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Walden University

College of Social and Behavioral Sciences

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Kerry Morrell

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Review Committee
Dr. Donna Dimatteo-Gibson, Committee Chairperson, Psychology Faculty
Dr. Frederica Hendricks-Noble, Committee Member, Psychology Faculty
Dr. John Schmidt, University Reviewer, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2020

Abstract

Rural Community Mental Health Agency's Strategies to Involve Parents in Children's Psychosocial Treatment

by

Kerry Morrell

MS, University of Kansas, 2005

BS, Wichita State University, 1978

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Psychology in Behavioral Health Leadership

Walden University

February 2020

Abstract

The increased prevalence of children's mental illness and the need for community-based treatment with enhanced outcomes is propelling the need to improve children's mental health treatment to the forefront of children's mental health policy reform. Including parental involvement in children's mental health treatment increases the possibility of improved treatment outcomes. However, policy, social, attitudinal, and fiscal factors have affected the strategies used to overcome the barriers to facilitating parental involvement. The purpose of this in-depth qualitative case study was to understand the strategies that one mental health agency used to overcome the barriers to facilitating parental involvement in the psychosocial treatment of their children. The Baldrige excellence framework served as the study's conceptual framework. Data collection occurred from semistructured interviews with 5 members of the agency senior leadership team, agency archival data, and public and government websites. These data were triangulated and then analyzed using inductive NVivo coding and thematic analysis software. Results indicated that policy, social, funding, and attitudinal factors affected strategy barriers and supports; leadership, communication, services, and measurement were important elements in overcoming the barriers, and that although some recommended strategies required additional funding, others did not. Implementing strategies to overcome parental involvement barriers in their children's psychosocial treatment may create social change by redirecting children's mental health treatment to a dual-focus (parent-child) treatment process and developing a long-term sense of well-being that reflect improved children's mental health outcomes and have the potential to reduce future health care costs.

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Dedication

This study is dedicated to my late parents, John and Helen Barnes, for transferring their valuable tacit knowledge of family, parenting, and unconditional love to me. You taught me to never be afraid to try, and I will always be grateful for your love. Thanks to my children, JR and Amanda, Corrie and Rus, Aaron and Alison, Mike and Lindsey, and Jenni for appreciating and forgiving my parenting adventures; To my grandchildren, Reilly, Collin, Liam, Lili, and James, you bring amazing joy to my life. Most importantly, I thank my husband, Rich, because without his support, understanding, and encouragement, this project would never have occurred. Finally, to the mental health providers of the agency and the children whom they serve, may you never tire of serving, and may your efforts be blessed with parents and children growing together.

Acknowledgments

I would like to thank my family and friends for supporting me through this journey. To my doctoral committee members, Dr. Donna DiMatteo-Gibson and Dr. Hendricks-Noble, thank you for your guidance and support through the consulting capstone experience. To my URR committee member, Dr. John Schmidt, a special thank you for the additional support you provided that ensured this journey was successful. I will always be appreciative of your time and contributions. To my editor, Barb Elwert, your gift and love for editing were invaluable to me, and I will always be grateful for your insights. Finally, I thank my client organization's leaders for their support and collaboration through this process.

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Section 1a: The Behavioral Health Organization

In the early 1960s, the U.S. government commissioned community mental health centers (CMHCs) to treat patients with mental illness in the least restrictive environment possible (Chow & Priebe, 2013). The CMHC, the site for this study, had compiled documents recording its history, but the documents' authorships, dates of authorship, and dates of last updates were unknown. According to the agency website and the CMHC report *Agency Beginnings* (n.d.), in 1961, a public mental health center began serving the residents of two counties in a rural Midwestern region of the United States. Information from *Agency's Beginnings* revealed that by 1979, agency services had expanded to the current six-county service area. To maintain the privacy of the participants, the CMHC that served as the mental health agency is referred to as the agency throughout the text, and no documentation retrieved from the agency's website is acknowledged in the reference list.

According to *Agency's Beginnings* (n.d.), the agency initially provided mental health services to adults and only minimal services to children. According to the agency document, *State Focus, A Family Centered Community Based System of Care for Children with Severe Emotional Disorders* (n.d.), in 1994, the agency was one of five CMHCs to receive a federal grant to start a system of care for children with severe emotional disturbances and their families. Case management; attendant care; and Medicaid waiver services (i.e., support for parents and wraparound care) are examples of the current support services resulting from that grant. According to the agency's November 2019 *Clients Open in Case Management* data report, the Children's Mental

Health Program currently serves more than 496 children younger than 18 years who are experiencing impaired behaviors in the home, school, or community setting. This increased enrollment has coincided with state, national, and global increases in the demand for child mental health services (Haine-Schlagel & Walsh, 2015; National Alliance of Mental Illness [NAMI], 2018).

As mentioned on the agency's website, it continues as a nonprofit CMHC that serves the adult and child residents of six counties in the Midwestern United States. All six counties are in rural areas, and their populations share the following characteristics (U.S. Census Bureau, 2017):

- Poverty levels between 13% and 18%.
- Residents younger than 18 years: 21% to 26%.
- Residents not receiving a high school degree or general educational development (GED) degree: 8% to 11%.
- Residents younger than 65 years and uninsured: 8% to 11%.

With only 14% to 22% of the population obtaining a college degree or higher (U.S. Census Bureau, 2017), retaining licensed staff in rural areas is challenging (Hernandez, Armstrong, Green, & Johnson, 2017; van Vulpen, Habegar, & Simmons, 2018).

Development of mental health center services, deinstitutionalization of patients, and use of psychotropic medications achieved the federal government's goal of decreasing health care costs and providing patient care in the least restrictive environment (Chow & Priebe, 2013). However, according to the agency's vision and mission statements on its website, the agency took patient care in the six-county service area one

step further. In addition to services meeting the population's needs in the least restrictive environment, the agency's service providers helped individual clients to improve their defined quality of life.

The mental health standards of care call for organizations to center their plans of care around the clients (Commission on Accreditation of Rehabilitative Facilities [CARF], 2019). Clients are to engage with providers in setting their own goals for improvement. The agency's mission statement on its website states that this course of improvement occurs through operationalizing its mission statement of implementing, advocating for, and coordinating quality mental health care, services, and programs.

The agency serves under a board of directors that governs the center's employee structure of the executive director (ED), program directors, therapists, case managers, attendant care workers, and children's psychosocial group staff (CARF, 2019). The ED also oversees the administrative directors of auxiliary services such as information technology (IT), quality improvement, and billing (personal communication, March 15, 2019). The [name of state redacted] Department of Aging and Disability Services statutes require the ED to provide leadership in overseeing the quality of services provided and the cost-effective and efficient management of resources. The ED develops the agency senior leadership team (ASLT) to determine and direct long- and short-term goals (Burns, 2012; Yue, Men, & Ferguson, 2019).

Figure 1 represents the agency's organizational chart (2016), which was adapted by the accreditation assistant to reflect the current organizational composition. Long- and short-term agency goals are implemented through the functioning of the agency structure.

The ED provides leadership and management guidance for the organization, especially the ASLT:

- Medical director (MD): Provides general oversight of the agency and manages the medication management licensed prescribers.
- Chief financial officer (CFO): Oversees accounts receivable and provides financial feedback for oversight by the board of directors.
- Director of quality and strategic innovation (DQI): Manages quality improvement through the Lean process and oversees the accreditation process.
- Director of human resources (DHR): Manages HR and social media.
- Director of clinical services (CD): Manages the mental health clinical program as well as substance abuse and crisis services.
- Director of adult community support services (DAS): Manages the mental health adult case management, adult psychosocial program, and supported housing programs.
- Director of children's community-based services (DCS): Manages the children's case management program, including the psychosocial group program and child attendant care.
- Information technology (IT) manager: Oversees all aspects of computer technology, including maintenance of software, hardware, privacy, and security.
- Executive administrative assistant: Serves as privacy officer and head office manager, manages the credentialing process, and assists the ED as instructed.

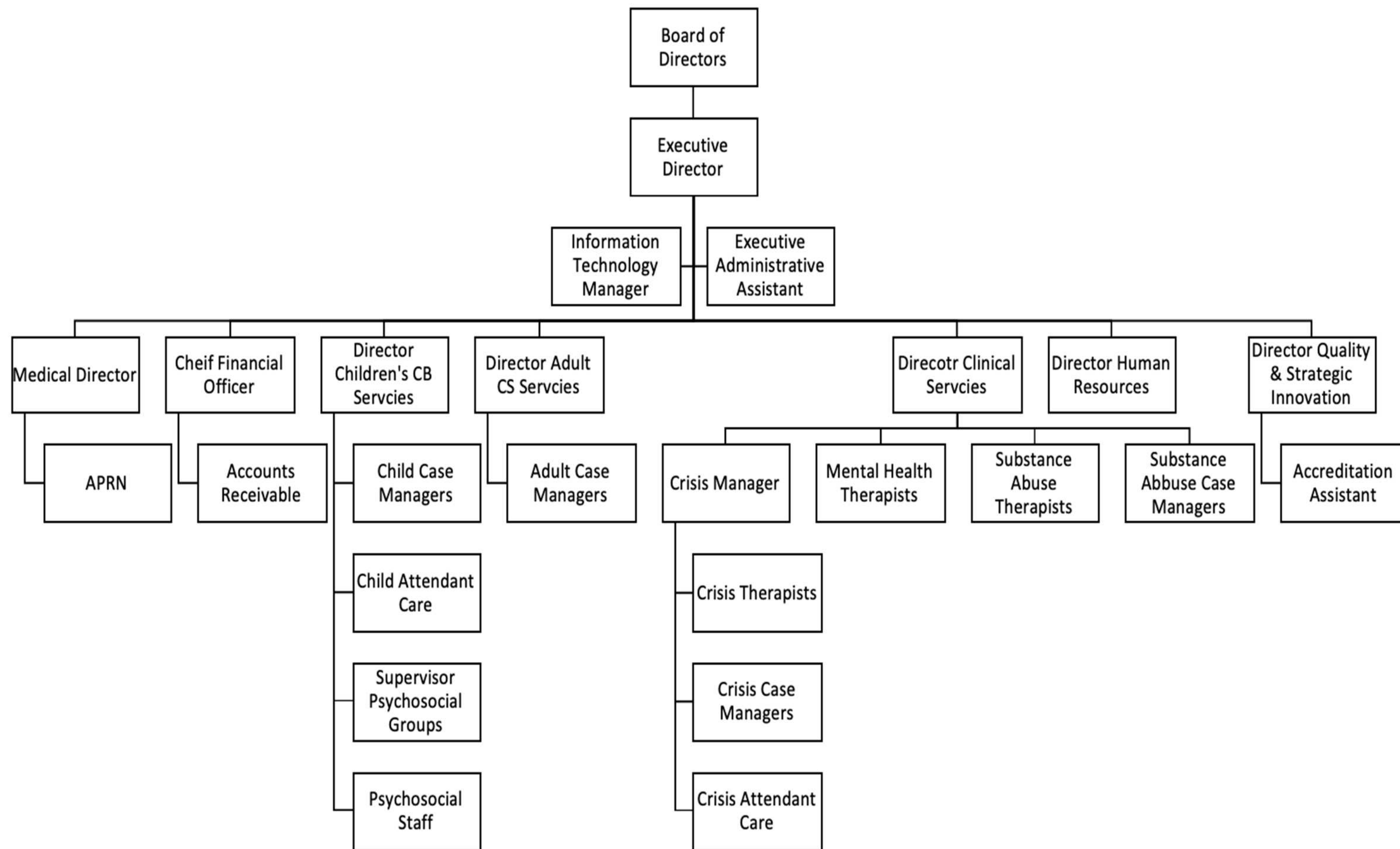

Figure 1. Organizational chart (2016) adapted to reflect the current structure of the agency.

Medication management services are offered by the advanced practice registered nurse (APRN) and supervised by the MD. Agency policies and procedures require that the medication management services of state-licensed psychiatric APRNs be used to evaluate and prescribe medication to adults and children. Information on the agency's website indicates that it offers outpatient mental health, substance abuse, and crisis services through licensed psychologists, clinical social workers, and professional counselors. These licensed provider services are available for individuals, families, couples, and crisis stabilization. Figure 2 reflects the clinical program structures.

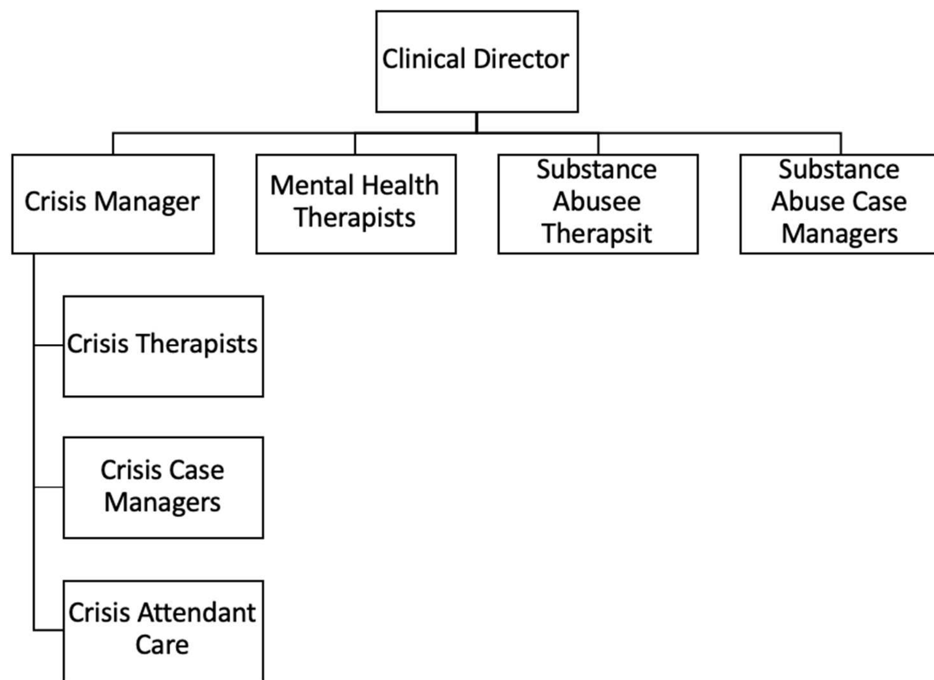

Figure 2. Clinical services program organizational chart (2016) adapted to reflect the current structure.

Hughes, Gorman, Ren, Khalid, and Sana Clayton (2019) reported a deficit in opportunities to access mental health care in rural parts of the United States. One service delivery mechanism designed to address this need is hybrid psychiatric care, a

combination of in-person and telepsychiatry services (Hughes et al., 2019). These services have the potential to impact rural mental health care positively. According to the agency's policies and procedures, with client-informed consent, services are provided through televideo media.

The [name of state redacted] Department of Aging and Disability Services has called for a mechanism to deliver mental health care services through the community-based service of case management. According to the agency's policies and procedures, along with the Centers for Medicaid and Medicare (CMM, 2019), when clients meet the eligibility requirements, case management is available for adult and child mental health services, adult and child crisis services, and adult substance abuse services. The agency website describes the focus of case management services as advocacy, coordination of care, and development of positive coping skills to enhance daily living and the quality of life.

Figure 3 reflects the agency's Children's Community-Based Services Program. As described on the agency's website, attendant care as well as psychosocial educational groups are available at the agency to support case management services. Attendant care assists clients in their activities of daily living, and psychosocial groups are offered to strengthen the skill sets of adults and children. Public schools and primary care physicians' offices have been requesting the integration of mental health services (Askell-Williams, 2016; Sherman & Hooker, 2018; van Vulpen et al., 2018), but the agency currently has no policies or procedures regarding the integration of mental health services in schools or primary care physicians' offices.

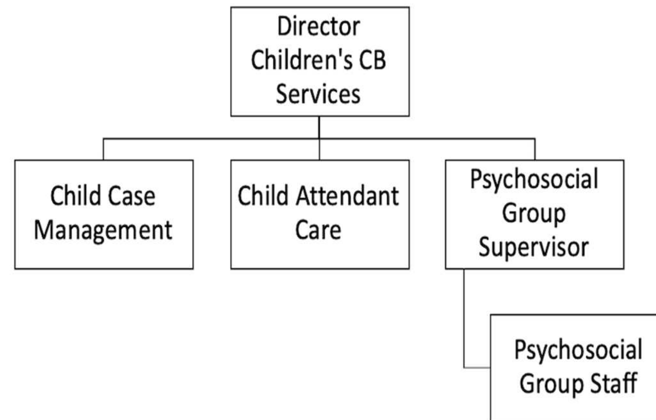

Figure 3. Children's community-based services program organizational chart (2016) adapted to reflect the current structure.

Practice Problem

Within the United States, there are fewer resources to meet the changing needs of families. The increase in service demand and the concomitant decrease in resources have revealed the need for policy and systemic reform within children's and family services (Bruns et al., 2014; McLennan, 2015; McMullan & Watson, 2017; Mendenhall & Frauenholtz, 2014; Pecora, 2017). The increased prevalence of children's mental illness and the need for community-based treatment with enhanced outcomes have driven efforts to improve children's mental health treatment to the forefront of this reform (Haine-Schlagel & Walsh, 2015; NAMI, 2018). Carman et al. (2013) stated that involving patients and families in their children's treatment offers a favorable pathway toward "better-quality health care, more efficient care, and improved population" (p. 223). Palinkas et al. (2017) asserted that successful outcomes from evidence-based practices

might depend on the harmonization of the desires and preferential rankings of the individuals who mold, provide, and take part in services.

According to the agency's November 2019 *Clients Open in Case Management* data report, the demand for children's mental health services is increasing and is coinciding with the rising demand in state, national, and international populations (Jones et al., 2014; Reardon et al., 2017). Many parents who are facing poverty, drug abuse, and leave restrictions from work do not engage in their children's mental health treatment (Acri et al., 2017; Romanowicz et al., 2019; Watson, Frank, & Krumpos, 2015). Reardon et al. (2017) identified poor access to services as a barrier to treatment for parents nationally and internationally. Knowing about and understanding mental health problems, the help-seeking process, stigma, and costs were specific barriers to parents who wanted and needed access to services (Knopf, 2018; Reardon et al., 2017; Salloum, Johnco, Lewin, McBride, & Storch, 2016).

Parents have expressed confusion because of the lack of service coordination between and among the multiple agencies providing services to their children (Acri et al., 2014; Colvin, 2017). Feeling blamed, judged, not listened to by therapists, unsupported by the formal system, and dissatisfied with mental health treatment have been viewed by researchers as challenges to parental involvement (Haine-Schlagel & Walsh, 2015). Stadnick, Haine-Schlagel, and Martinez (2016) argued that parental involvement increases the possibility of improved behavior by children transferring from one setting to another. Isobel, Allchin, Goodyear, and Gladstone (2019) said that policy reform for improved outcomes must include the voices of the children and their parents. Dowell and

Ogles (2010) and Tchernegovski, Hine, Reupert, and Mayberry (2018) asserted that involving parents in children's mental health treatment improves outcomes. Bee et al. (2014) and Garland, Lebensohn-Chialvo, Hall, and Cameron (2017) stated that establishing access to and engagement in children's mental health services occurs through a variety of social, fiscal, policy, and attitudinal factors. As the agency's November 2019 *Clients Open in Case Management* data report indicated, the number of children enrolled in child mental health services is increasing. It was important to identify the strategies that the agency used to overcome the barriers to facilitating parental involvement in the psychosocial treatment of their children.

Purpose

The purpose of this qualitative case study was to understand the strategies that one mental health agency used to overcome the barriers to facilitating parental involvement in the psychosocial treatment of their children. Studying the effect of the agency's workforce, leadership, plans and policies, clients, measurements, analysis, knowledge management, and operations on parental involvement in their children's psychosocial treatment occurred through the guidance of the Baldrige excellence framework (Baldridge Performance Excellence Program, 2017). The policies and regulations governing the provision of services, funding streams, and operational processes were examined.

Significance

The results of this study will be of value to the practice of mental health organizations because even though enrollment in children's psychosocial treatment

programs is increasing, barriers to parental involvement in their children's treatment remain (Jones et al., 2014; Reardon et al., 2017; Romanowicz et al., 2019). Reardon et al. (2017) noted that parents are crucial gatekeepers for accessing children's mental health services. Stadnick et al. (2016) stated that parental engagement not only facilitates treatment attendance but also improves behavioral outcomes and generalizes these improved outcomes to nontherapeutic settings. Sanders, Kirby, Tellegen, and Day (2014) asserted that the best strategy to influence positive mental health pathways is to engage and empower parents with the ability to create enriched environments in which their children can grow.

The agency's Children's Community-Based Service Program, in conjunction with the clinical program, was the specific focus of this study. Collins (2015) stated that when agencies understand their own strengths and challenges, they have the opportunity to build on their wins and prioritize their resources toward meeting challenges. Understanding the strengths of the agency could help the ASLT to plan new evidence-based interventions strategically, support directors to ensure that strengths are evident across the agency's multicounty locations, promote knowledge management between and among providers, and identify interagency and community partner service silos throughout the agency's service area (Acri et al., 2014; Colvin, 2017; Hamovitch, 2018; Hernandez et al., 2017; Yap et al., 2018). Understanding challenges also gives agencies the opportunity to make changes that can result in improving mental health practices (Collins, 2015). These opportunities for change may occur by identifying training needs,

necessary policy changes, lack of interagency service coordination, and state and national advocacy needs (Acri et al., 2014; Garland et al., 2017; Sipe et al., 2015).

The study's potential for social change lies in the ability of mental health leaders to evaluate what and how their programs involve parents to address the call for reform in children's mental health services (Acri et al., 2014; Isobel et al., 2019). The reform also calls for the professionals who provide children's mental health services to not only build interagency relationships but also change the culture by deconstructing organizational silos and rebuilding cooperative and integrated pathways that support parents in meeting the mental health needs of their children (Acri et al., 2014; Colvin, 2017; Hernandez et al., 2017).

Social change also can take place when mental health leaders address their data capacity and data infrastructure (Hernandez et al., 2017). The ability to collect the necessary data is important at the agency level (Boyle et al., 2019; Duncan, Boyle, Abelson, & Waddell, 2018; Hernandez et al., 2017). The capacity to provide state and national data on the effectiveness of parental interventions is needed, as is the identification of areas in need of improvement. Mental health leaders require data to attest to the cost efficiency and efficacy of services of children's mental health programs. Without these data, children's mental health programs remain challenged to capture and retain funding (Duncan et al., 2018; Hernandez et al., 2017).

Social, fiscal, policy, and attitudinal factors distinctly ordain access to and engagement in children's mental health services (Becker et al., 2015; Forman-Hoffman et al., 2017; Garland et al., 2017; Reardon et al., 2017). Leaders' assessments of identified

program strengths and weakness can aid in strategic planning and work at the state and national levels to influence policies and regulations that support parental involvement interventions (Sipe et al., 2015). Financial confidence gained from insurance coverage also may reduce parental stress enough to improve their sense of well-being (McMorrow, Gates, Long, & Kenney, 2017). Mental health leaders have the opportunity to lobby for Medicaid expansion (CMM, 2019; Garfield, 2019; Garland et al., 2017; Hoagwood, Atkins, et al., 2018; Neufeld, Jones, & Goodyer, 2017). The improved mental health status of parents receiving insurance coverage can strongly influence their children's sense of well-being (McMorrow et al., 2017).

Policies and practices that work toward the prevention of mental illness, the promotion of parental access to children's services, and a decrease in the culture of parental blame are needed (Reardon et al., 2017). Acri et al. (2014) stated that assessments of parents occur simultaneously with the initial evaluations of the children. Parental mental illness often causes harm to the family, and measures need to be taken to ensure the treatment of children and parents (Acri et al., 2014). Policies and regulations that promote the involvement and treatment of parents in children's psychosocial treatment offer parents the option of providing enriched environments from which children can build pathways leading to positive mental health (Sanders et al., 2014).

Nature of the Study

The research method for this project was qualitative, and the design was an in-depth case study. The chosen method and design allowed the researcher to determine and understand the strategies used by the agency to involve parents in their children's

psychosocial treatment. The focus of the case study was the process, that is, how was it done, what the outcome was, and whether it worked (Ravitch, 2016).

The data for the study came from a variety of sources: semistructured interviews; archival data from financial records, minutes of meetings, training logs, third-party payer and quality improvement audits; and public and government websites. Requests for data reports and archival data were directed to members of the ASLT as e-mails and face-to-face communication. Thematic analysis of the generated data took place and was then triangulated with archival as well as public and government website data. Thematic analysis identifies patterned meanings (i.e., themes) across data sets (Saldaña, 2016), whereas the triangulation of data sources increases the trustworthiness of studies through the convergence of information from different sources (Ravitch, 2016).

Summary

The agency is a government CMHC in the rural Midwestern United States that seeks to help clients to improve their quality of life. Part of its mission is to coordinate efforts and offer quality mental health services. Through the leadership of the ED and the program directors, the agency has recognized and acknowledged the value of parental involvement and the growing challenge of involving parents in the psychosocial treatment of their children. This qualitative case study was conducted to examine the strategies that the agency used to overcome the barriers to facilitating parental involvement in their children’s psychosocial treatment. The sources of data were triangulated during the analysis. Section 1b provides details about the agency’s

organizational profile, the key factors that were of strategic importance, and background and contextual factors supporting the need for the study.

Section 1b: Organizational Profile

Introduction

According to the agency's November 2019 *Clients Open in Case Management* data report, even though the number of children seeking mental health services increased from 380 in 2015 to 496 in 2019, barriers to facilitating parental involvement existed. Yap et al. (2018) reported that despite parents playing an important role in reducing the risks of depression and anxiety in their children, easily distributed parental interventions that are evidence based and cost effective have been missing. Stadnick et al. (2016) stated that parental engagement not only facilitates treatment attendance, but also improves behavioral outcomes and generalizes these improved outcomes to nontherapeutic settings. Although parental involvement improves children's mental health outcomes, barriers to facilitating parental involvement remain (Acri et al., 2014; Becker et al., 2015; Carman et al., 2013; Dowell & Ogles, 2010; Haine-Schlagel & Walsh, 2015; Hernandez et al., 2017; Isobel et al., 2019; Palinkas et al., 2017; Reardon et al., 2017; Weiss, Gross, & Moncrief, 2016).

The purpose of this study was to understand the strategies that the agency used to overcome the barriers to facilitating parental involvement in the psychosocial treatment of their children. The study was guided by one research question (RQ): What strategies did the agency use to overcome the barriers to facilitating parental involvement in the psychosocial treatment of their children? This section addresses the organizational profile of the agency to identify the key factors affecting the practice problem.

Organizational Profile and Key Factors

The organizational profile identified the key factors affecting the practice problem, gaps in critical information, processes, and results (Baldridge Performance Excellence Program, 2017). When identifying the strategies used to overcome the barriers to facilitating parental involvement, it is essential to consider factors such as services, the agency's mission and vision statements, suppliers, and partners. The two key factors in this study were the strategic challenges and then the clients and other stakeholders.

Organizational Profile

According to the agency's website, it is a nonprofit CMHC serving the outpatient mental health and substance abuse treatment needs of adults and the mental health treatment needs of children within a six-county area of the Midwestern region of the United States. The vision of the agency is to improve the quality of life of the clients whom it serves. The website also states that the mission of the agency is to provide, advocate for, and coordinate quality mental health care, services, and programs.

The agency's website states that providing and coordinating quality mental health services occur through several psychiatric outpatient services:

- Adult and child medication management.
- Adult and child mental health therapy (individuals, couples, families).
- Adult and child case management and attendant care.
- Adult substance abuse counseling and case management.
- Crisis intervention and crisis case management and attendant care.

- Adult and child psychoeducational groups.

Services are agency and community based. According to the September 2017 and January 2018 minutes of the agency's board of directors, the ASLT are staying true to the vision and mission by taking strategic steps to acquire a new electronic medical records (EMR) system through the assistance of lean quality improvement processes and answer the request from public schools for mental health support by placing therapists and case managers in the schools.

Leaders use the size, purpose, and type of industry of their agencies to determine the most appropriate organizational structure (Sun, 2019). Other factors that determine organizational design involve delegating tasks and understanding how work is approved, knowing who manages whom and the responsibilities of each department, and knowing where final decisions are made (Devaney, 2019). Geography and function are two types of organizational structure that could fit with the rural organization's size, purpose, and the mental health industry (Devaney, 2019; Sun, 2019).

The geographic structure allows organizations to be near the clients whom they serve (Devaney, 2019). For example, CMHCs serve different regions within the state, and each center then reports to the state. This structure allows the centers to adapt their services to their clients based on poverty rate, educational level, cultural context, and so on. Although it encourages decentralization, the state directs CMHCs through policies and regulations. At the agency level, a structure based on geography facilitates the tailoring of services to the population in the six counties; however, it also creates financial challenges (ED, personal communication, March 15, 2019). The low rate of

reimbursement for clinical services, for example, makes it difficult to fund more than one clinical supervisory position (Behrens, Lear, & Price, 2013; CMM, 2019; Delmatoff & Lazarus, 2014; Graaf & Snowden, 2017; Hamovitch, 2018).

The functional structure (Devaney, 2019) is the more common style of organizational structure. CMHCs and community-based services can be organized through a top-down flow chart, with the highest-ranking officer at the top and the direct service provider at the bottom (Burns, 2012; Davoren, 2019; Sun, 2019). Within the functional structure, the providers are grouped according to discipline or assigned tasks (Davoren, 2019). According to the agency's organizational chart (2016), which was adapted by the accreditation assistant to reflect the current structure, and CARF (2019), medication providers report to the MD; therapists report to the clinical program director; crisis case managers report to the crisis program manager; and children's mental health case managers, attendant care workers, and psychosocial group's supervisor report to the children's program director (CARF, 2019). This type of structure allows the providers to develop specialties that can increase productivity (Davoren, 2019).

A well-designed organizational structure results in effective communication (Sun, 2019). CARF (2019) standards state that supervision may occur through the supervisors' participation in treatment or service planning meetings, organizational staff meetings, side-by-side sessions with the clients being served, or one-on-one meetings between supervisors and the individuals providing direct services. CARF standards and the [name of state redacted] Department of Aging and Disability Services (2019) require one person to be designated coordinator of services for person-centered plans of care. The agency's

comprehensive treatment plan policies and procedures require therapists to be responsible for the construction of plans of care and the coordination of services.

According to the agency's policies and procedures regarding team meetings, therapists must meet with case managers weekly or biweekly to problem solve difficult cases. Case managers record the meeting notes. There are no policies, procedures, or processes in the agency regarding one-on-one supervision between the program director and staff or regularly scheduled meetings with program staff.

One challenge of the functional structure design is that the rigid group boundaries can interfere with communication between or among groups and inhibit innovation (Davoren, 2019). To address communication challenges, organizations can adapt the functional structure by using direct contact (Burns, 2012; Mirela, 2016). The direct contact functional structuring occurs when the staff of one functional department (e.g., therapists) directly contact the staff of another functional department (e.g., case managers) as the need arises.

The organizational chart (2016) described earlier in the study reflects the current top-down management structure. The ED leads the agency, with program directors in the middle and direct service providers at the bottom. Staff (e.g., case managers, therapists, medication providers) report to their respective directors, and direct contact communication is encouraged (CARF, 2019). Secondary to the lack of hierarchy and bureaucracy in a small agency, direct contact can give supervisors the opportunity to implement ideas championed by staff immediately (Barnett, Rosenberg, Rosenberg, Osofsky, & Wolford, 2014; Sanders et al., 2014).

CARF standards (2019) mandate that organizations identify their leadership structures and the responsibilities of each level of leadership. The agency's organizational chart (2016) reflects the current structure regarding services that affect parental involvement: ED, program directors, therapists, case managers, attendant care workers, and children's psychosocial group staff. The ED (personal communication, March 15, 2019) also oversees the administrative directors of auxiliary services such as IT, quality improvement, and billing. The ASLT comprise the ED and program directors, who, in turn, determine and direct the long- and short-term goals of the agency. The ED presents the goals to the board of directors, whose members then approve them or make further recommendations (CARF, 2019).

Key Factors

The Baldrige excellence framework (Baldridge Performance Excellence Program, 2017) identifies and assesses the "key strategic challenges and advantages in the areas of health care services, operations, societal responsibilities, and workforce" (p. 6). Clients and stakeholders are evaluated through the framework by identifying the key stakeholders, their expectations, and the requirements and expectations between stakeholders.

Strategic challenges. Delving into the strategic challenges of finances, technological needs, geographic proximity, accessibility, and costs involved in overcoming the barriers to facilitating parental involvement in their children's psychosocial treatment has helped researchers to clarify challenges and advantages (Acri et al., 2014; Hamovitch, 2018, Hernandez et al., 2017; van Vulpen et al., 2018; Yap et al.,

2018). Discussing the financial sources of support for the services offered across six counties, the benefits and challenges of IT, ways to maintain accessibility in six rural counties, and the actual costs of parental involvement was invaluable to understanding the practice problem.

Researchers have identified some of the barriers facilitating parental involvement in their children's psychosocial services as financial issues, stigmatization, poor access to services, and knowledge deficits in recognizing mental health needs and ways to access services (Hamovitch, 2018; Hernandez et al., 2017; Reardon et al., 2017; Salloum et al., 2016). Garland et al. (2017) contended that accessing and engaging in children's mental health services can involve social, fiscal, policy, and attitudinal influences. Parents are key stakeholders in their children's mental health services (Reardon et al., 2017). Third-party payer sources regulate the service eligibility criteria and the fee scales, thus also making them key stakeholders (CMM, 2019). Therefore, stakeholders are the second key factor.

Stakeholders. Stakeholders are individuals or groups whose interests or participation can affect or be affected by organizational practices or policies (Burns, 2012). In the current study, the stakeholders were the agency and its employees, clients, and community partners; managed care organizations because of their enforcement of government regulations; and private third-party payers. Evaluating the agency's ways of tracking contact with parents, including parents in the treatment planning process; training staff; and communicating between services and the proper billing procedures to address parental needs clarified the processes that encouraged or discouraged parental

involvement. Determining the best locations for parenting classes, how often they should occur, and who should present them required a clear understanding of the clients. Having a working knowledge of the fee-for-service payment structure and third-party payer service regulations further defined the stakeholders' views of parental involvement (CMM, 2019).

Organizational Background and Context

According to the November 2019 *Clients Open in Case Management* data report, although enrollment in the agency's Children's Mental Health Program increased from 380 in 2015 to 496 in 2019, barriers to facilitating parental involvement in their children's psychosocial treatment have persisted. Improving children's mental health treatment has moved to the forefront because of the increased prevalence of mental health issues and the need for community-based treatment with improved outcomes (Haine-Schlagel & Walsh, 2015; Hamovitch, 2018). Dowell and Ogles (2010), Isobel et al. (2019), and Tchernegovski et al. (2018) found that child-parent treatment was more effective than child-only treatment protocols. Dowell and Ogles emphasized that regardless of a child's age and presenting problem, child-parent treatment was more effective than child-only treatment. Tchernegovski et al. asserted that treating children and parents together led to improved outcomes by maintaining a balanced focus and not taking sides with either the parents or the children. Isobel et al. found that on an international scale, treating children with their families improved the children's mental health outcomes.

One might ask if involving parents in the treatment of their children's mental health can improve the quality of life. Bode et al. (2016) and Salloum et al. (2016) found that when parents felt empowered to manage their children's mental health, their stress levels decreased, and they were better able to access services. Sanders et al. (2014) suggested that the best way to improve the pathways to children's positive mental health occurs by involving the parents. Managing stress and developing positive mental health improve the quality of life (McMorrow et al., 2017; Reynolds & Crea, 2016; Salloum et al., 2016). According to the agency's mission statement on its website, its vision is to improve the quality of life of the clients whom it serves.

Children cannot identify their own mental health needs or access treatment, so they depend on their parents to engage in mental health services (Hernandez et al., 2017; Wozney, Radomski, & Newton, 2018). Children under the age of 18 years comprise 20.6% to 25.9% of the service area population, and 8.5% to 11.4% of the total population in the agency's service area under the age of 65 years are uninsured (U.S. Census Bureau, 2017). Across the agency's six-county service area, based on U.S. Census Bureau (2017) data, salaries range between $32,521 and $45,790, and each household has an average of 2.08 to 2.55 persons. These facts coincided with van Vulpen et al.'s (2018) findings that nationwide, children in rural areas are living in families experiencing financial challenges, are at higher risk of being uninsured, and have limited community resources. The educational level of the population in the agency service area is described as 13.7% to 21.7% having a bachelor's degree or higher and 8.6% to 11% not completing high school or receiving a GED.

A master's degree or higher is required by the [name of state redacted] Behavioral Sciences Regulatory Board for therapist positions. Hamovitch (2018),; Jones, Ku, Smith, and Lardiere (2014); and Watanabe-Galloway, Madison, Watkins, Nguyen, and Chen (2015) stated that recruiting and retaining the licensed professionals needed to provide program services remains a challenge for rural areas. Table 1 contains the demographics of the six-county service area affecting parental involvement in their children's psychosocial treatment.

Table 1

Demographics of the Population in the Six Counties Served by the Agency

County served by agency	% < 18 yr.	% < 65 yr. uninsured	Average household income	Average no. of people/ household	% with bachelor's degree or higher	% with high school diploma or GED
1	22.8	8.8	$40,911	2.37	18.3	9.6
2	24.3	8.5	$43,867	2.48	18.9	8.6
3	25.9	10.2	$41,529	2.55	21.7	9.5
4	23	11.8	$45,790	2.23	16	11
5	24.8	10.7	$42,146	2.41	19.2	9.1
6	20.6	11.4	$35,321	2.08	13.7	10.2

The agency is regulated through federal, state, and private third-party payers (CMM, 2019); the state licensing board (name of stated redacted] Behavioral Sciences Regulatory Board, 2019); federal laws (i.e., Health Information Portability and Accountability Act [HIPAA]); Occupational Safety and Health Act [OSHA]; CMM, 2019); and industry accreditation standards (CARF, 2019). Regulations affecting parental involvement the most are those governing treatment reimbursements and, because of the rural area, provider licensing requirements (Hamovitch, 2018; Hernandez et al., 2017; Ravitch, 2016).

The agency's fiscal resource planning occurs at the ASLT level (CARF, 2019). Predicted fees for service and other projected revenue against operational and facility costs determine program budgets (CARF, 2019). Based on the minutes of board meetings, the CFO presents the annual budget to the board members for approval. Section 3 discusses the specific effects of the fee-for-service structure on the agency's budgeting.

Management of and compliance with federal and state health care policies are achieved through various agency programs. CARF (2019) calls for organizations to have policies and procedures to protect clients' privacy and ensure their safety. Federal laws of the U.S. Department of Health and Human Services, such as HIPAA and OSHA, support this standard. The agency maintains a compliance officer to ensure concurrence with regulatory and policy mandates, and ways to address any ethical issues that might arise (CARF, 2019). The Association of Community Mental Health Centers website (n.d.) can serve as an avenue for directors to stay apprised of upcoming state and federal policy changes and the ways that these changes may be implemented in CMHCs across their respective states.

Definitions of Terms

Understanding the terms used in an in-depth qualitative case study is paramount to its successful completion (Ravitch, 2016). The following definitions clarify the data collection, analysis, and interpretation protocols used in the study:

Agency: Agency refers to the CMHC that was the research site.

Agency Senior Leadership Team (*ASLT*): Members of the ASLT are the ED, CFO, MD, CD, DAS, DCS, DQI, and DHR.

Children: CMM (2019) referred to children, including preschool, school age, and adolescents younger than 18 years as clients.

Licensed providers: Mental health providers who require a minimum of master's level of education ([name of stated redacted] Behavioral Sciences Regulatory Board, 2019; CMM, 2019);

Managed care organizations: These organizations are the insurance companies that are contracted to manage the state Medicaid insurance program (CMM, 2019).

Mental health providers: These nonlicensed employees provide mental health services (CMM, 2019);

Parental involvement: Parental involvement refers to engaging in the treatment process through attitudinal (i.e., belief that treatment benefit outweighs the cost) and behavioral (i.e., seeking meaningful interactions within and outside therapy sessions) means (Becker et al., 2016);

Parents: Parents refer to children's primary caregivers. They can be foster parents, grandparents, aunts, uncles, and others.

Program directors: The program directors are responsible for supervising the direct service providers in their designated programs.

Psychosocial treatment: This type of treatment refers to any mental health treatment, including therapy, community-based services (case management), and groups, available to children.

For the purpose of this study, the term *children* referred to individuals ages birth to 18 years, and the term *parents* refers to biological or nonbiological primary caregivers. The same was true for the service providers. The term *licensed provider*s referred to employees who required more education and received higher salaries than mental health providers, employees who did not require licensing. Understanding whether parental involvement meant engaging in parental interventions in the treatment plans or only bringing the children to services affected the selected parental involvement strategies. Identifying key players in the agency aided in data collection and interpretation (Ravitch, 2016).

Summary

Enrollment in the agency's Children's Mental Health Program is expanding, but barriers to facilitating parental involvement in their children's treatment remain. The organizational profile presented details about the agency to better understand the agency's efforts to implement its vision and mission. Identifying the agency's services was completed in conjunction with its current strategic goals.

The leadership structure also was discussed in terms of geographic and functional style, along with the use of direct contact to improve communication. The agency had a top-down organizational structure. Discussion took place in regard to the two key strategic challenges of funding services and meeting stakeholders' needs.

The organizational background and context were presented. Levels of poverty and education, insurance coverage, support systems, and age affected parental involvement in their children's mental health treatment. Demographic information of the specific six

counties served by the agency was included in the section. Details about the agency's management of federal, state, and private third-party payers, along with industry standards, were discussed. Also included were definitions of terms relevant to the study. In Section 2, the background and approach of the study are discussed.

Section 2: Background and Approach: Leadership Strategy and Assessment

Introduction

The number of children enrolled in psychosocial treatment is increasing in local, state, national, and international populations (Herman, Reinke, Thompson, & Hawley, 2019; Reardon et al., 2017). Martin (2019) stated that the suicide rates of adolescents have doubled in the last 8 years. Approximately 27% of youth ages 13 to 28 years live with a mental health condition, 11% have mood disorders, 10% have behavioral or conduct disorders, and 8% have anxiety disorders (NAMI, 2018). Being connected to and participating in mental health services are acutely reliant on social, fiscal, policy, and attitudinal factors (Acri et al., 2014; Becker et al., 2015; Bee et al., 2014; Forman-Hoffman et al., 2017; Garland et al., 2017; Jones & Tullt, 2017; Neufeld et al., 2017). The increased prevalence of children's mental illness and the need for community-based treatment with enhanced outcomes has moved improving children's mental health treatment to the forefront of mental health reform (Haine-Schlagel & Walsh, 2015; NAMI, 2018).

Because of age-appropriate deficits in children's ability to recognize the need for and access mental health services, parental involvement is essential for improved outcomes in children's mental health programs (Reardon et al., 2017; Wozney et al., 2018). Carman et al. (2013) asserted that involving clients and families in their treatment offers a favorable pathway toward "better-quality health care, more efficient care, and improved population" (p. 223). Isobel et al. (2019) and Palinkas et al. (2017) noted that successful outcomes from evidence-based practices might depend on the harmonization

of the desires and preferential rankings of those who mold, provide, and take part in services.

Parental involvement with children in psychosocial treatment is a defined problem in the agency's Children's Mental Health Program (DCS, personal communication, September 7, 2018). Many parents, particularly parents who are facing poverty, drug abuse, and leave restrictions from work, do not engage in their children's mental health treatment (Acri et al., 2017; Romanowicz et al., 2019; Watson et al., 2015). Research has indicated that feeling blamed or judged, not being listened to by therapists, not feeling supported by the formal system, and lacking satisfaction with mental health treatment are challenges to parental involvement (Haine-Schlagel & Walsh, 2015). Some parents' untreated mental illness is another barrier to their participation in their children's treatment (Acri & Hoagwood, 2015; Kim, Szigethy, Meltzer-Brody, Pilowsky, & Verhulst, 2013). Meeting these challenges may increase the avenues for parents to become actively involved in their children's mental health treatment.

The purpose of this study was to understand the strategies used by this agency to overcome the barriers to facilitating parental involvement in their children's psychosocial treatment. The researcher used the Baldrige excellence framework (Baldridge Performance Excellence Program, 2017) as the conceptual framework to study the effect of the agency's workforce, leadership, strategies, clients, measurements, analysis, knowledge management, and operations on overcoming the barriers to facilitating parental involvement in their children's psychosocial treatment. Research has indicated that it is important to use a systemic perspective when assessing strategies relevant to

policies and regulations that governed the provision of services, funding streams, and operational processes (Bee et al., 2014; Forman-Hoffman et al., 2017; Garland et al., 2017; Hernandez et al., 2017; Isobel et al., 2019; Reardon et al., 2017). Data were collected from semistructured interviews with five members of the ASLT; archival data on financial records, training logs, third-party payer and performance improvement audits; and a review of public and government websites (Ravitch, 2016). Section 2 presents discussions of the supporting literature, sources of evidence, leadership strategies and assessments, clients and population served, and the analytical strategy.

Supporting Literature

The literature review began by using keywords in associated disciplines to identify various databases. Initially using the databases of PsycINFO, PsycEXTRA, and SocINDEX with full text, the researcher searched the disciplines of social work, psychology, and counseling for relevant literature. These databases provided a foundation of intervention types of strategies that addressed parental involvement. Some identified articles were searched further and accessed through Google Scholar.

The search in nursing, health sciences, and business and management disciplines occurred through the databases of Business Source Complete, Psychiatry Online, Science Citation Index, Journals@Ovid, Science Direct, Complementary Index, and MEDLINE. Additional intervention types of strategies, along with minimal administrative ideas, resulted from this search. Finally, in searching the health sciences and public policy and administration disciplines through the databases of ERIC and SAGE Journals, the researcher found several studies of policy and regulatory information that affected

parental involvement. This administrative information, along with the intervention strategies, provided a well-rounded picture of current practices for parental involvement in children's psychosocial treatment.

The keywords used for the literature review search started with *parent*, *involvement*, *parental involvement*, *parenting classes*, *participation*, *engagement*, *child*, *mental health*, *psychosocial*, and *treatment*. This list organically grew to include *management*, *leadership*, *personnel*, *administration*, *policies*, *strategies*, *operations*, *techniques*, *evidence-based treatment*, *practice*, *health*, *family*, *implementation*, *interventions*, *funding*, *financial*, *safety*, *process*, and *outcome measurement*. Expanding the search term *child* included *preschool children*, *school-age children*, *and adolescence*. Further expansion occurred using Boolean phrases and a search for all words with the root of *child*, *parent*, *treat*, *fund*, *finance*, *administer*, *engage*, and *involve*. The scope of the literature review was comprehensive in looking at clinical as well as administrative factors that could influence parental involvement within the treatment of children's psychosocial needs.

The literature supported the call for children's mental health policy and systemic reform (Anderson, Howarth, Vainre, Jones, & Humphrey, 2017; Bee et al., 2014; Haine-Schlagel & Walsh, 2015; Hernandez et al., 2017; Isobel et al., 2019; McMorrow et al., 2017; Pecora, 2017; Reardon et al., 2017). Approximately 27% of youth ages 13 to 28 years live with mental health conditions, 11% of youth have mood disorders, 10% of youth have behavior or conduct disorders, and 8% of youth have anxiety disorders (NAMI, 2018). Approximately 50% of students age 14 years and older with a mental

illness drop out of school. Suicide is the leading cause of death among youth ages 10 to 14 years (NAMI, 2018). Martin (2019) stated that the suicide rates among adolescents have doubled in the last 8 years. Less than 10% of children assessed as needing mental health services obtain services within 3 months, and less than half of those children diagnosed with severe emotional disorders ever get treatment from the proper mental health providers (Behrens et al., 2013).

Although the Affordable Care Act of 2012 created an opportunity to expand children's mental health services, the system of children's mental health services remains underdeveloped and faced with funding shortages, and it reflects a disconnection between institutions and the families whom they serve (Behrens et al., 2013; Graaf & Snowden, 2017; Reid, Green, Parsons, & Rothoiz, 2018). Addressing numerous associated and embedded levels, such as the macroenvironment (e.g., states); organizations or systems (e.g., community mental health clinics); programs (e.g., children's mental health and partnering children's welfare programs); practitioners (e.g., therapists and case managers); and clients (e.g., children and their parents), generally improves the outcomes and sustainability of particular interventions (Forman-Hoffman et al., 2017). Carman et al. (2013) believed that patient and family engagement was the answer to spiraling health care costs, limited budgets and mandates, and the provision of services, regardless of the clients' ability to pay.

CARF (2019) stated that families are encouraged to participate in the services offered and that they may be sought for involvement when their input affects treatment outcomes. Children who have a mental illness or are experiencing mental health

symptomology most often do not have the tools or resources to access the necessary interventions (Reardon et al., 2017; Wozney et al., 2018). Because of children's age-appropriate barriers to obtaining treatment, they rely on their parents, who are expected to recognize their children's mental health problems and then advocate for and assist their children in receiving the appropriate services. Parental involvement does not end at helping the children access services; rather, it continues into the children's treatment.

Sanders et al. (2014) asserted that the best strategy to influence positive mental health pathways is to engage parents and empower them to create enriched environments in which their children can grow. Dowell and Ogles (2010) found that child-parent treatment was more effective than child-only treatment. Stadnick et al. (2016) posited that parental engagement not only facilitates treatment attendance but also improves behavioral outcomes and generalizes these improved outcomes to nontherapeutic settings. The parents and their children need to be at the center of the children's mental health system. Being in the center positions them to become part of the solution, shifting their role from becoming less passive to being more active, informed, and influential in their health care treatment (Carman et al., 2013; Isobel et al., 2019; Palinkas et al., 2017).

Nanninga, Jansen, Knorth, and Reijneveld (2015) found that children's enrollment in psychosocial care was associated with family social support and parenting skills. Children's psychosocial problems could mediate these associations. Haine-Schlagel, Fettes, Brookman-Frazee, Baker-Ericzen, and Garland (2012) stated that in the treatment of children with disruptive behavior disorders, therapist-directed treatment strategies toward parents occur an average of 44% of the time spent in therapy sessions. Therapists

were more likely to involve parents when the children experienced more severe behavioral problems, the parents reported increased and suppressed caregiving strain, and the therapists were more experienced (Haine-Schlagel et al., 2012).

Haine-Schlagel et al. (2012) and Stadnick et al. (2016) pointed out the need to train less experienced therapists to focus on strategies that involve the parents. Palinkas et al. (2017), on the other hand, reminded providers that successful outcomes of evidence-based practices may depend on the harmonization of the desires and preferential rankings of those who mold, provide, and take part in services. Palinkas et al. cautioned that the implementation of new evidence-based practices requires knowledge of the principles and processes of implementing and sustaining innovative practices within CMHCs.

Parent participation engagement (PPE) is an example of an evidence-based treatment that involves the parents. PPE requires attitudinal and behavioral engagement (Becker et al., 2015). Attitudinal engagement refers to the parental belief that treatment benefit outweighs the cost, whereas behavioral engagement refers to seeking meaningful interactions within and outside therapy sessions (Becker et al., 2015). PPE institutes "active independent and responsive contributions from the parent during therapy sessions, including sharing opinions, asking questions, participating in session activities, and following through on the parent or child-directed between-session activities" (Haine-Schlagel & Walsh, 2015, p. 134).

Parental engagement is the most effective at the time of assessment (Lindsey et al., 2014). As the therapists assess the children, they also should be evaluating the systems impacting the children's behaviors. Acri et al. (2014) and Kim et al. (2013)

stated that even though untreated mental health problems in parents harm the family unit, parents often do not entertain services addressing their emotional well-being. Acri et al. believed that concentrated efforts are needed to ensure that workforce providers, administrative structures, and funding regulations are fortified and collaborative in nature to meet the needs of children and parents. These concentrated efforts present opportunities for shifts in health care policies and practice through the use of integrated care services within mental health care, medical health care, and educational systems (Dawson-McClure et al., 2015; Neufeld et al., 2017; Sherman & Hooker, 2018; van Vulpen et al., 2018).

Garfield (2019) asserted that reform must include economic and policy factors that affect parental involvement. In January of 2014, the Affordable Care Act required states to expand Medicaid (Garfield, 2019); however, the U.S. Supreme court ruled that states could opt out of Medicaid expansion. Garfield stated that 2.5 million adults ages 19 to 64 years have fallen into a coverage gap, earning too much to qualify for Medicaid but not enough to qualify for subsidies for marketplace coverage. Without insurance, parents face financial barriers to seeking mental health treatment, a situation that can result in adverse effects on their children (Pruett, Pruett, Cowan, & Cowan, 2017). In addition, laws through the federal and [name of state redacted] Department of Aging and Disability Services require that all children receive services, regardless of their ability to pay, leaving CMHCs with the financial task of absorbing the cost of providing services.

Carman et al. (2013) noted that involving patients and families in their children's treatment offers a favorable pathway toward "better-quality health care, more efficient

care, and improved population health" (p. 223). Better quality health care, more efficient care, and improved population health reflect the CMM's (2019) Value-Based Program's (VBP) three-part aim of better care for individuals, better health for populations, and lower costs. VBPs are part of CMM's broader quality strategy to reform the delivery and payment of health care, so it is a new paradigm for CMM's delivery and reimbursement structure. VBPs are a shift in focus from the current fee-for-services volume model to the provided services value model. Wagner (2014) noted that physician groups have successfully navigated the shift from volume to value by using outcome measures to clarify organizational strengths and weaknesses. This knowledge then directs the decision-making process in collaborating with insurers.

VBPs are on the horizon for mental health services. Children's mental health services will be required to provide VBPs, which require efficient definitions and measures of program outcomes. Mental health leaders will need to define VBPs by measuring their mental health service outcomes.

In summary, the increasing enrollment of children in mental health services, in conjunction with the lack of funding as well as barriers to facilitating parental involvement, has put children's mental health services in the forefront of mental health care reform. This reform needs to occur on all systemic levels, including local, state, national, and international. Updating policy by receiving feedback from clients, providers and funders; providing training in evidence-based practices; expanding funding to be more inclusive of parental involvement and support; screening and treating parents for signs of mental illness; tracking parental attitudinal and behavioral engagement;

measuring program outcomes; and assessing for providers' hidden agendas, attitudes, and judgments are elements of understanding the strategies used to overcome barriers to facilitating parental involvement in their children's psychosocial treatment.

Sources of Evidence

Sources of evidence for this study included semistructured interviews with members of the ASLT, a review of public and government websites, and archival data. Documents that already existed in the agency were known as archival documents (Ravitch, 2016). Examining the archival materials was essential in providing a history and a contextual understanding of parental involvement in children's services. Archival data included, but were not limited to, financial reports, annual reports, board meeting minutes, ASLT meeting minutes, third-party payer and quality improvement audits, and training logs.

Interviews with members of the ASLT allowed the researcher to understand individual leadership perspectives, describe the strategies that the agency used to overcome the barriers to facilitating parental involvement in the psychosocial treatment of their children, and develop full detailed and contextualized descriptions of ASLT experiences and perspectives of the strategies (Ravitch, 2016). The interview data were analyzed using thematic coding to identify the emergent themes (Saldaña, 2016). Information gleaned from financial reports, training logs and materials, audits, meeting minutes, and so on, and the information gathered from public and government websites were triangulated with the coded qualitative data.

Leadership Assessment and Strategic Planning

Assessment

Burns (2012) stated that an organization's mission, values, and strategic directions are decided upon by a board of directors and top-level management. CARF (2019) stated that an organization's board of directors is responsible for "ensuring that the organization is managed effectively, efficiently and ethically by the organization's executive leadership through defined governance accountability mechanisms" (p. 41). The [name of state redacted] Department of Aging and Disability Services (2019) statute posits that the CMHC is licensed with the county in which it serves.

The agency's bylaws indicate that its governance is to be provided by a governing board appointed by the county commissioners. Membership on this board includes two members from each county, with each member serving 3 years. The function of the board is to endorse the agency's mission goals; approve bylaws, policies, and procedures regarding the agency's processes; agree to annual plans as required by the state's legislative statues and the agency's budget; implement general supervisory authority over the operations of the agency, including the power to hire, appraise, and fire the chief executive officer (CEO); and serve as the definitive authority with the agency to resolve policy disputes. The board of directors is required to meet four times a year, with one gathering to be the annual meeting. The agency's CEO is its ED, and the ED alone reports to the board of directors.

CARF (2019) instructs organizations to identify their leadership structures. In large organizations, the leadership teams comprise CEO, CFO, chief informational

officer (CIO), and so on; they do not include managers at the program director level (Burns, 2012). At the time of this study, the agency had no policies or procedures that defined the ASLT. According to the agency's organizational chart (2016), the ASLT holds a leader or director from each auxiliary and clinical department: ED, CFO, MD, CD, DCS, DAS, DQI, and DHR.

Transformational leaders earn the respect and trust of followers, express current industry and agency challenges, and lead followers to collective support of their new visions (Lussier, 2015; Yue et al., 2019). Witmer and Mellinger (2016) stated that within the framework of resilience, transformational and servant leadership styles are factors that ensure the success of leaders in navigating funding changes. Wilson (2018) believed that servant leadership is the most effective way to achieve results, drive change, and make a difference. She described servant leadership as mentoring, investing in followers, giving others the gift of time, and putting service first (Wilson, 2018). Emotionally and behaviorally intelligent leaders build strong relationships (Delmatoff & Lazarus, 2014; Fenwick, Brimhall, Hurlburt, & Aarons, 2019). Wang, Owens, Li, and Shi (2018) reported that the followers of leaders who model humility experience more relational energy and less emotional exhaustion.

Mirela (2016) stated that leadership may be defined as autocratic or democratic. Autocratic leaders make the decisions, direct employees in tasks, and supervise staff closely (Drouin, Müller, Sankaran, & Vaagaasar, 2018; Lussier, 2015; Mirela, 2016). CARF (2019) requires internal audits to ensure compliance with policies and regulations. Case management service fees are paid at a higher rate (in relation to cost of service) than

therapist service fees (CMM, 2019). Audit processes require closer supervision of staff members' documentation to help to prevent regulatory violations that could result in funding being denied or recouped (CMM, 2019).

Democratic leaders include staff in the decision-making process, determine what to do or not do, and do not supervise staff closely (Drouin et al., 2018; Lussier, 2015; Mirela, 2016). Laissez-faire leaders address problems only as they arise (Lussier, 2015). These management styles are appropriate for clinical services programs because regulatory compliance is essential, but not as budget driving as the case management services.

Research has indicated that through relationship building and clear communication, leaders can play a role in forming mental health service delivery (Davies, 2017; Fenwick et al., 2019). How leadership engage strategic planning is discussed next.

Strategic Planning

According to CARF (2019), organizations must establish a foundation of success through strategic planning focused on taking advantage of strengths and opportunities and addressing weaknesses and threats. The plan for the agency in this study was to be developed with input from clients served, personnel, and other stakeholders. The plan was to reflect the agency's financial status at the time that it was written and at projected points in the future.

Strategic plans set goals, establish priorities, and allocate financial and workforce resources to accomplish the goals. The plan was to be reviewed once a year (CARF, 2019). According to the September 2017 minutes of the board meeting, the agency

contracted with a consultant to lead a strategic planning session with the ASLT and the board of directors. From this meeting, goals for operations; marketing; IT; personnel; and facility, financial, and capital improvements were developed.

CARF (2019) encourages organizations to acquire and implement various types of IT (e.g., cellphones, texting, computers) to support and enhance business processes and practices. CARF also encourages technology supporting and enhancing service delivery, performance management and improvement, privacy, and stakeholder satisfaction. According to the September 2017 board meeting minutes, the agency had two strategic goals for IT: purchase a new EMR system and improve data reporting.

Strategic goals are guided by policies, but to be effective, they must be efficiently translated at the operational level (CARF, 2019; Rubenstein et al., 2018). Bryson (2011), who stated that it is not unusual for nonprofit agencies to develop plans based on goals or visions, cautioned agencies to build into their strategic plans enough resources (i.e., people, time, attention, money, etc.) to ensure successful implementation. At the time of this study, the agency did not have policies and procedures to implement its strategic plans and goals.

Improving the lives of children is a political and public health concern (Bee et al., 2014; Garland et al., 2017; Haine-Schlagel & Walsh, 2015). One key strategic challenge facing the agency that involved political and public factors was the need to acquire adequate finances to fund programs (Acri & Hoagwood, 2015; Behrens et al., 2013; Graaf & Snowden, 2017). As stated in the September 2017 board meeting minutes, the board and the ASLT acknowledged increasing finances as a key strategic challenge. They

set the following strategic goals that directly or indirectly affected parental involvement in the agency's children's services:

- Board of directors and ED work with local and state elected officials to support increased funding, specifically Medicaid expansion.
- Board of directors and ED educate county commissioners on funding needs.
- Write grants.
- Assess access to services and staff efficiencies.
- Identify other sources of revenue (e.g., increase private pay and Medicare clients, provide services to corporations).

Acri and Hoagwood (2015) called attention to the need to strengthen the reimbursement rates and connect services to parents and children to improve family outcomes. CARF (2019) called for organizations to engage the family members of the clients whom they served. Positive outcomes of parenting classes include enhanced parenting skills, improved behaviors of children, and stronger child-parent relationships (Smith, Granja, Ekono, Robbins, & Nagarur, 2017). Smith et al. (2017) found that only 12 of 50 state Medicaid programs provided reimbursements for parenting classes, creating a significant gap in services in communities. As indicated in the agency's list of community partners, the agency received court-ordered referrals for parenting classes but received no funding to pay for the classes (CMM, 2019).

Another gap in services affecting parental involvement was the lack of funding in the Medicaid program for couples counseling or therapy without the clients being present (CMM, 2019). Acri and Hoagwood (2015) found that parental mental health treatment

within children's mental health treatment was not reimbursable in all systems. Pruett et al. (2017) recommended addressing coparenting and couples' relationships as elements of children's mental health treatment. Children progress better when parents set aside conflict, relate positively to each other, and work together for the good of their children (Pruett et al, 2017).

Currently, Medicaid does not reimburse for couple counseling (CMM, 2019). Although addressing parental and couple problems is necessary treatment, but not always appropriate with the children in the therapy room, reimbursement for services is provided only when the children are present in the therapy session (CMM, 2019; Pruett et al., 2017; Tchernegovski et al., 2018). For children who do not qualify for the Medicaid Waiver program, which comprise 88% of the agency's caseload, as per the agency's Waiver report, there are no funds for parental support, therapy without the children present (couples counseling), or parent education (CMM, 2019; Smith et al., 2017).

A second key strategic challenge facing the agency was the provision of access to mental health services. The [name of state redacted] Department of Aging and Disability Services (2019) statutes state that CMHCs must make every reasonable effort to overcome barriers to services that clients might experience. State mental health directors have reported a lack of or limited access to services as a significant barrier to service delivery (Hernandez et al., 2017). Hamovitch (2018) mentioned that more than 50% of mental health agencies had wait-lists longer than 2 weeks and that one fifth of the agencies had wait-lists of at least 4 months. According to CARF (2019), if agencies cannot provide available services, they must maintain wait-lists.

Anderson et al. (2017) emphasized the need to mental health issues early in life to prevent impairments in long-term functioning and sense of well-being. Anderson et al. also reported that without early intervention, potential impairments could lead to increased health care usage, unemployment, and antisocial behavior, culminating in significant costs to society. Reardon et al. (2017) and Wozney et al. (2018) identified parents as gatekeepers to accessing children's mental health treatment.

Parental involvement starts at the intake into services (CARF, 2019; Nakash, Cohen, & Nagar, 2018). The agency requires that clients' intake assessments be completed by provisional or fully licensed therapists holding master's degrees (CARF, 2019; CMM, 2019). Maintaining the required workforce to provide children's services can be challenging (van Vulpen et al., 2018). Hernandez et al. (2017) reported that without sufficient funding and opportunities for career advancement in the field, it is difficult to retain a qualified workforce. This factor, along with the severe shortage of APRNs (National Council Medical Director Institute, 2017) and increasing client participation in services, challenged the agency to keep wait times for services at a minimum.

As stated in the September 2017 board meeting minutes, the agency addressed the need for additional methods to recruit licensed employees by revitalizing the internship program and making a presence at college career fairs. Simona, Marinas, and Igret (2017) identified the five elements of a quality internship as job arrangements, mentorship and employability benefits, learning content, academic supervision, and bureaucracy and accessibility. Organizations that engage students in internships find that the students are

more likely to accept employment offers postgraduation (Bandow, 2015; Slaughter & Hofer, 2019).

Community organizations such as school districts and primary care physician offices support the on-site integration of mental health services (Askell-Williams, 2016; van Vulpen et al., 2018). CARF (2019) called for organizations to coordinate services with clients and other agencies that the clients might have been referred to in an effort to maintain cooperative working relationships with other community services, including, but not limited to, schools, physicians' offices, health departments, law enforcement agencies, the courts, and hospitals.

Clients/Population Served

As described on the agency's website, the service area covers six rural counties in the Midwestern region of the United States. The population across the six counties ranges from 3,178 to 16,209 people (U.S. Census Bureau, 2017). Within this population, the poverty rate spans 13.3% to 18.3%, the percentage of uninsured people under the age of 65 years ranges from 8.5% to 11.8%, the average household income is from $35,321 to $45,729, and the average household size ranges from 2.08 to 2.55 persons.

Because approximately one in every 10 people has not graduate from high school and only two in every 10 people has received a college degree or higher (U.S. Census Bureau, 2017), the challenge of retaining licensed mental health providers for the rural population remains. Mental health continues to carry a stigma within the communities served (Reardon et al., 2017; Salloum et al., 2016; Weiss et al., 2016), but placing licensed and nonlicensed mental health providers in the schools and physicians' offices

met the community service providers' request to integrate mental health services into these two venues. The integration of services helped to decrease mental health stigma (Askell-Williams, 2016; Sherman & Hooker, 2018; van Vulpen et al., 2018).

Kaiser and Karuntzos (2016) reported on screening tools designed to assist primary care physicians in identifying clients needing referrals to mental health services. Kawahara et al. (2017) stated that patients released from the hospital emergency room without health care follow up plans experienced a higher risk of suicide. According to the agency's list of community partners, referrals came from community entities such as hospitals, physicians' offices, governmental and community agencies, family members, police departments, schools, and pastors. Hoagwood, Olin, et al. (2018); Potter (2018); Sherman and Hooker (2018); and van Vulpen et al. (2018) wrote about the importance of integrating mental health care into the community, being responsive to and receiving referrals from community partners, and engaging in service coordination.

Nakash et al. (2018) reported that the intake session is generally the first meeting between therapists and clients and that most clients and therapists agree on the primary reasons for accessing services; however, as more information is gathered, some differences in treatment goals might arise. Nakash et al. also noted that the goals of the intake appointment include establishing a diagnosis, facilitating rapport, and planning treatment. The intake session is to be conducted in a manner that identifies the clients' strengths, needs, abilities, and preferences (CARF, 2019). The second source of client information is the intake packet that clients complete before the first appointment.

As indicated in the agency's policies and procedures, the clinicians use the intake packet to gather information on current and contextual factors. Following is a list of current factors:

- Reason for services.
- Clients' (parents and children) goals for treatment.
- Clients' (including any parental mental health needs) current symptoms, with intensity and duration noted.
- Clients' (i.e., parents and children if age appropriate) perceptions of their (parents and children) part in reaching this goal.
- Clients' strengths and limitations.

Contextual factors are the following:

- Past psychiatric and medical treatment histories.
- Current psychiatric and medical medications.
- Substance abuse and legal involvement.
- Names of parents, siblings, and children, and level of contact.

Parental engagement is most effective at the time of assessment (Lindsey et al., 2014). At the intake assessment, information gathering and relationship building become inseparable.

Building Relationships

Because of the nature of the services provided by the agency, building relationships is foundational to successful outcomes (Maurer, Dardess, Frosch, & Carman, 2015; Wong & Koloroutis, 2015). The therapeutic relationship depends on

building trust with the clients and ensuring a sense of safety so that clients are willing to share personal topics (Begum, 2014). CARF (2019) directs organizations to work with clients in order to learn their strengths and their needs, and to engage family members, as needed, to obtain assessment information,

Providers begin this relationship building at the intake appointment (Nakash et al., 2018). Research has indicated that feeling blamed, being judged, not being listened to by therapists, not feeling supported by the formal system, and lacking satisfaction with the mental health treatment have been challenges to parental involvement (Haine-Schlagel & Walsh, 2015). Providers can use verbal and nonverbal strategies to build relationships with clients to help clients to feel relaxed and accepted, and they can encourage problem-solving thinking (Begum, 2014) by communicating empathy and interest to the clients. Relationship building through therapeutic communication achieves the goals of improved well-being through collecting data about the presenting problems, assessing and changing impaired behaviors or difficulties, and offering psychoeducation (Begum, 2014).

B. A. Harris and Panozzo (2019) found that providers' awareness of clients' symptoms could have an adverse impact on their evaluations of the quality of the relationships. Providers and clients rank needs differently, with providers' interactions subjective to program demands. Hamovitch (2018) cautioned mental health leaders and providers to remain alert to the possibility of hidden or unintentional stigmatizing approaches in agencies' policies and staff attitudes or actions. Provider training programs could have a positive effect on client-provider relationships (B. A. Harris & Panozzo, 2019).

Contact with the parents is reimbursable by coding the interactions as targeted case management (TCM; CMM, 2019). TCM was the primary reimbursable avenue for case managers at the agency to communicate with parents. According to the agency's policies and procedures, case managers used TCM as an intervention to listen to, interact with, and observe parents in order to obtain actionable information. CMM (2019) also identified case management as important to coordinate and bill services.

Acri et al. (2014) found that the lack of service coordination in the multiple agencies providing services to children left parents feeling confused and with more significant treatment challenges. Communication has been recognized as vital for the shifting of skills, interventions, and feedback across all domains to ensure optimal success (Stadnick et al., 2016). Case manager communication and service coordination through TCM services are key to the attainment of goals in all areas (CARF, 2019; CMM, 2019).

As indicated in the agency's policies and procedures, CARF (2019), and CMM (2019), TCM services are an essential line of communication for therapists because they can provide evaluative information on how interventions are or are not working and how parents themselves are managing under the stress of the impaired behaviors. Therapists could optimize the knowledge gained from case managers to assist in building and maintaining client-parent relationships while addressing discerned parental needs (CARF, 2019). At the time of this study, the agency's policies and procedures as well as CMM (2019) require parental involvement only at the intake into services and at 90-day treatment plan updates.

Hernandez et al. (2017) reported that state mental health directors expressed concern that parents' feelings of shame and responsibility for their children's problems impeded their reaching out for services. Salloum et al. (2016) found that 66% of parents did not know where and from whom to seek services. Stigma, confidentiality, and costs were the main factors related to parents' decision whether or not to complete their children's treatment (Salloum et al., 2016).

Wong and Koloroutis (2015) stated that providers have a responsibility to build their actions based on what matters the most to the clients. This focus results in increased patient satisfaction (Wong & Koloroutis, 2015). CARF (2019) requires the use of person-centered treatment plans. According to the agency's policies and procedures, comprehensive treatment plans are constructed with clients that specifically identify the clients' goals and steps to goal attainment. CARF (2019) also has identified cultural training as essential in relationship building. Staying attuned to possible hidden or unintentional attitudes or actions could support treatment success (Hamovitch, 2018). Cultural sensitivity training is part of the orientation for all employees at the agency.

Children who meet the requirements for the Medicaid Waiver program have access to parent support workers (CMM, 2019; Frimpong, Kuang, Wang, & Radigan, 2018). Yap et al. (2018) found that parents play an essential role in the treatment of children with depression and anxiety. Bee et al. (2014) stated that parents with serious mental illness could negatively affect their children's quality of life. Relationship building between parents and the workers happens as the workers reach the parents in the home or community and focus on meeting parental needs that positively affect the

children's treatment goals. According to the agency's Waiver report, only 12% of children enrolled in the agency's Children's Mental Health Program qualify for the Waiver program. Frimpong et al. (2018) reported that even though the Waiver program increases costs initially, children released from waiver services might require fewer services, potentially lowering service costs when compared to TCM services only.

Becker et al. (2015) and Garland et al. (2017) stated that attitudinal factors can be involved in accessing mental health treatment. Swank and Shin (2015) stated that participation in groups builds relationships. According to the agency's policies and procedures, the case managers are responsible for leading psychosocial groups. Positive group experiences could help to create and build relationships between clients and the agency (Swank & Shin, 2015).

Reardon et al. (2017) described the importance of reducing parental barriers to service through increased awareness of ways to access services. CARF (2019) supports the use of technology in business practices. Liddy, Hunter, Mihan, and Keely (2017) and Salloum et al. (2016) reported that accessible and time-efficient avenues that minimize stigma and maximize accessibility would improve parental engagement. Accessing services through social media also might assist in the deconstruction of mental health treatment stigma and ease access to mental health services.

Hernandez et al. (2017) reported on the desire of state mental health directors to ensure data-driven decision making, the monitoring of practices, and the measurement of outcomes through data infrastructure and data collection abilities. Hernandez et al. also identified receiving information from the state on the effectiveness of practice methods

and areas of needed improvement as data-driven needs. At the time of this study, the agency had no policies or procedures regarding data collection. The state required only a monthly data report that included demographic information.

The Medicaid Waiver program was designed to keep high-acuity children out of hospital (CMM, 2019). Participation in the program required parental signature and participation in a specified number of service supports (i.e., parenting classes, wraparound services); otherwise, the children would be discharged from the Waiver program (CMM, 2019). However, outside of the Medicaid Waiver program, once consent for services and the updated 90-day treatment plans were signed, there were no state, federal, or agency regulations or policies to monitor or collect data on the amount of parental involvement (CARF, 2019; CMM, 2019).

Analytical Strategy

Interviews allowed the researcher to understand and integrate the participants' perspectives, describe processes and experiences in depth, and develop full detailed and contextualized descriptions (Ravitch, 2016). For this study, interviews were conducted with five members of the ASLT to understand the strategies that the agency used to overcome barriers to facilitating parental involvement in their children's treatment. Data analysis through thematic coding with theme identification (Ravitch, 2016) was conducted on the transcriptions of the five interviews. Information gleaned from financial reports, training logs and materials, audits, board meeting minutes, and public and government websites was triangulated (Ravitch, 2016) with the coded qualitative data.

Archival and Operational Data

Archival data refers to data routinely collected by organizations that reflect the organizational intent and actions, and provide history and context to practice problems (Ravitch, 2016). Agency data used for the analysis in this study included clients' initial intake forms, minutes of board meetings, minutes of ASLT meetings, training logs, training materials, policies, Medicaid waiver eligibility and services, chart and third-party payer audits, and third-party regulations for service reimbursement. These data had been collected either by the ASLT or through forms and policies that had been approved by the ASLT and the board of directors. Board members generated minutes of their meetings and approved their transcription. McNamara (2015) described the need to delineate the roles of a board of directors and an ED, clarify the overall missions and visions of organizations, and ensure that progress is being made to define strategic goals clearly.

As stated in the agency's policies and procedures, and in accordance with the [name of state redacted] Department of Aging and Disability Services and CARF (2019), training materials are provided on required topics during the orientation process. The purpose of training is to acquire or increase knowledge, skills, and perceptions to further the implementation (McNamara, 2015) of strategies to improve parental involvement in their children's treatment. Agency training logs and schedules were assessed.

Policies guide employee behavior in the workplace (Lussier, 2015). The agency policies provided information on the expectations for involving parents in their children's psychosocial treatment. Medicaid regulations direct the Medicaid Waiver program (CMM, 2019). An agency-designated staff member, overseen by the DCS, manages the

Waiver program. This staff member gave the researcher a Medicaid Waiver program parent brochure and a copy of the program's service eligibility criteria. The DCS also provided agency-specific data regarding the Medicaid Waiver program.

Access to agency staff-generated chart audit data, third-party payer audit data, and written Medicaid regulations governing reimbursement for children's mental health services occurred through the DQI. For children's mental health policies to be effective, leaders must be able to communicate their intent and translate them into operational and strategical agency processes (Rubenstein et al., 2018). Hamovitch (2018) called for mental health leaders to remain alert to the possibility of hidden or unintentional stigmatizing approaches in agencies' policies and staff attitudes or actions. The IT manager provided minimal data on the population demographics from 2018. Information from the U.S. Census Bureau (2017) helped the researcher to understand who the clients (children and parents) were, information that determined the strategy choice for engagement (Carman et al., 2013; Mauer, 2018).

The procedure to gain access to the data began with the initial request to research the practice problem identified within the agency. Explaining the need to access various documents and reports occurred in the initial conversation. With approval secured from Walden University's Institutional Review Board (IRB approval #03-07-19-0739206), the ED directed access to specific leadership documents via the ASLT. Documents pertaining to individual programs were requested through the program directors. The request for documents occurred through face-to-face communication, e-mail, and telephone conversation.

The agency's directors who manage programs affecting parental involvement determined the number of leader participants in this study. Four program directors and the ED manage services that directly affect overcoming the barriers to facilitating parent involvement in their children's psychosocial treatment. As indicated in the agency's CD job description and the therapists' job descriptions, the CD completes compliance chart audits and supervises the therapists who complete the intake assessment, determine treatment interventions, direct referrals to other services, manage the treatment planning process, and determine the time of discharge. The DCS completes compliance chart audits and supervises the case managers, attendant care workers, and children's psychosocial group supervisor and staff. The DHR recruits and hires all levels of staff that interact with parents and children, and evaluates their engagement through benefit requests and exit interviews. The DQI requires the auditing of charts for third-party regulation compliance and serves as the agency's Lean manager. The ED provides organizational leadership for strategic activity and adherence to the vision and mission statements (Burns, 2012; Delmatoff & Lazarus, 2014).

Evidence Generated for the Doctoral Study

Examining topics selected for research can occur through the qualitative methods of asking questions, listening to the answers, and then asking more questions (Rubin, 2012). Evidence can be generated from archival data that have been or are routinely collected from organizations or through processes that create information only for studies (Ravitch, 2016). Next, the generation of data through semistructured interviews is

explained by presenting details about the participants, data collection protocol, and type of information obtained.

Participants

This qualitative case study sought to understand the strategies that the agency used to overcome the barriers to facilitating parental involvement in the psychosocial treatment of their children. The IRB is a federal regulatory board that determines standards for universities to mandate approval before students are allowed to conduct research. The IRB process ensures that ethical standards are followed and that research participants are not harmed. This in-depth qualitative case study received approval from Walden University's IRB to interview five of the mental health leaders at the agency under investigation: ED, CD, DCS, DQI, and DHR.

Access to and engagement in services are affected by social, fiscal, policy, and attitudinal factors (Becker et al., 2015; Garland et al., 2017; Hoagwood, Atkins, et al., 2018; Mauer, 2015; Neufeld et al., 2017). Interviews with ASLT members gave the researcher the opportunity to learn how the agency understood and interpreted its policies. This knowledge provided valuable information about the ways that the agency led, managed, provided, evaluated, and measured strategies to overcome barriers to facilitating parental involvement in their children's treatment. Savage and White (2019) expressed the importance of understanding policies, policy process, context, and stakeholders and their interest. The interviews with five members of the ASLT gave the researcher insight into the agency's operations; context of services (e.g., policy, political, funding, and socioeconomic factors); and stakeholders and their interests.

Procedures

Case study research involves in-depth investigations into real-life events or behaviors (Ravitch, 2016). In qualitative case studies, the researchers are the primary data collection tool, and they tend to use a variety of sources, including interviews, archival documents, and artifacts (Ravitch, 2016). For this study, the real-life event involved understanding the strategies that the agency used to overcome barriers to facilitating parental involvement in the psychosocial treatment of their children.

Data sources included transcriptions of the semistructured interviews, archival data, and websites. Examples of these data sources were financial records, policies and procedures, audit reports, annual reports, board and ASLT meeting minutes, and demographic reports. Data also were obtained from public and government websites such as the U.S. Census Bureau and CMM.

According to Ravitch (2016), informed consent is necessary when researchers wish to view documents and collect data not accessible to the public; informed consent also must be obtained from study participants. All of the agency's program directors were contacted initially by phone or in person. The researcher gave them a verbal explanation of the project and the purpose of their voluntary participation. Next, the researcher e-mailed potential participants the consent form, which they had to agree to before they could be interviewed. The consent form included the following information:

- Explanation of the invitation to interview.
- Interview procedures.
- Voluntary nature of their participation in the study.

- Risks and benefits of being in the study.
- Maintenance of their privacy.
- Contacts and questions regarding participants' rights.

Participants replied to the e-mail with "I Consent" to indicate their willingness to be interviewed on the agreed-upon dates.

Interviews are the preferred qualitative methodology when trying to understand the participants' subjective experiences (McGrath, Palmgren, & Liljedahl, 2019). Ravitch (2016) stated that thoughtfully developed interview questions may result in deep, rich, contextualized, and individualized data. He also discussed the four kinds of interview questions: experience and behavior, opinions and values, knowledge, and background and demographic. The Baldrige Performance Excellence Program (2017) and the RQ provided further guidance on the selection of interview questions.

Appendix A displays the interview questions for the CD and DCS. Appendix B presents questions about each director's particular program role in facilitating parental involvement. Themes were identified from the analysis of the participants' responses to the common goal of overcoming barriers to facilitate parental participation. Strengthening the validity of the study took place by completing semistructured interviews with the CD and DCS with an additional nine questions and by sending two follow-up questions via e-mail to the ED, DHR, and DQI.

The researcher set individual appointments for the interviews in the directors' offices. The ED, CD, and DCS interviews took place on the first day, and the DHR and DQI interviews were completed on the second day. Before the interviews, the researcher

informed the participants of receipt of their consent to interview, gave them copies of the interview questions, and gave them the opportunity to ask questions. Participants also were advised that the interviews would be recorded to ensure the accurate review of the data to determine follow-up questions, analyses, and the provision of evidence if the data were to be questioned (Rubin, 2012). In addition to recording the participants' interview responses, the researcher also took notes while observing their facial reactions and other nonverbal communication (McGrath et al., 2019).

The researcher transcribed the interview recordings using Transcribe by Wreally transcription software. Transcriptions were completed within 48 hours of the individual interviews. Participants received copies of their transcriptions via e-mail for participant validation, or member checking. This protocol allowed the researcher to check in with the participants to ensure that the transcriptions were accurate depictions of their responses (Ravitch, 2016). Participant validation establishes credibility that strengthens the validity of research.

One form of data analysis occurred through coding. Codes are tags or labels that researchers use to organize their collected data into manageable units (Saldaña, 2016). Researchers use these units to find, group, and thematically cluster the data (Ravitch, 2016). Inductive coding took place on the transcriptions using NVivo coding and thematic software.

Multiple sources of data may be collected using a variety of methods (Ravitch, 2016). In the current study, data were collected from the five interviews, and archival data were requested from the ED, program directors, and the administrative assistant

through face-to-face conversations, secure e-mail, and telephone calls. Triangulation of the data sources allows researchers to analyze their research questions from multiple sources to improve the validity (i.e., trustworthiness) of their studies through the convergence of information (Houghton, Dympna, Shaw, & Murphy, 2013; Ravitch, 2016). All documents related to the interview responses and the analysis of all collected data were kept on a password-protected laptop computer in a password-protected file. In compliance with Walden University's IRB requirements, all study data will be deleted or destroyed 5 years after completing the study.

Summary

Because of the increased enrollment in children's mental health treatment; the national call for mental health reform (Carman et al., 2013; Haine-Schlagel & Walsh, 2015; McMorrow et al., 2017; Pecora, 2017); and research highlighting the importance of parental involvement in their children's psychosocial treatment (Bode et al., 2016; Dowell & Ogles, 2010; Sanders et al., 2014; Stadnick et al., 2016; Wozney et al., 2018), the researcher conducted this study to understand the strategies that the agency used to overcome barriers to facilitating parental involvement in their children's psychosocial treatment. Section 2 provided details regarding support in the research literature, sources of evidence, leadership strategies and assessments, and the clients being served. The data analysis also was discussed. Presented in Section 3 are explanations of the agency's workforce and operations, analysis of the organization, and knowledge management.

Section 3: Measurement, Analysis, and Knowledge Management Components of the Organization

Introduction

The number of children enrolled in psychosocial treatment is increasing in state, national, and international populations (Haine-Schlagel & Walsh, 2015; NAMI, 2018; Reardon et al., 2017). Parental involvement is negatively affected through financial, access, social, and attitudinal barriers (Acri et al., 2017; Reardon et al., 2017; Salloum et al., 2016; Wozney et al., 2018). Stadnick et al. (2016) stated that parental engagement not only facilitates children's treatment attendance, but also improves their behavioral outcomes and generalizes these improved outcomes to nontherapeutic settings. As indicated in the agency's November 2019 *Clients Open in Case Management* data report, even though the number of children in the agency's psychosocial treatment program increased from 380 in 2015 to 496 in 2019, barriers to facilitating parental involvement in their children's treatment remain. This qualitative case study attempted to understand what strategies the agency used to overcome barriers to facilitating parental involvement in their children's psychosocial treatment.

Sources of evidence for this study were information from public and government websites, archival data, and semistructured interviews with five members of the ASLT. Archival documents were requested through e-mail and face-to-face conversations following receipt of IRB approval. The interviews were recorded, and the transcriptions of their responses were completed within 48 hours. Then the interview transcriptions were e-mailed to the participants for member checking. Section 3 presents an analysis of

the ways that the agency built an effective, supportive, and engaging workforce environment; designed, managed, and improved its essential services and work processes; and ensured the effective management of operations.

Analysis of the Organization

The reformation of children's mental health treatment includes improving outcomes with fewer resources (Pecora, 2017). For the agency, meeting this challenge involved building an effective and supportive workforce environment, maintaining workforce capacity and ability, engaging the workforce, designing and managing effective processes, and managing emergency preparedness and workplace safety to ensure the presence of supports that gave parents the opportunity to be involved in their children's psychosocial treatment.

Workforce and Operations

Effective and Supportive Workforce

Hughes et al. (2019) reported a deficit in opportunities to access mental health care in rural areas of the United States. Jones et al. (2014) stated that low socioeconomic status, lack of health insurance, and rural location are three factors affecting access to mental health services. Kaplan and Haas (2014) noted that the inefficient use of highly skilled and technical staff increased health care costs. Evaluations of providers' skills, licensure requirement, and state-structured service fees have affected strategies to improve service accessibility to parents (CARF, 2019; CMM, 2019; [name of state redacted] Behavioral Sciences Regulatory Board, 2019). Without an increased availability of services, children's mental health needs have either not been addressed or

have been addressed in higher and more costly levels of care (Hamovitch, 2018; Hernandez et al., 2017).

According to the agency's policies and procedures as well as the CMM (2019), two direct service providers of the Children's Mental Health Program are case managers and therapists. Case managers require a bachelor's degree, but no state licensure; therapists require a minimum of a master's level of education and state licensure ([name of state redacted] Behavioral Sciences Regulatory Board, 2019). Reimbursement for therapeutic services is a lower rate than for case management services, even though the cost to the agency to employ therapists is substantially higher than that of case managers (CMM, 2019).

CARF (2019) called for organizations to establish business practices that cover daily operational costs and incorporate plans for long-term sustainability. Hobson and Levine (2014) reported that low reimbursement rates and billing hassles have deterred therapists from accepting state insurance payments. The CMM's (2019) fee-for-service reimbursement scale facilitates case management services by enabling mental health centers to net more revenue on case management services than for therapy services. In addition, case management services are available only through mental health centers (CMM, 2019).

The strategy of under incentivizing clinicians has allowed the state to regulate mental health services through a few CMHCs rather than several hundred practitioners (CMM, 2019; Hobson & Levine, 2014). Although this government strategy has accomplished the state's goal of regulating state-licensed mental health service providers,

it has resulted in a barrier to hiring and retaining licensed staff in rural areas (Hernandez et al., 2017; Jones et al., 2014; van Vulpen et al., 2018).

Jones et al. (2014) reported that widespread shortages of mental health providers have been a likely barrier to mental health treatment. Low wages (Hobson & Levine, 2014) and the lack of career advancement opportunities (Hernandez et al., 2017) have made the retention of staff difficult. However, work that aligns with employees' values brings meaning to their lives and increases their work engagement (Baldrige Performance Excellence Program, 2014). An effective way to have qualified staff is to recruit and retain individuals who either feel called to work in this field or have an attachment to a rural setting (Briki, 2017; Johnson, 2017).

Recruiting new therapists and medication managers requires knowledge of the workforce. Rebecca (2019) reported that it is essential to distinguish among future employees who are disciplined and loyal traditionalists, optimistic and hardworking Baby Boomers, self-reliant and task-oriented Gen Xers, self-directed and eager Millennials, or creative and flexible Gen Zers. Offering benefits that can meet the needs of employees is vital in recruiting and maintaining staff (Rebecca, 2019).

Research has indicated that the children's mental health system in the United States is full of underfunded programs (Behrens et al., 2013; Graaf & Snowden, 2017; Reid et al., 2018). Jones and Tullt (2017) found that the lack of services in underfunded programs can lead to the exacerbation of mental health symptoms that require a higher level of care and increased health care costs. Parental involvement is effective in

managing childhood depression and anxiety, but there are few cost-effective and evidence-based parental interventions available (Yap et al., 2018).

McMorrow et al. (2017) reported the potential for increased positive benefit to children's sense of well-being when their parents had insurance coverage. According to the agency's November 2019 *Clients Open in Case Management* data report, 25% of the children in the agency's mental health program were uninsured. According to the [name of state redacted] Department of Aging and Disability Services (2019) statutes, mental health services must be provided, regardless of ability to pay. Further work in lobbying for parental insurance coverage also would benefit children (McMorrow et al., 2017; Sipe et al., 2015).

Training programs for providers can have a positive effect on client-provider relationships (B. A. Harris & Panozzo, 2019; L. A. Harris, 2015; P. Harris, 2014). CARF (2019) stated that organizations must maintain state licensing and educational standards. Maintaining a competent workforce includes ensuring that staff engage in appropriate levels of training (CARF, 2019). Licensed mental health providers must attend and accrue their required licensure continuing education units (CEUs; [name of state redacted] Behavioral Sciences Regulatory Board, 2019). The agency's employee handbook states that continuing education leave to attend professional education meetings may be allowed if approved by the ED. This education benefit begins after 6 months of employment, and the educational allowance increases with years of service. One component of provider training focuses on safety (CARF, 2019).

CARF (2019) called for CMHCs to provide education designed to reduce identified physical risks. According to the agency's policies and procedures and the CMM (2019), many of the agency's children's services are community based. Part of being a supportive and effective agency means implementing safety precautions in the field (CARF, 2019; CMM, 2019). The agency's policies and procedures require that safety education be completed through online courses through Essential Learning. These courses include, but are not limited to, health and safety practices, deescalation, identification of unsafe environmental factors, and emergency procedures. Completion of these courses during orientation is monitored by the program supervisor. CARF called for organizations to complete safety training during orientations as well as annually.

CARF (2019) also called for organizations to engage their workforces by respecting all employees through recognition, compensation, and benefits. One benefit that the agency has given to employees is a confidential employee assistance program that is available to any staff member in need of counseling services. Providing assistance in preparing their wills and offering some corporate discounts also are available to staff.

Providing service delivery with adequate supplies, materials, space, equipment, training, and human resources is a requirement of CARF (2019) standards. Ensuring that clients have a warm and inviting environment, along with reducing the stigma of treatment, may increase the likelihood of parents engaging in their children's treatment (Hamovitch, 2018; Hernandez et al., 2017).

According to Relias, the agency's online training log of required courses, the office receptionists received training to work with clients experiencing mental illness.

Hamovitch (2018), Song, Mailick, and Greenberg (2018), and Weiss et al. (2016) stated that this training had a positive impact on decreasing the effect of stigma. Nemec (2018) commented that the indirect benefits of training were improved staff attitudes, increased retention rates, and increased competency. As stated in the January 2018 board meeting minutes, the DQI was responsible for managing the Lean evaluation of the agency's processes. The goal of Lean is to increase work efficiency and decrease resource waste (Abdallah, Dahiyat, & Matsui, 2019; Acri et al., 2014; Merlino, Petit, Weisser, & Bowen, 2015). According to the agency's Lean Charter document, billing processes have been affected the most by the Lean assessment. Lean documents indicated that these improvements have improved the agency's sustainability by increasing the amount of revenue collected while decreasing the time to collect revenue. Increasing work efficiency and decreasing resource waste can result in reduced wait times for reimbursements and allow CMHCs to maintain service access (Abdallah et al., 2019; Acri et al., 2014).

Workforce Capacity and Capability

According to CARF (2019), wait-lists for services may be used for planning purposes. Developing strategies that promote the expansion of clinical staff may result in increased access to services (Hernandez et al., 2017; Kaplan & Haas, 2014). The need for additional staff is evaluated secondary to delayed accessibility to services (CARF, 2019). Determining the staff workload capacity is based on staff members and supervisors working together to determine when further expansion of their caseloads would impair the quality of client services (CARF, 2019; Fenwick et al., 2019). The agency's policies

and procedures require that children's case managers report their caseloads to the program director on the 15th of every month. The program director then works with the case managers to evaluate caseload sizes versus the quality of care for clients. Caseload decisions are based on this evaluation. Licensed mental health providers' caseload management is challenged through lengthy wait-lists that not only delay clients' access to services but also increase the number of no-show appointments (Lamsal, Stalker, Cait, Riemer, & Horton, 2018).

CARF (2019) has encouraged the use of technology to enhance program management and improvement. Boyle et al. (2019), Hernandez et al. (2017), and McLennan (2015) reported on the need to monitor practices, measure outcomes, and use data consistently to support informed decision-making processes. The [name of state redacted] Department of Aging and Disability Services (2019) statutes require that organizations compile and report to the state any statistics concerning their operations and the use of services by community members. The CMM (2019) requires submission of a monthly report to receive payment for services. At the time of this study, the agency had no policies, procedures, or processes to collect data that would aid in strategic planning, goal attainment, workforce capacity, or capability.

The [name of state redacted] Department of Aging and Disability Services (2019) statutes require that all agencies ensure that all professionals meet their state licensing, registration, or certification requirements. The statutes direct organizations to ensure that the professionals employed by them maintain their required job skills. Organizations are

to engage in workforce development activities that may include time off to attend conferences, courses, or collaborative educational events (CARF, 2019).

CARF (2019) has continued to reinforce the importance of supervision by persons appropriately licensed by the state regulatory board to do so. An example of an ethical policy violation that might require supervision consultation involves working with parents during the children's therapy: How long can a therapist speak with a parent alone before the session becomes therapy without the client (i.e., child) and is nonbillable (CMM, 2019)? An example of a policy question that does not necessarily need clinical supervision response might be following: How can the staff attitudinally and behaviorally engage the distant parent of a child who needs more parental involvement? (CMM, 2019). The agency's policies and procedures require that team meetings take place at least every other week to provide treatment team consultation time in managing challenging cases.

Achieving a High-Performance Work Environment and Engaging the Workforce

As indicated in the organizational profile, the agency serves clients with socioeconomic barriers. The [name of state redacted] Department of Aging and Disability Services (2019) has mandated that all clients receive services, regardless of their ability to pay, and that case management services be provided only through CMHCs. The [name of state redacted] Department of Aging and Disability Services also has mandated that clients receive services from their assigned CMHCs, unless the needed services were not offered. Because of these socioeconomic factors and state law service restrictions, the agency does not engage in marketplace competition. Therefore, achieving a high-

performance workplace environment is not applicable to the CMHC; however, engaging the workforce is important (Osborne & Hammoud, 2017; Rebecca, 2019).

Ciampa (2017) reported that CEOs need to think through the capital and technology issues as well as pay equal attention to the behaviors and attitudes of their employees. A transformational leader creates support for a new direction of an organization by earning the respect and trust of followers (Lussier, 2015). Effective leaders must build trust within teams that encourages communication at every level of employment and relationships that promote employee engagement (Osborne & Hammoud, 2017; Rebecca, 2019).

Vallerand (2012, 2015) stated that individuals who engage in activities that they are passionate about have a sense of purpose and well-being in their lives. Witmer and Mellinger (2016) asserted that commitment to the mission, servant and transformational leadership styles, hope, optimism, and fiscal transparency support organizations through change. Wilson (2018) described servant leadership as the most effective way to achieve results, drive change, and make a difference. It is essential for organizational leadership to demonstrate a person-centered philosophy through processes and actions (CARF, 2019).

Disengaged employees generally cost U.S. corporations $350 billion annually (Osborne & Hammoud, 2017). Research has indicated that rapidly changing workplace conditions encourage employees to put more time and effort into their work areas (Shimazu, Schaufeli, Kamiyama, & Kawakami, 2015; Smollan, 2017; Yuksel, 2014). Shimazu et al. (2015) and Yuksel (2014) further indicated that continuing to spend

increasing amounts of time and effort at work can either stem workaholism or promote work engagement. Workaholism is an uncontrolled compulsion to work that often leads to ill health and fewer quality outcomes. Work engagement stems from an intrinsic motivation to produce a positive and meaningful work-related state of mind. Work engagement often energizes employees and builds dedication to the organization, leading to more positive outcomes (Shimazu et al., 2015).

Multiple researchers have stated that providing employees with recognition and awards is essential to building employee engagement (Makoni, 2019; Osborne & Hammoud, 2017; Rai, Ghosh, Chauhan, & Singh, 2018; White, 2016). Lantara (2019) reported that the best way to prevent employee burnout is to express gratitude for employees' work. CARF (2019) called for organizational leadership not only to demonstrate a person-centered philosophy but also to guide the delivery of services.

Effective leadership depends on communication (Fibuch & Robertson, 2019; Hopp, 2016). Kacik (2018) reported that top leaders remaining humble, interact with staff, build rapport, and boost performance. Osborne and Hammoud (2017) noted that effective employee engagement involves establishing a bond between leaders and employees. It also is important for leadership to respect staff members through open communication mechanisms, a value-driven focus, initiatives, and policies (CARF, 2019). At the time of this study, the agency had no policies, procedures, or processes directing workforce engagement.

The goal of managing essential products and work processes is to create value for clients and ensure organizational success and sustainability (Baldrige Performance

Excellence Program, 2014). Parental involvement in children's psychosocial treatment provides value for the children (Acri et al., 2014; Ferreira, 2019; Reardon et al., 2017; Sanders et al., 2014; Stadnick et al., 2016; Yap et al., 2018). Meeting the agency's mission and vision statement of improving children's quality of life through the coordination and provision of services reflected organizational success and sustainability (ED, personal communication, March 15, 2019).

Process Design

Successful process design must include all stakeholders (Baldrige Performance Excellence Program, 2014). CARF (2019) called for the scope of services to be determined by stakeholders' needs. The needs of the community, government regulations, and third-party payers determined the design of the agency's services (CARF, 2019; CMM, 2019). Once needs were identified, operational policies originated from funding regulations, best practices, and state mandates. The increased prevalence of mental health challenges experienced by children (NAMI, 2018; van Vulpen et al., 2018) has identified the need for services. Because of children's age-appropriate knowledge deficits, parents have been considered critical to obtaining psychosocial treatment for their children (Reardon et al., 2017; Wozney et al., 2018).

CARF (2019) stated that families are encouraged to participate in clinical programs. Although agency processes were designed to include the parents, the focus has always been on the children (CMM, 2019). Fee-for-service reimbursement structures support this focus by requiring that the children be present in therapy to receive reimbursement, not providing funding for parenting education or couples' counseling,

and reimbursing TCM at a lower rate than case management services (CMM, 2019). In 2002, Hocutt, McKinney, and Montague wrote about the negative effect of managed care on children's mental health treatment through decreased TCM service reimbursement and restriction of provided services. These two adverse effects in 2002 continue to create barriers in the processes needed to involve parents in their children's psychosocial treatment (CMM, 2019).

The [name of state redacted] Department of Aging and Disability Services (2019) statutes require organizations to develop cooperative relationships with community agencies serving common clients. It is important that individuals be designated to coordinate services to ensure a seamless process for the clients or families served. Despite the agency's policies and procedures requiring that therapists be responsible for writing and managing comprehensive treatment plans, there is no reimbursable TCM services to cover the coordination time needs of the therapists (CMM, 2019). Without service coordination, treatment of children and families occur through service silos (Acri et al., 2014; Colvin, 2017). Service silos create, not resolve, challenges for families (Acri et al., 2014).

The intake appointment often is the initial meeting between therapists and clients (Nakash et al., 2018). Nakash et al. (2018) reported that the goal of the intake appointment is to build rapport, plan treatment, and establish a diagnosis. The [name of state redacted] Department of Aging and Disability Services (2019) statutes require that the intake assessment be completed within 14 days of the initial appointment by a professionally qualified staff member. The initial appointment includes completion of

comprehensive treatment plans with input from the clients and designated family members.

At the first appointment, clients also receive information regarding their rights and responsibilities, including their behavioral expectations (CARF, 2019). According to the agency's policies and procedures, parents are required to attend the intake appointment, and treatment for the children cannot commence until the parents provide written consent. In addition, being referred to case management services or qualifying for the Medicaid Waiver program initiates a second intake process that requires the parents' attendance and signatures. Improved outcomes result from parental involvement in children's psychosocial treatment (Reardon et al., 2017; Sanders et al., 2014).

It is vital for organizations to provide staff to coordinate services (CARF, 2019). The agency's policies and procedures allow the therapists to support parental involvement through interventions of family therapy versus individual therapy with the children. Case managers can meet with parents with or without the children being present (CMM, 2019). According to the Medicaid Waiver brochure, children meeting Medicaid Waiver eligibility requirements qualify for parent support workers and parent education. Therapists, with feedback from case managers, screen children for Medicaid Waiver eligibility and make the appropriate referrals (CMM, 2019).

Differences in clients' expectations regarding support options can affect the process design (Baldrige Performance Excellence Program, 2014). Researchers have identified parental stress as a major barrier to engaging in their children's treatment

(Hoagwood, Atkins, et al., 2018; Salloum et al., 2016). Bee et al. (2014) reported that parents' mental illness substantially affects their children's quality of life.

CARF (2019) and the [name of state redacted] Department of Aging and Disability Services (2019) statutes intended for assessments to be completed by qualified personnel and to identify historical and current information regarding the clients' strengths, needs, abilities, and preferences. This assessment data may be collected from family members or significant others. The policies and procedures of the agency require that therapists screen for parental strengths and challenges at the time of intake. When needed, licensed mental health providers can encourage parents to seek treatment through adult mental health services; however, without the ability to pay, most parents do not (Hernandez et al., 2017; Reardon et al., 2017). The licensed mental health providers then ethically manage the billable time spent with the children and the nonbillable time spent with the parents (CMM, 2019).

Even though case managers provide resources such as food, clothing, utility support, housing options, and so on, the focus of case management services is always on the children (CMM, 2019). Parents requiring assistance accessing needed resources must seek their own services, qualify for case managers, and engage in the services. As stated above, parents often do not seek adult mental health services due to financial barriers (Hoagwood, Atkins, et al., 2018; Neufeld et al., 2017). McMorrow et al. (2017) reported that the receipt of insurance relieved some of the financial pressure on the parents and improved their mental well-being, resulting in the children's improved state of well-being.

Designing processes effectively also includes having an awareness of time cycles, delivery processes, and client expectation for support options (Baldrige Performance Excellence Program, 2014). A fundamental responsibility of the agency is to provide a comprehensive program structure (CARF, 2019). According to literature on the agency's Children's Psychosocial Group, the program provides psychosocial services during the school year for 3 hours daily for 4 days each week. During the summer, the psychosocial group increases to 6 hours a day, 4 days a week. This time cycle requires increased resources.

The [name of state redacted] Department of Aging and Disability Services (2019) statutes identified transportation to services as a barrier that has to be addressed. As indicated by the agency's policies and procedures, the agency provides transportation to and from the group as long as it has received written parental consent. The service delivery model, which is based on accepted practices in the field, incorporates current research, evidence-based practices, and expert professional consensus (CARF, 2019).

According to the agency's summer Children's Psychosocial Group curriculum, the process has very little parental involvement, and there are minimal, if any, accountability processes for parents to reinforce the skills that their children are learning. However, the curriculum structure is provided to ensure the maintenance of a therapeutic environment, not an afterschool and summer child care.

The process design includes documentation (Baldrige Performance Excellence Program, 2014). The agency's policies and procedures mandate that medical record progress notes communicate service elements necessary for compliance with state,

federal, contractual, and third-party requirements. CARF (2019) has continued to support agencies using technology in business processes and efficient operations. According to the agency's policies and procedures, processes are formatted through the EMR system, where documentation of processes takes place.

Process Management

Communication plays a vital role in managing operational processes (Braun, Bark, Kirchner, Stegmann, & van Dick, 2019; Davies, 2017). Because 80% of leaders' time is spent interacting with employees, it is important that a simplified communication process to prevent risks, identify threats, and address workplace issues be used in the workplace (Braun et al., 2019; Davies, 2017). Through this simplified mechanism of communication, employees feel listened to and valued, factors that can improve quality and performance (Davies, 2017; Lantara, 2019).

Braun et al. (2019) cautioned that although e-mail communication is convenient, staff prefer face-to-face communication. Organizations can have open communication through regular meetings, open-door policies, management rounds, suggestion boxes, or other opportunities for employees to provide input into organizational plans and activities (CARF, 2019). At the time of the study, the agency did not have policies, procedures, or processes on communication mechanisms between leadership and staff. CARF (2019) has required that organizations maintain healthy and safe workplace environments. According to the agency's own policies and procedures, employee orientation includes completion of training on safety and emergency policies and procedures through the Essential Learning program.

Evaluating the agency's processes requires the identification of critical process points for performance measurement and observation (Baldrige Performance Excellence Program, 2014). The intake process is one critical process point of measurement and observation (Wong & Koloroutis, 2015). Important performance tasks to be evaluated and observed during the intake appointment are (a) the level of expectation of parental involvement, (b) observations of the parents' ability to meet their children's needs, and (c) ensuring that they understand the parents' goals of services at the time of intake (Nakash et al., 2018; Reardon et al., 2017). Becker et al. (2015) stated that parental involvement is attitudinal and behavioral.

For person-centered treatment planning, CARF (2019) has mandated regular reviews and updates based on ongoing assessments through the determined time of discharge. According to the agency's policies and procedures, a point of measurement and observation is at the 90-day treatment plan update. At this time, clients, parents, therapists, and case managers evaluate services and outcomes for the past treatment period and set treatment goals for the next 90 days.

As indicated by the CMM (2019), treatment interventions performed without updated treatment plans will not be reimbursed. Treatment plans must be endorsed by the parents (CMM, 2019). Addressing the level of parental involvement can occur every 90 days (CMM, 2019). It is during these updates that decisions about discontinuing treatment when the parents are not engaged in the treatment of the children or when the minimum required number of Medicaid Waiver appointments does not occur (CARF, 2019).

CARF (2019) stated that the workforce development activity of education and training is a mental health standard. According to [name of state redacted] Department of Aging and Disability Services (2019) statutes, CMHCs are to have and adhere to written policies and procedures that provide for a utilization review of services to ensure their appropriateness, high quality, and cost-effectiveness. According to the policy, the agency conducts a utilization review of records every 30 days to ensure (a) compliance with state, federal and agency policies and regulations; (b) the appropriate use of resources and facilities; and (c) delivery of high-quality, cost-effective, and appropriate services.

The policy directs the utilization review of records to be returned to the primary clinician for educational and quality improvement purposes. The CMM (2019) routinely reviews agency documentation and requires recoupment of services if documentation of service compliance is not provided. Outside of the Medicaid Waiver program, the agency has no policies, procedures, or processes providing for the monitoring of the amount, type, time, and effect of parental involvement on their children's psychosocial treatment.

Budget approval can be conducted through the ASLT, the board of directors, or some other authority (CARF, 2019). The agency's organizational chart (2016) indicated that the CFO reports to the ED and that the board of directors approves the agency's annual budget. Affiliation with the State Mental Health Association also can alert leadership to upcoming policy changes that may affect funding (ED, personal communication, March 15, 2019). Hughes et al. (2019) and Sipe et al. (2015) stated that rural areas have increased challenges to accessing funding and providing mental health services.

Making funding needs known in local and state legislation can improve mental health outcomes. According to the May 2016 board meeting minutes, counties were requested to provide increased funding to replace revenues lost to decreased state funding, fewer reimbursement fees for crisis services, and the increased demand for services secondary to the moratorium on admissions to the state hospital. According to the September 2018 board meeting minutes, the agency was continuing to request additional funds from the county. At the time of this study, states were lobbying for expanded Medicaid services (CMM, 2019).

Identifying the agency leadership structure is a mental health care standard (CARF, 2019). The [name of state redacted] Department of Aging and Disability Services (2019) states that the ED is responsible for the daily operations of the agency, the quality of services provided, and the effective and efficient management of the agency's resources. At the time of this study, the agency had no policies, procedures, or processes regarding its leadership structure.

The support services necessary for parental involvement in their children's psychosocial treatment include billing and accounting, front office staff, management of facilities, IT, and HR management (Acri et al., 2014). Billing and accounting provide notification of billing errors preventing the reimbursement of services. According to the agency's organization chart (2016), supervisor of the billing program reports to the CFO. The executive administrative assistant serves as the head office manager, and the front office staff often are the first point of contact for parents who may lack confidence in

reaching out for services (Acri & Hoagwood, 2015; Haine-Schlagel & Walsh, 2015; Kim et al., 2013).

The agency's DHR manages operations regarding recruiting, hiring, personnel issues, and benefits, all of which affect the provision and retention of staff to offer services to clients. Mental health care standards expect the agency to have written policies regarding the functioning, maintenance, and security of the IT system (CARF, 2019). The IT processes are managed by the IT manager, who reports directly to the ED. The IT manager troubleshoots technology problems and maintains the EMR system. The IT manager, in conjunction with the ED, ensures that cybersecurity and HIPAA measures are in effect (CMM, 2019). Without IT capabilities, it would be nearly impossible for the agency to complete the monthly state reports required for service reimbursement and organizational sustainability (Hernandez et al., 2017).

Effective Management

Cost Control

The goal of the Lean process is to increase the value of care and the management of financial resources through less waste and decreased service costs, making it a useful quality improvement tool (Abdallah et al., 2019; Merlino et al., 2015). As mentioned in the board's January 2018 meeting minutes, the Lean process is the primary quality improvement tool in use at the agency. According to the lean project charter document, the first lean improvement process was applied to the timely documentation of services provided. The goal was to increase the judicious filing of service claims to increase revenue for preformed services. Acri et al. (2014) stated that concerted efforts are needed

to ensure that workforce providers, administrative structures, and funding regulations are fortified and collaborative in order to meet the needs of children and parents.

Cost control for case management services flows from auditing medical records continually and training licensed providers and mental health providers on documentation and treatment plan compliance (CMM, 2019). Comprehensive treatment plans direct the services provided to children by the agency (CARF 2019; CMM, 2019). Services provided to children who are not documented on the treatment plans or after their treatment plans have expired cannot be billed for reimbursement (CMM, 2019). This results in lost revenue for the agency and the nonproductive use of staff time.

CARF (2019) has called for organizations to support the mental health care standards of workforce development through education and training, along with the use of technology for improving employees' job satisfaction. To date, the agency has no written policies, procedures, or processes relevant to the use of the SharePoint, an IT tool that provides resource information and is located on the agency's intranet. According to the agency's Facebook page, employees have access to intraoffice communication that facilitates the sharing of generic productive changes that have resulted in positive support of the agency; clients also can view the agency's activities and learn about provided services. At the time of this study, the agency had no policies, procedures, or processes that used technology to assess client satisfaction.

Safety

Huang et al. (2016) found that employees' perceptions of workplace safety affect their job satisfaction and organizational engagement. All organizations have a

responsibility to provide a healthy and safe workplace environment (CARF, 2019). The agency prohibits sexual harassment and workplace bullying, and it provides training to recognize and report such behaviors. In addition, a compliance officer is available so that employees can be whistleblowers of unethical leadership practices.

Emergency Preparedness

Mental health care standards require that agencies evaluate safety concerns related to natural disasters (CARF, 2019). McCabe et al. (2014) reported on a successful model used to unite government and faith-based organizations to revise a policy that promoted public health preparedness and resiliency. The agency also has written policies and procedures regarding the proper responses to emergency disasters such as fires or tornados.

Mental health care standards require that client crisis needs are met directly or through referrals (CARF, 2019). The agency's policies and procedures, along with CARF (2019), ensure that part of the intake appointments for new clients is establishment of crisis plans that state explicitly what the clients (children or parents) will do if the children become a danger to themselves or others. Parents receive crisis resources at intake, including the agency's 24-hour crisis hotline number. In emergency situations when agency staff cannot be reached (i.e., phone lines inoperable, fire, inclement weather, etc.), the parents are instructed to take their children to the nearest hospital emergency room or call the police if they feel endangered by the children.

Knowledge Management

Measuring, Analyzing, and Improving Performance

A mental health care standard is the preparation of a written analysis on the effectiveness of service delivery (CARF, 2019). The minutes of the board's January 2018 meeting approved and reported on the training of agency staff on the use of the Lean quality improvement process, whose goal is to increase the value of care and the management of financial resources through less waste and decreased service cost (Abdallah et al., 2019; Merlino et al., 2015; Wnuk-Pel, 2018).

The agency's policies and procedures direct the completion of utilization reviews on a routine basis. The completed reviews are to be studied by the primary clinicians for training and quality improvement. Per the agency's 2018 data reports, one manual report indicating wait times for initiating services and one data report indicating the number of insured (Medicaid) and uninsured (self-pay) clients are available. To receive reimbursement for services, state agencies are required to submit one monthly data report on clients' demographics and services provided to the clients (CMM, 2019).

Researchers have indicated that mental health leaders have expressed their concerns about their data-gathering capacity and the lack of infrastructure to support their data-based decision-making processes (Boyle et al., 2019; Duncan et al., 2018; Hernandez et al., 2017). Kandadi (2018), who supported building IT infrastructure to improve data reports, warned that computers, data collection technologies, and infrastructures are just decision-making tools and that people are the decision makers. Clinicians' intuition, not hard data from outcome measures, is the primary method of

decision making at the agency (ED, personal communication, March 13, 2019). The agency's policies and procedures regarding the collection of parental involvement data remain limited to the consent for treatment at intake and parental signatures for the 90-day treatment updates. Children enrolled in the Medicaid Waiver program receive more parental support, and parental involvement is required to remain active in the program.

Communication mechanisms that foster feedback between stakeholders and the agency are a mental health standard of care (CARF, 2019). As already mentioned, client feedback is solicited at the intake appointment and at every 90-day update; however, agency policy states that client satisfaction surveys are to be distributed and collected in the office on a monthly basis. Stakeholder communication occurs through quarterly board meetings and participation in third-party payer audits.

Children's mental health services have been and continue to be underfunded (Behrens et al., 2013; Graaf & Snowden, 2017; Neufeld et al., 2017; Reid et al., 2018). Without collected data to highlight the importance of parental involvement outcomes, lobbying effort to obtain needed funding have been impaired. Lobbying efforts have resulted in just trying to maintain extant funding rather than accessing new funds (Hernandez et al., 2017). The standards of mental health care call for organizational measures from stakeholders (CARF, 2019). Third-party payer audits occur routinely, and supervisors audit select clients' EMR monthly. Strict service reimbursement regulations determine the audit criteria (CMM, 2019). Agency policy directs that audit results be provided to the primary clinicians for training on compliance with agency and stakeholder regulations.

Nemec (2018) identified the indirect benefits of training as improved staff attitudes, increased retention rates, and increased competency. Mental health standards require orientation competency training (CARF, 2019). Regulatory orientation trainings are required at the agency through Essential Learning. Outside of the orientation period, the agency has not had any policies or procedures to document completed trainings, measure effectiveness, or assess the need for follow-up instruction.

Measuring, analyzing, and improving performance is an essential step in executing and attaining strategic plans (Baldrige Performance Excellence Program, 2014). Relying on data generated from the interrelatedness of the agency's analysis, performance review, and planning supports relevant decision making. Basing decision making on significant data guides the attainment or adaptation of plans to meet strategic goals (Baldrige Performance Excellence Program, 2014; Boyle et al., 2019).

The agency's strategic plans, as stated in the September 2017 board minutes, were validated through (a) the need for more data-driven decisions, (b) increased enrollment in the number of children in the mental health program, (c) the lack of data to lobby for more funds, and (d) the emerging presence of the CMM's (2019) VBPs. The lack of decisions based on data-driven information, along with the inability to track the opportunities for and the amount of parental involvement, supported the strategic goal of a new EMR system and support of mental health standards in using technology to improve business processes (CARF, 2019).

Data collection can support the agency's strategic plan in acquiring more funding for mental health services such as parent support groups, parenting classes, payment for

parent counseling, involvement incentives, preventative outreach programs, and so on (Boyle et al., 2019; Duncan et al., 2018). The increased enrollment in the number of children in the mental health program and responses to the public schools' request for mental health support (Dawson-McClure et al., 2015; van Vulpen et al., 2018) endorsed the strategic plan to hire school-based therapists in an effort to reach more parents through the educational setting. Working with third-party payers to be reimbursed for hybrid services (Hughes et al., 2019) and testifying through written and verbal communication to the state legislature for Medicaid expansion (Sipe et al., 2015) supported the agency's strategic plan to increase access to services and financial programming support.

Knowledge Assets, Information, and Information Technology

Research has defined knowledge management as accessing and using all sources of an organization's knowledge. Examples of the agency's sources of knowledge include the tacit knowledge and skills of its licensed and unlicensed mental health providers, ASLT knowledge about the agency's programs and state regulations, and results of past third-party payer audits. This knowledge has the potential to support problem solving to enhance performance, ensure sustainability, increase employees' job satisfaction, and stimulate innovation (Albream & Maraqa, 2019; Corcoran & Duane, 2017; Rathi & Given, 2017). Research also has indicated that communication tools such as social media, e-mail, and virtual meeting rooms enhance the ability of organizations to generate and share knowledge. However, Rathi and Given (2017) found that small nonprofit

organizations often used physical and print documents, along with websites and intranets, to manage their knowledge.

Omotayo (2015) asserted that knowledge management has shifted from natural resources to intellectual assets. Rathi and Given (2017) indicated that when nonprofit organizations experience reduced government funding, they often face monetary challenges that emphasize the need for the effective management and use of knowledge. Bryson (2011) stated that that when organizational structures are set up according to tasks, specializations can occur. At the time of this study, the agency had no policies, procedures, or processes for managing the specialized knowledge of its licensed and unlicensed mental health providers.

CARF (2019) has required that organizations specifically outline their program services and provide appropriately licensed personnel as required by state licensing as well as regulations. According to the agency's job descriptions, the tasks required by the job positions are listed along with the required level of licensing. These job descriptions, the CMM (2019), and the [name of state redacted] Behavioral Sciences Regulatory Board (2019) direct clinical service providers interacting with children and parents to have required licensing at the masters' or doctoral level. According to the agency's policies and procedures, as well as the [name of state redacted] Behavioral Sciences Regulatory Board (2019), newly graduated therapists must be supervised by licensed therapists until the requirement regarding the number of licensing hours is met. This supervision provides an opportunity for the transfer of tacit knowledge to new therapists so that they can expand their skills and knowledge.

Mental health standards of care support the use of technology for business processes and require documentation of services (CARF, 2019). According to the agency's policies and procedures, documentation of therapists' expertise and knowledge occurs in the EMR system through the transfer of knowledge regarding the chosen interventions and the clients' responses to treatment. Orientation training includes documenting required repository knowledge in the EMR system, and service elements necessary for compliance with state, federal, contractual, and third-party requirements are embedded in the EMR forms. CARF (2019), the [name of state redacted] Department of Aging and Disability Services (2019), and the agency's own policies and procedures require a utilization review of documentation for compliance and performance improvement.

Agency policies and procedures contain embedded knowledge. Policies are written based on standards of care, industry regulations, and best practices (CMM, 2019). The [name of state redacted] Department of Aging and Disability Services (2019) requires written policies and procedures that communicate the expectations of the agency for quality and ethical practice, thus indirectly providing knowledge to the employees. Community partners add to the organizational knowledge base by sharing information about parental and client needs, services that they have provided, and services that have been beneficial or nonbeneficial (Acri et al., 2014).

Information: Building, Sharing, and Transferring

A mental health standard of care involves providing resources and education to personnel so that they can stay current in their field of expertise (CARF, 2019). Licensed

staff are required to earn CEUs to renew their professional licenses ([name of state redacted] Behavioral Sciences Regulatory Board, 2019). The agency provides a monetary allowance for CEU programs or training in evidenced-based practices. The agency also pays hotel and conference expenses for therapists to attend the annual state mental health conference. Information from the Mental Health Association website indicates that CEUs are available at this conference.

Kandadi (2018) stated that 80% of shared information occurs during informal meetings and 99% of innovation occurs during informal knowledge sharing. According to the agency's policies and procedures, treatment team meetings occur either weekly or biweekly to strategize treatment options for challenging cases. CARF (2019) states that organizational communication mechanisms may include supervisors' participation in treatment or service planning meetings, organizational staff meetings, side-by-side sessions with the clients being served, or one-on-one meetings between the supervisors and the individuals providing direct services. Outside of the policy on team meetings, the agency has no other policies or procedures on communication mechanisms.

Information Management

According to the September 2017 minutes of the board meeting, a strategic goal is to replace the agency's aging EMR system. The agency's IT manager manages the software and hardware systems and data and information to ensure compliance with all HIPAA regulations (CMM, 2019), resolve operating malfunctions, install needed updates, and oversee nightly operation backups to protect information and make it available during emergencies. In case of the EMR system not being available, the crisis

response teams are to have paper evaluation forms to gather necessary information and provide documentation of valuable and transferable information (CARF, 2019).

Summary

Section 3 addressed the ways that the agency has built an effective and supportive workforce environment by recruiting and retaining qualified staff, understanding the reimbursement structure of fee for services, maintaining access to services, acquiring funding for program services, providing training opportunities, and attending to safety and facility needs. Also discussed was the agency's use of wait-lists and providers' sense of service quality to determine case management caseloads and how therapists, whose numbers are limited by the lack of office space, manage their caseloads to ensure high attendance rates. Agency capability is measured through verbal interactions between providers and parents and children, along with compliance with policies and state regulations.

Because of the population served and the [name of state redacted] Department of Aging and Disability Services (2019) statues, the agency did not have marketplace competition. However, efforts to engage employees occurred through transformational and servant leadership styles that provided recognition and awards, allowed work time for holiday celebrations, offered training, and ensured the flow of communication.

The agency has designed and managed its processes around clients' needs, best practices, and government regulations. The effective design of processes also has included an awareness of time cycles, delivery processes, and client' expectations of support options (Baldrige Performance Excellence Program, 2014). Management of the

operational processes can occur through supervision from program directors, direction from the ASLT, and guidance from the board of directors. Critical process points for measurement and observation are intake appointments and 90-day treatment plan updates. Also included in the section were details about the agency's finances, support services, and facility management processes. Effective management was discussed through cost control and safety.

Finally, a discussion of the agency's knowledge management occurred through the aspects of measuring, analyzing, and improving performance, and managing knowledge assets, information, and technology. Knowledge assets include mental health providers, licensed providers, and repository knowledge. The importance of sharing and transferring information was addressed, along with the management responsibilities for IT.

Section 4: Results: Analysis, Implications, and Preparation of Findings

Introduction

According to the agency's November 2019 *Clients Open in Case Management* report, the demand for children's mental health services is increasing, matching the increasing demand in state, national, and international populations (Jones et al., 2014; Reardon et al., 2017). Researchers have found that although parental involvement can improve children's mental health outcomes, barriers to facilitating parental involvement continue to exist (Acri et al., 2014; Becker et al., 2015; Carman et al., 2013; Dowell & Ogles, 2010; Haine-Schlagel & Walsh, 2015; Hernandez et al., 2017; Isobel et al., 2019; Palinkas et al., 2017; Reardon et al., 2017; Weiss et al., 2016). This in-depth qualitative case study sought to understand the strategies that the agency used to overcome barriers to facilitating parental involvement in their children's psychosocial treatment.

Semistructured interviews with five members of the ASLT, archival data, and information from public and government websites were the sources of evidence. Following IRB approval, consent to conduct the interviews with all five directors was obtained from the individual ASLT members via e-mail. Each interview was initially conducted and audiotaped in each respective director's office. Using Wreally transcription software, the transcription of each interview was completed within 48 hours of the interview. Individual directors received e-mailed copies of their own transcriptions.

Following the initial interviews, two other interviews were held, one with the DCS and one with the CD. Both interviews were completed and recorded using the virtual program Zoom. Using Wreally transcription software, these two interview

transcriptions were completed within 48 hours and then e-mailed to the respective directors for member checking. All participants checked their interview transcriptions for accuracy and provided feedback in return e-mails. Member checking is the process of allowing the participants to confirm or amend the accuracy of their transcribed interview responses. It also increases the trustworthiness of the research (Ravitch 2016).

In addition to the DCS and CD follow-up interviews, the ED, DHR, and DQI were e-mailed two follow-up questions. All three participants replied to the e-mail with their responses. Archival data were gathered from public and government websites; the agency's website; and the agency's audits, training records, minutes of board meetings, data reports, service brochures, policies, employee handbook, and direct service forms. Financial records and third-party payer audit results were not provided.

The data were analyzed through inductive coding using NVivo, thematic analysis, and triangulation. In qualitative research, coding occurs when chunks of data are summarized and given codes representative of the summarized content (Saldana, 2016). Inductive coding involves using the participants' words to name the code (Adu, 2015). Ravitch (2016) stated that open coding is the first step in giving meaning to the data.

Adu (2015) described *open coding* as placing a summarized chunk of data in a small container and then labeling that container with a code that is representative of the contained data. NVivo refers to this small container as a child node, and within NVivo, the development of child nodes occurs during the first cycle of coding. Adu explained further that the second cycle of coding occurs by sorting the child nodes into familiar groups and then placing each group into its own larger container. This larger container is

labeled with a new code that is representative of the smaller groups of codes within. NVivo refers to these codes as parent nodes. Adu then explained that the parent nodes are grouped to form themes. Some coding may take several cycles, but the goal is always to group the parent nodes according to the themes or patterns that occur when referenced to the RQ (Adu, 2015; Ravitch, 2016; Saldana, 2016).

The coding was completed using NVivo's child and parent node systems. NVivo refers to codes as nodes (Adu, 2015). Coding and theme analysis were completed in reference to the RQ (What strategies did the agency use to overcome the barriers to facilitating parental involvement in the psychosocial treatment of their children?).

The results of the data analysis identified eight themes: services, policy, communication, measurement, attitudinal, societal economics, leadership, and funding. These eight themes were reviewed through a discussion of the agency's programs, services, and new initiatives; as well as client focus, leadership, and financial factors. The themes were developed by identifying the top two child nodes from the first cycle of coding and the top two parent nodes from the second cycle of coding. Following is a discussion of the analysis, results, and implications that begins by addressing the strategy findings in the agency's programs, services, and new initiatives.

Analysis, Results, and Implications

Agency Programs, Services, and New Initiatives

In looking at the agency's programs, services, and new initiatives, three major themes emerged: services, policies, and communication. The first theme to be discussed is Services.

Theme 1: Services

Theme 1: Services was dominant in the agency's strategies. Services, as referenced on the agency's website, refer to the agency-directed programs that provided opportunities to involve parents in their children's treatment. Theme 1 was developed from a combination of the two parent nodes of case management services and clinical (therapy) services. Further analysis indicated that the parent nodes of case management services and clinical (therapy) services were significant enough to be considered individual themes under Theme 1: Services.

Case management services. The significance of the Case Management Services theme in overcoming barriers to facilitating parental involvement was demonstrated through the participants' responses.

P3 said, "Case managers could routinely schedule time with parents."

P2 stated:

> We also use our case management and parent support services to reach out directly to parents so, we are doing services within the home via case management, attendant care, that sort of thing trying to reach out where the parent is.

These comments supported the agency's strategy of having case managers routinely reach out to parents in the home and community setting to overcome barriers to parental involvement.

When analyzing the case management services data, an important distinction was observed: Although under the umbrella of case management services, the agency

differentiated between the use of case management services and TCM services. TCM is the primary billable service used to communicate with parents when the children are not present (CMM, 2019). Even though TCM services are a separate billable service, TCM is used only by case managers, so it was coded as a child node in the theme of Case Management Services, which overlapped with the themes of Communication and Policy. Because policy determines the communication function of the TCM services, further discussion of the parent nodes of TCM and communicates with parents is in the discussion of the Policy and Communication themes.

Clinical (therapy) services. A second significant theme under the Theme 1: Services umbrella was Clinical (Therapy) Services.

P2 shared thoughts about parents' involvement in clinical (therapy) services:

> It's one on one with the clinicians, with the case managers, you know, having those initial contacts. What I've tried to push out over the last several years is trying to have that message sent at time of intake and trying to help parents understand their role kind of from Day 1 and outlining what treatment is, and I think that's really kind of the key. It has to kind of happen, mostly one on one as they come in the services.

P2 added:

> [In regard to parents' involvement in clinical (therapy) services], I'm having them participate in part of the treatment service such as the first part of the therapy session to give the therapist feedback and their perspective of things, how things

are going, and also to include them in strategies to help improve things with their child.

These statements supported the agency's efforts to overcome barriers by providing one-on-one contact with parents at the initiation of services and helping them to understand the importance of their role and ways that they could be involved in treatment.

In further analysis of the themes of Case Management Services and Clinical (Therapy) Services under Theme 1: Services, the number of participant references regarding case management would seem to indicate Case Management Services as the dominant theme. However, when analyzing the themes by content, they were found to be of equal importance.

Agency policies directed case management and clinical (therapy) services. Therapists were responsible for writing the treatment plans based on completed client assessments and then directing the case manager to support the clients in implementing the treatment plans at home and in the community. State and agency policies determine not only the service content but also the ability to be reimbursed for services rendered (CMM, 2019).

Theme 2: Policy

Policies are written directives that guide the provision and quality of program services (Burns, 2012). Theme 2: Policy overlapped with the Case Management and Clinical (Therapy) Service themes. Within Theme 2, the first cycle of coding produced two child nodes: policy barriers and training. The second cycle of coding produced two parent nodes: policy support and policy barriers. As Theme 2 was being developed, there

were far more indicators for policy supports than for policy barriers; however, there were enough references to policy barriers to acknowledge it as a parent node, but not a theme. Of the policy barriers, the Medicaid Waiver policy was referenced the most often. An example of a policy creating barriers to parental involvement was the Medicaid Waiver policy.

P1 explained how the policy update in the Medicaid Waiver program created barriers to parental involvement:

> The Medicaid Waiver policy provides for additional reimbursable services for the parent and child to prevent hospitalization of the child. In 2018, the state updated this policy and changed the implementation timeline. In the original policy, once the child met eligibility requirements, and the parents signed the parent choice document, services could begin immediately on Day 1. The updated Waiver policy did not acknowledge the crisis component to keep children from being hospitalized, and the start day went from Day 1 to Day 60. This delay of service meant that children and parents needing extra support to prevent hospitalization would have to wait 60 days for additional services, raising the probability of the hospitalization of the child and increased health care costs. Through the Children's Directors State Association, state directors worked with the state to correct the policy, and adjustments were made so that services could start on Day 5.

This description of a change in the state's Medicaid policy demonstrated how policy could create a barrier for the agency to provide and the parents to receive additional services.

Within the development of Theme 2: Policy, there were many references to policies supporting strategies to overcome barriers to parental involvement. The most referenced child nodes within the policy support parent node were training and intake process. Agency policy requires training to provide case management services. This need for training was verified through CARF's (2019) standards directions for the agency to provide training and support for the delivery of services, including how to communicate with and reach parents. Policy mandates, such as the intake session and the 90-day treatment updates, provided parental contact opportunities for clinicians and providers (CMM, 2019). CARF (2019) requires opportunities to educate, build relationships with, and engage parents in their children's treatment.

P2 commented on the effect of policy on parental contact at the first appointment, noting that "we have to have parental consent from them even to enter treatment, and we require that they be part of the treatment planning process, sign treatment plans, do that piece of things." P2 also identified another task at the first appointment as "educating the family and the client on this is their role and trying to see that this is really a dual process."

These comments supported the policy requirements that served as strategies to overcome barriers to parental involvement. Concerning strategies used by the agency to overcome

barriers to parental involvement, Theme 3: Communication also overlapped with the Policy, Case Management, and Clinical (Therapy) Services themes.

Theme 3: Communication

As already stated, Theme 3: Communication had a strong presence in the Policy, Case Management and Clinical (Therapy) Services themes. This overlapping of themes occurred in the nodes of communicates with parents and TCM. Again, TCM was the primary billable service used to communicate with parents when the children were not present (CMM, 2019). Although TCM services are a separately billed service, agency policy indicates that only case managers are trained in the use of TCM, particularly within the case management and TCM services.

P1 described the importance of communication as “talking about community-based services; the case managers are trained to use their [TCM] training and services in that way and so they are encouraged to communicate with parents weekly on how it’s going for the kids.”

P5 stated, “I think our staff utilizes case management to communicate to parents/guardians regarding updates, attending IEP meetings, phone calls, etc.” These comments demonstrated the use of policy to direct case managers’ services that increased communication with parents and generated revenue.

Triangulation of the agency, the [name of state redacted] Department of Aging and Disability Services (2019), and CMM (2019) policies, plus CARF (2019) standards, verified the intersection of the Policy, Communication, and Case Management Services themes. Triangulation of different sources and methods challenging or confirming a point

or set of interpretations improved the validity of the study (Ravitch, 2016).These data on policy and standards confirmed the purpose of case management as serving the needs of clients and parents in the home and community settings and allowing for billable service coordination and parent communication without the children being present (CARF, 2019; CMM, 2019). The policy and standards directions for therapists are to provide services as clients come to the therapists (CARF, 2019; CMM, 2019). Case management policy allowed the case managers to overcome barriers to parental involvement by going to the parents in the home or community settings (CARF, 2019; CMM, 2019).

The importance of case management communication was evident when analyzing the child node of communicates with parent within the Case Management Services, Communication, and Policy themes. When analyzing the references to this child node, they all mentioned communicating with parents. However, they could not be separated into case management versus TCM billable services because billing the appropriate services depended on the presence or absence of the children, not what was being communicated. As indicated in the state's Medicaid policy (CMM, 2019), the TCM billing code provided a reimbursable service that communicated with and involved parents in their children's treatment without the children being present. This contact had to last more than 8 minutes to be billable (CMM, 2019). Time spent in unsuccessful outreach through letters, phone calls, home visits, or unattended appointments were not billable. The therapists could not bill for services if the children were not present (CMM, 2019).

TCM was coded as a child node under the Case Management Services theme, but it also overlapped within the Communication theme strongly. As already stated, TCM is a separately billed service from Case Management Services. However, a vast majority of the references in the child node of TCM referred to communication around service coordination. For this reason and the purpose of analysis, under the Case Management Services theme, the child nodes of communicates with parents and TCM were combined. This combination strongly supported the Communication and Policy themes, demonstrating the overlap of the themes.

P1 commented about communicating with parents:

> I then in turn teach mom to use that workbook of anger skills, whether it's case management staff doing parents support with that mom or targeted staff [TCM] for non-Waiver kid doing some with that mom, how much further we're going to get, how much more family changes that we're going to affect if we get everybody on the same page.

In relation to service coordination, P1 added, "How far are we really going to get with a family if we're not bringing everybody in and getting everybody on the same page?"

CMM (2019) policy aligned with this finding by directing the role of case management services to communicate with parents and coordinate services with other child service providers in the community. Through new initiatives, the agency has taken service coordination to a new level and has facilitated mental health service integration into the community.

The September 2017 board meeting minutes addressed two of the agency's new initiatives. Through grant funding, mental health services were integrated into one school district. The agency also was permitted by the board to begin the search for a new EMR system. The July 2019 board minutes indicated that the school-based mental health services would be integrated into nine school districts beginning in August 2019. However, because of reduced revenues, the identified EMR system would not be purchased. Further discussion of the new initiatives will take place in the Leadership and Funding sections. The next section discusses themes within the results relevant to client focus.

Client focus. Examination of the agency's client focus results led to the emergence of three additional themes: Measurement, Attitudinal, and Societal Economics. The first theme to be discussed in relation the agency's client focus is measurement.

Theme 4: Measurement

Theme 4: Measurement referred to the process or tools that the agency used to measure parental involvement, client feedback, and program outcomes. The first cycle of coding identified no measurement of parental involvement as the top child node and different levels of parent contact success as the second child node.

Regarding the case managers' different levels of parent contact success, P1 stated:

> I think it's just kind of depending on the training and the case manager that you get: Some are successful at navigating through that, and some are just not because

they just kind of figure out after a while, okay, this parent's not going to get involved so we're going to do our own thing.

This statement showed that the agency did not have a means to measure the effectiveness of the case manager training in reaching out to poorly responsive parents.

In the second cycle of coding of the development of Theme 4, most of the child nodes referenced the parent node of not measuring parental involvement.

P2 made the following comments about not measuring parental involvement:

> I don't think that we have a specific measure as far as an outcome tool for that, that we use. I think it's, it's more loose than that. I think it's more therapist and case managers having the recognition; this parent's not very involved. I think it's less of a specific scientific measure as much as are they being involved in treatment, and are they following through with homework assignments or suggestions? I think it's more just kind of one-on-one evaluating. How are they doing with that?

P1 stated, "I would love to have something like that [Child Behavior Checklist] to measure that [parental involvement], now measuring the parent involvement, I don't know how we would do that."

These comments indicated that the agency did not have a tool to measure parental involvement or program service outcomes. Measurement was more of a one-on-one evaluation through the providers than an organizational outcome.

Theme 5: Attitudinal

The client focus was also addressed under Theme 5: Attitudinal. Becker et al. (2015) defined attitude as the belief that the benefit of treatment outweighs the cost. The first cycle of coding produced child nodes related to attitudes toward parental involvement in children's treatment. The second cycle of coding produced two parent nodes: parents' attitude toward being involved in their children's treatment and the agency's attitude toward involving parents in their children's treatment.

In regard to parental attitudes, P2 said:

> It's just that families don't want to participate in treatment. They want us to fix the child. I think society has sort of become a situation where people want to drop off their child and have them fixed or have a quick fix with a pill.

P1 stated, "You get parents that don't understand maybe the service very well, and so they're cautious and afraid that we're there to investigate them. And so, they keep us at arm's length."

These statements demonstrated how the parental attitudes of not wanting or afraid to be involved in their children's treatment created treatment barriers.

Acknowledging the importance of parental involvement and training were important nodes in the agency's attitude toward parental involvement. Regarding parental involvement in their children's treatment, P2 remarked, "I mean, I think it's [parental involvement] just something we see as very important."

P1's reflection on the choice of the ASLT to view the lesser paid TCM services equal to the higher paid case management service when calculating productivity rates was as follows:

> They [leadership] acknowledged that [parental involvement importance] in paying the same level of incentive for an hour that we're out working on the phone or in a meeting with the family [TCM services], which is a vastly lesser rate than the other rate [case management services]. So, I do appreciate that about our center.

When comparing the agency to other CMHCs in the state, P1 commented, "I have seen some centers that have a ratio when you're looking at direct service [TCM and case management] requirements."

These comments supported the value that the agency placed on parental involvement by giving equal credence to TCM services and case management services, even though the TCM was reimbursed at a lower rate.

The agency's attitude toward the importance of parental involvement was nearly equal to the references for training case managers to involve parents. Demonstrating the importance of parental involvement through Agency training, P1 explained:

> I always train them to use the language - Let's see if this is something you're interested in because that little nuance of language says to that person, I don't have to do this. Do I want to do this? And they feel like they have choice.

P1 continued by commenting on the required additional trainings over and beyond the mandated state trainings that case managers must complete during orientation:

> There are four of them [trainings)] that are not musts, that I always have them do, and one of them is motivational interviewing, and it talks about how you interact and how you contact a family and interact with and ways to get them to open up and have a successful relationship.

In reference to training new therapists on educating parents about their expected role and involvement, P2 stated:

> We try to emphasize that, I know in my initial trainings with staff, I developed kind of a training manual, and as I'm going over the training manual, I'm talking about what it takes. I always try to include that piece.

P1 identified the agency's view of parental involvement importance by explaining the follow-up training that the agency provided to case managers:

> Five or 6 weeks after I've met with them for training, I will meet with them at least once a week when they're new, and that's one of the things we talk about is how important it is to have that parent involvement.

These statements indicated the agency's value of parent involvement by the amount of detail and time spent training case managers and therapists on the importance of involving parents in their children's treatment.

Triangulation was completed by comparing the generated data with the agency's policies and CARF (2019) standards. Results of this analysis supported the importance of training through policy requirements for orientation training and weekly nonbillable

communication time for team meetings. New case managers and therapists complete 16 required online pieces of training regarding ethics, safety, cultural awareness, and specified program services. Although the supervisors continue training through 1:1 supervision, the agency has no policy directing this line of communication and training. Once the orientation training is completed, there are no training logs or evaluation means to track training effectiveness or future training needs.

Theme 6: Societal Economics

Theme 6: Societal Economics overlapped with the node of training in the Attitudinal theme's agency attitude toward the importance of parental involvement. Theme 6 referred to the societal factors affecting clients. In the first cycle of coding of the development of Theme 6, the child nodes of transportation and economic were the highest referenced. In the second cycle of coding, the child nodes of transportation and economics were all social problems related to economics, which developed the theme of Societal Economics.

P2 commented about the ways that societal economics affected clients:

> Many of the people we see may or may not have a car or may or may not have gas money. They [parents] may not even always have a working phone and another huge factor is because we treat many of the lower socio-economic clients here, those parents may work at a place that's on a point system. So, they're just not able to take the time off of work to be part of their child's treatment.

P1 described the experiences of clients experiencing societal economic barriers:

> You get families that that may be embarrassed of the home life that they have and so either it's wanting for niceties or I may not know how to put that, you know where they have dirt floors, or they have holes in the walls that you can see the outside or they don't have running water or they don't have a trash service.

P2 stated that the ASLT acknowledged the importance of overcoming parental barriers by "first providing the necessary means of doing their [case managers'] jobs such as having company cars for case managers, so they can drive to parents' homes and having company cell phones."

In regard to training case managers to reach parents who might have been experiencing multiple barriers, P1 said:

> I'm constantly bringing it up in supervision of how important the involvement is and how you know, it's just we need to do everything we can and bend over backwards and continue to bend over backwards to get it [parental involvement]…. We hang in there and keep trying because sometimes it's that one little thing where you can build relationship with them and they begin to value what you do, and they will get more involved.

These comments focused on the social barriers that some clients faced and provided examples of strategies that the agency used to try to overcome the increased challenges. The next section presents a discussion of themes affecting the agency's workforce.

Workforce. Data analysis did not determine a dominant theme for the workforce**.** However, the parent node of productivity in the Funding theme addressed overcoming

access and funding barriers in facilitating parental involvement. Currently, the agency uses service accessibility to determine workforce capacity.

P1 explained that in determining staff capacity,

> There's no magic number; it differs for each person. You know a full caseload is, "I can still do my job, and the kids' needs are being met," and that's honestly what we go by. I've seen people be super full, very full with 14 or 15 kids. I've had people with 30 kids, [and] they say, "I'm doing fine."

P2 described determining staff capacity:

> We really look at a kind of overall look at caseloads and productivity and how many billable hours and client hours individuals have and then when I start to see things like wait-lists are increasing because people are just booked out too long, really, it's a matter of kind of trying to measure access, and as access suffers, we try to look at that and staff.

As indicated in the aforementioned comments, the basis for determining the staff workload capacity was having staff and supervisors collaborate to determine when further expansion of their caseloads would impair the quality of client services versus the staff members' billable or client hours. For case managers and therapists, growing wait-lists of services were the determining factor in assessing the need to hire new staff.

The July 2019 minutes of the board meeting reported that the agency was experiencing a decline in revenue. At the time of this study, the agency did not have a productivity report to measure caseload management. Without such a report, it was difficult to measure the ability of therapists to manage their caseloads. Licensed mental

health providers’ caseload management is challenged through lengthy wait-lists that not only delay clients’ access to services but also increase the number of expensive no-show appointments (Lamsal et al., 2018).

P1 stated, “Besides the negative effect on clients, unfilled appointment times in providers' schedules negatively affects productivity rates and program revenues.”

According to P4, the current Lean management committee is addressing the process of using productivity levels to improve revenues and service accessibility. Minimal data reports are used at this time to determine capacity.

P1 stated, “I run a report every Monday morning that tells me the number of insured vs. uninsured kids, and I meet with the ED and discuss staffing needs. I’ve done this for 10 years.”

As already explained, the need for additional case managers is determined by the DCS and ED’s weekly monitoring of caseload numbers and delayed accessibility to services. Monitoring service accessibility is a function of leadership. The next section presents the leadership strategies used to overcome barriers in facilitating parental involvement.

Leadership. Reviewing the agency’s leadership results resulted in the development of the Leadership theme. In this study, leadership referred to the ASLT. Theme 7: Leadership is discussed next.

Theme 7: Leadership

For this study, Theme 7: Leadership referred to the ASLT. The first cycle of coding resulted in two child nodes: bigger footprint in the community and

communication. The second cycle of coding labeled the parent node of implement strategic plan. Initially, the parent node of implement strategic plan was coded as the child node of communication because communication was essential to strategic planning. Although communication was fundamental, resources had to be allocated to implement the strategic plan. Therefore, implement strategic plan was made a parent node under Theme 7.

P2 described the integrated school-based services program as a strategic plan that required communication and resources. P2 explained, "It has grown from one therapist and case manager in one school district to nine therapists and ten case managers in nine school districts. And I continue to be contacted by other school districts wanting this service."

Triangulation of the September 2018, March 2019, and July 2019 minutes of the board meetings indicated that the agency had made significant progress on implementation of the strategic plan of community service integration. In September 2017, through grant funding, one therapist and one case manager position were placed in the school district. By August 2019, nine therapists and 10 case managers had been laced in nine school districts, and one mental health conference had been hosted by a partnership between the agency and the school district. The conference theme was suicide prevention, and it was well attended by 150 families resulting in 400 people. Although the child node of bigger footprint in the community was a strong influence in the implement strategic plan parent node references, the significance did not rise to the level of a theme.

Communication was referenced frequently in the Leadership theme and was initially coded as a parent node. However, on further analysis, it warranted being designated a theme because of the significant number of references made by all participants. Thus, the Leadership and Communication themes overlapped. Statements were made by participants regarding communication between state mental health leaders, between ASLT and providers, between direct service providers, and between parents and providers.

Regarding communication during the agency's nonbillable team meetings and staff supervision, P1 stated, "I think to me, that [scheduled nonbillable team meetings] just reinforces that they [Leadership] do acknowledge that teamwork and that communication is an important part of treatment, right?"

P4 said, "There are treatment team meetings scheduled to facilitate conversation between team members as well to discuss concerns."

Concerning communicating with parents, P1 stated, "I feel like with the case managers and community-based services [case management], they are encouraged at every turn to be communicating and working with families."

P2 asserted, "We're doing services within the home via case management attendant care that sort of thing trying to reach out where the parent is."

Finally, in regard to an ineffective state policy change and the workings of the State Directors Association, P1 stated, "Basically, all the directors got together and said to the state [that] we know you're working on that because we know that wasn't correct when it was put in, so you just let us know when that's fixed."

These statements highlighted the importance of communication and the communication mechanisms used to support parental involvement at the client, agency, and state levels.

Although the child node of communication in the themes of leadership and communication addressed the importance of leadership's communication, it also pointed out the agency's mechanisms for communication.

Regarding mechanisms for leadership and staff communication, P1 said, "They [leadership] allow for individual supervision time away from the clients."

P1 also commented on the use of monthly staff meetings:

> So we just again talk about how can we better get that parent to talk to us. Have you tried this? Have you tried that? We do that in individual supervision and we do that in group supervision [staff meetings].

These statements referred to the two communication mechanisms that the ASLT used to communicate with staff. The next section is a discussion of Theme 8: Funding.

Financial. When reviewing the results of the agency's financial factors, one theme dominated: Funding. Theme 8: Funding is discussed next.

Theme 8: Funding

When reviewing the results of the agency's financial factors, one theme dominated. Theme 8: Funding referred to the financial aspects of the agency. The first cycle of coding identified the most referenced child node as funding, followed by the child nodes with equal strength of productivity and TCM rates. The second cycle of coding resulted in all 20 codes, or 100%, generating Theme 8. Nearly half of the

references referred to the child node of identify funding and were specific to grant funding.

P1 stated, “We identify we need this to be better, [but] how we gonna pay for it?”

P2 said, “Part of our strategic plan and something we’re moving towards is having a grant writer, which would be a big step for our agency to be able to do that. So that’s, that’s on the horizon, hopefully for us.”

P2 described their current grants activity as “we have several grants that we’ve applied for multiple times,” and “we also partner with other nonprofits such as Thrive here in our County, and they have grant writers on board and are always looking for opportunities and so we’re developing relationships with other organizations.”

P1 commented, “Other directors have done a lot of work going out to like I think it was the Reach Foundation to get a $50,000 grant to help pay for that accreditation.” These comments demonstrated the agency’s focus on grant funding as a revenue stream.

Other important but less referenced were the parent nodes of direct service productivity rates and protecting time for weekly meetings. Productivity rates were monitored for case managers, and decisions had to be made on the amount of time spent trying to reach disengaged parents.

P1 explained, “They [the agency] only track hours of the productivity that you are out there working with your clients or on behalf of your clients, which that’s what TCM is. So, you’re given credit for both TCM and CM rate there.” The effect of revenue from staff capacity and productivity rates was addressed in the Workforce section. At the

parent node juncture of protecting time for weekly meetings, the themes of policy and funding overlapped.

P1 commented about the nonbillable weekly team meetings:

> That comes at a great cost, a great cost because every, you know, if you've got 25 therapists that are meeting for at least an hour every week or every other week depending on the office. That's it. That's a huge. That's, I mean, you're talking tens of thousands of dollars over a year.

CARF (2019) standards, CMM (2019), and Agency policies all required service coordination. However, according to CMM, this hour was not reimbursable for therapists but was reimbursable for case managers at the reduced TCM rate.

The Policy and Funding themes intersected again through the child node of addressing financial restrictions. Although this child node had fewer references within the parent node of policy barriers, the content reflected the financial choices of the ASLT and resulting funding repercussions in addressing parental involvement barriers.

P2 said this about financial restrictions:

> So how much time can we put into driving to people's homes to see if they're there, making phone calls, doing outreach because those are all of course nonbillable services, as most of our contact with parents are mostly nonbillable services. And so, there's a financial piece there, where you have to sort of lay out, how much can we do this? You know how much time can we afford for a clinician to be trying to reach out to parents versus seeing the next 20? So those are kind of factors that all kind of come together, and you sort of have to make

> case-by-case decisions on how much time can we spend on some of those activities.

This comment reflected the financial restrictions created by agency policies in trying to increase parental involvement.

Triangulation with Medicaid policy (CMM, 2019) limited the activity billable under TCM and did not allow the case managers to provide parental assistance in gaining needed resources. According to the policy (CMM, 2019), parents would need to enroll in services and qualify for adult case managers, who could then help the parents to obtain community resources, mental health treatment, or other services to meet the parents' needs.

P2 explained:

> A lot of times, our parents have either real mental health issues or they have substance abuse issues. So, trying to get them the services that they need so that they're functioning better, I think, is really kind of key for many of our parents.

P1 stated, "We also even go to encourage parents to enter services themselves because another barrier that comes up is parents aren't functioning well enough themselves so that they're able to meet their children's needs."

These statements showed how the parents' personal challenges and their need for services could create barriers to being involved in their children's treatment.

Triangulation with the fiscal data analysis indicated that funding challenges occurred through the [name of state redacted] Department of Aging and Disability Services (2019) laws stating that services could not be denied because of clients' inability

to pay. According to the agency's November 2019 *Clients Open in Case Management* data report, 25% of the children enrolled in services did not have a payer source. According to state law, the agency had to absorb this cost of providing services. The July 2019 minutes of the board meeting indicated that the agency's ED gave legislative testimony to increase government expenditures on children's mental health services. According to the September 2018 meeting, the ED sought increased funding from the county government. The Societal Economics theme overlapped with the Funding and Policy themes at this juncture. According to the U.S. Census Bureau (2017) website, the percentage of families living in poverty over the six-county service area ranged from 13% to 18%, and the percentage of uninsured individuals under the age of 65 years ranged from 9% to 12%. These findings coincide with the agency's November 2019 *Clients Open in Case Management* data report that 25% of the children enrolled in services did not have a payer source and required the agency to absorb the cost of their services (CMM, 2019).

In summary, eight themes emerged from the data analysis: Services (Case Management and Clinical Therapy), Policy, Communication, Measurement, Attitudinal, Societal Economics, Leadership, and Funding. These themes reflected the strategies used by the agency to overcome barriers in facilitating parental involvement in their children's psychosocial treatment. These strategies were defined within the agency's context of services, programs and new initiatives, client focus, workforce, leadership, and finances. Having completed the data analysis, attention now turns toward the implications of the findings and the potential for social change.

Implications of the Findings and the Potential for Social Change

There is a call for policy and systemic reform within mental health services for children and families (Bruns et al., 2014; McLennan, 2015; McMullan & Watson, 2017; Mendenhall & Frauenholtz, 2014; Pecora, 2017). Providing children's mental health services is a political and public health concern that involves social, fiscal policy, and attitudinal factors (Beck, 2016; Bee et al., 2014; Garland et al., 2017). Implications of reform have individual, organizational, community, and systemic effects. These implications have the potential for positive social change.

Individual Implications

Funding and policy reform have the potential to increase service access to parents and decrease the stigma of engaging in services. Providing reimbursement for parenting education, concurrent treatment of parental mental illness, couples therapy, and TCM for licensed providers increases the opportunity for the involvement of parents in their children's psychosocial treatment (Acri et al., 2014; Hocutt et al., 2002; Lantara, 2019; Preyed, 2015). Positive social change occurs through early intervention in children's mental health issues. Early intervention provides the opportunity to increase the children's long-term sense of well-being and prevent the high societal costs of increased health care usage: unemployment and antisocial behaviors (Anderson et al., 2017; Reardon et al., 2017; Sanders et al., 2014). Involving families in treatment can help to improve outcomes and lower health care costs (Carman et al., 2013; Palinkas et al., 2017).

Organization Implications

Data-driven decision making, measurement of outcomes, and monitoring of practices are a concern of state mental health directors (Hernandez et al., 2017). The results gleaned from this study have the potential to encourage the agency to evaluate its data infrastructure and data reporting needs to assist in measuring, monitoring, and making decisions about the involvement of parents in their children's psychosocial treatment. The data would give the agency the opportunity to identify barriers specific to parental involvement as well as those that affect accessing services. Data on parental involvement also could demonstrate the effectiveness of the program and provide information to support funding for new programs (Boyle et al., 2019; Duncan et al., 2018; Hernandez et al., 2017).

Training is a second potential organizational implication from this study. The effect of instruction is not measured, except through third-party payer audits. Informal training occurs through 1:1 supervision, but as stated by P1 and P2, the agency has no specific way to measure the effectiveness of training regarding involving parents or soliciting feedback from parents. Developing a measurement tool or agency standards of care involving parents could support strategies to engage parents and improve program outcomes (Duncan et al., 2018). It also could identify any unknown agency barriers such as judgment, poor coordination of services, difficulty accessing services, or lack of understanding the importance of their role (Haine-Schlagel & Walsh, 2015; Lantara, 2019; Reardon et al., 2017).

Knowledge management is a third potential implication for the organization. With therapists working in offices spread over six counties, the reservoir of knowledge is extensive. The agency pays a designated allowance for the therapists to attend training. At clinical staff meetings, the therapists can give short reports on the skills learned and their contact information. Encouraging interagency support between and among county offices is an efficient way to manage the agency's knowledge reservoir. Planning can occur with the permission of supervisors to address tacit knowledge needs.

Community Implications

P3 commented that "communities benefit when the Agency is doing its job and meeting the needs of its members." The potential implication for the community from this study is an increased emphasis on community education regarding preventative mental health tools, signs and symptoms indicating the need for mental health interventions, and the types and means of recommended services. Integrating services through community partnerships opens the door to increased access, awareness, and the ability to engage in services. Clients' understanding, paired with access and ability, has the potential to decreases the stigma of mental health and improve treatment outcomes. Improved community well-being has the potential to provide a vibrant community environment that provides support in overcoming poverty, impaired parenting, stigma, and other barriers to facilitating parental involvement in their children's psychosocial treatment. Improved community well-being is addressed next.

Systemic Implications

Children's mental health services are child focused in that the criteria for engagement in mental health services are children's behaviors that result in impairment in the social, community, or home setting (CMM, 2019). Increased parenting support and services occur as the severity of the children's behaviors reach a designated level of impairment (CMM, 2019).

Results of this study have the potential to encourage policymakers to move from a child-focused system to a system that focuses on and treats the family unit, a system that moves from treating children's behaviors to treating family behaviors. A policy requiring the measurement of parental contact and outcomes can support funding for parental involvement interventions such as parenting classes, therapy without the children present (couples therapy), or the provision of parental insurance. Five million children are living with parents who are dealing with mental illness, and parental mental illness affects the quality of children's lives (Acri et al., 2014; Bee et al., 2014). Providing parents with some financial relief through insurance can increase their sense of well-being, which can then improve children's sense of well-being (McMorrow et al. 2017).

Results of the study also have potential implications for cross-system service coordination. Hoagwood, Atkins, et al. (2018) argued against cutting funding for policies that support health, housing, education, and family income. These policies collaborate to create "collective efficacy-neighbors positively influencing each other" and work to create rich environments that support the well-being of children and adults (Hoagwood, Atkins, et al., 2018, p. 268). Collective efficacy is supported through cross-system service

coordination and policy development supporting basic medical health, mental health, housing, education, child welfare and social services, and juvenile justice services (Hoagwood, Atkins, et al., 2018).

Mental well-being does not occur in a vacuum, and this study has the potential to point policymakers and service providers toward working together to overcome parental involvement barriers on a systemic level. The best strategy for influencing positive mental health pathways is to engage and empower parents so that they can create enriched environments in which their children can grow (Becker et al., 2015; Carman et al., 2013; Dowell & Ogles, 2010; Haine-Schlagel & Walsh, 2015; Nanninga et al., 2015; Sanders et al., 2014). This study has the potential to drive social change related to improved outcomes through policy reform in children's mental health by providing treatment in concert with other programs for the entire family unit, not just the children.

Strengths and Limitations of the Study

According to Ravitch (2016), the more rigorous the research, the more trustworthy are the findings. Ravitch also stated that rigor comprises transparency, validity or credibility, reliability or dependability, comparativeness, and reflexivity. Following are strengths that reflected the rigor of the study.

Strengths

The case study research method and design strengthen the dependability of studies (Ravitch, 2016). The use of generated data, archival data, and data from government and public websites provided a contextual understanding of the practice problem. Further understanding occurred by evaluating data through the conceptual

framework (Baldrige Performance Excellence Program, 2017). Interviews were recorded, and the transcriptions of the participants' responses to the interview questions took place within 48 hours.

Triangulating the interview responses with archival data and information from public and government websites strengthened the credibility of the study (Gibbert & Ruigrok, 2010; Ravitch, 2016). The validity of the study occurred through transparent and collaborative processes, including participant collaboration. The ASLT were adequately instructed on the project, consent to participate was obtained, and transcriptions of the interviews' recordings were e-mailed. Member checking was completed using e-mail confirmation regarding the researcher's interpretation of the participants' interview responses.

Reflexivity addresses the awareness of researchers regarding their influence on the construction of meanings throughout the research process (Ravitch, 2016). Reflexivity, through the researcher's employment at the agency, strengthened the rigor of the study by providing in-depth knowledge of the agency's policies and processes. This knowledge enabled the researcher to increase the descriptiveness of the data with the use of knowledgeable probing questions. Results of this study are generalizable to other CMHCs across the region because of the thick descriptions of the clients being served, CMHCs sharing state and federal stakeholders, and national and global increases in the enrollment of children in mental health services.

Limitations

Ravitch (2016) reported that ethical and valid research requires criticality and reflexivity. The criticality of the study was limited because of the data collection being restricted to five members of the ASLT. Collecting data from the direct service providers would have enriched the descriptive thickness of the data. A future qualitative study would benefit the agency by learning about the specific barriers their parents faced, measurable therapeutic interventions for these barriers, and hard data from intervention outcomes.

Future qualitative research would benefit national and global mental health reform by studying specific evidence-based practices used to engage parents, parental responses to interventions, and measurable program outcomes. Specifically, future research could address gaps in effective interventions to involve parents and the lack of data to lobby for new funding as well as retain current financing.

One limitation of the study was the lack of data collection and reporting by the agency. There were minimal data reports and program outcome measures to affirm the participants' intuitive-based decisions. A qualitative study that includes parental input would help to fill the gap in the agency's program outcomes.

Reflexivity was a strength as well as a limitation of the researcher of this study (Gibbert & Ruigrok, 2010; Ravitch, 2016). As a practicing therapist, the researcher has developed a strong proclivity toward the vital role of parents and the need for their involvement in their children's treatment. Reflexivity can result in personal experiences being perceived as collected data. Member checking was performed to validate the

transcribed interview responses and prevent threats to validity. Data were verified using the transcriptions and the archival data. The researcher also kept field notes and memos regarding data interpretations throughout the research process. The field notes and memos also assisted in keeping data collection aligned with the RQ (i.e., What strategies did the agency use to overcome the barriers to facilitating parental involvement in the psychosocial treatment of their children?).

The final limitation was the exclusion of the medication management program. Because medication use is one protocol used in the treatment of children's mental illness, it would give a broader and more holistic view to include this program in future studies. Including medication management services also could highlight the service coordination barriers within agency programs (i.e., medication management programs from clinical services or children's services) as well as the ways that this program involves parents. Obtaining insight from the agency's MD would increase the descriptive thickness of the data collected.

Section 5: Recommendations and Conclusions

According to the agency's November 2019 *Clients Open in Case Management* data report, enrollment in children's mental health services is increasing, matching the increased demand among state, national, and international populations (Jones et al., 2014; NAMI, 2018; Reardon et al., 2017). Parental involvement can have a positive influence on children's mental health treatment outcomes (Dowell & Ogles, 2010; Hamovitch, 2018; Palinkas et al., 2017; Haine-Schlagel & Walsh, 2015). However, parents face such barriers as poverty, drug abuse, mental illness, stigma, leave restrictions from work, knowledge deficits in children's mental health disorders, and service access that can preclude their engagement in their children's mental health treatment (Acri et al., 2017; Romanowicz et al., 2019; Watson et al., 2015). The purpose of this study was to investigate the strategies that one CMHC used to overcome the barriers to facilitating parental involvement in their children's psychosocial treatment.

Researchers have asserted that the barriers to parental involvement in their children's treatment are related to policy, fiscal, attitudinal, and social factors (Acri et al., 2014; Becker et al., 2015; Bee et al., 2014; Forman-Hoffman et al., 2017; Garland et al., 2017; Jones & Tullt, 2017; Neufeld et al., 2017). When answering the RQ (What strategies did the agency use to overcome the barriers to facilitating parental involvement in the psychosocial treatment of their children?), results of the thematic data analysis aligned with the literature. Four of the eight themes that emerged were related to policy, funding, attitudinal, and societal economic strategies used to overcome barriers to facilitating parental involvement. The themes of Services, Communication, Leadership,

and Measurement promoted and strengthened the strategies used by the agency to increase parental involvement. Next is a discussion of the study's recommendations.

Recommendations

Nine recommendations are made to the agency for potential strategies in overcoming barriers to parental involvement. These recommendations are discussed within the context of support from the literature and the aforementioned eight identified themes.

Recommendations 1 to 3

The first three recommendations involve increasing direct service strategies that may help to overcome the barriers to parental involvement. These recommendations support the Policy, Communication, Services, and Attitudinal themes. Agency policy indicates treatment plans as a means of identifying treatment needs and organizing service provider interventions and communications to reach client-directed goals. The following three strategies also reflect the agency's attitude toward the importance of parental involvement in their children's mental health treatment.

Recommendation 1 is to add parental interventions to the children's treatment plans to support the focus of treatment as a dual process. CMM (2019) policy requires parental involvement at the intake session and every 90-day treatment plan update and that the therapist compose the treatment plans. Although the policies and standards also indicate the inclusion as needed of significant others in the assessments, the treatment plans remain focused on the clients (i.e., the children) through the use of child-directed interventions.

In the data analysis, clinical (therapy) services were referenced less often than case manager services, leading to the assumption that case manager services were more critical. However, upon further analysis, clinical (therapy) services were found to be equally as crucial to facilitating parental involvement. The therapists explain the expectations regarding parental involvement, educate the parents of their role, and direct the treatment plans. The case managers support the implementation of treatment plans in the home and community settings with the children and their parents (CMM, 2019).

Tchernegovski et al. (2018) stated that it is easy for mental health providers to side with either the children or the parents. However, developing a strengths-based perspective that empowers parents supports a balanced view of the parent and their children, providing a dual treatment process. Haine-Schlagel and Walsh (2015) described PPE as an evidence-based intervention that encourages parental engagement in sessions through asking questions, giving their opinions or participating in activities, and incorporating assigned parental and child homework between therapy sessions. Adding PPE interventions to treatment plan objectives provide the opportunity for increased parental education and communication between case managers and parent in the home or community settings, all of which are billable through TCM.

This additional support between therapy sessions can enhance the practice and attainment of new parenting skills. Sanders et al. (2014) noted that the best strategy for influencing positive mental health pathways is by engaging parents and empowering them with the ability to create enriched environments in which their children can grow. Including parents in their children’s treatment plans conveys the message that they are an

important part of the process, provides an opportunity for active engagement in the service, and maintains a dual process focus on the children and their parents (Haine-Schlagel & Walsh, 2015; Tchernegovski et al., 2018).

Recommendation 2 is to delineate between the children and parents' responses in the client intake packet regarding the clients' role and expectations of treatment. According to the agency's policies and procedure, clients receive intake packets that collect current and contextual information, including the clients' goal for treatment and treatment expectations.

In the Presenting Problem section of the client intake packet are three questions: What do you hope to get from treatment? What do you expect from your treatment team? and What do you think your role in treatment will be? The questions could be amended, creating a second set of questions directed to the parents: What do you think your role will be in your child's treatment? What do you as a parent expect from your child's treatment team? and What do you as a parent hope to receive from your child's treatment?

The agency's procedures provide for parental involvement at the intake session in two ways: (a) submission of the completed intake packet, and (b) required attendance (CMM, 2019). Lindsey et al. (2018) indicated that the best time for parental engagement is at the initial appointment. Nakash et al. (2018) reported that the intake sessions are generally the first meetings between the therapists and their clients and that most clients and therapists agree on the primary reasons for accessing services; however, as treatment continues, some differences in treatment goals may become evident. Parental attitudes

toward being involved in their children's treatment can be discerned by assessing parents' hopes, expectations, and beliefs about their role. This information also can give the therapists the opportunity to educate the parents about the agency's attitude toward the important role of parents in their children's treatment. Education and communication around parental involvement have the potential to maintain a dual focus treatment process that maintains alignment of the goals of the treatment team as well as the parents. Although adding the parent questions to the intake packet is a small change, it prompts the parents to think about their role and allows the therapists to explore and educate the parents about their importance to treatment.

Recommendation 3 is to provide additional parental involvement training within the therapists' initial orientation training. Haine-Schlagel et al. (2012) reported that therapists might be more likely to involve parents when the children experience more severe behavioral problems, the parents reported increased caregiving strain, and the therapists were more experienced. The Medicaid Waiver Program provides additional parent support services and wraparound services once the children meet eligibility requirements generally indicating that without interventions, the children may be at risk of hospitalization (CMM, 2019). Although the Medicaid Waiver Program provides additional services, the therapists continue to direct the treatment plans (CMM, 2019). It is important to train less experienced therapists to focus on strategies that involve the parents (Haine-Schlagel et al., 2012; Stadnick et al., 2016).

Becker et al. (2015) reported that parental involvement is attitudinal, meaning that to engage in services, parents must believe that the benefit of services outweighs the cost.

Feeling blamed, feeling judged, not being listened to by therapists, not feeling supported by the formal system, and lacking satisfaction with the mental health treatment have been identified as challenges to parental involvement (Haine-Schlagel & Walsh, 2015). Hamovitch (2018) cautioned mental health leaders and providers of the need to remain alert to the possibility of hidden or unintentional stigmatizing approaches from agency policy and staff attitudes or actions. Provider training programs can have a positive effect on client-provider relationships (B. A. Harris & Panozzo, 2019). Appendix C provides a sample of an additional parent involvement education tool with a pre- and posttest that could be inserted into the orientation training manual for therapists.

Recommendations 4 to 6

Recommendations 4 to 6 are for strategies to overcome the barriers to facilitating parental involvement supported the Measurement theme, which addressed the need to measure the service provision (program) outcomes, training programs effectiveness, policy compliance, and client (parent) satisfaction. The Measurement theme intersected with the Leadership, Policy, Services, Communication, Funding, and Attitudinal themes. The ASLT is responsible for providing and managing policy that directs service provision, training, communication, resource distribution, and regulation compliance (CARF, 2019; CMM, 2019).

Recommendation 4 is to further the use of the Child Behavior Checklist (CBCL) for case managers and the Child and Adolescent Functional Assessments (CAFAS) for therapists. According to the agency's policies and procedures, completion of both evidence-based assessments occurs at intake and then every 90 days. The CBCL can be

completed by the case managers and the parents, and the CAFAS can be completed by the therapists while the parents are present. Both assessments remain child focused by evaluating the children's behavior in the home, school, and community settings. Because scores are currently recorded and available electronically, the agency could generate data reports to compare old and new scores to indicate outcome improvements, or lack thereof, and compare the perspectives of parents and case managers regarding the children's level of improvement. Involving the parents in evaluating the children's progress brings the parents' voice into treatment planning and service provision (Isobel et al., 2019). Agencies need to know if their programs are effective, efficient, and sustainable (Duncan et al., 2018; B. A. Harris & Panozzo, 2019; Hernandez et al., 2017).

Recommendation 5 is to implement a non-evidence-based parent satisfaction survey until agency funds are available to purchase an evidence-based tool. The purpose of this survey would be to evaluate the effects of staff training in managing parental attitudes, identifying hidden stigma in agency policies and staff actions, and assessing overall service provision satisfaction. The survey purpose aligns with the research literature indicating that barriers to facilitating parental involvement in children's treatment includes parents feeling blamed, judged, not being listened to by their therapists, and being confused by the lack of service coordination between and among the multiple agencies serving their children (Acri et al., 2014; Colvin, 2017; Haine-Schlagel & Walsh, 2015).

Within the clinician-client relationship, B. A. Harris and Panozzo (2019) found that although clients' symptoms can have a negative influence on clinicians' views of the

quality of the relationships, the symptoms do not affect the clients' view of the relationship quality. B. A. Harris and Panozzo also found that service providers and clients rank needs differently, with providers' interactions subjective to program demands. B. A. Harris and Panozzo's findings support the research by Hamovitch (2018), who cautioned mental health leaders and providers to remain aware of the possibility of hidden or unintentional stigmatizing approaches from agency policies and staff attitudes or actions.

B. A. Harris and Panozzo (2019) followed these words of caution with the reminder that service provider training programs can have a positive effect on client-provider relationships. A parent satisfaction survey cannot only elicit parental feedback regarding the program but also indicate current training effectiveness and future training needs. Appendix D is a sample of a non-evidence-based client satisfaction survey tool that was constructed from the literature and had previously identified parental involvement barriers. This non-evidence-based tool could be used until the agency purchases an evidence-based tool.

As stated in the July 2019 minutes of the board meeting, no funds were available to purchase a new EMR system or evidence-based outcomes measuring tool. P1, P2, and P3 expressed the desire for and the importance of these tools, but until funds are available, the recommendation is to provide the same non-evidence-based client satisfaction survey consistently to parents biannually over a period of 5 days as well as when they check in for appointments. A locked container would be identified as such and

would be made available for completed surveys. Volunteers from each county could be recruited through social media or community partners and trained to tabulate the results.

Recommendation 6 is to include parental involvement indicators in the chart audit of policies and regulations. Auditing parental involvement documentation in the EMR could occur in three places: (a) intake progress note regarding education of the importance, role, and expectations for parental involvement; (b) documentation of attitudinal and behavioral parental involvement in ongoing therapy notes; and (c) examination of treatment plans for the presence of PPE interventions. The chart audit process could be an evaluative and educational tool for supporting parental involvement.

According to agency policy, chart audits are completed monthly to ensure policy and regulation compliance and the effective use of agency resources. Current policy also directs the clinicians to review, sign, and return the chart audits to their supervisors. Enforcing this policy requires using the audit process as a tool to evaluate training, identify training needs, and affirm the quality of service provision. Fenwick et al. (2019) found that audit and feedback interventions help to compare expected performance standards against actual performance. Fenwick et al. also noted that comparing the ideal to reality can highlight discrepancies indicating either training effectiveness or the need for more training. Nemec (2018) identified the indirect benefits of training as improved staff attitudes, increased retention rates, and increased competency.

Because the audit process also indicates policy compliance, audit results can be used to affirm excellence in the provision of services. Researchers have stated that providing recognition and awards can build employee engagement (Makoni, 2019;

Osborne & Hammoud, 2017; Rai et al., 2018; White, 2016). Auditing tools could be used to recognize work that was well done by employees.

Recommendations 7 and 8

The next two recommendation for strategies to overcome barriers to facilitating parental involvement lies within the Funding theme. Recommendations regarding funding intersected with the Communications, Services, Measurement, Policy, and Leadership themes. Policy directs the type of service and the amount of reimbursement for services rendered (CMM, 2019). The amount of reimbursement and the choice of service depend on communication taking place in the absence or presence of the clients (children; CMM, 2019).

Recommendation 7 is to employ a full-time grant writer. Researchers have asserted that child welfare reform has been and remains underfunded and burdened with funding challenges (Graaf & Snowden, 2017; Reid et al., 2018). Managing better outcomes effectively with fewer resources for the changing needs of families continues to be a current theme for child and family services systemic and policy reform in the United States (Bruns et al., 2014; McLennan, 2015; McMullan & Watson, 2017; Mendenhall & Frauenholtz, 2014; Pecora, 2017).

The November 2019 agency *Clients Open in Case Management* data report indicated that even though 25% of the children enrolled in agency services do not have a payer source, the [name of state redacted] Department of Aging and Disability Services (2019) has mandated that no client can be denied services because of an inability to pay. In addition, reimbursement of therapeutic services occurs at a lower rate, despite the

agency cost to employ therapists being substantially higher (CMM, 2019). Absorbing the cost of clients who cannot pay for services and receiving less reimbursement for the higher cost of services align with research pointing to funding challenges and the need for policy reform and additional funding streams.

According to the September 2017 and July 2019 board minutes, integration of mental health services within the school setting began with grant funding for one therapist and one case manager in one school district and then expanded to nine therapists and 10 case managers in nine school districts. The agency is using grant funding and would benefit from employing a full-time grant writer.

One benefit of a full-time grant writer would be to have that individual prepare a grant to purchase a new EMR system. Bryson (2011) suggested that agencies build into their strategic plans enough resources (i.e., people, time, attention, money) to ensure the successful implementation of evidence-based practices. Research has indicated that mental health leaders have expressed concern about their data-gathering capacity and the lack of infrastructure to support data-based decision-making processes (Boyle et al., 2019; Duncan et al., 2018; Hernandez et al., 2017). Monitoring program practices and measuring outcomes through data infrastructure and collection have become increasingly important as organizational leadership seek funding and sustainability (Duncan et al., 2018; Hernandez et al., 2017; Wagner, 2014).

VBPs are on the horizon for mental health services (CMM, 2019). VBPs are part of CMM's (2019) broader quality strategy to reform the delivery and payment of health care; VBPs are a new paradigm for CMM's delivery and reimbursement structure. VBPs

reflect a shift in focus from the current fee-for-services volume model to the provided services value model (Wagner, 2014). In future, all children's mental health services will be required to provide VBPs that will require efficient definitions and measurements of program outcomes (CMM, 2019). Mental health leaders will need to define VBPs by measuring their mental health service outcomes. This pending CMM policy change will require the agency to have a means of collecting and providing program outcome measures, a necessary function of the EMR system.

Recommendation 8 is the development of a caseload management process that uses the agency's policies on walk-in status, cancellation lists, and therapists' productivity reports. Long wait-lists delay clients' access to services and increase the number of expensive no-show appointments that challenge licensed mental health providers' management of their caseloads (Lamsal et al., 2018). Productivity requirements have the potential to impact staff retention rates negatively; however, self-efficacy and job satisfaction can mediate the negative impact partially (Franco, 2015). Agency policies and procedures regarding walk-in status allow clients with an excessive number of no-show appointments to schedule same-day appointments so that they can seek services and the agency can protect its revenues against excessive and expensive no-show appointments. Agency procedures allow therapists to place clients wanting more frequent appointments on the cancellation list. As appointment cancellations are received, clients on the list are offered the newly open appointment times. P1, P2, and P3 mentioned the use of a manual waiting list as one way to increase service access. P4 indicated that the current Lean project committee is working to develop service provider

productivity rates and processes supporting clients' desire for service, the providers' ability to manage caseloads, and the agency's sustainability.

Recommendation 9

Recommendation 9 is to prepare a policy or a procedure that identifies the agency's communication process. CARF (2019) standards require evidence of communications that reflect a "mutual exchange of information and ideas, transparency, and access to people and information" (p. 84). Because 80% of a leader's time is spent interacting with coworkers, it is important to establish a simplified communication process that can prevent risks, identify threats, and address workplace issues (Braun et al., 2019; Davies, 2017). Through this simplified mechanism of communication, employees feel listened to and valued, which can then improve quality and performance (Davies, 2017; Lantara, 2019).

Although e-mail communication is convenient, employees prefer face-to-face communication (Braun et al., 2019). The five study participants cited department staff meetings, team meetings, and 1:1 supervision between directors and providers as avenues of agency communication. P1 and P2 identified several types of communication occurring during staff meetings, one-to-one supervision, and team meetings: informal training, agency and policy updates, identification of staff feedback and needs, problem-solving challenging cases, knowledge sharing, and building of relationships. These types of communication occur between coworkers and between leadership and staff. Currently, the agency's policies and procedures direct the team meetings, but there are no policies or procedures regarding program staff meetings or one-to-one supervision.

Future Studies

This study was conducted at one CMHC in a rural Midwestern region of the United States. Recommendations for future studies include developing evidence-based parental involvement measures to define the factors that comprise parental involvement and evaluate their effectiveness on children's mental health outcomes. Research also is needed to identify specific evidence-based parental interventions and their measured effect. Data from these two potential research endeavors could help mental health leaders to obtain funding support for interventions that increase parental involvement and improve children's mental health outcomes.

Further research on the effect of service coordination on overcoming the barriers to parental involvement and improving mental health program outcomes is needed. Specifically, cross-system service coordination among mental health services, child welfare services, and other social support systems could address the effect of service silos on parental involvement, health care costs, and program outcomes. A fourth area for future study is understanding the agency's parents' attitudinal and behavioral choices to not engage in their children's treatment and then identify needed strategies. Finally, this study encourages research comparing the child-focus and the dual-focus (i.e., child-parent) treatment of children's mental health disorders that could add to the current literature addressing the effects of parental involvement on improving children's mental health outcomes.

Summary

Managing better outcomes effectively with fewer resources for the changing needs of families is a current theme of child and family services systemic and policy reform in the United States (Bruns et al., 2014; McLennan, 2015; McMullan & Watson, 2017; Mendenhall & Frauenholtz, 2014; Pecora, 2017). The increased prevalence of children's mental illness and the need for community-based treatment with enhanced outcomes have thrust the need to improve children's mental health treatment to the forefront of this reform (Haine-Schlagel & Walsh, 2015; NAMI, 2018). The system of children's mental health services remains underdeveloped and faced with funding shortages, and it reflects a disconnection between institutions and the families whom they serve (Graaf & Snowden, 2017; Reid et al., 2018). Addressing numerous associated and embedded levels, such as the macroenvironment (e.g., states); organizations or systems (e.g., community mental health clinics); programs (e.g., children's mental health and partnering child welfare programs); practitioners (e.g., therapists and case managers); and clients (e.g., children and their parents), generally improves the outcomes and sustainability of particular interventions (Forman-Hoffman et al., 2017).

Accessing and engaging in services are affected by social, fiscal, policy, and attitudinal factors (Becker et al., 2015; Garland et al., 2017; Hoagwood, Atkins, et al., 2018; Mauer, 2015; Neufeld et al., 2017). As seen in the results of this study, policy, funding, social, and attitudinal factors have contributed to barriers to facilitating parental involvement, highlighting the need for policy and systemic reform. However, policy,

funding, social, and attitudinal factors also have presented the opportunity to educate parents about the importance of their involvement in their children's treatment.

Although overcoming some barriers may include large funding strategies such as the purchase of a new EMR system or the hiring of an agency-based grant writer, other strategies are not dependent on new funding. The strategies include the ongoing evaluation of hidden or unintentional stigmatizing approaches from agency policies and staff attitudes or actions through parent satisfaction surveys, parental response to selected questions in the intake packet, orientation training on strategies to involve parents, and the provision of parental interventions in addition to interventions in treatment plans directed toward children. Parental involvement strategies can encourage dual-focus child-parent (family) mental health treatment.

The best strategies to influence positive mental health pathways are to engage and empower parents to create enriched environments in which their children can grow (Becker et al., 2015; Carman et al., 2013; Dowell & Ogles, 2010; Haine-Schlagel & Walsh, 2015; Nanninga et al., 2015; Sanders et al., 2014). As parents gain the capability to create enriched environments for their children, the families' sense of well-being can develop. Improved family well-being has the potential to effect social change by becoming part of a vibrant community environment that provides support in overcoming poverty, impaired parenting, and stigma regarding mental health treatment, along with developing children's long-term sense of well-being. Developing families and communities that offer children the chance to develop a long-term sense of well-being

has the potential to reduce current and future health care costs while improving children's mental health treatment outcomes.

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Appendix A: Interview Questions for CD and DCS

1. How are the mission and vision statements cascaded through the organization?
2. What strategies does the agency use to facilitate parental involvement in the psychosocial treatment of their children?
3. How does agency leadership support the staff in facilitating parental involvement in the psychosocial treatment of their children?
4. What type of barriers to facilitating parental involvement in the psychosocial treatment of their children are you seeing?
5. What strategies does the agency use to overcome barriers in facilitating parental involvement in the psychosocial treatment of their children?
6. How does the strategic plan address barriers to facilitating parental involvement in the psychosocial treatment of their children in the future?
7. How is the agency responding to the barriers in facilitating parental involvement in the psychosocial treatment of their children?
8. What do you believe needs to occur in the agency to address the barriers in facilitating parental Involvement in the psychosocial treatment of their children?
9. What is the agency's key short- and long-term action plans, and do they address increasing parental involvement?
10. How is staff capacity determined?
11. How do you feel like the agency builds relationships with their clients?
12. How does the agency measure the effectiveness of each practice?

13. What specific operational processes are in place that support parental involvement in children's psychosocial treatment?
14. What are your key management principles and what do you hope they accomplish?
15. How does the agency enable clients to seek information and support (website, hotline, resource library, social media, etc.)?

Appendix B: Interview Questions for ED, CD, DCS, DHR, and DQI

ED

1. How are the mission and vision statements cascaded through the organization?
2. How does the agency conduct strategic planning?
3. What are the agency's key strategic objectives and timetable for achieving them?
4. Does the agency have key short- and longer term action plans?
   a. Subquestion: influence increasing parental involvement?
5. How does the agency ensure availability of financial and other resources (including human resources) to achieve action plans?
   a. Subquestion: to increase parental involvement?
6. How does the agency determine programs and service offerings?
   a. Subquestion: for supporting parental involvement?
7. How does the agency build and manage client relationships?
   a. Subquestion: to enhance parental involvement?
8. How is staff capacity determined?
9. How does the organization foster a culture characterized by open communication, high performance, and an engaged workforce?
   a. Subquestion: What is high performance in behavioral health?
10. How does the organization assess staff engagement?
11. How does the agency control overall costs?
12. Who over sees the categories below:

a. safe operating environment

b. disasters/emergencies preparation

c. reliability of information systems

d. security and cybersecurity of sensitive of privileged data and information

CD

1. What practices does the agency use to involve parents in their children’s psychosocial treatment?
2. What regulations and policies effect the practices used to involve parents in their children’s psychosocial treatment?
3. How do you know the regulations and policies that govern the parental involvement in children's psychosocial treatment are being followed?
4. How do you support developing strategies to involve parents in treatment?
5. How are the learning needs of involving parents in treatment identified?
6. How does the organization evaluate effectiveness/efficiently of its learning/ development system regarding strategies for parental involvement?

DCS

1. What practices does the agency use to involve parents in their children’s psychosocial treatment?
2. What regulations and policies effect the practices used to involve parents in their children’s psychosocial treatment?
3. How do you know the regulations and policies that govern the parental involvement in children's psychosocial treatment are being followed?

4. How do you support developing strategies to involve parents in treatment?
5. How are the learning needs of involving parents in treatment identified?
6. How does the organization evaluate effectiveness/efficiently of its learning/ development system regarding strategies for parental involvement?

DHR

1. How are the mission and vision statements cascaded through the organization?
2. How does the agency recruit, hire, place, and retain new staff members (that affect parental involvement)?
3. What benefits and policies do you think appeal to staff?
4. What makes this work environment safe and accessible for staff?
5. What are the human resource (HR) challenges that affect parental involvement?

DQI

1. How are the mission and vision statements cascaded through the organization?
2. How does the QI process work?
3. What key performance indicators (KPIs) do you use to track the success of action plans?
4. How does the agency determine key programs, services, and work process requirements?
5. How does the organization support innovation? Include the organization's strengths and challenges with innovation.

6. How does the agency improve its work processes to improve client services and staff performance, as well as enhance required skill sets?

Appendix C: Therapist Orientation on Parental Involvement

Why Involve Parents

a. Because of children's age-appropriate knowledge deficits, parents are critical to engaging children in psychosocial treatment (Reardon et al., 2017; Wozney et al., 2018).

b. Feeling blamed, judged, not being listened to by therapists, not feeling supported by the formal system, and lacking satisfaction with the mental health treatment were all challenges to parental involvement (Haine-Schlagel & Walsh, 2015).

c. The best strategy for influencing positive mental health pathways is through engaging and empowering parents with the ability to create enriched environments in which their children can grow (Haine-Schlagel & Walsh 2015)

d. Parental involvement can be attitudinal and behavioral. Attitudinal engagement refers to the parents' belief that treatment benefit outweighs the cost, whereas behavioral engagement means seeking meaningful interactions within and outside the therapy session (Becker et al., 2015).

e. Pruett et al. (2017) recommended addressing coparenting and couples' relationships as elements of children's mental health treatment. Children progress better when parents can set aside conflicts, relate positively to each other, and work together for the good of their children (Pruett et al., 2017).

f. Stadnick et al. (2016) stated that parental involvement increases the possibility of improvements in children's behavior transferring from one setting to another.

Therapist Role

At time of intake:

a) Provide education on the importance of parental involvement.

b) Provide education on the parental role in treatment.

c) Provide expectations for parental involvement in treatment.

d) Assess parents for referral to services.

e) Collaboratively develop treatment planning goals with parents and children.

f) Assess parents for attitudinal engagement, believing the benefit of services outweighs the cost

g) Assess for behavioral engagement through parent participative engagement (PPE) interventions.

h) Provide PPE interventions in addition to children's interventions on the treatment plans. PPE interventions include parents:

   i. sharing opinions.

   ii. asking questions.

   iii. participating in session activities.

   iv. following through on the parent- or child-directed between-session activities (Haine-Schlagel, 2015).

At 90-day treatment plan update:

a) Review treatment planning needs and goals.

b) Collaboratively complete the Child and Adolescent Functional Status (CAFAS) with parents.

c) Evaluate treatment planning and adjust children's and parents' interventions as needed. Complete treatment goals and obtain signatures of parents on the treatment plans.

d) Continue ongoing assessments for referral to services, attitudinal and behavioral engagement, and effectiveness of parental involvement

At team meetings, meet with case managers minimally biweekly to staff challenging clients, including:

a) Engaging in problem solving.

b) Clarifying treatment plans, service coordination with coworkers and other child care services.

c) Evaluating treatment progress.

Agency Support for Parental Involvement

a) Provides therapists with one weekly service hour for team meetings. The agency absorbs the cost of this nonreimbursable therapy service.

b) Does not have direct service hour ratio requirements of higher paying CM services to lower paying TCM services. Equal productivity credit is given to CM and TCM services, which encourages communication time with parents.

c) Provides company cars and phones for case managers to maintain communication and meet with parents at home or in the community.

d) Provides training on communication and community outreach to engage parents.

Pretest-Posttest Therapist Parental Involvement Training

Answer True or False for each question

1. ___Child mental health outcomes improve when parents drop their child off for therapy and decrease their stress by running necessary errands while the child is in services

2. ___Parental involvement (PI) is both attitudinal and behavioral.

3. ___Case management is more important than therapy because the case manager can meet with the parent at home or in the community.

4.___Medicaid will reimburse therapist at a reduced rate for time spent in team meetings.

5.___Case managers, with the parents, adjust the treatment plan after day 30 of treatment.

6.___As long as the therapist is talking to the parents about the child, the agency can bill for therapy services when the child is not present.

7.___Therapist should not educate parents on their role and parental involvement expectations at intake, as it may scare the parent and prevent their involvement.

8.___According to research, parents often feel judged, blamed for their child's behavior and not listened to by the therapist.

9.___Five million children live with parents experiencing a mental illness.

10.___Parental interventions cannot be included in the treatment plan.

11.___The therapist should not include parental input when completing the Child and Adolescent Functional Assessment (CAFAS).

12.___Parent participative engagement (PPE) is an evidenced based intervention that includes sharing opinions, asking questions, participating in session activities, and following through on the parent or child-directed between-session activities.

13.___Attitudinal engagement means believing that the benefit of services outweighs the cost.

14.___PI may increase child improved behavior when transferring from one setting to another.

Pretest-Posttest Therapist Parental Involvement Training

Answers

1. F_ Child mental health outcomes improve when parents just drop their child off for therapy and decrease their stress by running necessary errands while the child is in services.

2. T__Parental involvement is both attitudinal and behavioral.

3. F__Case management is more important than therapy because the case manager can meet with the parent at home or in the community.

4. F__Medicaid will reimburse therapist at a reduced rate for time spent in team meetings.

5. F__Case managers, with the parents, adjust the treatment plan after day 30 of treatment.

6. F___As long as the therapist is talking to the parents about the child, the agency can bill for therapy services when the child is not present.

7. F__Therapist should not educate parents on their role and parental involvement expectations at intake, as it may scare the parent and prevent their involvement.

8. T__According to research, parents often feel judged, blamed for their child's behavior and not listened to by the therapist.

9. T__Five million children in the United States live with parents experiencing a mental illness.

10. T__Parental interventions cannot be included in the treatment plan.

11. T__The therapist should not include parental input when completing the Child and Adolescent Functional Assessment (CAFAS).

12. T__Parent participative engagement (PPE) is an evidenced based intervention that includes sharing opinions, asking questions, participating in session activities, and following through on the parent or child-directed between-session activities.

13. T__Attitudinal engagement means believing that the benefit of services outweighs the cost.

14. F__ PI may increase child improved behavior when transferring from one setting to another.

<u>Note</u>. The Pretest-Posttest Therapist Parental Involvement Training assessment items and response key were based on information gleaned by the researcher from the participant interviews and the research found in the reference list below. It was intended to measure training participant knowledge prior to training based on their previous experience and then after training to determine what additional knowledge they acquired. Permission is granted to anyone interested in using/adapting it for training and research purposes.

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Appendix D: Parent Satisfaction Survey

Below are things that parents say about being involved in their child's mental health treatment. Please read each one carefully and circle your answers. Keep in mind the mental health treatment you are now receiving.

How strongly do you agree or disagree with the following statements?

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
1. The therapist listens to me.	1	2	3	4	5
2. The therapist told me I am important in my child's treatment.	1	2	3	4	5
3. The therapist blames me for my child's behavior problems.	1	2	3	4	5
4. It is not my job to fix my child. It is the Agency's job, that's why I am here.	1	2	3	4	5
5. I often don't have gas money or a car to come to the appointments.	1	2	3	4	5
6. I don't understand why I am here and what the services are for.	1	2	3	4	5
7. In the beginning, I knew how to get the first appointment.	1	2	3	4	5
8. I am satisfied with the services we are receiving.	1	2	3	4	5
9. I would recommend these services to a friend.	1	2	3	4	5

In the past 90 days, I have (check all that apply)

_____brought my child to the appointment only, did not talk to therapist

_____talked to the therapist about my child's behavior

_____talked with therapist about what I am doing as the parent

_____did homework between counseling sessions assigned by the therapist

Note. The Parent Satisfaction Survey was developed by the researcher with information gleaned from the participant interviews and the following research as identified in the study reference list: Becker, K. D., Lee, B. R., Daleiden, E. L., Lindsey, M., Brandt, N. E., & Chorpita, B. F.; Haine-Schlagel, R., & Walsh, N.; Reardon, T. H., Harvey, K., Baranowska, M., O'Brien, D., Smith, L., Creswell, C.; Wozney L. R., Radomski, A. D., & Newton, A. S. It was intended to measure the parent's experience, satisfaction, and level of involvement in their child's mental health treatment. Permission is granted to

anyone interested in using/adapting it for program outcome measurement and research purposes.