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Therapist, Parent, and Youth Perspectives of Treatment Barriers to Family-Focused Community Outpatient Mental Health Services

Mary J. Baker-Ericzén,
Child and Adolescent Services Research Center, Rady Children's Hospital, 3020 Children's Way, MC5033 San Diego, CA 92123

Melissa M. Jenkins, and
University of North Carolina, Chapel Hill, NC

Rachel Haine-Schlagel
Child and Adolescent Services Research Center, Rady Children's Hospital, 3020 Children's Way, MC5033 San Diego, CA 92123

San Diego State University, San Diego, CA

Mary J. Baker-Ericzén: mbaker@casrc.org

Abstract

This exploratory qualitative study describes treatment barriers to receiving family-focused child mental health services for youths with disruptive behavior problems from multiple perspectives. Data were collected during a series of focus groups and interviews, including: 4 therapist focus groups, 3 parent focus groups, and 10 youth semi-structured interviews. Therapist, parent, and youth stakeholder participants discussed perceived barriers to effective treatment, the problems with current child outpatient therapy, and desired changes (i.e., policy, intervention, etc.) to improve mental health services. Results indicate similar themes around treatment barriers and dissatisfaction with services within and across multiple stakeholder groups, including inadequate support and lack of family involvement; however, parents and therapists, in particular, identified different contributing factors to these barriers. Overall, stakeholders reported much frustration and dissatisfaction with current community-based outpatient child therapy services. Study findings can inform service provision, intervention development, and future research.

Keywords

child services; community mental health; treatment barriers; parent engagement; qualitative study

Introduction

Improving the quality of care in community practice continues to be a national health care priority (U.S. Public Health Service, 2000). Effective clinical care is particularly critical for children with disruptive behavior problems (DBPs), including oppositional, defiant, aggressive, and/or delinquent behavior, as these children represent the vast majority of youth in the publicly-funded mental health system (Garland, et al., 2001). Untreated or under treated youth with DBPs are at significantly elevated risk for a variety of maladaptive

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Correspondence to: Mary J. Baker-Ericzén, `mbaker@casrc.org`.

outcomes in adolescence and adulthood, including adult conduct problems, criminal behavior, and psychopathology (Copeland, Miller-Johnson, Keeler, Angold, & Costello, 2007; Earls, 1994). A number of psychotherapeutic treatment models have demonstrated impressive efficacy for this patient population (Eyberg, Nelson, & Boggs, 2008). The majority of these treatment models are familyfocused in design and train parents on behavioral strategies. In fact, more evidenced-based practices (EBPs) have been developed for DBPs than for any other childhood disorder (Eyberg, et al., 2008; Ollendick, King, & Chorpita, 2000; Weisz, Jensen-Doss, & Hawley, 2006). Additionally, recent work has identified several core elements common across efficacious treatment models for children with DBPs (Garland, Hawley, Brookman-Frazee, & Hurlburt, 2008), which primarily include family-focused strategies such as parent training.

Given the important role of parent involvement in efficacious treatment models for children with DBPs, it is critical that parents fully engage in the treatment to address their child's behavior problems. Promoting parent engagement in community care is gaining attention in the policy and research arenas. Policy makers have emphasized the role of parents in child services. For example, the American Psychological Association Working Group on Children's Mental Health defines "appropriate and effective services" as "developmentally appropriate, culturally competent, empirically-tested, and family-centered…" (Tolan & Dodge, 2005). Additionally, from a policy perspective, understanding and then addressing barriers to treatment participation has fiscal implications as no-shows and frequent cancellations are both expensive (i.e., clinic resources, staff time) and inefficient (i.e., time could have been used to treat others).

Research often cites parent engagement problems as reasons for the ineffectiveness of care (Brannan, 2003; Staudt, 2007). The term "parent engagement" is a complex construct with multiple facets including: treatment attendance, treatment adherence, and active participation in treatment including treatment compliance. In particular, premature termination represents a significant problem in child therapy and has been associated with negative outcomes for families (Armbruster & Kazdin, 1994; Kazdin, Mazurick, & Siegel, 1994). Research indicates that as many as 40–60% of families stop treatment prematurely (Gopalan, et al., 2010) and that client intentions and expectations may be more useful in understanding drop out compared to demographic and clinical characteristics (Wierzbicki & Pekarik, 1993). Poor treatment adherence and compliance are also highly problematic, in particular for mental health treatment for DBPs (Brookman-Frazee, Haine, Gabayan, & Garland, 2008; Nock & Ferriter, 2005). Clearly, treatment effects for children are highly dependent upon parents and when families repeatedly miss therapy appointments or do not follow treatment recommendations, treatment effects are largely compromised (Nock & Ferriter, 2005). Several parent/family factors have been shown to be associated with parent engagement in family-focused treatment for child mental health problems, including motivation, expectations, and perceived barriers (Kazdin, Holland, Crowley, & Breton, 1997; McCabe, 2002; Miller & Prinz, 2003; Nock, Ferriter, & Holmberg, 2007; Nock & Kazdin, 2001; Nock & Photos, 2006).

A qualitative study comparing treatment completers with non-completers in a family-focused community child mental health program found that the groups differed on the parents' perspectives of the effectiveness of treatment and perceived obstacles interfering with treatment participation. Specifically,, completers identified treatment effects including positive outcomes for their child and family. Completers also identified factors that facilitated their involvement in treatment (i.e. parenting differently) and, indicated fewer obstacles than non-completers (Attride-Stirling, Davis, Farrell, Groark, & Day, 2004). Evidence also suggests that compared to families who remain in treatment, parents who terminate services prematurely are more likely to report situational obstacles (e.g., additional life stressors, lack of resources) (Prinz & Miller, 1994). Other studies examining factors associated with treatment completion have produced conflicting results (Armbruster & Kazdin, 1994; Gould, Shaffer, & Kaplan, 1985; Wierzbicki & Pekarik, 1993), and there remains a lack of knowledge about the variety of barriers (attitudinal, situational, structural) that exist for complex, real-world families to fully engage with services and derive maximum benefits (Attride-Stirling, et al., 2004).

A recent observational study of community-based child therapy for children 4–13 years old with a DBP found that parents are present in the treatment session for at least part of the time in 70% of the videotaped psychotherapy sessions (Garland, Hurlburt, Brookman-Frazee, Taylor, & Accurso, 2010). It is important to note that although parents are present in the majority of sessions in the Garland et al. study, therapists were observed to use active parent-focused skill-building strategies infrequently (less than 25% of sessions) and with low intensity (cursory use of the strategy) (Garland, Hurlburt, et al., 2010). These data indicate that even when parents attend sessions, therapists may not be involving them in treatment, and that the lack of family-focus and parent involvement may be related to therapists' behaviors rather than parents' behaviors. Thus improving parent engagement and participation may need to be a multifaceted approach; one that addresses parent and therapist barriers.

To date, strategies to enhance parent engagement have been developed and tested specifically to address parents' practical and psychological barriers toward treatment attendance (Ingoldsby, 2010) and treatment adherence to manualized protocols (Nock & Kazdin, 2005). Research has also begun to attend to family factors that promote clinical gains and how to best support parents' roles in treatment (Chacko, et al., 2009; Fabiano, et al., 2009; Nock & Kazdin, 2005; Watt & Dadds, 2007). However, little attention has been paid to improving active participation in treatment, and the existing interventions have not been widely disseminated to community-based clinics. To further implement family-focused interventions, it is necessary to improve parent engagement and active participation. Understanding what the recipients of child services (including both parents and youth) value and desire in regards to services and outcomes and the challenges that community-based therapists face in providing effective services to families remains vital (Farkas, Gagne, Anthony, & Chamberlin, 2005; McKay & Bannon Jr, 2004). No research to date has qualitatively investigated multiple perspectives of treatment barriers to familyfocused interventions in community-based outpatient mental health setting.

This study was designed to gather in depth information about the relevant treatment barriers in community samples that are of importance according to multiple stakeholders: therapists, parents, and youth. Specific study aims include: (1) learning more about families' and therapists' perceptions and experiences in community mental health services, identifying specific barriers to parent participation within family-focused treatment; and (2) examining relationships of identified problems and perceived treatment barriers across informants.

Methods

Design

This exploratory study was designed as a fundamental qualitative description (Patton, 2002) to obtain a "thick description" (Geertz, 1973) of multiple stakeholders' perspectives of the challenges involved in delivering family-focused interventions for youth with DBPs in community-based outpatient mental health care. Open-ended stimulus questions were provided to each stakeholder group to elicit their candid responses. Qualitative methods were chosen for the study because they are especially relevant to research questions concerned with subjective experiences, meanings, and processes (Marshall & Rossman, 2010). This method was deemed the most appropriate as the aim of the study is to identify the current barriers to treatment in community care for children with behavior problems from multiple stakeholder perspectives (therapists, parents, and youths) without a fixed a priori hypothesis. The focus was purposely broad in nature to elicit meaningful themes, gathering depth and richness to fully grasp the complexities of community-based care and examine the concordance across informants.

Participants and Recruitment

Using a maximum variation sampling procedure (Bernard, 1988), purposeful (not random) recruitment took place until it was determined that sufficient saturation (i.e., collection of the same information across groups or informants) was reached. Thus, we completed four therapist (n=26) focus groups, three parent (n=14) focus groups, and ten youth (n=10) semi-structured interviews with stakeholders involved with the delivery or receipt of treatment for DBPs from six large community child mental health clinics in a metropolitan county in Southern California. Following procedures developed by Morgan, (1988) groups were structured having 4–8 participants per group. Participants were recruited from distributed study flyers at each of the six clinics and by word of mouth (i.e. family to family or therapist to therapist). The six clinics were selected as clinician recruitment sites because they represent the largest contractors for publicly-funded, clinic-based out-patient care for children in the county. They are geographically dispersed throughout the county to maximize representativeness of urban, suburban, and semi-rural areas, as well as race/ethnic diversity. All clinics have the same funding source and serve children/families with an age range of 2–18 years old. . Participants who responded to the flyer were screened for inclusion/exclusion criteria. Inclusion criteria for therapists were the following: 1. currently treating youth with DBPs between ages 5–13 years; 2. providing treatment at a publicly-funded community based mental health program; and 3. English-speaking. Inclusion criteria for parents included caring for a child 5–13 years old with a DBP who was currently receiving mental health treatment at one of the 6 clinics and English-speaking. Youth inclusion criteria included age 10–13 years, English-speaking and currently receiving treatment for a DBP at one of the 6 participating clinics. Parents and youths at any stage of treatment were eligible to participate as long as the current treatment episode was to address a DBP. Parent and youth participants were provided assurances that their participation in the research study in no way impacted their current or future treatment and therapists were informed that their participation would not negatively impact their position. It was unknown as to whether any of the therapists involved treated any of the families or children involved as that information was not collected (therapists did not report on identifiable cases and parents/youth did not report on identifiable therapists).Two of the parent participants had youth who participated in the semi-structured interviews. The parents were not involved in these interviews. Two interested proivders did not participate due to schedule conflicts. Two interested parents did not participate (1 did not meet study criteria and 1 had scheduling conflicts) and 4 interested youth did not participate due to schedule conflicts. Participants received compensation for their time: therapists received $40, parents received $20 and youths received $10 gift certificates. About half of the participants had been involved in child treatment for over 1 year (often 3–4 years) and the others were involved for less than 1 year. Therapist demographics are provided in Table 1. Therapists in this study appeared to be generally representative of those within the larger county community mental health system in terms of gender, education, mental health discipline, and service settings (refer to the county's Annual Children's System of Care Report http://www.casrc.org/documents/projects/soce/reports) and similar to other national community clinic samples (Baumann, Kolko, Collins, & Herschell, 2006; Glisson, et al., 2008). Parent and youth demographics are provided in Table 2.

Procedure

Each focus group lasted 1.5- 2 hours. Each youth interview lasted 20–45 minutes. Participants were given a study information page and background questionnaire which included demographic questions. Focus groups were conducted for therapists and parents separately in order to obtain unbiased, thorough descriptions of barriers. Focus groups are particularly suited for conducting exploratory investigations such as the one reported in this article because they allow for participants to interact with each other and limit participants' interaction with the interviewer, in turn leading to greater emphasis on participants' perspectives (Morgan, 1988, 2006). The natural settings of focus groups (versus controlled experimental environments) relax participants' inhibitions, stimulate greater candor, and provide flexibility to explore unanticipated issues in greater depth (R. Krueger & Casey, 2000; Morgan & Spanish, 1984). Individual interviews were conducted with youths to protect their personal health information as youths are less able to provide perspectives and experiences without self-identifying with the stimulus questions. Stimulus questions were generated by the first two authors on the basis of study goals. After the questions were developed, they were pilot tested within a community participatory research group made up of 5 therapists, 6 researchers, and 2 parents. Wording of questions was revised accordingly based on group consensus. All study procedures were approved by the relevant Institutional Review Boards. All participants consented, youth assented, accordingly and agreed to be audio and video taped.

Parent and Therapist Focus Groups—After reviewing the rules and brief introductions, the moderator (first author) and interviewer (second author) asked the participants to respond to stimulus questions regarding: (1) their experiences in community mental health services; (2) problems they encounter in participating in treatment, and (3) ways to improve usual care practices. The moderator introduced the stimuli (i.e. open-ended probes) and monitored dynamics of the group discussion, insuring that all views were represented. Specifically, The moderator addressed questions to participants who did not initially volunteer responses, thus reducing the tendency of more vocal participants to dominate the discussion and skew the results (R. A. Krueger, 1998). All participants were encouraged to respond and share differing ideas and opinions. All Verbal and non-verbal (i.e. head nods) responses were recorded. A structure was imposed using a focus group guide so that comparable data was collected from all groups.

Stimulus questions asked to therapists included: How do you work with families with DBPs? How often does the case go beyond the child you are treating? Could you talk about what a "severe" family is? Can you describe the layers of obstacles? What are some barriers in treating such cases? Could you describe what makes your work more challenging? Can you give us some examples of what factors made it easier or harder to deal with family issues that may have been related to the system you work in?

Stimulus questions asked to parents included: What have you or others you know experienced to date in child therapy? Do therapists ask about parent or family issues? What are your perspectives on how comfortable or uncomfortable parents might feel in child treatment and in being asked about parent/family issues? If you could change something about your child's therapy what would it be? What could therapy be like to make it better or to make it different? Results from both stimulus question topics (experiences and problems/ barriers) will be provided in this paper.

Youth Interviews—Informed consent was obtained from all parents of youth participating in the study and written assent was obtained from all youth participants. Interviews were conducted either at the families' homes or at the outpatient clinic where they receive psychotherapy, depending on the family’s preference. Youths were eligible to participate if they were 10–13 years of age and currently receiving services for a DBP in a community setting. Youths were asked a series of open-ended questions regarding their experiences in treatment. Stimulus questions followed a funnel interview structure,(Morgan, 1988) starting with broader topics and narrowing to more child-specific illustrations of the issues. For example, what kinds of information about your family do you think your therapist needs to know in order to help? These broad questions were then followed by specifics such as, is it OK if your therapist talks to your parent about stress, sadness, family problems etc.? Youth were also asked to discuss their perspectives of therapy and how to improve it. For example, what do you think will make counseling better? Can you think of what other kids might say to make counseling better? This paper contains findings from youths’ responses to what they liked and disliked about their experiences in therapy and how they felt about having their parents involved in therapy (including discussions of their parents’ own issues).

Analysis Plan

Data analysis followed inductive, iterative processes typical of qualitative research using an “editing style” and thematic content analysis approach (Glaser & Struss, 1967). The constant-comparative method of analysis as outlined by Willms et al.(1990) was used to give codes and themes precision and specificity (Strauss & Corbin, 1990). First, audiotapes of focus group sessions and semi-structured interviews were transcribed. Several transcriptions were then independently coded by the research team at a very general level to condense the data into analyzable units. The research team included research scientists (two authors), research coordinator (one author) and one research assistant (undergraduate student). Transcript segments ranging from a phrase to a paragraph were assigned codes based on emergent themes (i.e., themes that arose from the interview data). Disagreements in assignment or description of codes were resolved through discussion and enhanced definition of codes. The final list of codes, constructed through a consensus of research team members, consisted of a list of themes, issues, and attitudes that relate to therapists’, parents’, and youths’ experiences in community mental health services and were included in a codebook. Themes differed by informants.

Three research team members (2 authors and 1 research assistant) were assigned to code the focus group and interview transcripts. The transcripts were then assessed for coding agreement following the codebook among the research team, based on a procedure used in other qualitative studies (Boyatzis, 1998; Bradley, et al., 2002). Interrater reliability was assessed for 40% of the transcript for each focus group (n=7) and for each youth interview (n=10). The coders achieved 76% total agreement for therapist groups, 76% total agreement for parent groups and 74% total agreement for youth interviews, indicating good reliability in qualitative research (Boyatzis, 1998). Coding discrepancies (e.g., one coder attached a code to a particular utterance when the other did not or two coders attached two different codes to the same utterance) were discussed until the two coders and primary author arrived at an agreement for all coding discrepancies for each transcript. The codes were categorized into two levels: general (codes at the broadest level of themes), and subthemes (codes at the second level of themes). Transcripts were then entered, coded, and analyzed in QSR-NVivo 8.0, (Frasser, 2000) a software package that is widely used to support qualitative research (Tappe, 2002). Finally, using a process of constant comparison, (Glaser & Struss, 1967) taxonomies of codes were created for each of the focus groups and interviews and compared with one another to identify themes and subthemes that were consistent across stakeholder groups and themes/subthemes specific to particular groups.

Results

Key themes are presented for each informant group. Each theme's subthemes are provided and described as specific treatment barriers. Participant verbatim quotes are presented to illustrate the main themes and treatment barriers. Table 3 presents the subthemes and counts of utterances across informants per theme. According to Miles and Huberman (Miles & Huberman, 1994), counting themes via frequencies can help in identifying patterns or in verifying the salience of a theme. However, it is important to interpret the number of utterances carefully as they are a count of the number of times a theme was stated and it should not be assumed that every participant discussed the theme equally. Counts may be increased due to lengthy back and forth discussions amongst multiple group members on a particular topic. Thus, the description of the theme may be more important to attend to than the frequency count in understanding the results.

Providers

The dominant theme that emerged from the analyzed transcripts of provider focus groups was that therapists felt frustrated in their experience of providing family-focused therapy. Across all four focus groups, therapists discussed similar treatment barriers in connection with their frustration. Further analysis resulted in these treatment barriers emerging as three subthemes of therapists' frustration. In general terms, the three subthemes were: 1) therapists feeling overwhelmed by families' complex needs; 2)parents' lack of involvement and perceived unwillingness to participate; ; and, 3) therapists not feeling adequately supported.

Frustration with Providing Family-Focused Treatment

Therapists Are Overwhelmed by Families' Complex Needs—Therapists found the complex needs of families seeking services in community-based mental health overwhelming. Therapists discussed different parent and family contextual factors that are characteristic of these families and viewed as important considerations in their case conceptualizations and treatment planning. *"They have the children coming into the clinics but frequently we have to refer the parents for outpatient therapy because of their own mental health issues."* And, *"That happens a lot, you know, where I'll meet with the parents or whatever. I can think of my case load right now, three [cases] and they happen to be single moms where, um, they're like, 'I wish I could just see you, you know'."* Therapists' frustration with respect to the families' many needs seemed, in part, to stem from the interference of these needs with treatment compliance. *"Just what does that financial stress add to the whole thing? Cause you're gonna give them a whole list of things to do and they're gonna go 'yeah, right'."* The other component of therapists' frustration in addressing families' complex needs was closely associated with therapists not feeling supported, which is discussed in more detail below.

Parents' Lack of Involvement and Perceived Unwillingness to Participate—Therapists expressed a desire to conduct family-focused therapy but felt constrained by parents' lack of involvement and unwillingness to participate in their youths' treatment. Many therapists commented on parents' resistance and/or absence in session. *"The family kind of refused to participate or couldn't physically be there for some reason"* and, *"You have the resistance of parents that are just, they're own defense mechanism, or denial."* Therapists viewed parents' behavior as an obstacle in treating youth. "*You can only do so much work without the family involved because they live under the family rules. So even if you think you can get a lot of change with an individual, that's only one dimension."*

Therapists Not Feeling Adequately Supported in Meeting Families' Needs—A major treatment barrier for therapists involved lack of support. In particular, therapists pointed to a lack of formal service system support as interfering with meeting families' needs and maximizing service delivery. *"I think we could provide better service. We ourselves maybe can't see the parent but it would be nice if you know our neighbor next door could see them so it's not such a big search to find someone who takes Medi-Cal* (Medicaid in California)*… so that they don't have to go to two different, three different places"* and *"Well, it's like what about, you know, some in-home support? Some parent education, some, you know, behavior management, some home restructuring, some actual hands-on teaching and education. I think that piece is missing in the community."*

Therapists also pointed to policy issues, such as rigid, time-consuming protocols, and lack of coordination with services in other agencies or related systems as unsupportive in their care of youth and their families. Therapists had a lot to say about the large amounts of paperwork they are required to complete. *"I think it's overwhelming. I mean, I've been at the clinic fifteen years and… I kind of think it's parallel to a lot of other industries where the focus has gotten more off what you're actually doing and [more into] being more accountable"* and *"It's almost like it's a measure somehow of how good a clinician you are if you fill it out, you know, like almost proving you're doing the work that you're doing… I don't like that autonomy is like taken away from me as a professional."* They also commented on the impact of feeling unsupported. *"And we've lost some good clinicians that they, they come in and they just feel like they're so bogged down with keeping up with paperwork and that stress, we spend more meetings sort of figuring that out than talking about clinically what's the latest."*

And, with respect to lack of support in coordinating care, therapists voiced several problems they encounter. *"These agencies would not work with them because they thought oh it's kind of a scary looking kid. They don't really fit our profile. But they do. We should be working with them together"* (referring to agencies that will treat substance problems but not comorbid conditions like substance abuse and depression or other psychiatric problems), and *"[Legislators] have to make sure that we don't spend a whole lot of money on things that they can't show some worthwhile results from",* and *"And we've now been working together for quite awhile and he's doing great. But now he's getting denied his SSI… And so I'm still battling with them now, because it's like it's just not right. He's definitely responding to treatment and he's doing well, but it's not like he's at 100% yet. He still needs a lot more work and they're denying it saying nope, nope, he's not in that category anymore."*

, Therapists also discussed relationships between subthemes. Specifically, subtheme 1, therapists feeling overwhelmed by the complexities of families, was described as integrated with subtheme 3, therapists not feeling supported by the service system.. For example, therapists believe that their organization and/or the larger service system are not providing them with direct supports for working with complex and high need youth/families. In fact, they feel that service system structures like high productivity expectations, rigid protocols, large amounts of documentation, and limited trainings negatively impact their ability to provide quality treatment to children and families. *"I have a family where maybe I have a couple of sessions where they come in and have some real serious things to talk about. And I feel this pull or this pressure because I'm like, 'Ok but… I need you to sign this and we have to get through this because otherwise I'm going to be in trouble.' You know, that's not helpful therapeutically"* and *"…well the forms and the questions you ask obviously they're really pertinent and really helpful but I think there's a lot of paperwork that we have the clients do and that we're expected to do that are not of all useful to the treatment of this client."*

Parents

The dominant themes that emerged from the analyzed transcripts of parent focus groups were that parents felt overwhelmed by their youth's symptoms and problems and felt frustrated with service delivery of family-focused therapy. Both of these general themes were similar to themes from therapist focus groups. Additionally, three subthemes emerged under parents' frustration with service delivery across each of the parent focus groups and were considered common treatment barriers for parents. In general terms, the three subthemes were: 1 parents not feeling supported by formal service systems;2)) parents feeling blamed and ignored by their therapist; and 3) parents feeling dissatisfied with mental health services.

Parents Feel Overwhelmed by Their Youth's Symptoms

A dominant theme was parents feeling overwhelmed in dealing with their youth's problems. *"She stomps me, she throws things at me, she hits me. She is almost as big as me… And I am not supposed to lay a hand on her"* and "*It drains you, it absolutely drains you. Every morning you get up and go ok what phone call am I going to get today"* and *"Everything we do is wrong, everything we do doesn't work with her."* and *"…but just every once in a while he socks you in the face or mine runs away from home and talks to strangers"* and *"I think that really when you are afraid of your own child, of them hurting you and you can't touch them or they are going to call CPS or tell the therapist, it changes the relationship."* Parents reported feeling exhausted by these constant struggles with their youth's behavior, *"Usually it was because I was so exhausted from him pushing and pushing I was dead, nothing left."*

Frustration with Delivery of Family-Focused Therapy

Parents Do Not Feel Supported by Formal Service Systems—

Parents discussed a substantial lack of support for them in addressing their youth's needs. *"And it is a constant struggle with too much help, not enough help and nobody to really guide you"* and *"I don't know what these people want me to do- I have done everything they have told me to do."* Additionally, parents highlighted system barriers, such as the lack of service system coordination and ineffective treatment strategies, as contributing to them feeling unsupported. *"It's not that I am not being a parent but when you get in front of these people- like the psychiatrists, the teachers, the CPS- you feel like you are one of the kids"* and *"So you're reaching out to get some help and they come over and slap your hand."*

Parents Feel Blamed, Judged, and Not Listened to By Therapists—

Parents' attributed part of their frustration to feeling blamed and not listened to by the child therapists. *"And that's been really frustrating and that's when you just think 'oh my God why don't [the therapists] believe me?'"* and *"They would bring up things and I would just feel myself turning red. I always felt like I was having a major hot flash right then and I would feel just like I was being blamed"* and *"I am totally uncomfortable because every time I say anything I get blamed and I am tired of getting blamed,"* and *"I don't think they believe us"* and *"They don't listen they don't really care what you got to say. All they care about is what they got to tell you"* and *"That is what is so frustrating, sometimes some of these people already have an assessment."* Further, parents' experiences of feeling blamed and/or ignored seem to make them feel unimportant and disinterested in their youth's treatment, fueling their frustration with service delivery. *"It is very hard when the professionals don't understand. You know they look at the parents, who are tired by the time they get to that point and they just gather the same old information from them"* and *"We've been to therapists who don't understand at all."*

Parents Feel Dissatisfied with Their Children's Mental Health Services—Parents found their experiences with community-based mental health services dissatisfying. *"And you know he wasn't really saying anything. I was kind of wasting my time"* and *"Yeah and they came in acting like we never tried stupid sticker charts. And they wouldn't believe me when I said sticker charts, poker chips, whatever you want to use is not going to work."* In particular, parents did not seem confident in the therapy process. *"And you know sometimes the extreme behavior problems I don't think the mental health system is prepared to deal with"* and *"…that is how I feel that his treatment is. I feel like the arms are doing something and it is not connected to the head."* Overall, parents' dissatisfaction was a significant source of their frustration. *"And what really bothered me about that [outpatient therapy] was not only was I wasting my time but my other four kids are sitting out there for an hour. And the drive and all of that junk. And it was just a waste of their whole day"* and "*And now, you know I have been and talked to four therapists, the police, everybody and no one has an answer for me for that."*

Youth

Unlike therapists and parents, who provided many descriptions about their frustrations with therapy, youth tended to not provide as much detail about their perceived problems with outpatient therapy. Overall, their comments were relatively short. The dominant themes that emerged from the analyzed transcripts of the youth interviews were that 1) youth were interested in family-focused treatment with active parent involvement and 2) youth had dissatisfaction with therapy. Theme 1, interest in family-focused treatment, involved two subthemes: 1) openness to discussing parents' problems; and 2) openness to parents' active involvement in therapy. Theme 2, dissatisfaction with therapy, also had two subthemes that were interrelated: 1) interest in more directive, active therapy; and 2) less time spent on question asking and casual conversation.

Interested in Family-Focused Treatment with Active Parent Involvement

Openness to Discussing Parents' Problems—Several youths indicated that their parents had problems, specifically indicating that their parent was sad, stressed, and/or had anger management issues, medical issues or financial problems. *"Well she is always really stressed out… she has to get her blood pressure checked. She got it checked today 'cause it is really, really, really high from being so stressed out"* and *"The cancer has come back inside her stomach."* Youth perceived that their parents' problems were important and that the therapist should feel free to ask about parents' difficulties. *"Yeah all the questions that he asks about my mom, yeah they are pretty good"* and *"I have no problem with my therapist asking anything."* Additionally, youth recognized that their parents' problems are relevant to their own problems. "*Helping the parents will also eventually help most people in the family because everyone has an influence on each other… the child is an influence on the parents, the parent has an influence on the child. They say that a child takes after her mother but they all take after each other in the end."*

Openness to Parents' Active Involvement in Therapy—Youth spoke positively about the times when their parent/s (and other family members) were in the therapy session with them but revealed that it did not occur very frequently. Youth stated *"Yeah so we solved those problems"* referring to when he had a family session but then also commented on the infrequency *"Umm that was four weeks ago when he met my whole family"* and *"My whole family has only met [my counselor] one time."* One youth responded *"Not really anymore"* when asked about having sessions with parents. Another youth stated that *"If my mom's in the room I'm usually not there. I'm not aware of what happens."* Youth also felt that the lack of parent/family involvement was a concern: "*Well, she doesn't really know my family and stuff here- we talk about it but she's never really come to our house and been* *around us."* Youth seemed to think that their parents' participation was important. In response to whether having her mother attend her therapy session was useful or not, a youth states: *"Yes it helped solve things because when there was issues my mom would sometimes yell at me."*

Dissatisfaction with Therapy

Youth commented overall about their dissatisfaction with therapy, particularly feeling that it had not helped: *"I've gone through three helpers* (referring to therapists) *and they hardly can help… Well, they couldn't really help* (referring to previous counselors)*. So I went to three."* Another youth spoke positively about the time he spent in therapy because it was time away from home and life stressors, but he did not provide information about how therapy helped when asked. "*It's quiet most of the time* (referring to therapy)*- Yeah. Spend three hours in my house and you'll leave and you won't hear anything for the next few minutes.* (Older brother) *won't stop getting angry about things, my little sister can't stop talking…".*

Interest in Directive, Active Therapy and Less Time Spent on Question Asking and Casual Conversation—Youth felt that therapy should actively target their current difficulties, including therapists asking relevant questions. *"They should spend less time asking stupid questions like, 'How was your day?' or 'Are you feeling fine?'… Get right to the stuff- There's too much time being wasted… and, um, mindless chatter"* and *"The point there is to help someone or fix someone or whatever you're trying to do- You're not getting anything accomplished by talking about whatever that kid did on the weekend."* Youth felt that casual conversation was not therapy and not helpful: *"I suppose my least favorite thing would be when, um, when the therapist is too lazy to do anything and decides just to start idle chatter."* Other youth described casual conversations as the part of therapy they did not like. "*Tell her um tell her what kind of week I had that's about it"* and *"don't like to answer them [questions] all that much."*

Discussion

Results from this study highlight the value of learning about community mental health services from multiple stakeholders involved in outpatient community-based therapy by providing insight into the problems in usual care practices and perhaps signaling next steps in combating treatment barriers. Even though therapists and parents had thematic agreement regarding their experiences in community mental health and both voiced frustrations with services, lack of service system support, and feeling overwhelmed with the complexities of families' needs, the two stakeholders had different perspectives about the underlying causes of their frustration. Therapists highly endorse using family-focused therapy and want parents to participate in their youth's treatment; however, parents do not feel supported by their child therapists. Parents' experiences of feeling blamed and not listened to by service providers impact their attitude about service delivery, which can make them feel uncomfortable and resistant to participating in their youth's treatment. Youth also discussed dissatisfaction with mental health services, specifically related to their direct experiences in therapy.

One of the most striking findings is this apparent disconnect between parents and therapists' perspectives regarding treatment engagement. Therapists identify parents' lack of involvement as a key treatment barrier while parents report feeling excluded and unimportant by their respective therapists. Parents are stating they are feeling blamed for their youth's mental health problems, a phase of history that the field has assumed has passed (Oswald, 2006). The results from this study suggest that resistant parents may actually be willing participants in their children's treatment. However, parents are sensitive to providers' judgments and may need open acknowledgement of their struggles and efforts with childrearing. Open communication from the start of treatment regarding the treatment process including goals and strategies may circumvent misunderstandings and make parents feel more a part of the solution (McKay, Stoewe, McCadam, & Gonzales, 1998). Parents may also benefit from explicit discussions about how to be an informed consumer by asking questions and assessing gains. Acting as an informed consumer may reduce parent frustrations regarding their dissatisfaction with treatment and result in greater involvement in treatment and an increased likelihood of following treatment recommendations, both of which can lead to better outcomes (Alegría, et al., 2008; Greenfield, Kaplan, & Ware, 1985; Greenfield, Kaplan, Ware, Yano, & Frank, 1988; Rost, Flavin, Cole, & McGill, 1991).

The format of therapy may be contributing to parents feeling unsupported. Studies have revealed that group administration of therapy, especially those providing parent training for addressing childhood behavior problems, may have benefits over individual therapy (Lundahl, Risser, & Lovejoy, 2006; Pevsner, 1982). Specifically, a study comparing multiple methods of intervention: 1) individually administered parent training, 2) group delivered parent training, 3) group delivered discussions, and 4) control group, found that the two group-administered interventions demonstrated larger effect sizes and better outcomes compared to the individually-administered therapy, with the group parent training intervention demonstrating the most substantial effects (Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). A recent qualitative study exploring why parent participation in the Incredible Years group parent training program is successful revealed that parents stated the group format allowed for a safe, supportive environment to learn behavioral principles and change their parenting practices within a context of parents with similar experiences and challenges. The parents specifically stated they did not feel judged or blamed nor isolated in the group, which facilitated their participation in treatment and an openness to reflect on their parenting so that they felt supported in practicing the newly learned strategies with their children at home (Levac, McCay, Merka, & Reddon D'Arcy, 2008). Parents involved in our focus groups also clearly valued meaningful components of a group process such as the ability to share their stories openly and connect with others with shared experiences. Parent participants did not want to end the focus group and exchanged phone numbers following the group's completion after each of the three groups, which is anecdotal evidence of feeling supported and accepted in the group format.

The parents' perspectives are also consistent with other findings involving recovery-oriented or consumer empowerment approaches. The need for hope among parents with youth with behavior problems is largely apparent. Oswald (2006) reports that "parents are beaten down by the stresses and complications of caring for a child….they are stigmatized by the view that emotional and behavior disorders in children are the result of poor parenting….they are discouraged by 'helpers' who strive to keep them grounded in the 'reality' of serious mental illness." Oswald recommends that the field embed a recovery-oriented approach within quality improvement efforts in children's mental health system to inspire and support hope in youth and their parents (2006). Re-defining efficacy to include those values and outcomes that are most important to parents and youth may mean a renewed emphasis on interventions and approaches that maximize consumer empowerment (Oswald, 2006). Consumer empowerment as a construct is taking hold in adult psychiatric treatment in interventions such as the Right Question Project-Mental Health (Alegría, et al., 2008), which supports adults with serious mental illness in confidently asking questions about treatment and in seeking shared decision making with their providers. Extending this approach to parents of youth with mental health problems may provide tools parents can use to communicate their needs and to problem-solve with their therapist regarding the often difficult issues facing these families.

Findings from this study reinforce the complex nature of real-world families. These youth and their families have abundant needs that therapists and parents struggle to effectively address. Baker-Ericzén and colleagues (Baker-Ericzén, Hurlburt, Brookman-Frazee, Jenkins, & Hough, 2010) found that children receiving care in community outpatient programs were similarly complex to those reported about in this study, with 59% of the children having comorbid conditions and over one third of the families reporting at least one significant psychosocial issue; 42% reported current parental clinical depression and over 80% reported having at least one major contextual stressor. Therapists in this study view parental needs as integral to treatment while parents perceive their needs as isolated from their youth's therapy, possibly as a result of feeling blamed and not validated by therapists. Parents, however, enthusiastically discussed their needs and stressors, including their own psychological conditions along with feeling overwhelmed by their youth's mental health condition(s). Parents appear to want to be heard and validated and receive services for their families' needs, and communicating this message to therapists may help bridge the gap in alliance that is highlighted in this study's findings.

Inadequate service system support is problematic for therapists and parents alike. Therapists identified organizational factors, such as rigid and time-consuming protocols, as well as a lack of training on working with complex families, as impacting service delivery. Parents emphasized the lack of service systems coordination and repeatedly receiving ineffective therapeutic strategies. Their discussion of inadequate support makes it clear that therapists and parents are dissatisfied with current usual care practices and seek improvement in treatment delivery systems. The incorporation of EBPs into public service systems may be one method for improvement. For example, there are a number of EBPs that have been found to work effectively with complex families that have children with challenging behaviors and parents with multiple psychosocial issues, such as Multisystemic Therapy (MST) (Schoenwald, Brown, & Henggeler, 2000) and Parent-Child Interaction Therapy (PCIT) (Eyberg, 1988). However, implementation science models that identify effective methods to integrate EBPs into community-based practices highlight the challenges in doing so (i.e. training, funding and adoption) and the need for understanding the community context (Aarons, Hurlburt, & Horwitz, 2011; Damschroder, et al., 2009; Powell, et al., 2012). One article states that without this application of knowledge of the intended contexts the EBP uptake can be inefficient, costly and/or limited (Hoagwood & Kolko, 2009). Therefore merging information from this paper and others on community contexts with those from existing EBPs to increase the availability of EBP training and ongoing consultations to community therapists in a way that is supportive and cost-efficient may provide therapists with the necessary tools to address challenging behaviors with complex family issues, and provide therapists and parents with the efficacious treatment strategies they desire. .

Results also suggest the need to improve treatment quality through the use of transparent care coordination. A quantitative study found that caregivers who viewed services for children with serious emotional disorders as more coordinated reported less stress (Yatchmenoff, Koren, Friesen, Gordon, & Kinney, 1998), reinforcing the need for coordinated care. However, an observational study of the therapeutic strategies used by usual care therapists who treat children with DBPs indicated that case management was the most frequently used strategy directed towards parents (Garland, Brookman- Frazee, et al., 2010) and 71% of all sessions directed towards parents or children involved case management procedures but only 29% of these sessions had an intensity rating of moderate to high (>3 on 1–6 scale) (Zoffness, Garland, Brookman-Frazee, & Roesch, 2009). Thus, it may be that the nature of care coordination needs to be more transparent to caregivers as well as more concentrated in order to have a meaningful impact.

Youth provided different perspectives than parents and therapists. Perhaps the most surprising finding is that youth desire therapists to be experts whose purpose is to help them with their problems and not engage in substantial amounts of casual conversation. This is an interesting perspective given the clinical attention often placed on building client rapport within clinical practice. Youth desire directed, focused, and short term treatment protocols, which are common components of EBP treatment models for DBPs (Garland, et al., 2008). The types of treatment requested by the youth are consistent with EBPs, providing some support for the value of the current efforts of dissemination and implementation of EBPs within community care. Qualitative study directly examining youth perspectives as they relate to EBPs is recommended.

Further, this study has limitations that need to be considered. First, the method of using qualitative methods, especially focus groups, to gather information from the informants may have affected the number and type of themes derived. For example, when one person mentions a topic, other individuals in the group may elect not to because it has already been mentioned. This would result in under enumeration of topics and could impact the overall interpretation of the salience of any one topic or the overall theme by informants. This potential limitation was addressed by recording all verbal and nonverbal comments (e.g. nodding of head to indicate agreement) that occurred during the “to and fro” of conversations. Anecdotally speaking, we observed the opposite to occur in that when one person mentioned a topic and it was meaningful to others, a discussion would take place among the participants.

Second, qualitative methods involve a higher level of subjectivity of analysis, especially compared to quantitative methods (e.g., surveys or standardized assessment measures). Procedures were used to limit subjectivity in analysis by utilizing multiple coders to code all of the data and triangulating the data across coders as well as designing the study to include multiple sources of information (therapists, parents, and youth). Additionally, the enrollment of participants continued until it was determined that saturation was reached, meaning that the data reported from the informants repeated based on the principal of theoretical saturation described in Strauss and Corbin (1998). Previous studies relying upon this methodology have typically found that information becomes repetitive and little new information is gained after analyses of data collected from as few as twelve respondents (Guest, Bunce, & Johnson, 2006; Patton, 2002) to up to 20–30 participants (1998). Our sample size per informant group is consistent with previous findings with the exception of our youth sample, which was slightly smaller than previous studies; however, satisfactory saturation was reached with at least 80% of the youths reporting on each identified theme.

Another limitation of the study is the participant group. There was a lack of representation from culturally diverse populations. Families and therapists of diverse cultural groups were eligible to participate and informed of the study; however, a higher number of therapists,, parents and youth from a White background participated in the study. The therapists’ group representation closely matched the racial/ethnic diversity of county records of child therapists, who have a higher representation of White race/ethnicity; however, parents and youth of Hispanic and Asian cultures were underrepresented in this study compared to the larger county population of families receiving treatment. Another possible limitation of the sample was the differences in gender distributions for parents and youth. Youth in this sample were primarily males (90%) which is an over representation compared to reports of community samples (typically about 60% males) (Garland, Haine, & Lewczyk Boxmeyer, 2007; Haine, Brookman-Frazee, Tsai, Roesch, & Garland, 2007). Although the parent sample was predominantly mothers (79%) we had more fathers participate than is typical in these same publically-funded clinics as published by another study providing descriptive data on parents and youth involved in community mental health services (Garland, et al., 2007). Although the data were not compared by gender, anecdotally speaking no differences appeared between genders for level of active participation or content of shared experiences. Especially in the parent groups, there was strong group cohesion and high consensus on topics discussed. Additionally, the purposeful sampling methods used may have recruited members that differ from the larger community in other factors (i.e. attitude, motivation, etc.) that were not studied, limiting the generalization of the results. For example, the finding that youths desire more active strategies and less casual conversation may be a self-selection bias as the youths who agreed to participate in the semi-structured interviews and provide detailed responses may be more likely to want active treatment than those youths who declined to participate.

Finally there was no direct inquiry made regarding the informants’ experiences, attitudes, and perceptions of any direct quality improvement effort such as the use of an EBP within current community-based care. Further studies should be explicit in questioning community care stakeholders on such efforts.

Overall, the results from this qualitative study suggest several avenues for intervention development and general improvements in practice to enhance parent engagement and participation in treatment for youth DBPs. First, the findings suggest that it is critical that parents are heard and supported at the onset of treatment. Therapists need alternative communication strategies to effectively listen to parents while teaching parenting skills that do not convey a sense of blame or causation for the youth’s problems. This may be facilitated by using group therapy formats. Given that parent and therapist alliances influence outcomes in child services (Hawley & Weisz, 2005), more consideration of therapeutic alliance, specifically therapist and parent dialogue (Cruz & Pincus, 2002), is also warranted.

Second, parent engagement should be addressed by actively involving parents from the onset of treatment, including both the assessment of child, parent, and family contextual problems and the development of the treatment plan through shared decision making processes and consumer empowerment, thus increasing positive intentions and expectations of treatment. Shared decision making has been shown to positively impact patient satisfaction and health outcomes and has been recommended for the mental health field (Hamann, Leucht, & Kissling, 2003; Hetrick, Simmons, & Merry, 2008; President's New Freedom Commission on Mental Health, 2003; Swanson, Bastani, Rubenstein, Meredith, & Ford, 2007).

Third, to address youths’ desire for more specific, directive treatment strategies and to improve the perceived value of treatment, therapists may want to engage youth in specific active techniques common to EBPs (Garland, et al., 2008). A study examining community treatment in this same county revealed that therapists do not typically use psychotherapeutic strategies common in EBPs frequently or intensively (Garland, Brookman-Frazee, et al., 2010). Further, current community practice has been found to be less effective than EBPs (Andrade, Lambert, & Bickman, 2000; Chorpita & Nakamura, 2004; Daleiden, Lee, & Tolman; Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001; Weisz, et al., 2006) suggesting that change to current practices, as the youth propose, may be warranted.

Lastly, the findings also speak to challenges within the organizational systems where communitybased treatment takes place. Research on the culture and climate of child and family mental health organizations supports the therapist findings that organizational challenges can directly impact service delivery, and efforts are currently underway to design interventions to improve the clinic culture and climate as a method of improving service effectiveness and consumer satisfaction (Glisson, 2007).

Learning about therapists', parents', and youths' experiences with community-based mental health services elucidated important barriers to effective service delivery as well as common frustrations across stakeholder groups. More importantly, a comparison of the dialogues from the focus groups and interviews supports prior findings in the literature regarding the importance of particular treatment elements, such as parent participation, shared decision making, active strategies and explicit communications about treatment, which are integral to many evidenced-based practices. In addition, study findings highlight new areas of focus, such as current shortcomings in service coordination for realworld families, youth wanting less casual conversation in therapy and more direct help with their problems, and policy issues that may interfere with therapists' effectiveness. Taken together, this knowledge can inform providers, administrators, and future research studies--impacting community-based services on multiple levels.

References

Aarons GA, Hurlburt M, Horwitz SMC. Advancing a conceptual model of evidence-based practice implementation in public service sectors. Administration and Policy in Mental Health and Mental Health Services Research. 2011; 38(1):4–23. [PubMed: 21197565]

Alegría M, Polo A, Gao S, Santana L, Rothstein D, Jimenez A, et al. Evaluation of a patient activation and empowerment intervention in mental health care. Medical Care. 2008; 46(3):247–256. [PubMed: 18388839]

Andrade AR, Lambert EW, Bickman L. Dose effect in child psychotherapy: Outcomes associated with negligible treatment. Journal of the American Academy of Child and Adolescent Psychiatry. 2000; 39(2):161–168. [PubMed: 10673825]

Armbruster P, Kazdin AE. Attrition in child psychotherapy. Advances in clinical child psychology. 1994; 16:81–108.

Attride-Stirling J, Davis H, Farrell L, Groark C, Day C. Factors influencing parental engagement in a community child and adolescent mental health service: A qualitative comparison of completers and non-completers. Clinical child psychology and psychiatry. 2004; 9(3):347.

Baker-Ericzén M, Hurlburt M, Brookman-Frazee L, Jenkins M, Hough R. Comparing child, parent and family characteristics in usual care and empirically supported treatment research samples for children with disruptive behavior disorders. Journal of Emotional and Behavioral Disorders. 2010; 18(2):82–99.

Baumann BL, Kolko DJ, Collins K, Herschell AD. Understanding practitioners' characteristics and perspectives prior to the dissemination of an evidence-based intervention. Child Abuse and Neglect. 2006; 30(7):771–787. [PubMed: 16846644]

Bernard, HR. Qualitative methods in cultural anthropology. Newbury Park, CA: Sage Publications, Inc; 1988.

Boyatzis, RE. Transforming qualitative information: Thematic analysis and code development. Thousand Oaks, CA: Sage Publications, Inc; 1998.

Bradley EH, McGraw SA, Curry L, Buckser A, King KL, Kasl SV, et al. Expanding the Andersen Model: The Role of Psychosocial Factors in Long Term Care Use. Health Services Research. 2002; 37(5):1221–1242. [PubMed: 12479494]

Brannan AM. Ensuring effective mental health treatment in real-world settings and the critical role of families. Journal of Child and Family Studies. 2003; 12(1):1–10.

Brookman-Frazee L, Haine RA, Gabayan EN, Garland AF. Predicting frequency of treatment visits in community-based youth psychotherapy. Psychological services. 2008; 5(2):126–138. [PubMed: 20396643]

Chacko A, Wymbs BT, Wymbs FA, Pelham WE, Swanger-Gagne MS, Girio E, et al. Enhancing traditional behavioral parent training for single mothers of children with ADHD. Journal of Clinical Child & Adolescent Psychology. 2009; 38(2):206–218. [PubMed: 19283599]

Chorpita BF, Nakamura BJ. Four considerations for dissemination of intervention innovations. Clinical Psychology: Science and Practice. 2004; 11(4):364–367.

Copeland WE, Miller-Johnson S, Keeler G, Angold A, Costello EJ. Childhood psychiatric disorders and young adult crime: A prospective, population-based study. The American Journal of Psychiatry. 2007; 164(11):1668–1675. [PubMed: 17974931]

Cruz M, Pincus HA. Research on the influence that communication in psychiatric encounters has on treatment. Psychiatric Services. 2002; 53(10):1253–1265. [PubMed: 12364673]

Daleiden, E.; Lee, J.; Tolman, R. Annual evaluation report: Fiscal year 2004. Honolulu, HI: Hawaii Department of Health Child and Adolescent Mental Health Division; 2004. Retrieved January 15, 2007

Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implementation Science. 2009; 4(1):50–65. [PubMed: 19664226]

Earls FJ. Violence and today's youth. The Future of Children. 1994; 4(3):4–23. [PubMed: 7859042]

Eyberg SM. Parent-child interaction therapy. Child & Family Behavior Therapy. 1988; 10(1):33–46.

Eyberg SM, Nelson MM, Boggs SR. Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. Journal of Clinical Child & Adolescent Psychology. 2008; 37(1):215–237. [PubMed: 18444059]

Fabiano GA, Chacko A, Pelham WE Jr, Robb J, Walker KS, Wymbs F, et al. A comparison of behavioral parent training programs for fathers of children with attention-deficit/hyperactivity disorder. Behavior Therapy. 2009; 40(2):190–204. [PubMed: 19433150]

Farkas M, Gagne C, Anthony W, Chamberlin J. Implementing recovery oriented evidence based programs: identifying the critical dimensions. Community Mental Health Journal. 2005; 41(2): 141–158. [PubMed: 15974495]

Frasser, D. QSR Nvivo. NUD*IST Vivo. Reference Guide. Melbourne, Australia: QSR International; 2000.

Garland AF, Brookman-Frazee L, Hurlburt M, Accurso EC, Zoffness R, Haine-Schlagel R, et al. Mental health care for children with disruptive behavior problems: A view inside therapists' offices. Psychiatric Services. 2010; 61:788–795. [PubMed: 20675837]

Garland AF, Haine RA, Lewczyk Boxmeyer C. Determinates of youth and parent satisfaction in usual care psychotherapy. Evaluation and Program Planning. 2007; 30(1):45–54. [PubMed: 17689312]

Garland AF, Hawley KM, Brookman-Frazee L, Hurlburt MS. Identifying common elements of evidence-based psychosocial treatments for children's disruptive behavior problems. Journal of the American Academy of Child and Adolescent Psychiatry. 2008; 47(5):505–514. [PubMed: 18356768]

Garland AF, Hough RL, McCabe KM, Yeh M, Wood PA, Aarons GA. Prevalence of psychiatric disorders in youths across five sectors of care. Journal of the American Academy of Child & Adolescent Psychiatry. 2001; 40(4):409–418. [PubMed: 11314566]

Garland AF, Hurlburt MS, Brookman-Frazee L, Taylor RM, Accurso EC. Methodological challenges of characterizing usual care psychotherapeutic practice. Administration and Policy in Mental Health and Mental Health Services Research. 2010; 37(3):208–220. [PubMed: 19757021]

Geertz, C. The interpretation of cultures. New York, NY: Basic Books; 1973.

Glaser, BG.; Struss, AL. The discovery of grounded theory: Strategies for qualitative research. Chicago, IL: Aldine Publishing Company; 1967.

Glisson C. Assessing and changing organizational culture and climate for effective services. Research on Social Work Practice. 2007; 17(6):736–747.

Glisson C, Landsverk J, Schoenwald S, Kelleher K, Hoagwood KE, Mayberg S, et al. Assessing the organizational social context (OSC) of mental health services: Implications for research and practice. Administration and Policy in Mental Health and Mental Health Services Research. 2008; 35(1):98–113. [PubMed: 18085434]

Gopalan G, Goldstein L, Klingenstein K, Sicher C, Blake C, McKay MM. Engaging Families into Child Mental Health Treatment: Updates and Special Considerations. Journal of the Canadian Academy of Child and Adolescent Psychiatry. 2010; 19(3):182–196. [PubMed: 20842273]

Gould MS, Shaffer D, Kaplan D. The characteristics of dropouts from a child psychiatry clinic. Journal of the American Academy of Child Psychiatry. 1985; 24(3):316–328. [PubMed: 4008823]

Greenfield S, Kaplan S, Ware JE. Expanding patient involvement in care: Effects on patient outcomes. Annals of Internal Medicine. 1985; 102(4):520–528. [PubMed: 3977198]

Greenfield S, Kaplan SH, Ware JE, Yano EM, Frank HJL. Patients’ participation in medical care: Effects on blood sugar control and quality of life in diabetes. Journal of General Internal Medicine. 1988; 3(5):448–457. [PubMed: 3049968]

Guest G, Bunce A, Johnson L. How many interviews are enough? An experiment with data saturation and variability. Field methods. 2006; 18(1):59–82.

Haine RA, Brookman-Frazee L, Tsai KH, Roesch SC, Garland AF. Clinician Perspectives of Diagnosis and Perceived Client Change in "Real World" Psychotherapy for Youth Emotional and Behavioral Disorders. Journal of Child and Family Studies. 2007; 16(5):712–728.

Hamann J, Leucht S, Kissling W. Shared decision making in psychiatry. Acta Psychiatrica Scandinavica. 2003; 107(6):403–409. [PubMed: 12752015]

Hawley KM, Weisz JR. Youth versus parent working alliance in usual clinical care: Distinctive associations with retention, satisfaction, and treatment outcome. Journal of Clinical Child and Adolescent Psychology. 2005; 34(1):117–128. [PubMed: 15677286]

Hetrick S, Simmons M, Merry S. SSRIs and depression in children and adolescents: the imperative for shared decision-making. Australasian Psychiatry. 2008; 16(5):354–358. [PubMed: 18665469]

Hoagwood K, Burns BJ, Kiser L, Ringeisen H, Schoenwald SK. Evidence-based practice in child and adolescent mental health services. Psychiatric Services. 2001; 52(9):1179–1189. [PubMed: 11533391]

Hoagwood K, Kolko DJ. Introduction to the special section on practice contexts: A glimpse into the nether world of public mental health services for children and families. Administration and Policy in Mental Health and Mental Health Services Research. 2009; 36(1):35–36. [PubMed: 19115103]

Ingoldsby EM. Review of Interventions to Improve Family Engagement and Retention in Parent and Child Mental Health Programs. Journal of Child and Family Studies. 2010; 19(5):629–645. [PubMed: 20823946]

Kazdin AE, Holland L, Crowley M, Breton S. Barriers to treatment participation scale: Evaluation and validation in the context of child outpatient treatment. Journal of Child Psychology and Psychiatry. 1997; 38(8):1051–1062. [PubMed: 9413802]

Kazdin AE, Mazurick JL, Siegel TC. Treatment outcome among children with externalizing disorder who terminate prematurely versus those who complete psychotherapy. Journal of the American Academy of Child and Adolescent Psychiatry. 1994; 33(4):549–557. [PubMed: 8005908]

Krueger, R.; Casey, MA. Focus groups: A practical guide for applied research. London: Sage Publications; 2000.

Krueger, RA. Moderating focus groups. Thousand Oaks, CA: Sage Publications, Inc; 1998.

Levac AM, McCay E, Merka P, Reddon D’Arcy ML. Exploring parent participation in a parent training program for children's aggression: Understanding and illuminating mechanisms of change. Journal of Child and Adolescent Psychiatric Nursing. 2008; 21(2):78–88. [PubMed: 18429838]

Lundahl B, Risser HJ, Lovejoy MC. A meta-analysis of parent training: Moderators and follow-up effects. Clinical Psychology Review. 2006; 26(1):86–104. [PubMed: 16280191]

Marshall, C.; Rossman, GB. Designing qualitative research. 5th ed.. Thousand Oaks, CA: Sage Publications, Inc; 2010.

McCabe KM. Factors that predict premature termination among Mexican-American children in outpatient psychotherapy. Journal of Child and Family Studies. 2002; 11(3):347–359.

McKay MM, Bannon WM Jr. Engaging families in child mental health services. Child and Adolescent Psychiatric Clinics of North America. 2004; 13(4):905–921. [PubMed: 15380788]

McKay MM, Stoewe J, McCadam K, Gonzales J. Increasing access to child mental health services for urban children and their caregivers. Health and Social Work. 1998; 23(1):9–16. [PubMed: 9522199]

Miles, MB.; Huberman, AM. Qualitative data analysis: An expanded sourcebook. Thousand Oaks, CA: SAGE publications, Inc; 1994.

Miller GE, Prinz RJ. Engagement of families in treatment for childhood conduct problems. Behavior Therapy. 2003; 34(4):517–534.

Morgan, DL. Focus groups as qualitative research. Newbury Park, CA: Sage Publications, Inc; 1988.

Morgan, DL. Emergent methods in social reserach. Thousand Oaks, CA: Sage Publications, Inc; 2006. Practical strategies for combining qualitative and quantitative methods; p. 165-182.

Morgan DL, Spanish MT. Focus groups: A new tool for qualitative research. Qualitative Sociology. 1984; 7(3):253–270.

Nock MK, Ferriter C. Parent management of attendance and adherence in child and adolescent therapy: A conceptual and empirical review. Clinical Child and Family Psychology Review. 2005; 8(2):149–166. [PubMed: 15984084]

Nock MK, Ferriter C, Holmberg E. Parent beliefs about treatment credibility and effectiveness: Assessment and relation to subsequent treatment participation. Journal of Child and Family Studies. 2007; 16(1):27–38.

Nock MK, Kazdin AE. Parent expectancies for child therapy: Assessment and relation to participation in treatment. Journal of Child and Family Studies. 2001; 10(2):155–180.

Nock MK, Kazdin AE. Randomized controlled trial of a brief intervention for increasing participation in parent management training. Journal of Consulting and Clinical Psychology. 2005; 73(5):872. [PubMed: 16287387]

Nock MK, Photos V. Parent motivation to participate in treatment: Assessment and prediction of subsequent participation. Journal of Child and Family Studies. 2006; 15(3):333–346.

Ollendick, TH.; King, NJ.; Chorpita, B. Empirically supported treatments for children and adolescents. In: Kendall, PC., editor. Child and adolescent therapy: Cognitive behavioral procedures. 2 nd ed.. New York, NY: The Guilford Press; 2000. p. 386-425.

Oswald DP. Recovery and child mental health services. Journal of Child and Family Studies. 2006; 15(5):525–527.

Patton, MQ. Qualitative research and evaluation methods. 3rd Ed.. Thousand Oaks, CA: Sage Publications, Inc; 2002.

Pevsner R. Group parent training versus individual family therapy: An outcome study. Journal of Behavior Therapy and Experimental Psychiatry. 1982; 13(2):119–122. [PubMed: 7130407]

Powell BJ, McMillen JC, Proctor EK, Carpenter CR, Griffey RT, Bunger AC, et al. A Compilation of Strategies for Implementing Clinical Innovations in Health and Mental Health. Medical Care Research and Review. 2012; 69(2):123–157. [PubMed: 22203646]

President's New Freedom Commission on Mental Health. Achieving the promise: Transforming mental health care in America. Final Report. (DHHS Pub. No. SMA-03-3832). Rockville, MD: U. S. Department of Health and Human Services; 2003.

Prinz RJ, Miller GE. Family-based treatment for childhood antisocial behavior: Experimental influences on dropout and engagement. Journal of Consulting and Clinical Psychology. 1994; 62(3):645–650. [PubMed: 8063993]

Rost K, Flavin K, Cole K, McGill J. Change in metabolic control and functional status after hospitalization. Impact of patient activation intervention in diabetic patients. Diabetes Care. 1991; 14(10):881–889. [PubMed: 1773686]

Schoenwald SK, Brown TL, Henggeler SW. Inside Multisystemic Therapy: Therapist, Supervisory, and Program Practices. Journal of Emotional and Behavioral Disorders [Special Issue: School Safety, part 1]. 2000; 8(2):113–127.

Staudt M. Treatment engagement with caregivers of at-risk children: Gaps in research and conceptualization. Journal of Child and Family Studies. 2007; 16(2):183–196.

Strauss, AL.; Corbin, JM. Basics of qualitative research: Grounded theory procedures and techniques. Thousand Oaks, CA: Sage Publications, Inc.; 1990.

Strauss, AL.; Corbin, JM. Basics of qualitative research: Techniques and procedures for developing grounded theory. Thousand Oaks, CA: Sage Publications, Inc; 1998.

Swanson KA, Bastani R, Rubenstein LV, Meredith LS, Ford DE. Effect of mental health care and shared decision making on patient satisfaction in a community sample of patients with depression. Medical Care Research and Review. 2007; 64(4):416–430. [PubMed: 17684110]

Tappe, A. Using Nvivo in qualitative research. Melbourne, Australia: QSR International; 2002.

Tolan PH, Dodge KA. Children's mental health as a primary care and concern: a system for comprehensive support and service. American Psychologist. 2005; 60(6):601–614. [PubMed: 16173893]

U.S. Public Health Service. Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC: Department of Health and Human Services; 2000.

Watt BD, Dadds MR. Facilitating treatment attendance in child and adolescent mental health services: A community study. Clinical child psychology and psychiatry. 2007; 12(1):105–116. [PubMed: 17375812]

Webster-Stratton C, Kolpacoff M, Hollinsworth T. Self-administered videotape therapy for families with conduct-problem children: Comparison with two cost-effective treatments and a control group. Journal of Consulting and Clinical Psychology. 1988; 56(4):558–566. [PubMed: 3143750]

Weisz JR, Jensen-Doss A, Hawley KM. Evidence-based youth psychotherapies versus usual clinical care: A meta-analysis of direct comparisons. American Psychologist. 2006; 61(7):671–689. [PubMed: 17032068]

Wierzbicki M, Pekarik G. A meta-analysis of psychotherapy dropout. Professional Psychology: Research and Practice. 1993; 24(2):190–195.

Willms DG, Best JA, Taylor DW, Gilbert JR, Wilson D, Lindsay EA, et al. A systematic approach for using qualitative methods in primary prevention research. Medical Anthropology Quarterly. 1990; 4(4):391–409.

Yatchmenoff DK, Koren PE, Friesen BJ, Gordon LJ, Kinney RF. Enrichment and stress in families caring for a child with a serious emotional disorder. Journal of Child and Family Studies. 1998; 7(2):129–145.

Zoffness R, Garland A, Brookman-Frazee L, Roesch S. Case management as a significant component of usual care psychotherapy for youth with disruptive behavior problems. Child Youth Care Forum. 2009; 38:185–200. [PubMed: 19657458]

Table 1

Therapist Demographics

	Therapists N=26
Gender (n)	
Female	89% (23)
Race/Ethnicity (n)	
Caucasian	73% (19)
Latino	12% (3)
African-American	4% (1)
Asian/Pacific Islander	8% (2)
Mixed/Other[a]	4% (1)
Discipline (n)	
Marital & Family Therapy	50% (13)
Social Work	35% (9)
Psychology	15% (4)
Licensed (n)	50% (13)
Mean years of experience	10.4
Primary Orientation (n)	
Family Systems	46% (12)
Cognitive Behavioral	38% (10)
Psychodynamic	8% (2)
Humanistic	4% (1)
Other	4% (1)

Note. Therapists practiced in 1 of 6 representative community-based mental health clinics in a metropolitan county.

[a] No participate reported “other” to indicate their race/ethnicity.

Table 2

Parent and Youth Demographics

	Parents N=14	**Youths N=10**
Gender (n)		
Female	79% (11)	10% (1)
Age: Parent (n), Youth (M, SD)		11.4 (.97)
26–45	28% (4)	
46–60	71% (10)	
Race/Ethnicity (n)		
Caucasian	86% (12)	90% (9)
Latino	7% (1)	0
African-America	7% (1)	0
Asian Pacific Islander	0	0
Mixed/Other[a]	0	10% (1)
Parent Type (n)		
Biological	50% (7)	
Foster/Adoptive	43% (6)	
Relative	7% (1)	
Marital Status (n)		
Married	64% (9)	
Divorced/Separated	7% (1)	
Single (no partner)	14% (2)	
Single (with partner)	14% (2)	
Average number of children	2.9	

Note.

[a] No participate reported "other" to indicate their race/ethnicity.

Table 3

Frequency of Subthemes for Therapist and Parent Focus Groups and Youth Interviews

Subtheme	**Therapists N = 26**	**Parents N = 14**	**Youths N = 10**
Overwhelmed by families complex needs	227		
Parents lack of involvement & perceived unwillingness to participate	86		
Inadequately supported in meeting families' needs	38		
Overwhelmed by children's symptoms		130	
Unsupported by formal service system		88	
Blamed and ignored by therapists		33	
Dissatisfaction with mental health services		50	
Openness to discussing parents' problems			31
Openness to parents' active involvement in therapy			21
Interest in more directive, active therapy			10
Less time spent on question asking and casual conversation			11