large-scale positive change for children and families – which might be considered a community-, state-, and national-level outcome promoting child development and family flourishing. In their chapter (this volume), Graaf and Sweeney provide many useful ideas for policy change, enacted through collaboration with families as partners, which is supported at systems levels. They recommended that policymakers engage families in the policymaking process by reaching out to organizations like the Family-Run Executive Director Leadership Association (FREDLA, https://www.fredla.org/). This is an association of family-run organizations calling for families to be involved as partners in decision-making at the community, state, and national levels (Stroul et al., 2021). This organization has adapted Carman and colleague's model (Carman et al., 2013) for understanding how to engage families in children's mental health services, emphasizing commitment to and communication with families as partners to develop policy and programs that reflect family-driven care models. To achieve successful programs, families would be integrated into the development, implementation, and evaluation teams. Family members would help in determining therapeutic activities, outcomes to measure, and evaluation and dissemination of results of program evaluations. In this way, families would be engaged throughout the process of care for the child and family, making family-centered care the heart of service provision and evaluation of future goals (Carman et al., 2013). Graaf and Sweeney (this volume) proposed key areas for assessing outcomes including (a) assessment of factors related to continuous quality improvement at the program level (e.g., satisfaction with the intervention, change in family quality of life), (b) child-level change (e.g., academic progress, improvement in mental health), (c) family change (e.g., decreased parent stress, improved family living situation or conditions), (d) systems-level outcomes (e.g., reduced inpatient hospitalizations and out-of-home placements for young children, improved academic readiness for preschool-age children), (e) managed care outcomes (improved child mental health

outcomes, improved family quality of life), and (f) community outcomes (e.g., reducing health disparities in access to mental health services, reducing cultural disconnects in service provision, changing stigmatized attitudes to accessing mental health services).

Contemporary research on family engagement highlights the critical importance of integrating lived expertise, including both family and community voice, throughout the planning, treatment, and evaluation of interventions to improve the social and emotional development of young children and their caregivers – a key principle of trauma-informed care ("Empowerment, Voice and Choice;" SAMHSA, 2014, p. 11). It is also consistent with Irving Harris Foundation's Diversity-Informed Tenets for Work with Infants, Children, and Families in that high-quality family engagement honors diverse family structures and recognizes the importance of non-traditional "ways of knowing" when developing, implementing, and evaluating which service approaches are best for which families under which conditions (see https://diversityinformedtenets.org/the-tenets/overview/; https://diversityinformedtenets.org/the-tenets/english/). Diversity-informed practice involves respect for culturally nondominant ways of understanding and dealing with problems and focusing on healing within different families and communities. Relatedly, we believe it is positive that outcomes in the aforementioned areas overlap, and this means that evaluators can provide outcome data across settings by assessing child outcomes, changes in perceptions of participating in mental health services, changes in family living conditions, and reducing health disparities in accessing mental health services for young children and their families. Consequently, families having a "voice" in what interventions would work and help the family and child should be related to positive outcomes, producing successful results in terms of family functioning and child mental health and positive developmental trajectories.

Future Directions

Training the Workforce

Bartlett, Nabors, and Chase (this volume) discuss the importance of training the workforce, including teachers and medical and mental health professionals, to engage families of young children and to promote their growth and development. Providing more education, training, and professional development on the treatment of mental health problems in young children is needed both in graduate and continuing education, as well as workforce training, to ensure the availability of well-trained mental health providers who specialize in treating young children and their families (Kim et al., 2021). Professional development and training to improve professionals' abilities to consult with teachers and parents is needed to help service providers and families in schools and homes, as well training focusing on diversity and culture to engage family members in families who are facing health disparities

(Shivers et al., 2022). Examining training on skills to promote family-centered care and improving knowledge of assisting very young children with mental health problems are two areas of focus for training about consulting and meeting the needs of diverse families in hospital or clinic settings (Smith & Sheridan, 2019; Vilaseca et al., 2019). Training providers in need for parents and family members from different cultures, and developing evidence-based interventions for parents from groups that may face health disparities, such as the "Effective Black Parenting Intervention" (Alvy, 2019 see https://www.dcctf.org/aboutebp), which has already been identified as a promising intervention; see https://preventionservices.acf.hhs.gov/programs/460/show), or Mamás y Bebés (Muñoz et al., 2007), which is available in Spanish, will improve the availability of interventions to engage families from different cultures.

When discussing care of children with intellectual and developmental disabilities (IDD), Malone and her colleagues also emphasize other training needs – for understanding how to work with youngsters with IDD and learning to work with children and family members in low-income families. Understanding how to work with young children with IDD and orienting education and care to needs of their families allow professionals to collaborate with families (incorporating a "whole child-family-engaged approach," advocated by the National Head Start Association; https://nhsa.org/whole-child-whole-family/) to develop treatments that fit within the bounds of their resources (Fadus et al., 2019). Nabors and her colleagues echoed the need to develop care that meets family and child needs, as it has the potential to improve health literacy and family adherence to medical recommendations for families and young children who have chronic medical conditions. Furthermore, research pinpointing needs of those in different cultures and at different family income levels, for children with chronic illnesses or developmental disabilities, will provide new knowledge to reach those who can be underrepresented in terms of receiving mental health services. Within a whole child and whole family approach, children with special needs and children who are developing typically can receive services to engage the child and family (https://nhsa.org/whole-child-whole-family/).

Addressing Health Disparities, Access to Services, and Related Policy

Three factors needed to improve care – addressing disparities, improving access to services, and adding and changing policy – are related but uniquely important. Nguyen and Harden (this volume) point to the continuing health disparities in providing mental health services among low-income families and those in minoritized groups (Butler & Rodgers, 2019; Rodgers et al., 2022). Families living in extreme poverty may face the greatest difficulty in accessing mental health services for their children (Lee & Zhang, 2022; Strohschein & Gauthier, 2018). Linking ideas for

policy change to overcome health disparities is important and will help build child and family resilience. Moreover, accessing mental health services may boost child functioning in future years and reduce costs of care. For example, Oppenheim and Bartlett reviewed the benefit-cost literature on infant and early childhood mental health treatment and found that an investment of $1 in mental health prevention yields $1.80–$3.30 in savings in healthcare, education, criminal justice, and labor market expenditures. Moreover, the return on investment (ROI) for evidence-based treatments is encouraging – child-parent psychotherapy has an average ROI of $13.82 per child, and parent-child interaction therapy has an average ROI of $15.11 per child (see https://gucchd.georgetown.edu/Docs/iecmh/Cost-Effectiveness%20of%20Infant%20and%20Early%20Childhood%20Mental%20Health%20Treatment.pdf).

Structural changes can improve access to care and some of these are decreasing costs, improving scheduling to include weekend hours, improving service coordination for youth needing multiple services (e.g., occupational therapy and mental health), providing transportation, and training more providers to address care shortages (Bringewatt & Gershoff, 2010; Garvey et al., 2006; Stevens et al., 2006; Thomas & Holzer, 2006).

Graaf and Sweeney (this volume) provided recommendations for practice to engage families in mental health services. At the program level, conducting strengths and needs assessments for families of color and families residing in poverty might assist in directing administrators and mental health providers to programs that meet family needs and capitalize on their strengths. Once the program is selected, mental health professionals and teachers can engage parents by discussing positive changes that can result from interventions and arranging meetings with parents (at convenient times for the family) to model ideas for implementing interventions. Providing reinforcement for parent and family change efforts and successes and building rapport with families by understanding and accepting cultural differences are critical for all families, to acknowledge growth and promote further engagement. Graaf and Sweeney cite Lindsey et al.'s (2014) research as showing that increasing preparation for, investment in, and knowledge of the treatment process can positively impact adherence to intervention steps and process, resulting in positive outcomes for children and their families treatment (Lindsey et al., 2014).

Additionally, if parents have difficulty engaging in mental health services, providing parent peer support groups or advocates – through mentoring networks or small group – may engage parents in the intervention, use it at home, and potentially experience higher levels of satisfaction with mental health services, leading to more positive outcomes at the child and family levels (Gopalan et al., 2017; Lindsey et al., 2014). We also recommend having family and cultural celebrations – to support change efforts – and program-level celebrations to emphasize the value of family engagement and partnerships and to emphasize the importance of partnering with families from diverse backgrounds. Celebrating the value that families bring to services for young children also communicates that providers and programs have prioritized engagement of all families.

Policymakers can be especially influential in helping infant and early childhood mental health providers and programs to address health disparities and improve access to early childhood mental health services. In light of the multiple challenges to family engagement (e.g., mistrust, power imbalances, family stressors and logistical challenges, implicit bias and structural racism), leveraging policy to advance the field is essential to health and mental health equity. First, federal, state, and local policymakers should consider requiring a high level of cultural competence among all providers whose work brings them into contact with young children and their families. Mandated training in Irving Harris Foundation's Diversity-Informed Tenets for Work with Infants, Children, and Families or similar approaches to family engagement grounded in sociocultural perspectives are one potential approach (https://diversityinformedtenets.org/the-tenets/english/). Policy solutions also are needed to address racial, ethnic, and socioeconomic disparities in mental health access and use. Importantly, all policies with the aim of improving young children's mental health and reducing mental health inequities among minoritized families must be grounded in the empirical literature as well as ongoing, meaningful input from populations served. Family engagement might be increased, for example, by offering sliding fee scales for children's mental health (e.g., Blizzard et al., 2017), transportation and childcare vouchers (e.g., Gopalan et al., 2017), and other services to meet the concrete needs of families with young children including childcare, early intervention, and nutritional supports (Klawetter et al., 2021).

One interesting policy approach is to keep a scorecard to assist programs in tracking family engagement outcomes. Karoly et al. (2001) suggested a policy scorecard to track the benefits of early intervention programs. This scorecard is intended to track key program components (or descriptors), costs, and outcomes. It is a mechanism for tracking what is implemented and how it works. Other potential variables to track might include the number of children in served and outcomes for young children in very low-income families or those in minoritized groups to determine if the intervention is reaching those who may be in need of services. Another area to track would be any changes made to disseminate the program effectively and changes needed to hire or train staff (e.g., hiring a mental health provider, teacher training). Thus, our preliminary idea for a scorecard, adapted from and developed after considering two publications by Karoly and colleagues (Karoly et al., 1998, 2001) for the RAND Corporation and Casey Family Programs, is presented in Table 10.1.

A scorecard, such as the one in Table 10.1, can facilitate tracking of program costs and benefits, changes needed to disseminate the program in the setting, and adaptations that will reduce disparities in accessing care for young children from minoritized groups and those who are residing in low-income families. Our list of outcomes to track is preliminary, and leaving a category for other types of outcomes allows programs to record outcomes that are meaningful to their own growth and development. Comparing the results of different interventions on a scorecard allows program administrators and providers to assess which programs work and how they need to be adapted. Conducting program evaluations and research in the areas on the scorecard and, ultimately, conducting randomized-controlled trials and

Table 10.1 Scorecard for tracking program use and impact

Site name			
	Program A	**Program B**	**Program C**
Costs Supplies Personnel Staff effort/time			
Providers *Required/training* Mental health Other			
Program components Type(s) of intervention Number of sessions Critical components			
Dissemination What works What needed to change			
Adaptations for minoritized groups			
Adaptations for low-income families			
Outcomes *Child* Developmental changes Cognitive Academic achievement Physical development Health Mental health *Family* Resilience Functioning Parent satisfaction *Program* Teacher satisfaction Quality of care Child functioning Cost savings *Other outcomes* (a) (b)			

Notes. Other outcomes could include assessment of family engagement, assessment of program quality, assessment of child reading levels, assessment of academic readiness, and assessment of outside funding for selected programs. Adaptations for minoritized groups should be at all the levels cited for low-income families.

comparisons of outcomes for different interventions will add to the literature and provide ideas on how to adapt programs to fit community needs and reach young children in very low-income families or who are in minority groups. To reach this goal, collaboration in evaluation and research across programs may be required, and policy changes, which facilitate collaboration and documentation of program

implementation and outcomes, may add information to advance the field. In many instances, policy change may be needed to facilitate the support and mandated change that will foster the value of engagement, making the results of scorecard data that much more meaningful and pragmatic for advancing needs of families.

Future Research

Research on family engagement in infant and early childhood mental health treatment has grown in recent years and expanded operationalization, definition, and implementation of the construct across fields of practice. However, there are a number of areas that warrant further investigation in the future if families are to reap the full benefits of engaging in their children's services. First, mental health services for young children are increasingly integrated into broadly accessible, community-based services, such as early childhood education and home visiting (Goodman et al., 2021), yet rigorous testing of such interventions remains limited. For instance, infant and early childhood mental consultation (IECMHC), which is offered in multiple early childhood settings (e.g., early childhood education, home visiting, primary care, child welfare), has not yet been established as an evidence-based practice, and there is little understanding of what "dose" is needed to produce intended outcomes (Zeanah et al., 2023). Generally speaking, there is a dearth of research on strategies on effective approaches to reducing such inequities through strong family engagement and professional development. Finally, we find it deeply concerning that research continues to be scant on equitable family engagement, culturally targeted and adapted mental health interventions for young children, and specific strategies for reducing racial, ethnic, and socioeconomic disparities in treatment access, engagement, and outcomes. Only with increased attention to these issues from researchers, policymakers, and practitioners will we make significant progress toward all young children and families receiving the care they need.

Conclusions

It is our hope that this book presents timely and actionable information about the evidence based for promoting family engagement in infant and early childhood mental health care, as this fosters positive outcomes for youth and their families. Advancing our understanding of *how* promoting family-engaged interventions leads to program success (i.e., moderators and mediators) will continue to increase our understanding of how using interventions engage the family; promote child, family, and program well-being; and contribute to high quality of care for the young child. We also discussed behaviors related to engagement, highlighting the impact of trust and collaboration in engaging families and facilitating care of the child. Engaging the family and especially the parents of young children makes sense, as this allows

parents to continue integrate key components of care at home through the most important relationships in a young child's life. Meeting the needs of families in all types of cultural groups, such as military families, families of different races, and families of children with disabilities or chronic illnesses, remains a critical step in engaging families (FREDLA, 2020, https://www.fredla.org/wp-content/uploads/2020/01/NeedsOfAllFamilies__FINAL_SCR-1.pdf). Continuing to advance research on interventions that engage families and young children is important – understanding how to engage families and address well-being may address health disparities for those from low-income and marginalized groups while contributing to long-term flourishing of the child and family, thereby ultimately changing trajectories to more positive avenues for child and family development.

Finally, infant and early childhood mental health both describes the young child's developing social and emotional development and the multidisciplinary nature of the field. Accordingly, there are opportunities for service providers across fields of practice to play a role in promoting children's psychological well-being, first and foremost by engaging caregivers in the services that promote healing. Zeanah and colleagues (2023) reported that children's mental health is not separable from cultural and family contexts and the factors that influence caregiving. Ultimately, the mental health of our youngest citizens will depend largely on the extent to which there is an ample, well-trained workforce that recognizes the inextricable link between parent/caregiver and child well-being and can successfully engage families from all backgrounds in services to prevent and address mental health challenges that emerge in the earliest years of life.

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