Administration and Policy in Mental Health and Mental Health Services Research (2021) 48:1019–1033
https://doi.org/10.1007/s10488-021-01124-8

ORIGINAL ARTICLE

Engaging Parents in Mental Health Services: A Qualitative Study of Community Health Workers' Strategies in High Poverty Urban Communities

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Accepted: 19 February 2021 / Published online: 8 March 2021
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Abstract
Empirical engagement-promoting strategies in child and family mental health services have been identified largely within the context of clinic-based services delivered by mental health professionals. However, the magnitude of unmet youth mental health need necessitates expanding the scope of mental health services, and the associated engagement strategies, beyond traditional models and service providers. The present study aimed to extend our understanding of engagement strategies to a school-based mental health service model, using a community health worker (CHW) workforce implementing an early intervention program with parents and school-aged children (K-4) in high poverty urban communities. Qualitative semi-structured individual interviews were conducted with 16 CHWs to capture their descriptions of the engagement strategies they utilized with parents throughout program implementation. Transcripts were coded and themes were identified following procedures for thematic analysis. Thematic analyses revealed ten themes describing a range of engagement strategies falling into two overarching categories: (1) rapport building, and (2) responsive delivery. Themes within the rapport building category included non-judgmental supportive listening, increasing social proximity, praise, privacy and confidentiality, and leveraging relationships. Themes within the responsive delivery category included flexibility, consistency, advocacy, incentives, and meeting needs. Findings provide preliminary evidence regarding the ability of CHWs to identify and implement a range of engagement strategies with parents and families that parallel empirically-based engagement strategies in traditional services. These findings speak to the potential of this workforce to engage underserved families in mental health services, underscoring the important role for CHWs in reducing mental health disparities.

Keywords Parent engagement · Community health workers · Paraprofessionals · Mental health services · Children's mental health · Urban poverty

Access to and engagement in mental health services has been a longstanding challenge for children and families with mental health needs. An estimated 60–80% of children and adolescents with a psychiatric disorder do not receive treatment (Merikangas et al. 2011; Simon et al. 2015), and of those who initiate treatment, 40–60% drop out prematurely (Gopalan et al. 2010). This large treatment gap poses a significant public health concern for the child and adolescent population at large, and particularly for poor youth and youth of color who are even less likely to receive treatment compared to affluent and White peers (Alegria et al. 2010). Thus, addressing barriers to services stands to enhance supports for some of the most vulnerable and underserved populations in child mental health.

Engagement in traditional mental health services has been conceptualized as multidimensional (Becker et al. 2018; Chacko et al. 2016; Haine-Schlagel et al. 2019; Lindsey et al. 2014; Pullmann et al. 2013), with aspects that are social (therapeutic alliance), cognitive (understanding of treatment approach), affective (emotions related to treatment such as trepidation or hopefulness), and behavioral (attendance and

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homework completion). Moreover, engagement is dynamic (i.e., changes over time) and transactional, reflecting interactions among clients, families, providers, and broader ecological factors (e.g., availability and quality of services in the community, other sources and settings of help; Becker et al. 2018). Other research differentiates between preparatory engagement strategies implemented in the initial stages of treatment, and continuous engagement strategies implemented throughout the entire course of treatment (Nock and Ferriter 2005).

Barriers to services reflect the multidimentsional nature of engagement, and include patient, provider, contextual, and systemic factors such as stigma, therapeutic alliance, perceived need for treatment, accessibility (e.g. transportation, insurance), availability of quality services and providers, and cultural competence of providers (Alegria et al. 2010; McKay and Bannon 2004). Addressing these barriers to increase child and family engagement requires a multifaceted approach that includes specific provider-implemented strategies (e.g. reminder phone calls, problem solving access barriers), employing certain workforces that can naturally reduce some engagement barriers such as stigma or cultural competence (e.g. near peers, lay health workers), or embedding services in natural settings where children and families can more easily participate (e.g. schools, community organizations). The present study explores these factors by examining strategies for engaging parents in services within the context of a non-traditional mental health workforce and setting – community health workers (CHWs) within schools.

Clinic-Based Engagement Strategies

A growing body of research has examined factors that promote youth and family engagement in mental health services (Becker et al. 2018; Ingoldsby 2010; Lindsey et al. 2014; McKay and Bannon 2004). Systematic reviews of engagement interventions for children's mental health services highlight that the most frequently studied intervention components include assessment of strengths and needs, accessibility promotion, psychoeducation about services, homework assignment, and appointment reminders (Lindsey et al. 2014). These intervention components have been further examined by Becker and colleagues (2018) to evaluate the evidence supporting their association with improving distinct types of engagement problems, such as problems with attendance, or with the therapeutic relationship. Overall, this literature makes an important contribution toward increasing engagement in mental health services, and ultimately improving population level mental health outcomes.

However, engagement-promoting factors identified to date have largely been within the context of clinic-based services delivered by mental health professionals, with much less known about engagement strategies used by alternative providers in non-clinic settings. For example, in Lindsey et al.'s (2014) review of 40 studies examining common elements of treatment engagement, clinic-based services were represented in 65% of studies, followed by home-based settings in 47.5% of studies, and community settings in 7.5% of studies. Only one study included a school setting (some studies examined multiple settings; therefore, percentages add up to over 100%). Additionally, in a review of research related to child mental health engagement practices, all studies that reported provider data utilized a workforce with advanced, specialized mental health training (i.e., masters or doctoral-level professionals, graduate students) (Becker et al. 2018). The focus on engagement strategies administered by professionals within clinic-based services aligns with the predominant mental health service model in the U.S. (Olfson et al. 2014). However, the magnitude of unmet youth mental health needs, coupled with engagement barriers and provider shortages, necessitates expanding the scope of mental health services and engagement strategies to include other settings and workforces.

Non-Traditional Service Models

Beyond strategies implemented at the individual provider–client level, mental health service engagement can also be promoted via considering alternative workforces and settings. Paraprofessional workforces such as community health workers (CHWs; also referred to as lay health workers, *promotoras*, natural helpers, etc.) have a long history of being leveraged to address a variety of health conditions across the globe, including HIV/AIDS, childhood chronic illness, malaria, tuberculosis, cardiovascular health, and diabetes, amongst others (Perry et al. 2014; Liu et al. 2011). CHWs have gained increased attention for their potential to address health disparities via task shifting (WHO 2008), "a method of strengthening and expanding the health care workforce by redistributing the tasks of delivering services to a broad range of individuals with less training and fewer qualifications than traditional health care workers" (p. 173, Kazdin and Rabbit 2013). Despite the recent increase in research on CHW models, mental health has been a less common target of CHW programs, with most instead focusing on physical health (Schneider et al. 2016). Furthermore, while there are some examples of CHW mental health models (e.g. Patel et al. 2011), most of this research has been conducted in low- and middle-income countries. In the U.S., there has been less research on CHW-delivered mental health interventions, particularly in the area of child mental health services (Barnett et al. 2018).

However, there is growing recognition that CHWs are well positioned to address child mental health disparities

in the U.S. by providing a readily available, sustainable, and culturally and linguistically diverse workforce, thereby increasing access to mental health services, particularly for minorities and those living in communities of poverty who are less likely to access services (Barnett et al. 2018). Additionally, CHWs are uniquely positioned to support engagement in services by leveraging their social proximity (i.e., their shared experiences and/or understanding of clients and client's' community), thereby reducing stigma and aligning services with community norms (Frazier et al. 2007; Serrano-Villar et al. 2017).

Embedding services in non-clinic settings, such as schools, similarly allows for greater accessibility and can reduce stigma associated with mental health treatment (Atkins et al. 2017; So et al. 2019). School-based services are the primary setting for youth mental health services (Burns et al. 1995; Farmer et al. 2003); further, schools have a strong influence on youth well-being and development (Atkins et al. 2017). Thus, school-based mental health services provide a natural opportunity for expanding access to and engagement in mental health supports, particularly for youth from marginalized communities who may not otherwise access clinic-based services (Atkins et al. 2015).

Engagement Approaches in Non-Traditional Models

As the field moves toward incorporating more non-traditional workforces and service delivery settings, it will be necessary to understand the engagement strategies relevant in these contexts. Some programs have trained CHWs in existing empirically-based engagement strategies. For example, peer outreach workers have been trained in motivational interviewing to increase retention of youth in HIV care, and to promote engagement in cancer screenings (Brandford et al. 2019; Narr-King et al. 2009). Within the child mental health field, the Parent Empowerment Program (PEP), is an example of a caregiver-focused paraprofessional-led mental health program in which family peer advocates provide support to caregivers of youth with mental health needs. PEP incorporates existing engagement strategies from traditional children's mental health services as part of its training curriculum on how to engage and develop effective working relationships with families (Olin et al. 2010). Other examples of CHW-led parenting programs include training natural helpers to implement Parent Child Interaction Therapy (Barnett et al. 2016), and training promotoras to implement a four-session home-visiting parenting intervention (Williamson et al. 2014). However, these studies do not mention whether CHWs received any training on engagement strategies. Thus, in the limited literature on CHW-led parenting interventions, CHWs have either been trained on engagement approaches drawn from existing mental health provider-delivered clinic-based strategies, or engagement strategies have not been mentioned as part of their training. Furthermore, even less is known about strategies naturally generated by CHWs when allowed full agency to determine their approach to family engagement.

The distinction between training in existing engagement strategies originating from mental health professionals in clinics versus strategies organically generated by CHWs is important to note. One of the strengths of a CHW workforce is their contextual knowledge of the community served (Gustafson et al. 2018); therefore, examining CHW-driven engagement strategies allows for the identification of ecologically relevant approaches to engaging traditionally underserved and hard-to-reach families in mental health services. By considering how to integrate knowledge derived respectively by the experiential approaches of CHWs and the empirical approaches of the evidence-based practice movement (cf., Springett et al. 2007), exploring CHW-generated strategies provides an opportunity to capitalize on their indigenous knowledge and expertise, thereby expanding our understanding of valuable engagement strategies to encompass more diverse settings and providers.

Present Study

Given the scant research on CHW engagement strategies in children's mental health services, the present study aimed to examine engagement strategies generated by CHWs within a school-based mental health service model focused on parents and their school-aged children (kindergarten – 4th grade). The goal was to explore and characterize the strategies that this workforce generated without formal engagement training. By capturing CHWs' experiences and perspectives via qualitative interviews, we aimed to better understand engagement in a non-traditional service model.

In a previous manuscript, we reported findings from a separate analysis of these data, which focused on understanding the role of shared similarities and community membership, or *social proximity*, between CHWs and parents (Gustafson et al. 2018). Consistent with guidelines for multiple publications from a dataset (Drotar 2010), the present study addressed a different question by examining the engagement strategies used by this workforce. This study contributes to a growing literature on engagement and adds to a our understanding of the CHW role and function within child and family mental health services.

Methods

The present study was guided by the question: what strategies do CHWs employ to engage families in mental health services when allowed full agency in their approach to engagement? This study was aligned with a constructivist-interpretivist paradigm in which knowledge is derived from multiple equally valid realities (Ponterotto 2005); in this case, the unique personal experiences of the CHWs. Grounded in this paradigmatic orientation, we utilized a phenomenological qualitative design, consisting of semi-structured individual interviews with CHWs, to provide a descriptive and exploratory understanding of engagement grounded in CHWs' perspective and experience (Giorgi and Giorgi 2003; Sofaer 1999).

Setting

A school-based prevention and early intervention two-generation program served as the setting for data collection. Mehta et al. (2019) have described the service model in detail. In brief, the program was based in 16 public schools in four high poverty communities in a large Midwestern city. The program served predominantly Latinx and African American families of kindergarten through fourth grade children with emerging behavioral, social, and academic problems. CHWs were hired and employed by one of four community mental health agencies. Agencies prioritized hiring community members and people with knowledge of and familiarity with the community served, and some CHWs had previous employment at the agency as well. Many CHWs were parents themselves, living in or adjacent to the community served, and some had children who currently or previously attended the schools within which they were based. Two CHWs were based in each school, and each CHW served a caseload of approximately 20 families and received ongoing supervision from masters-level mental health providers. CHWs provided behavioral, academic, and social-emotional skill building support to students, and worked closely with parents to promote positive parenting strategies and parental involvement in children's schooling through parent groups, informal contacts (i.e. phone calls, drop-ins, etc.), home visits, and liaising with school staff, as well as meeting families' needs via case management. CHWs were trained on the Chicago Parent Program, an empirically-based parent intervention (Gross et al. 2009), to support their promotion of positive parenting strategies, but did not receive any formalized training in strategies to promote engagement in services (see Mehta et al. 2019). Instead, CHWs were given full liberty in deciding how to approach engaging families in services and were encouraged to leverage their expertise of their schools and communities to identify what worked best to engage their families.

Although CHWs did not receive formalized training in empirically based engagement strategies, the service model, similar to other community-based interventions (e.g., Javdani and Allen 2016; Sullivan and Bybee 1999), was grounded in a set of guiding principles and a flexible service delivery model. Over eight months of program development and refinement, CHWs and agency staff in collaboration with university consultants, and inspired by previous values-based interventions (Sullivan and Bybee 1999), identified core values to anchor program implementation (e.g., family-centered, strengths-based, empowerment-focused; see Mehta et al. 2019). This process also resulted in a flexible service delivery format that emphasized leveraging natural opportunities for connection, including informal contacts (e.g., school drop-offs or pick-ups), home visits, parent groups, texts, calls, and emails.

Participants

Participants were recruited through informational sessions held at each of the four partnering agencies, after which interested CHWs had the opportunity to consent or schedule a later time to consent. CHWs not present during the informational sessions were contacted by email to inform them of the study opportunity, and interested individuals scheduled a time to be consented by study staff. All 32 CHWs implementing the program were eligible. Twenty CHWs consented to this study and of those, sixteen CHWs participated. Four CHWs did not participate due to scheduling conflicts.

Participants were 56% ($n=9$) African American and 44% ($n=7$) Latinx, and predominantly female ($n=15$). CHWs ranged in age from 23–58 years old ($M=34$). Half of the sample ($n=8$) had a four-year college education, while educational experience for the other half ranged from completion of high school or GED to a two-year college education. Time working for the program ranged from 6–62 months ($M=29$ months). At least one CHW participated from 11 of the 16 schools in which the program was implemented.

Procedures

University IRB approval was obtained prior to the study and written consent obtained from all participants. Prior to data collection, interview questions were developed via an iterative process. Specifically, two agency supervisors who had familiarity with the intervention model and the workforce were consulted about question relevance and acceptability, and questions were edited accordingly. The semi-structured interviews consisted of ten central questions, each with 2–3 follow up probes, spanning a range of topics regarding CHWs' roles and responsibilities, their motivation for

engaging in this line of work, and shared experiences with the families they served. The current study focused on interview questions related to CHWs' strategies for engagement and approaches to connecting with parents, including: *What are some strategies you use to engage families?; What kinds of conversations have you had with parents that have helped them open up to you?; What are important skills/attributes necessary for a CHW to be effective?* During the 2015–2016 school year, the first author met with each participant for one individual audio-recorded interview. Sixteen interviews were conducted, each lasting 60–90 min. Participants were compensated with a $20 gift card.

Data Analysis

Each interview was audio-recorded, professionally transcribed, reviewed for accuracy, and segmented into smaller units for coding. The first author segmented transcripts using thematic criteria, in which meaningful, complete, coherent and independently understood coding units were demarcated (Saldaña 2015). Prior to transcript analysis, the first author generated an initial list of provisional a priori codes based on anticipated categories from the interview questions and initial transcript review (Saldaña 2015). As transcripts were further reviewed, additional codes emerged inductively from the data, and the codebook was refined. Through this iterative process of transcript review, codes were either revised (i.e., refining the code definition to better align with and reflect the data), retained with their original definition, or a new code was created when the data reflected concepts that could not be captured by existing codes. For example, a priori codes included "incentives," "meeting needs," and "flexible implementation." The first two codes were retained in their original form, while the flexibility code was broadened in definition from only referring to flexibility in logistics of meeting with parents (i.e., time, place, and mode of communication) to include flexibility in the framing and delivery of content.

Analyses were conducted with qualitative software *Dedoose* (Version 7.5.9) and followed Braun and Clarke's (2006) structured guidelines for thematic analysis, including identifying themes, reviewing and revising themes, and refining themes and subthemes. The coding team was comprised of the first author and one advanced undergraduate student. Coder training began by reviewing and practicing code applications on two randomly selected transcripts. Coders then trained to reliability using random representative subsamples from transcripts. Discrepancies were addressed by clarifying, discussing, and reestablishing consensus on operational definitions or determining whether revisions of the coding scheme were needed (i.e. collapsing/combining codes, redefining codes, creating new codes), followed by additional independent coding until a pooled Cohen's Kappa for all codes of 0.9 was reached (Lombard et al. 2010). Once adequate reliability was achieved, the full sample of interviews were then independently coded. Following Lombard et al. (2010) guidelines, 40% of interviews were coded by both coders.

Once all interviews were coded, the second and third authors, who were involved in the intervention project but not in collecting or coding interview data, served as external auditors to minimize subjective bias, check for congruence between code applications and excerpt content as well as coherence of all excerpts within a given code (Hill et al. 2005). Themes were identified through an iterative process of considering all excerpts within a given code and identifying patterns within the data, followed by considering multiple codes concurrently and identifying patterns across code categories. Emergent themes were refined through ongoing discussion. In the final stage of analysis, previous stages were corroborated by scrutinizing code applications, identified patterns, and emergent themes to ensure that final themes were representative of data excerpts and their assigned codes (Fereday and Cochrane 2006).

Results

Qualitative analyses resulted in ten main engagement strategy themes. All themes were present in at least 50% or more of the 16 transcripts. Themes were organized into two superordinate categories based on themes' function. The rapport building category encompassed themes related to interpersonal strategies relevant to the relationship building process with parents, including: (1) non-judgmental supportive listening; (2) increasing social proximity; (3) praise; (4) privacy and confidentiality; and (5) leveraging relationships. The responsive delivery category encompassed themes related to the implementation of the program and the way that CHWs structured their program delivery to respond to parents' specific circumstances, including: (1) flexibility; (2) consistency; (3) advocacy; (4) incentives; and (5) meeting needs. Below we discuss engagement strategy themes along with illustrative excerpts; direct quotes are presented in *italics* followed by an initial denoting a unique alias for each quoted CHW. See Table 1 for a summary of themes with corresponding exemplar quotes.

Rapport Building

CHWs endorsed using various strategies to promote rapport in the relationship-building process with parents. As detailed below, these strategies formed a relational backdrop that CHWs utilized to encourage parental engagement, setting the foundation for service delivery.

Table 1 Engagement strategy themes

CHW engagement strategy themes	Exemplar excerpt
Rapport building	
Non-Judgmental supportive listening: supportive practices, including being non-judgmental, providing supportive listening, and being genuine and warm	*[S]ometimes they [parents] just need someone to talk to and they know that I'm someone that is working with their children, therefore I must care about their children. Therefore, I guess, someone to be trusted, or, at least, someone that they can talk to that won't judge them or just go vocal about their issues – just someone that can listen. And, even if I don't have any of the answers, I'll be there with ears open. –H*
Increasing social proximity: relating to parents through shared similarities and experiences, and creating a sense of equality and "being on their level" with parents	*I just try to relate and just show them I'm no different. So that's the biggest strategy I can use, is just to not be different. Not try to make myself be the ultimate professional in the room. No, I'm with you. We're together. So, I just make them feel like it's just us. I'm your girlfriend and we're just having a conversation, and it won't go no further. –E*
Praise: acknowledging positive gains and efforts of both parents and children	*Always encourag[ing] them, "Oh, I'm glad you – I see what you're doing. You're doing a great job. Last month, you were ready to snap somebody, this month…" you know, showin a way I can see that they're progressing. –A*
Privacy and confidentiality: maintaining families' personal information private, maintaining a separation between what was shared with the CHW vs the school	*[L]etting them know that our conversations are private, and I don't share anything with anybody, because I think that's what makes them feel more comfortable. […] And then I explained the whole [confidentiality]. She was like, she felt very comfortable doing that. And just someone was listening to her. –I*
Leveraging relationships: word-of-mouth process in which school staff (e.g. teachers, security, principals), parents and students already involved in the program vouch for the CHW's work to less involved families	*[S]chool is like a small world because this person is a cousin of this person, and so then that's how word gets around, too […] Then she must've talked to this mom about what I've provided, and then they're like, "Oh, okay, so she is genuine, and she is trying to help out." –C*
Responsive delivery	
Flexibility: flexible with time, place, and mode of communication; flexibility in how CHWs framed and delivered program content; flexibility to incorporate content outside of program curriculum	*So we do a lot. We text. If we need to do home visits, we do home visits. If they don't want us to come to their homes, that's fine, but let's meet at Dunkin Donuts, let's meet at McDonald's, let's meet at library. –B*
Consistency: regularly and reliably reaching out to parents, attempting to meet parents' needs or connect them to a resource, and being a regular visible presence at school	*And just being consistent. Always being there. Always giving them that phone call. Even though they don't answer, at least they know, "Well, I got a voice mail from this lady. She's not gonna leave me alone. But at least I know that she's there." They know that I'm resourceful in some way or that I can be their eyes and ears [at school]. –C*
Advocacy: centering families' perspectives and preferences when interfacing with the school, thus serving as advocates on behalf of families; being "on their [families'] side" and promoting their voice	*I have families who need help with their children's IEP or advocating for their child for there to be a revision or whatever the case may be in. It's like, okay, well, I'm that person who constantly is in the middle communicating with Mom, so I make sure that I voice her opinion and her thoughts as well. – K*
Incentives: using physical rewards (i.e. gift baskets, food, gift cards) to promote desired parental behaviors (mainly participation in intervention program and school)	*[N]ot saying that you always have to have something for the parents, but some of our parents love to get like the little incentive, like a cleaning supply basket. They love like the cleaning supply baskets. So if I can provide a cleaning supply basket, then I try to have an incentive for my parents to come out to the school. –D*
Meeting needs: providing case management to meet families' basic needs	*We might not be able to solve your problem, but we can kind of lead you in a direction or lead you to somebody who might be able to go one more step. […] So, resources play a huge part. We've always got somewhere [to refer], it's not just that I don't know and you leave. You always leave with hope, with another step. Okay, I can't do anything, but if you go here and ask this person this question, they can give you a little bit more information. Not promising they're gonna solve your problem, but they can give you a little bit more information than I can give you. They can point you in another direction and we take it from there, one step at a time. – J*

Non-Judgmental Supportive Listening

Within this theme, CHWs described using several interrelated supportive practices in order to build rapport, including being genuine, warm, non-judgmental, and providing supportive listening. Through this interpersonal approach, CHWs described being able to better connect with parents:

> *So actually I've learned that just being genuine, so being real with the parents is how I've been able to connect with them […] There is that [sense of] I am here for you. –C.*

Increasing Social Proximity

CHWs discussed the importance of leveraging their social proximity as near-peers to parents in order to garner parent buy-in. Two subthemes described strategies through which CHWs leveraged their social proximity: (1) being mindful of how they (CHWs) presented themselves to parents, and (2) relating to parents. CHWs shared the importance of getting *"on their level"* when interacting with parents:

> *I don't present myself to be here and they're there and I'm above them [parents]. So I think I just made her feel comfortable. They like that sister girl attitude. –B.*

Furthermore, CHWs related to parents through shared similarities and experiences such as parenthood, culture, neighborhood, and life challenges. For example:

> *[L]iving in [same neighborhood as parent] is a great asset […] – they're more open to listen and respond if you live where they are versus you living outside of the neighborhood. Because to them, they don't think you understand what they're […] dealing with because you don't live where they live, but I do. –A.*

Thus, relating through shared similarities and presenting themselves as equals to parents, CHWs worked to leverage their social proximity, which in turn supported parents' comfort with and responsiveness to the program.

Praise

CHWs described the importance of acknowledging the positive gains and efforts of parents and children, particularly because often received negative feedback from the school:

> *I also praise the parents. Like "You're doing a good job, Mom. I know you're working really hard and I know it's really hard for you to get the counseling, but is it okay if we try and find other ways?" So like I guess providing praise to parents is another way to kind of like bring them in. […] Maybe there is nobody, not even a teacher saying, "Oh, you're doing a great job as a parent." You know, and sometimes you need that as a parent. Who doesn't need praise? –C.*

This excerpt illustrates how recognizing and validating parents' efforts created opportunities for CHWs to *"bring them in."*

Confidentiality and Privacy

CHWs also reflected on the importance of confidentiality and privacy in building rapport with parents. Confidentiality was described as central to relationship building and gaining trust:

> *You have to build that relationship, and that trust. They have to be able to trust you. They have to know that you're not going to go back and tell somebody what they talked to you about. So I just try to make them feel comfortable, let them know they can trust me. They don't have to worry about me telling somebody else something. It's not the school's business, it's your business. –A.*

Emphasizing privacy and confidentiality was a way for CHWs to set themselves apart from the school, a system which many parents did not trust. This in turn garnered trust and promoted engagement.

Leveraging Relationships

Lastly, CHWs discussed how they leveraged positive relationships with teachers and school staff, other parents, and students to promote engagement. Having the endorsement of school staff (e.g. teachers, security, principals, etc.) and parents already involved in the program, and who could vouch for the CHW's work fostered increased trust and engagement from newer and/or less involved parents. Similarly, students' descriptions of their positive experiences with CHWs helped promote their parents' involvement:

> *The students that you work with is going to be your key to get that parent involvement that you need […] So you know, if they see how helpful that you wanna be to them, they're gonna […] praise you […] to that parent, and that's gonna be that open door […] to some of your parents. –D.*

Responsive Delivery

The second broad category of themes encompassed engagement strategies CHWs used as part of direct service delivery. We conceptualize strategies used to enhance

direct service provision as responsive delivery; in other words, throughout the course of delivering services CHWs incorporated these strategies to be more responsive to families' needs and situations, and in turn promote their engagement.

Flexibility

Within the theme of flexibility, three subthemes described the ways in which CHWs incorporated flexibility into service provision, including (1) logistic flexibility, (2) flexibility in the approach to and framing of content, and (3) flexibility around integrating non-program content. CHWs indicated that logistic flexibility was critical for engagement due to a variety of barriers parents faced including time constraints (e.g., due to working multiple jobs), transportation limitations, and negative relationships with their children's schools. Because of this, CHWs expressed the importance of being flexible concerning time, place, length and frequency, and mode of communication, which included phone calls, texting, emails, home visits, meeting in the community, and contacting families after standard work hours (see Table 1 flexibility excerpt). CHWs also described implementing flexibility through their framing and delivery of program content. CHWs noted that rather than present parenting information in a direct curriculum or lesson-like manner, they found it easier to engage parents by framing content in a more casual and indirect format:

> *The way I painted the picture is, it's not a parent group. We're sitting and having coffee and donuts, and we're just talking. It's our parent café. […] It was almost like a, "Oh, this isn't planned. […] But let me show you this video. And, let me see how you feel about it. What would you do different?" [T]hat allows for the conversation to go in a different way because there are no right or wrong answers. –E.*

CHWs also described using a flexible approach in the content they provided to parents. While CHWs were tasked with conveying content related to key positive parenting practices, they indicated it was also important to incorporate content outside of the curriculum to maintain parent interest and engagement. Therefore, CHWs flexibly incorporated other topics into service delivery as part of their responsive practices:

> *I used to incorporate wellness in some of our parent groups, so every week it wasn't time management or traditions. […] I had a breast cancer group where I went to the university and I got a DVD on […] how do you check for breast cancer and hotlines and all of that. We've done groups on […] domestic violence, […] financial literacy. I engage them in different ways. We've done resumé writing. […] Wherever they are, I try to meet them where they at. –E.*

These subthemes highlight the various ways CHWs used the strategy of flexibility to engage parents, focusing on being responsive to parents' circumstances, needs, and interests, ultimately promoting their participation in the program.

Consistency

CHWs discussed how consistently reaching out to parents, making consistent attempts to meet parents' needs or connect them to a resource, and being a consistent visible presence at school played a role in engaging parents:

> *Definitely being consistent, and they like when you're consistent and you're not standoffish […] that you're willing to help, no matter what the situation is. If you don't have that resource, you're gonna try to provide them with one […] So yes, just being consistent with your parents is a big key. –D.*

Even, or perhaps particularly, in the face of little parental response, CHWs emphasized how important it was to "not give up on parents, you have to keep trying, just keep trying." Thus, consistency and reliability in reaching out to parents was described as important for engagement.

Advocacy

CHWs shared how throughout service provision they tried to center families' perspectives and preferences when interfacing with the school, thus serving as advocates on behalf of families:

> *[S]ome of them [parents], they don't want medication for their kid. And it's just like, "Well, they don't want this. They say they don't." So […] trying to see it from their [parents'] point of view, and try and advocate their choice. Sometimes they feel, "Oh, okay. She's not with the school. She's with me," type of thing. – F.*

By advocating for parents' needs and preferences, CHWs created a sense that "I [CHW] was on their [parents'] team," which CHWs identified as facilitating parental openness and engagement.

Incentives

CHWs described frequent challenges related to parents' attendance at in-person drop-ins, groups, or school meetings; in response, they reported using incentives to promote attendance. Strategies around incentivizing in-person

Table 2 Select strategies and definitions identified in Lindsey et al.'s (2014) review of engagement strategies alongside parallel engagement strategy themes

Empirically based engagement strategies	Definition	Parallel CHW engagement strategies
Therapist reinforcement	*Reinforcers (e.g., monetary rewards, verbal praise) used by therapists to increase desired behaviors (e.g., attendance, homework completion) that are related to engagement*	Praise; Incentives
Accessibility promotion	*Any strategy used to make services convenient and accessible in order to proactively encourage and increase participation in treatment*	Flexibility
Case management	*Providing coordination and oversight of multiple formal and informal support/services for the identified client such that families receive a lot of assistance navigating multiple domains (e.g., home, school, medical, behavioral health, juvenile justice)*	Meeting Needs
Peer pairing	*Pairing the youth, family, or caregiver with another youth, family or caregiver to provide support around seeking/obtaining services, encourage participation in services, enhance skill development, and provide/share information*	Leveraging relationships
Relationship/Rapport building	*Strategies to increase the quality of the relationship between the youth/caregiver/family and the therapist (e.g., ''joining'' in family systems engagement) to help enhance youth/family engagement in services*	Non-Judgmental supportive listening; Increasing social proximity

school-based contacts were deployed alongside other strategies noted above, such as a flexible contact strategy (e.g. texts, home visits, meeting in the community). CHWs also described using incentives that were responsive to parents' needs in order to increase the likelihood of in-person attendance at the school. As one CHW described:

> *I take food for them. […] When they come for the parent drop-ins. "Oh, we have this and this to give away," and they're more likely to come, type of thing. –F.*

Meeting Needs

While services focused primarily on supporting involvement in school and positive parenting practices, CHWs also engaged in considerable case management efforts to meet families' basic needs. CHWs noted that meeting needs was particularly important given that they were working with families living in poverty. Additionally, some CHWs observed that offering case management supports when families first joined the program, rather than immediately focusing on parenting, helped promote parental engagement. Thus, there seemed to be a temporal component to using case management as an early engagement strategy:

> *[T]he program has to be the last thing you even talk about, initially. […] We're here to help you but how can I help you? What is it that do you need as a parent […]? And almost 100 percent of the time, it has nothing to do with that child being in that school. Resources. You can't have a parent help a kid with homework if they don't have pencils. They can't get pencils and paper and everything else if they need if they don't even have a job or they're bouncing around from home to home. –G.*

CHWs described how providing resources in response to families' needs early on in their work together conveyed to families that the CHW had both the intention and ability to support the family, and thus encouraged parental trust and involvement.

Discussion

The primary aim of this study was to examine parent-focused engagement strategies generated by a CHW workforce within a school-based child mental health service model. We employed a qualitative design in order to gain an exploratory overview of CHWs' range of engagement strategies through individual interviews. Thematic analyses revealed ten main engagement strategies centered around broader domains of rapport building and responsive delivery. There are several points of convergence between the engagement strategies identified in the present study, and strategies generated from the professional-led clinic-based engagement literature, as well as the practices identified in peer-led family support programs in children's mental health. Table 2 displays CHW engagement strategies alongside parallel strategies identified in Lindsey et al.'s (2014) review of clinic-based engagement strategies. Seven of the ten identified engagement strategies used by CHWs appear to align with strategies in the clinic-based engagement literature. However, while noting these

parallels, it is important to highlight the nuances with which CHWs implemented strategies to accommodate the needs and culture of the community served.

For example, although the strategies of incentives and praise both map onto the empirically based strategy of therapist reinforcement, CHWs' use of incentives consisted of intentionally selecting those that met parents' concrete needs (e.g., cleaning supplies, food), reflecting their knowledge of what would be relevant to the families they served. Additionally, CHWs demonstrated understanding the importance of praise within a specific context: given that families often received negative feedback from the school, CHWs used praise to acknowledge families' efforts and progress, thereby leveraging the strategy to counterbalance the negative communications that were common from the school. In another example, the CHW strategy of meeting family needs closely aligns with the empirically based strategy of case management. However, the unique aspect of CHWs' implementation of this strategy was their recognition of the importance of providing these resources prior to discussing parenting. This appeared to reflect their understanding that providing these resources could demonstrate their ability to help families and thus gain buy-in. Indeed, the importance of community service providers demonstrating their ability early in the intervention to respond quickly and effectively to client needs has been demonstrated in other paraprofessional-led services (Allen et al. 2013).

These parallels also mirror mental health clinicians' perspectives on barriers and promoters to youth and family mental health treatment. In one focus group-based study, clinicians reported that treatment barriers included stigma, cultural differences, and concrete obstacles such as transportation or socioeconomic status, while treatment promoters included therapeutic alliance, outreach (e.g. home-visits), and cultural and experiential similarities (Gearing et al. 2012). CHW-generated strategies in the present study reflect many of these areas, such as minimizing cultural differences and stigma by leveraging their social proximity,[1] or flexibily addressing concrete participation barriers. Collectively, these parallels demonstrate how CHWs were able to leverage engagement strategies similar to those used in clinic-based mental health services, while implementing them in a contextually relevant way. CHWs were able to identify empirically-based strategies *and* integrate their knowledge and expertise of their community, which underscores the strengths and potential of this workforce.

CHW Engagement Strategies and Peer-Led Family Support Activities

Peer-led family support programs in children's mental health services offer another useful reference point for understanding engagement strategies in the context of paraprofessional-led mental health services. The literature on peer-led family support programs in children's mental health services has identified several core types of activities, including informational, instructional, emotional, instrumental, and advocacy support (Hoagwood et al. 2010). Many of these support activities overlap with the engagement strategies identified in this study. Specifically, the engagement strategy of praise for parents' skills and efforts aligns with the focus on parent coping, problem-solving, and communication in parent peer-led programs (Hoagwood et al. 2010). Similarly, meeting needs through case management aligns with referrals to other services and addressing emergent needs in peer-support programs; additionally, both programs provide advocacy support (Hoagwood et al. 2010). Peer-led programs in children's mental health highlight how emotional support often centers on experiential knowledge and relational similarities, which parallels the theme of increasing social proximity in which CHWs relied on their shared similarities and experiences with parents to engage.

These parallels suggest that some practices may serve a dual purpose as both an engagement strategy *and* a support activity. Advocacy can be leveraged as both a direct support service for families *and* as a strategy to promote engagement and buy-in. Case management can function as both an instrumental support service, *and* as a strategy to increase participation in services. The dual function offered by such practices suggests that service models that integrate a variety of supports to meet families' needs may also be well positioned to engage families simply by virtue of matching what families hope to gain from participating in services and effectively addressing their needs. This study builds on peer-led family support research by suggesting that peer-led service models designed to meet multiple needs may also show more promise in bringing families into services and keeping them in services.

Engagement Strategies and Program Model

The present study's engagement strategies can also be better understood by considering how they may have been informed by the structure of the service model, which was grounded in a set of guiding values and an ecologically-informed flexible school-based service delivery format. For example, the strategy of increasing social proximity reflects the core value of community connectedness. CHWs discussed relating with parents through shared community membership and/or experiences, and also being mindful

[1] In a separate analysis of these data, we found that social proximity was leveraged by CHWs to relate to parents, and this process of relating served to normalize parents' challenges, create a sense of equality, and promote buy-in (Gustafson et al. 2018).

of presenting themselves "on the parent's level," both of which allowed CHWs to engage parents by virtue of creating a sense of connectedness grounded in some form of shared community. Consistent with empirically-supported community-based advocacy (e.g., Allen et al. 2013; Sullivan and Bybee 1999), intentionally establishing program values may help guide CHWs in identifying and employing flexible engagement strategies.

Furthermore, strategies that did not appear to have parallels in Lindsey et al.'s (2014) review of empirically supported engagement practices (privacy and confidentiality, advocacy, and consistency) can also be traced back to the values-based, school-embedded service model. Privacy and confidentiality emerged as an important engagement strategy in relation to the school context because of the need to assure parents that their personal information would not be disclosed to teachers, staff, or other members of the school community. The strategy of advocacy, in which CHWs promoted engagement by centering families' perspectives when interfacing with the school, was another theme that emerged in relation to the school-based context. Lastly, the strategy of consistency, in which CHWs were persistent in reaching out to families even when parents were unresponsive, reflected an explicit program value of "not giving up on families." This stands in contrast to traditional clinical service policies that often dictate case closure after a certain number of no-shows or cancellations. Thus, in addition to identifying engagement strategies that paralleled those in the broader clinic-based literature, CHWs also identified engagement strategies that seem to have emerged as a function of the service model. This suggests that non-traditional mental health service models may necessitate both established strategies and novel contextually-responsive approaches to engagement.

The fact that engagement strategies mirrored aspects of the service model highlights how engagement considerations are not simply confined to the implementation stage of an intervention. Our study suggests that how an intervention program is designed – its values, setting, and service delivery format – can shape engagement practices. That is, while acknowledging that the service model was unique to this program and that the structure of other intervention programs will inherently vary based on the parameters and needs of the context in which they are based, it is not the specific components of our service model nor the specific engagement strategies generated by the CHWs but the interaction of the two that is important. As the field explores more non-traditional mental health service models with varied providers and settings, it will be important to consider how the structure of a program impacts approaches to engagement.

Implications for Practice

CHWs are increasingly recognized as an important workforce to address mental health disparities for underserved populations (Barnett et al. 2018). Mental health providers are not sufficient to address the treatment gap, and "task-shifting these interventions to more available and affordable members of the health workforce or community is widely acknowledged to be the only sustainable way of addressing this barrier" (p. 524, Patel et al. 2011). In addition to being a more available and affordable workforce, CHWs increase accessibility through their outreach and trust-building as members of the communities they serve (Malcarney et al. 2017). The present study illustrates this workforce's promising capacity to engage families, with important implications for practice.

As CHWs become more integrated into child and family mental health, the broader context of the service model – factors such as service setting, service modality, and level and type of supervision and ongoing support – will be a critical consideration in order to optimally support CHWs in their community engagement. It is important to also note policy-level factors that will both impact the feasibility of implementing CHW-led mental health interventions as well as shape the types of engagement strategies that can be utilized. For example, CHWs may not be able to use a strategy such as flexibility in program content if they are expected to only engage in certain billable services. Currently in the U.S., there is no formal consensus and acknowledgment of the CHW profession as a standardized role eligible for third party payment and reiumbursement (Corder-Mabe et al. 2019). Thus, as the CHW role becomes more formalized within healthcare, it will be necessary to evaluate the types of engagement strategies that are relevant and feasible within the bounds of healthcare and insurance policies.

Another key consideration is how to train CHWs on using engagement strategies. The CHWs in this study did not received formalized training on engagement, yet they identified a range of engagement strategies that were borne from the need to address considerable engagement challenges. The results of this study do not suggest that the CHW workforce as a whole has no need for training and ongoing support in engagement. Instead, these findings can offer guiding principles for how to formulate training and support of engagement strategies for CHWs. Specifically, training efforts may benefit from a focus on eliciting CHWs' knowledge of their communities, as this was a key feature that informed their identification and implementation of strategies. The task of training may be well served by a bi-directional exchange that capitalizes upon CHWs' contextual understanding of their communities by linking it to established empirically-based engagement strategies, and

by leveraging it to identify novel contextually-responsive strategies that may not be present in existing literature.

The question of *how* and *when* to choose to utilize a particular engagement strategy is another important consideration for training, particularly with the goal of being responsive to community context and family needs. This is overlooked in research examining engagement in traditional mental health services as well, though mental health professionals may rely on a narrow set of strategies to address engagement, and may not always implement the best strategies for the specific engagement problem at hand (Becker et al. 2020). We did not address the process by which CHWs decided which engagement strategy to use and when to implement it; however, results indicated that CHWs flexibly used a variety of strategies rather than relying on a particular one. This suggests that CHWs may benefit from training on a range of strategies, thereby allowing for a flexible and tailored approach to engagement. Promisingly, Becker and colleagues (2019) piloted a system for training providers on an array of evidence-based engagement practices, along with a decision-making framework to integrate client perspectives, provider perspectives, and research evidence to support selection and implementation of practices to improve engagement. A framework that allows CHWs to develop an engagement toolbox that builds on their inherent strengths to support flexible and adaptive implementation may optimize the integration of their experiential knowledge to the existing evidence base.

Limitations and Future Directions

Several limitations should be noted when interpreting these findings. This qualitative study was specific to a two-generation school-based mental health-promoting intervention set in urban high poverty communities, and consisted of an almost all-female African American and Latinx CHW participant sample. Thus, generalization to other types of interventions, communities, and CHW workforces may be limited. Furthermore, we do not know the degree of efficacy the reported strategies had in impacting parental participation and engagement. Notably, however, a longitudinal examination of parent participation in the program over the course of a school year found multiple trajectories of participation, including a group of parents who participated with low but consistent frequency over the school year; a group who demonstrated initially low, then steadily increasing participation; a group who demonstrated a decline and rebound in participation; and a group with high, consistent participation (Lakind et al. 2019). The variability in parent participation and the specific trajectories that emerged align with themes identified in the present study such as consistency and flexibility, suggesting that CHWs' reported engagement strategies may have successfully promoted parent participation.

Future studies should further examine the use and implementation of engagement strategies for mental health services with other CHW samples in other settings and programs, and from clients' perspectives. It would also be helpful to examine the prevalence and patterns of usage across strategies to elucidate whether certain strategies may be more common or useful than others. Additional research should also study the impact of CHWs' engagement strategies on client outcomes. A mixed methods approach using direct measures of engagement strategy implementation (e.g., behavioral observations, CHW and/or client reports) could capture a wider range of relevant engagement constructs.

While the identified engagement strategies are an important tool in addressing the large gap in youth and families accessing needed mental health services, these strategies function on an individual provider–client level and do not address the broader system-level inequity. Structural barriers such as poverty or lack of available high quality services in a family's neighborhood constitute upstream social determinants of mental health that require broader system-level interventions (Lund et al. 2018). Individual provider–client level engagement strategies are necessary but insufficient to close the treatment gap, which will be accomplished in large part by creating more just and equitable systems that reduce the need for specialized mental health services. To comprehensively address the full extent of unmet youth and family mental health needs, it will be necessary to target both upstream structural determinants of mental health as well as downstream proximal factors, including engagement barriers and facilitators.

Conclusion

This study contributes to a growing literature on the potential of CHWs to promote mental health in underserved communities (e.g., Barnett et al. 2018; Barnett et al. 2018). Findings provide preliminary evidence regarding CHWs' ability to identify and implement a range of engagement strategies, many of which parallel empirically based engagement strategies in traditional clinc-based child and family mental health services, as well as practices in peer-led family support services. However, rather than indicating that the specific engagement strategies identified in this study are universally true across all CHWs in child mental health, this study provides evidence of the *capacity and feasibility* of CHWs leveraging engagement strategies, as CHWs demonstrated knowledge and contextually nuanced implementation of a variety of engagement practices. This speaks to the potential of this workforce for engaging underserved

families and underscores the important role CHWs stand to play in reducing mental health disparities.

Acknowledgements We thank Francisco Padron for his contributions to data coding.

Funding This research was supported in part by the National Center for Advancing Translational Sciences, National Institutes of Health, through Grant UL1TR002003. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

Compliance with Ethical Standards

Conflict of interest We have no known conflicts of interest to disclose.

Ethical Approval This study was guided by the Standards for Reporting Qualitative Research (SRQR).

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