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# Improving Foster Parent Engagement: Using Qualitative Methods to Guide Tailoring of Evidence-Based Engagement Strategies

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This qualitative study examined applicability and need for tailoring of an evidence-based engagement intervention, combined with Trauma-Focused Cognitive Behavioral Therapy, for foster parents. Qualitative methods were used, including individual interviews with participating foster parents ( $N=7$ ), review of interview findings with an independent group of foster parents ( $N=5$ ), and review of the combined foster parent findings by child welfare caseworkers ( $N=5$ ), an important stakeholder group. The engagement intervention, with its primary focus on perceptual barriers (e.g., past experiences with mental health), was relevant for the foster care population. However, the study identified areas for tailoring to better recognize and address the unique needs and situation of foster parents as substitute caregivers. Perceptually focused engagement interventions may have broad applicability to a range of populations, including foster parents, with the potential for improving caregiver participation in children's mental health services.

Approximately 400,000 children and adolescents reside in foster or kinship care in the United States at any point in time (U. S. Department of Health and Human Services [DHHS], Administration for Children, Youth, and Families, 2011). In the first nationally representative study of children involved in child welfare, nearly half of those residing in foster care had clinically significant emotional or behavioral problems (Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004). These rates are 2 to 4 times those of the general population (New Freedom Commission on Mental Health, 2003). Among these, behavioral difficulties are the most common (Garland et al., 2000) and have been associated with more frequent

placement disruptions and difficulty achieving permanency (James, Landsverk, & Slyman, 2004; Newton, Litrownik, & Landsverk, 2000). In the area of trauma and trauma-related symptoms, nearly 80% of children in foster care have been exposed to abuse and neglect (Garland, Landsverk, Hough, & Ellis-MacLeod, 1996) with 85% having witnessed violence (Stein et al., 2001). Unsurprisingly, children and adolescents in foster care have higher rates of posttraumatic stress (PTS) symptoms than the general population (20% vs. 1%, respectively; Copeland, Shanahan, Costello, & Angold, 2009; Kolko et al., 2010).

These high rates of trauma exposure, PTS, and behavioral difficulties in the foster care population make Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) a particularly relevant treatment approach, as it targets both trauma-related symptoms and behavior management

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(Cohen, Mannarino, & Deblinger, 2006). To date, 12 randomized controlled trials of TF-CBT have been conducted (see Dorsey, Briggs, & Woods, 2011). These studies demonstrate the efficaciousness of TF-CBT for treating PTS, general and trauma-specific behavior problems, and depressive symptoms (e.g., Cohen, Deblinger, Mannarino, & Steer, 2004; Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011). Follow-up studies demonstrate 1- and 2-year maintenance of treatment gains (e.g., Cohen, Mannarino, & Knudsen, 2005; Deblinger, Steer, & Lippmann, 1999). Initial studies focused on children with sexual abuse histories, primarily with polyvictimized youth (e.g., Cohen et al., 2004; Deblinger, Lippmann, & Steer, 1996). However, recent effectiveness studies (Cohen, Mannarino, & Iyengar, 2011) demonstrate positive outcomes with diverse traumatic experiences (e.g., domestic violence). TF-CBT typically involves 12 to 20 sessions, including individual sessions with children and their nonoffending caregiver(s) as well as conjoint child-caregiver sessions. Treatment includes nine components: (a) psychoeducation, (b) parenting, (c) relaxation, (d) affective expression and modulation, (e) cognitive coping, (f) trauma narrative and processing, (g) in vivo exposure, (h) conjoint sessions, and (i) enhancing safety and future development.

One TF-CBT study comparing a child-only versus a parent-only approach demonstrated that caregiver involvement was important for effectively addressing behavioral problems (Deblinger et al., 1996). By design, approximately half of overall session time in TF-CBT is dedicated to working with the caregiver(s). This substantial involvement facilitates the reinforcement of treatment components outside of sessions (e.g., practice of emotion regulation skills) and use of behavior management skills to address behavioral difficulties. In the foster care intervention literature, interventions that strengthen foster parents' behavior management skills have been shown to stabilize placements and positively impact permanency (e.g., Price, Chamberlain, Landsverk, & Reid, 2009). Given the high prevalence of behavior problems in this population and their negative implications for placement stability and permanency (e.g., James et al., 2004), caregiver involvement may be particularly important for youth in foster care.

Youth in foster care have been included in most TF-CBT studies, but only in small numbers (i.e., < 10% of the sample), precluding the examination of outcomes specifically for this subgroup. Only one study (Weiner, Schneider, & Lyons, 2009) focused specifically on youth in foster care. For youth who received 11 or more sessions of TF-CBT, PTS was significantly reduced. However, dropout rates were high, with nearly one third discontinuing treatment before receiving 11 sessions (Northwestern University, 2008). The authors reported substantial challenges engaging foster parents, with participation linked to treatment retention: Only 10% of those who dropped

out had a foster parent involved. Conversely, among those retained for 11 or more sessions, or still in treatment at the end of the study, 75% had a foster parent involved.

Looking beyond the foster care population, rates of engagement in community mental health treatment are low for all families. Approximately one half (48–62%) fail to attend the first appointment (Harrison, McKay, & Bannon, 2004; McKay, McCadam, & Gonzales, 1996). Barriers vary and include family stress, lack of social support around seeking help, and parental attitudes about mental health treatment (McKay, Pennington, Lynn, & McCadam, 2001). Length of treatment can average four sessions or fewer, with only 9% of youth and their families remaining in treatment after 3 months; more than two thirds drop out within seven sessions (McKay, Harrison, Gonzales, Kim, & Quintana, 2002; Miller, Southam-Gerow, & Allin, 2008). Predictors of premature treatment discontinuation largely overlap with predictors of failure to attend an initial appointment but also include trauma or maltreatment history; ethnic minority status; and having nonbiologically related caregivers, such as foster parents (Kazdin & Mazurick, 1994; Lau & Weisz, 2003; Miller et al., 2008). These predictors converge within the foster care population, making these youth particularly prone to early treatment disengagement.

Research suggests that targeted engagement strategies can effectively improve both initial engagement (e.g., attendance at the first session) and retention in treatment (e.g., Kim, Munson, & McKay, 2012). Prior studies have tested the combination of EBT and specialized engagement strategies for a range of populations, including child-welfare-involved parents and Latino families, among others (e.g., Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2011; Nock & Kazdin, 2005; Szapocznik & Kurtines, 1989). In conceptual models of engagement, “perceptual barriers” have sometimes emerged as stronger predictors of engagement than “concrete barriers” (Kazdin, Holland, & Crowley, 1997; McKay et al., 2001). McKay and Bannon (2004) broadly defined perceptual barriers as caregiver attitudes and experiences that may negatively influence the decision to access treatment (e.g., past negative experiences with mental health, perceived utility, stigma). Concrete or external barriers, alternately, are defined as logistical or contextual challenges that can impact families' ability to access services (e.g., childcare challenges, transportation difficulties; McKay & Bannon, 2004). Whereas even concrete barriers could be construed as perceptual (i.e., how much an individual perceives a concrete barrier to be an obstacle), in McKay's conceptualization, perceptual barriers are not logistical in nature. Once perceptual barriers are adequately addressed, concrete barriers can be problem solved and hopefully overcome, per the theory underlying McKay's work (M. M.

McKay, personal communication, 2008). Therefore, McKay's intervention focuses primarily on perceptual barriers via brief intervention during the first two contacts between the family and the agency: the first telephone contact and the first in-person appointment.

Building on the work of Szapocznik and colleagues (e.g., Szapocznik & Kurtines, 1989), McKay modified telephone intake procedures to proactively address perceptual and concrete barriers to treatment participation (e.g., McKay & Bannon, 2004). The first telephone contact is conceptualized as the beginning of treatment, rather than solely a logistics-focused encounter. The intervention includes four elements, three of which are perceptually focused: (a) identifying the caregiver's greatest concern about the child—potentially distinct from the reason for referral—to find a compelling reason for caregiver participation, (b) building a collaborative relationship and increasing caregiver investment in participation, (c) discussing prior experiences with mental health treatment, and (d) problem-solving concrete barriers to engagement.

During the first in-person visit, the clinician revisits the four elements from the phone call by providing and discussing a tangible resource (e.g., handout) to address the caregiver-identified concern mentioned on the call. Providing this resource demonstrates responsiveness to the caregiver's concern and allows some "treatment" to occur in this session, despite the predominant focus on required—and often minimally engaging—intake activities. While completing these "paperwork" heavy activities, the clinician links each item (e.g., consent, release of information) to a specific treatment goal or component.

Evidence for the engagement intervention is positive. The telephone engagement intervention resulted in better attendance at the first visit (72.7% vs. 45.3% for the "usual practice" control group; McKay et al., 1996). Delivery of the first visit intervention improved attendance rates at a second appointment (97% vs. 83%) and ongoing treatment retention (i.e., 7.1 vs. 5.3 sessions). The combined intervention yielded the best outcomes: Families who received both were more likely to attend the initial session and to remain in treatment, and less likely to "no show" (McKay, Stoewe, McCadam, & Gonzales, 1998). When paired with trauma treatments (including TF-CBT), the combined intervention was associated with 75% of families attending eight or more sessions (Hoagwood, Kelleher, Murray, & Jensen, 2006).

The purpose of the current study was to pilot McKay's combined engagement intervention and TF-CBT with a small group of foster parents to identify any population-specific areas of adaptation to the engagement intervention. We expected the McKay engagement strategies to be generally applicable to foster parents, given the focus on perceptual barriers relevant to any caregiver (e.g., addressing caregiver's own concern regarding youth, past

mental health experience). However, as listed in the National Institute for Mental Health [NIMH] Strategic Objective 3.3 (DHHS, 2008), there is a need to strengthen mental health interventions by examining delivery approaches that might affect intervention outcomes. One recommended strategy is to incorporate consumer and stakeholder perspectives early in treatment development so that interventions can be tailored to be most effective. Thus, although generally applicable, McKay's engagement strategies might require some modification for the foster parent population, who may have unique needs as substitute caregivers. Our goal was to use qualitative methods to identify if tailoring was needed, and if so, to have tailoring driven by foster parent (i.e., consumers) and child welfare caseworker (i.e., stakeholders) input and feedback.

## METHOD

### Overview

Data are from the first phase of a two-phase, NIMH-funded feasibility trial of TF-CBT with youth in foster care, with a focus on testing engagement strategies. The study was conducted in a large, urban county in Washington State, with a diverse population of youth in foster care. In Phase 1, a qualitative approach was taken to identify any need to adapt the engagement intervention. Foster parents received the combined engagement intervention and TF-CBT for the enrolled youth in their care. They participated in qualitative interviews shortly after receiving the engagement interventions (i.e., within approximately 1 week after their first in-person session). An independent group of foster parents (hereafter referred to as the foster parent board) then reviewed qualitative interview findings to assess generalizability to other foster parents. Subsequently, a group of child welfare workers reviewed findings from both the qualitative interviews and the foster parent board. The Washington State Institutional Review Board approved all study procedures. Phase 2 of the study (results forthcoming; Dorsey et al., 2014) involved a randomized trial of TF-CBT plus the engagement intervention—with adaptations from Phase 1 findings—compared to TF-CBT standard delivery.

*Qualitative interviews.* In-person qualitative interviews were conducted with the foster parent identified as most closely involved in the youth's treatment. The interview was conducted in two parts. The first half focused on the initial phone call, soliciting the foster parent's experience of the call, as well as feedback or advice on how to improve the call to facilitate engagement. The second half of the interview focused on the first in-person

therapy visit with similar goals. Initial questions were open-ended (e.g., “When you think back about that first phone call, what do you remember talking about?” “How did you feel about this part of the conversation?” “How was this different from/the same as first sessions you’ve had with other mental health counselors?”). Open-ended prompts were used to encourage elaboration on all answers. Then, after foster parents had exhausted responses to the open-ended questions, the interviewer used specific follow-up queries and prompts that focused on each element of the engagement intervention (e.g., “We are interested in several other things you may have talked about during your first phone call. For example, do you remember talking about: [engagement element]?”). Interviews ranged from 13 to 27 min and were audio recorded and transcribed verbatim by research assistants.

### Procedures

*Participants in the engagement intervention+TF-CBT.* In the fall of 2008, the research team visited child welfare offices in the study region to present an overview of TF-CBT and the study. Subsequently, supervisors of caseworkers with children in foster care on their caseload were contacted about potential referrals. Participants were referred by caseworkers, who first obtained passive consent from the child’s biological parents and then obtained foster parent permission to release their contact information to the study team.

Following study referral, research staff contacted the foster parent to set up an in-person meeting. The goal of this meeting was to review foster parent informed consent and child assent for conducting the eligibility screening and, if eligible, study participation. Consent forms clearly stated that foster parent involvement in treatment was not required for study participation (to not bias foster parent engagement findings). Following TF-CBT study procedures, eligibility criteria included youth exposure to at least one traumatic event, one PTS symptom from each of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev., American Psychiatric Association, 2000) symptom clusters for PTSD (i.e., avoidance, reexperiencing, hyperarousal), as well as one additional symptom from any cluster. Youth PTS was measured using the PTSD portion of the Schedule for Affective Disorders and Schizophrenia for School-Age Children, Present and Lifetime Version (Kaufman et al., 1997), a semistructured interview administered to the caregiver and child. Enrollment criteria could be satisfied by either child or foster parent report.

The enrollment goal was 10 youth–foster parent dyads. Due to enrollment challenges and time limits, only seven dyads were enrolled. Five youth were male, and three of the seven were ethnic minorities. All participating foster

parents were female; three were married. The sample included two kinship, one foster-to-adopt, three traditional foster caregivers (i.e., licensed, nonrelatives), and one suitable adult placement (i.e., nonlicensed individual known to the child).

*Foster parent review board.* Following completion of all interviews, findings were presented to and reviewed by a separate group of foster parents from within the study region in the summer of 2009. Use of this review board allowed for some assessment of generalizability of interview findings to the larger population of foster parents. These modified member check procedures allowed for some increased confidence in interpretive validity.

Board recruitment involved asking caseworkers in the study region to identify foster or kinship foster parents who had experience with youth in their care being referred to, or receiving, mental health therapy and who also would be willing to review study findings and openly share their experiences. Caseworkers made first contact. The first author then spoke with all interested individuals by telephone to explain the purpose of the board and to arrange a meeting time. Five agreed to participate and one declined. Participants included three traditional, nonrelative foster parents and two kinship foster parents of diverse ethnic and racial backgrounds.

The study team provided dinner, childcare, travel reimbursement, and a \$25 incentive for participation. The first author gave a 45-min presentation including study goals, the purpose of the review board, and major themes and findings from the foster parent interviews. For the remainder of the approximately 2½-hour meeting, participants were then invited to comment on, disagree or agree with, and elaborate on findings from the qualitative interviews. Board members also were provided with a one-page overview of the telephone and first visit intervention and were asked for specific advice on intervention improvement. All foster parents were encouraged to contribute. The first author facilitated the meeting and used open-ended probes (e.g., “What else?” “Tell us more”) to encourage elaboration and detailed input.

### Caseworker Review Board

Shortly after the foster parent board, a caseworker review board was convened to obtain perspectives on the combined interview and board findings, given that foster parents are uniquely embedded in the child welfare system with its professional requirements, expectations, and potential supports. Caseworkers were recruited through convenience sampling (i.e., were known to the first author) through their involvement in a state foster care mental health assessment program or

by nomination from supervisors of foster care-focused units in the five child welfare offices participating in the study. Criteria were that caseworkers had familiarity with attempting to engage foster parents involved in their child's mental health treatment and, if possible, some familiarity with TF-CBT. Six caseworkers were invited from across offices in the study region, and only one declined. Three of the five were familiar with TF-CBT (e.g., youth on their caseload had previously received TF-CBT); two identified as ethnic minorities. Caseworkers also were provided with dinner, travel reimbursement, and a \$25 incentive. The caseworker board meeting agenda and procedures mirrored those from the foster parent board meeting, although caseworkers were asked to comment on, agree or disagree with, and elaborate on findings from *both* the foster parent qualitative interviews and the reactions from the foster parent board.

### Data Analyses

A combined content analysis coding strategy, involving first directed content analysis and then conventional content analysis, was employed to qualitatively analyze foster parent interviews. First, for primary codes, directed content analysis was used (e.g., Hsieh & Shannon, 2005; Kyngas & Vanhanen, 1999) in that existing theory (i.e., McKay & Bannon, 2004) informed a priori codes developed to cover three of the primary targets of McKay's engagement intervention: (a) perceptual barriers, (b) foster parent identified treatment targets, and (c) concrete barriers. Given study goals (i.e., determining fit of the engagement intervention for foster parents), directed content analysis was chosen, as its goal is to validate or extend theory. One additional a priori code was added to specifically capture any foster parent recommendations for improving the engagement intervention. All three authors then coded transcripts independently and entered their codes into NVivo qualitative analysis software (Version 10; Fraser, 2000). The coding team convened four times via video, telephone conference, and in-person meetings to discuss and resolve any differences in assignment of codes through open dialogue and consensus methods (DeSantis & Ugarriza, 2000; Hill et al., 2005; Hill, Thompson, & Williams, 1997).

Once primary coding was completed using this initial scheme, each author developed subcategory themes (within each of the primary codes) using a conventional content analysis approach (e.g., Hsieh & Shannon, 2005). Conventional content analysis was used because theory about population-specific (i.e., foster parents) experience for these four categories was not available, and our goal was to allow for inductive subcategory development (Mayring, 2000). Each coding team member independently reviewed transcript text and developed a list of

themes. These subcategory themes were then reviewed, discussed, and consolidated by the coding team into a coding scheme for each subcategory. Resulting subcategory codes were then used by each coder to independently code text in each subcategory. Coding differences were again resolved using open dialogue and consensus methods via video and telephone conference.

## RESULTS

Descriptive results from foster parent interviews are presented first, by each primary category. We then present foster parent board reactions to interview themes, and finally caseworker board reactions to the combined foster parent interviews and board findings. In the sections presenting board findings, we highlight areas of agreement with foster parent interviews (for both the foster parent and caseworker board) and with the foster parent board (caseworkers only), as well as unique contributions for each group.

### Potential Perceptual Barriers

Six foster parents noted potential perceptual barriers to participation in the current treatment, with all six reflecting on past experience with mental health services. Beyond past mental health experience, other perceptual barriers were largely unique with limited overlap in the types of perceptual barriers reported by foster parents.

*Past mental health experience.* Six foster parents reported past mental health experiences with the target foster child ( $n=1$ ), other children in their home (most often foster youth;  $n=4$ ), or in the context of their own individual or couples therapy ( $n=3$ ). Foster parents had a mix of positive and negative past experiences.

For two foster parents, past encounters with mental health providers resulted in favorable attitudes toward mental health treatment in general: "I've had such positive experiences with therapy in the past." In contrast, for three other foster parents, enthusiasm about TF-CBT was specifically due to its apparent differences from past experiences with mental health: "I remember telling [the clinician] at some point, 'Wow! This is a very different intake than I've been to before....'" At another point she said, "... other intakes that I've been to, it wasn't very specific as to where we were going or what we were going to be doing." The second foster parent recounted several past frustrations about minimal or complete lack of parent involvement, compared to the explanation of substantial foster parent involvement in TF-CBT:

I've always said, "Why don't I get to be a part of this?" That's been so frustrating. I'd like to be part of the team.

The kids and the family and the staff, they're a team, and the foster parents are just out in left field. Totally. It's like a three-legged stool and we keep falling over. And I've been struggling with that. It makes no sense to me at all that the primary caretaker 24 hours a day isn't included. And I've never understood how come the staff—the therapists—can know so much when they don't even talk to us... when we're not involved.

For one foster parent, early involvement in TF-CBT seemed to engender a more positive therapeutic alliance, such that, "I've shared more with her than I have with others just because I have a relationship with her." A third foster parent, whose past mental health experience was limited to the target child, noted that prior therapy had involved "a lot of skipped times" and "someone that was more of a sounding board than let's deal with real specific issues." In contrast, she seemed pleased that the current treatment would address specific trauma-related concerns.

*Other perceptual barriers.* Barriers mentioned by only one or two foster parents included (a) concern about the level of parental involvement expected (i.e., involvement might be too overwhelming), (b) therapist–foster parent "fit" (i.e., therapist's clinical style, cultural differences in interaction style), (c) distrust of the broader system of which the clinician was viewed to be a part, (d) confusing/unclear information about therapy (i.e., inadequate orientation to who the therapist was, their agency affiliation, too many acronyms), and (e) believing that the child might be more comfortable receiving therapy in a school setting.

A few foster parents provided additional detail about these barriers, including the level of involvement expected and therapist–foster parent fit. When one foster parent reflected on the request that she be an active participant in treatment, she reported thinking, "Man, how much more can I be involved? Thinking about the other counselors at [redacted], we'd spend 15 minutes talking, and I thought, wow, they want me to be more involved." One kinship foster parent viewed the therapist as part of the larger child welfare system that she described as "so cold" and filled with professionals that act like "robots." This caregiver had no prior experience with mental health providers; however, her negative contacts with related systems (e.g., legal, child welfare) seemed to influence her perception of the therapist. This mistrust extended to the therapist, with whom she was afraid to talk openly due to concerns that her disclosures might influence child welfare investigations. She felt the system did not keep her sufficiently involved: "Maybe they tell me something, maybe not... I am directly her family, and she is in my home. Why not explain something to me for respect?" She also reported that her own interactional style and the

therapist's interactional style were not well matched: "English is not my language. I like to talk. I like to see people in the eye and I like to explain more." A second foster parent reported feeling that the therapist's personality and interpersonal style did not work well for her:

[The therapist] may have what the kids need, but I'm not sure she has what I need.... Instead of going to the sessions to be a part of it, now I'm thinking that I better take my book because I'm not going to be getting a whole lot out of it.

### Foster Parent Identified Treatment Priorities

In an attempt to better engage the caregiver, the engagement intervention involves asking caregivers about their own priorities for treatment and concerns about the child. In our sample of foster parents, all seven identified at least one distinct concern. These fell primarily within three categories: (a) behavior management skills ( $n=7$ ), (b) general support for and education related to the foster parent role ( $n=3$ ), and (c) wanting more information about their foster child's background and trauma history ( $n=3$ ).

Foster parents who prioritized behavior management skills requested assistance with a variety of behaviors, including redirection of youth problem behavior to more constructive activities, skills to communicate effectively with an argumentative youth, help managing and understanding unusual behavior (e.g., "goofy, obnoxious," "sleeping on the floor," "parentification"), and knowing when to ignore misbehavior. For one foster parent, identifying and offering assistance with her priority problem had implications for placement stability:

It definitely made me more interested [in treatment]. I guess I could see [treatment] having a positive impact on our family. The goofy, crazy behavior is sort of one of the things that makes [foster family member] really reconsider this placement. [The clinician] mentioned it was a sign of anxiety and that was something we could work on. So that gave me a lot of hope.

Foster parents who requested education and support specific to foster care issues reported interest in better understanding and communicating with youth about challenges unique to being in foster care. For example, one foster parent appreciated learning how to encourage their foster youth to talk openly about visits that the biological parents missed, without using "leading questions" or being invasive:

I used some of what [the clinician] said... "If I had an appointment today with someone I really wanted to see and it got cancelled, I would be upset too and, you know, feel bad about it." And I said, "I enjoyed spending time with you today... even though you're not usually here on Sundays, but I can see why you'd be disappointed."

Notably, all three of the foster parents who identified needing additional skills or support in their role as foster parents also discussed wanting more information about the youth's background and trauma history. One foster parent recalled her conversation with the therapist:

I mentioned a couple [behaviors]...and also said that without background information on [the youth]...it makes it difficult to know how to solve some problems because you don't quite know the history like you do with your own child: "Well, I can see why they're [engaging in the behavior] because they were having nightmares, they're upset about this, or this happened back when they were two."

While discussing treatment priorities, one foster parent reported that she would have preferred advance notice to more carefully consider her priorities, rather than being asked on the phone call for ideas: "I guess I wish that I might have had some time to think of it ahead... so that I could sit down and think of what was bothering [the youth]."

#### Potential Concrete Barriers

Six foster parents mentioned concrete barriers that might impede their ability, or that of other foster parents, to participate in mental health treatment. In general, these concrete barriers fell into three categories: (a) limited appointment times ( $n=2$ ); (b) overwhelming caregiving demands (e.g., multiple appointments, childcare at home) ( $n=4$ ); and (c) treatment convenience, with some preference for in-home or in-school therapy ( $n=3$ ). Foster parents reported wishing that agencies were more conveniently located and that there were more flexible appointment times: "It's hard if someone phones you up and right off the bat just says, 'the only time I'm available is Monday six o'clock.'" In the area of caregiving demands, one foster parent noted, "... between doctors and dentists and the university and you guys, schools and preschool... it just is overwhelming."

#### Foster Parent Suggestions Regarding Engagement Intervention

During the qualitative interview, foster parents were asked for advice to improve engagement during the first telephone and in-person contacts. All seven provided at least one recommendation. Six foster parents mentioned perceptually-related recommendations, including ways to improve early therapist-foster parent communication ( $n=5$ ), and therapy content that should be included ( $n=4$ ). Only one foster parent provided recommendations about concrete barriers, namely, a desire for more convenient treatment locations and a wider range of appointment times.

*Improving early communication/interactions.* Foster parents ( $n=3$ ) recommended improving overall orientation in the early contacts and, if possible, better attention to foster parent and therapist interactional style ( $n=2$ ). During the first call, one foster parent did not understand who the clinician was or why they were calling: "Maybe that person doesn't understand that I don't really know who they are... it's like they know who they are in their organization and they don't understand that I don't know how they fit into my life." She encouraged therapists to clearly explain treatment and avoid or explain acronyms. Two foster parents suggested better orientation to treatment activities and targets, as well as to the role of foster parents in treatment. One noted this would have helped her realize sooner that including another family member in treatment would be valuable: "Light bulbs are coming on saying this is going to be helpful to [the entire family] versus just [the youth]." Another suggested advance provision of therapy materials to foster parents (e.g., book the therapist would read with the child). Based on their early interactions with their study therapist, two foster parents requested that therapists pay more attention to, or inquire about, the foster parent's preferred interactional style. Recommendations here echo findings reported in the Perceptual Barriers section (e.g., potential cultural mismatch on preferred communication style, interpersonal style differences).

*Therapy content.* Four foster parents made suggestions about therapy content that would be beneficial. Reiterating concerns expressed to their therapist, three suggested including information about the child's history (e.g., specific trauma exposure) and advice for navigating the child welfare system to receive more information about the child's history. One noted,

I don't know if this is possible, but to say, "Okay, [the youth] has experienced this type of trauma."... At least if I knew that, then we would know a little bit more specifically how to handle that. I just don't know exactly what we're dealing with. So putting [the youth] in certain situations, is that a good situation to put [the youth] in? [Foster family member] raises his voice sometimes, I can see a shutdown there immediately so it's like, "Okay, was this something where somebody did that and you got whacked across the head?"

Two foster parents recommended that therapy include skills training. One particularly appreciated the child welfare-specific parenting information she had received: "... the information about foster children was so important because it was something I didn't remember understanding before... I've been able to apply all of these things to *all* of our kids." Referring to the usefulness of behavior management skills, the same foster parent



added, “I suggest [them] for every foster parent whether they think they need it or not!”

### Foster Parent Board

*Reactions to findings from qualitative interviews.* After reviewing major themes from the foster parent interviews, board members agreed with the finding that perceptual barriers were common and potentially most problematic for treatment engagement. Specifically, board participants agreed that clinicians should invest more time and effort into conveying how foster parents themselves can benefit from participating in the TF-CBT treatment. For example, they recommended that clinicians more explicitly articulate that TF-CBT also focuses on supporting the foster parent and alleviating their stress. One foster parent noted that this support was critical to enable foster parents to support the child: “It’s like [on airplanes]: put the oxygen mask on the mom first, then let her help the baby.”

Board members indicated that *how* the clinician communicated about foster parent involvement was important, reflecting McKay’s focus on building a collaborative relationship in the first contact (McKay & Bannon, 2004):

If the clinicians ask and invite the foster parents to work with them and the child to be a complete team to assist the child in overcoming their problems—that would be a lot better. In the past, I’ve really heard from a lot of clinics that they don’t want us to be involved. If they invite us, we’re probably going to be a lot more open about it.

*Additional considerations.* Kinship foster parents on the board elaborated on interview findings, suggesting that clinicians consider differences between kinship and traditional, nonrelative foster parents. As one explained: “If you’re a foster parent, you’re signing up for the program. If you’re a relative caregiver, you just picked up the phone one day. Man, it’s your whole life: my Master’s program, my job, my whole family changed overnight.” Another noted, “Not only did you not sign up for it, your spouse didn’t, your kids didn’t... you know, sometimes just the awareness of that will go a long way.” They further highlighted that kinship foster parents often navigate complicated dual relationships with the youth’s biological parents, may have strained relationships with extended family, and that kinship foster parents might need support associated with these experiences.

*Suggested improvements.* In modifying the engagement phone call, foster parent board members reiterated some aspects of the McKay intervention: that clinicians should clearly introduce themselves and their affiliated agency and clarify that the present call would

extend beyond logistics (e.g., suggested wording: “I’d like to talk with you a little bit about therapy planning and ask you a few questions; when might be a good time to call you?”). One unique suggestion was to describe how treatment might progress if the foster parent was not involved, to contrast this with the benefits of participation and the association between involvement and positive youth outcomes. A second unique suggestion, when working with kinship foster parents, was to tailor the engagement intervention to, and acknowledge the unique, added stress of being a kinship caregiver. For all foster parents, it was recommended that clinicians validate the challenges and associated stress: “When I signed up to be a foster parent, I think I knew what I was getting into probably better than most, but still it continues to expand and expand beyond what I had imagined.” As another noted, “I never really get to a point where validation doesn’t feel good. ... Validation is probably one of the biggest things that foster parents and caregivers need.”

Also consistent with McKay’s approach to problem-solving concrete barriers, board members stated that clinicians should be careful to be sympathetic and not “guilt producing:”

If someone says, “I recognize that this may not be that easy for you to commit to. I want to see if there are ways that I can really help you figure this out.” Then that feels different than if someone says, “If you’re going to commit to this, then this is the time commitment—I hope you’re not going to have a problem with that.”

To improve the first visit, board members recommended that clinicians spend time simply listening to foster parents and problem solving their most pressing concerns (i.e., instead of spending the majority of the time with the child), which is consistent with both the McKay intervention and TF-CBT. To invite open communication about perceptual barriers, board members suggested that clinicians ask, “Is there anything about this that is different from what you expected?” or “Is there anything here that’s not working for you?” They highlighted the need for clinicians to explicitly invite foster parents to give feedback or ask for clarification, as many may not want to be perceived as disrespectful of the clinician’s role or expertise by voicing concerns, uncertainty, or confusion about treatment goals, processes, or progress. It was also suggested that it might be helpful to involve a third party (e.g., caseworkers), to whom the foster parent could more comfortably express concerns and ask questions.

### Caseworker Board

After reviewing findings from the foster parent interviews and the foster parent board, caseworkers reiterated the

importance of emphasizing that treatment will benefit *both* foster parents and their children. They agreed that elements of the first visit intervention (e.g., handouts related to an identified need, clearly explaining and linking paperwork to treatment) were likely engaging elements for foster parents. They also provided a number of recommendations for improving the engagement intervention. As with both groups of foster parents (those who participated in the engagement intervention and those on the board), most recommendations were focused on perceptual aspects.

*Suggestions to better address perceptual barriers.* After reviewing the overview of both engagement interventions, caseworkers recommended flexibility in delivering the engagement intervention to allow tailoring to family and individual differences. For example, with families of color and/or kinship caregivers, caseworkers suggested *beginning* the call by asking about past mental health treatment experiences (vs. beginning the call asking about the caregiver's own priorities for treatment), as many may have had past mental health experiences that were not viewed as culturally appropriate. As one noted, "Models haven't traditionally been for children of color, and so we're like, 'Well, that's for white people.'" If not addressed first, past experiences may result in skepticism about cultural fit, which could affect foster parent perception of other elements of the engagement intervention (e.g., discussion of foster parent-identified needs). Caseworkers suggested specific wording, such as asking if treatment "spoke to their family values" and/or if the past clinician understood and respected their "family dynamic." In addition, when working with families of color, they recommended specifically saying, "This treatment *is* for your child."

*Suggestions for the first phone call.* Caseworkers noted that the warmth and tone of the phone-based interaction were also important factors: "The colder and more clinical this comes off, the less it's going to feel like, 'This is for my child.'" One unique suggestion was for clinicians to be careful with the term "evidence-based" when talking about TF-CBT and instead explain the meaning of the term, as child welfare-involved families may misinterpret this term as referring to the legal system's need for evidence.

*Suggestions for the first visit.* Caseworkers suggested that some foster parents may not be comfortable or prepared to discuss their top priority treatment need(s) in the first session, and that this should be revisited in subsequent sessions after rapport with families is further developed. They also suggested that clinicians be open to broader needs that the foster parent might have, even if

their need was "not hugely aligned with the original goals of TF-CBT." Caseworkers suggested that clinicians openly discuss possible perceptual barriers to normalize them: "If I were in your shoes right now, I might be sitting here thinking, 'What is this about?' or 'Why am I here?' ... or 'Just in case you're having the thought ...'" Clinicians should also acknowledge how uncomfortable it may be to discuss past experiences with mental health and concerns about the current treatment. Recommendations included explicitly stating that there was no penalty for talking openly (i.e., even given ongoing legal involvement for most child welfare cases) or for expressing dislike of services or disinterest in receiving them.

One suggestion to facilitate open dialogue about treatment concerns was to encourage foster parent–caseworker communication about treatment. They noted that clinicians may want to encourage foster parents to communicate frustrations or concerns to the caseworker, who could then relay information to the clinician or organize a team meeting for all involved parties to problem solve together: "If you ever feel that therapy is not going the way you might want it to, or if you are frustrated for any reason, I want to invite you to speak with your caseworker anytime, and the caseworker can talk with me, so that I can be more helpful to you."

Caseworkers also stated that clinicians should repeatedly revisit the rationale for foster parent involvement, both in the first and in subsequent sessions, and with greater frequency than clinicians might expect is needed. Similarly, clinicians should revisit engagement questions routinely throughout treatment. At the first session, some foster parents may not know their answers to these questions yet (especially to queries about what they like or dislike about treatment). However, they may have valuable feedback in subsequent treatment sessions that would help with retention in treatment if asked intermittently as treatment progressed.

*Suggestion for better addressing concrete barriers.* Caseworkers recommended that clinicians collaborate and communicate more with the child's caseworker in order to offer some assistance in problem solving identified concrete barriers. Caseworkers noted that communication was particularly important when foster parents or children were not showing up for appointments or there was a problem in therapy.

## DISCUSSION

This study examined the fit of McKay's engagement intervention with foster parents, with the goal of identifying any need for population-specific modification. Our findings provide support for the importance of inquiring about and discussing perceptual barriers to engaging in

mental health care. Foster parents who participated in the qualitative interviews and members of the foster parent and caseworker boards focused more on perceptual barriers to engagement than on concrete barriers. The most commonly identified perceptual barrier was past negative experiences with mental health care, which is a primary focus of McKay's engagement intervention (McKay et al., 2001). Other perceptual barriers were also mentioned, but with less consistency or overlap across participants (e.g., therapist-foster parent "fit"), likely due to our small sample size.

### Past Experience With Mental Health

For the group of foster parents who participated in the pilot, past mental health care experiences, both negative and positive, seemed to provide a lens through which TF-CBT was viewed. Specifically, foster parents who reported *negative* experiences often had not been included in therapy for this child or other foster children and were frustrated by those experiences. Thus, the engagement intervention, which involved asking about past experiences and addressing negative ones, may have been particularly important for engaging these parents. Discussions that highlighted the contrast between their past negative experiences (i.e., not involved) and the current treatment (i.e., expectations of high involvement) appeared to generate considerable enthusiasm about TF-CBT. For other foster parents who reported having *positive* experiences, their past encounters with mental health providers seemed to set the stage for interest in treatment and willingness to participate in TF-CBT.

The caseworker board ( $N=5$ ) noted that negative past mental health experiences might be particularly problematic for some foster parents of color who may not have viewed past treatment as culturally appropriate. For example, one foster parent who participated in the pilot noted frustrating cultural differences in communication style between herself and the current therapist. Caseworkers suggested that clinicians may want to begin the engagement intervention by directly discussing the cultural appropriateness of the treatment. Both Szapocznik's foundational engagement work (e.g., Szapocznik et al., 1988) and McKay's more recent work (e.g., McKay & Bannon, 2004) have shown that engagement interventions resulted in better engagement outcomes (i.e., initial attendance; retention) with families of ethnic and cultural minority. However, as ethnic minority clients are more likely to drop out of mental health treatment (e.g., Lau & Weisz, 2003), more attention may need to be paid to foster parents' perception of the cultural appropriateness of the mental health treatment itself. To our knowledge, foster parent perspectives regarding the cultural appropriateness of treatment have not been

examined specifically, despite the overrepresentation of ethnic minority children in foster care (DHHS, 2009).

### Foster Parent-Specific Tailoring: Broaden Possible Focus for Mental Health Need

Many of the recommendations for tailoring the engagement intervention to the foster care population corresponded with existing elements of the McKay intervention or of TF-CBT (e.g., involving the caregiver; identifying and addressing caregiver's treatment priorities). However, the foster parent and caseworker boards suggested that the engagement intervention could be improved for foster parents by placing greater emphasis on how the treatment could be beneficial specifically for this specific caregiver group. Recommended treatment targets included (a) understanding and managing unusual and/or abuse-related behavior in the target child and other foster children, (b) receiving support and education about caring for and communicating with children about their biological parents (e.g., when parents do not attend scheduled visitation), and (c) learning more about the child's history and experience of trauma and/or abuse. As in other studies (e.g., Dorsey et al., 2012), our small sample of foster parents reported very limited knowledge about the trauma history of children in their care. If clinicians identified these possible treatment targets during the engagement intervention, foster parents might be able to better recognize the potential benefits of treatment, feel better understood by the clinician, and anticipate that the clinician could be helpful with foster care-specific needs.

In addition to tailoring the treatment description to be more foster care-specific, the foster parent board recommended that clinicians validate and praise foster parents for doing what is an often difficult, ever-expanding, and thankless job. Board members highlighted stressors inherent to the kinship caregiver role, including difficult and/or complicated relationships with close family members who played some part in the child's abuse or neglect. It may be particularly important that clinicians be aware of and sensitive to the unique aspects of the kinship caregiver experience given that children in kinship placements now represent one-fourth of the foster care population, with the proportion in kinship placements continuing to grow (Annie E. Casey Foundation, 2012).

### Improving Clarity in the First Contact

As in some of McKay's work (e.g., McKay et al., 1996), this study highlighted the need for clinicians to better clarify their role, explain the purpose of the first phone contact, and more explicitly outline treatment goals and logistics. One foster parent illustrated the importance of clarity by reporting that for the first few minutes of the

phone call, it was unclear who was calling and why—there were too many confusing acronyms and questions. Another foster parent stated a desire to have known ahead of time that the conversation would focus on determining their goals and needs for treatment. To this end, one option may be to utilize supplemental communication tools (e.g., online, postal mail, e-mail) to provide families with the goals of the first contact in advance so that, if interested, caregivers can preview the call agenda and prepare in advance. For caregivers comfortable with technology, internet based methods present viable options for facilitating clarity in early treatment contacts.

### Recommendations for How to Talk about Engagement

The foster parent and caseworker boards provided valuable recommendations about *how* to talk about or introduce elements of the engagement intervention. For example, foster parents emphasized that when requesting foster parents' weekly treatment participation, clinicians should first acknowledge hectic schedules and competing demands for time. Foster parents and caseworkers also recommended specific wording and strategies that might increase foster parents' willingness to ask questions or express hesitation about treatment while conveying to foster parents that such feedback is appropriate. Finding ways to encourage clients to talk openly about their treatment-related concerns, so that they can be addressed early in treatment, is a challenge that extends well beyond the foster care population. In an attempt to better elicit treatment concerns and signs of treatment dissatisfaction, Miller, Duncan, Sorrell, and Brown (2005) developed the Session Rating Scale, a brief session-by-session measure designed to encourage routine conversations about alliance and satisfaction. Although our study was limited to two early treatment interactions (i.e., first phone call and first in-person visit), ongoing discussion regarding treatment satisfaction may be beneficial for maintaining open communication and for retention in treatment.

### Concrete Barriers

Given the wide-ranging responsibilities of foster parents, which can include ongoing involvement with caseworkers, making arrangements with biological parents, school-related meetings, and medical and mental health services, it was not surprising to find that concrete barriers were mentioned. Of interest, concrete barriers were mentioned less frequently than perceptual barriers by foster parents and both boards. Among the concrete barriers mentioned, foster parents noted the challenge of adding another demand to their weekly schedule. In a few cases, foster parents were able to participate in

treatment due to a particular support or circumstance (i.e., spouse's flexible job, foster parent in-between jobs), when otherwise, regular participation would have been challenging. Two foster parents were clearly interested in TF-CBT, but their enthusiasm was dampened by frustration over limited appointment time options and office locations, and the inability for study therapists to provide services in-home or in-school. When talking about concrete barriers, caseworkers suggested that clinicians liaise with them early in treatment when barriers are identified. Unique to child welfare-involved families, clinicians have an ally in the caseworker; if involved early, the caseworker can often help address concrete and other barriers (e.g., subsidizing transportation to sessions; child care assistance), increasing the likelihood that the foster parent may be able to participate.

### Limitations

This study has a number of limitations, the first of which is the small sample size. The enrollment goal (i.e., 10 dyads) was already modest, but the study time line and the challenging recruitment limited enrollment to seven dyads. Second, because foster parents could not always distinguish between details of the first phone call and the first visit, the study may have benefited from an additional qualitative interview (e.g., one interview after the first call, one interview after the first in-person visit). Third, the study eligibility interview that preceded the engagement interventions may have been engaging in and of itself, as the treatment was described in some detail and linked to university resources. Despite these limitations, using qualitative data to inform needed revisions proved valuable, particularly given our ability to review interview findings with foster parent and caseworker boards. Even when implemented on a small scale, our qualitative data guided tailoring and enhanced our confidence that the engagement intervention would have relevance for this population.

### Conclusions

Attention to engagement, and particularly to potential perceptual barriers that may hinder engagement, may have two important simultaneous effects: building interest and enthusiasm about treatment and mitigating potential barriers to participation. The findings in this study suggest that McKay's engagement intervention, with its perceptual focus and problem solving of concrete barriers, is applicable for the foster parent population with some minor tailoring to better target population-specific needs. By involving consumers and stakeholders early in the intervention development process and including patient preference, studies like this one allow both for strengthening the application of mental health

interventions in diverse care settings and for the identification of personalized elements, which follow NIMH strategic plan objectives 3.3 and 3.4 (DHHS, 2008). Including a targeted focus on engagement, with foster-care-specific tailoring, may be an effective method to enhance foster parent engagement in TF-CBT and in other EBT. By increasing foster parent engagement, children in foster care may be more likely to attend and be retained in treatment as well as benefit from active caregiver involvement, as involved caregivers can reinforce therapy content and skills at home. As such, methods for achieving higher levels of foster parent engagement hold promise for increasing the likelihood that mental health treatment will be effective for a group of children and adolescents with a high level of mental health need.

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