Life is Precious

Parental Engagement Training Guide: Best Practices

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Chapter 1.

Introduction

A key feature of the Life is Precious (LIP) model is the engagement of parents in the program. Helping parents can help address the needs of the family, which may be contributing to depressive symptoms and suicidal ideation in the adolescents, and can also give parents resources to help the adolescents, so that the impact of LIP is not limited to the time the participants are seen in the program. However, as in many programs serving adolescents, engaging parents can be challenging. Parents may face conflicting demands, with the needs of other children and family members, long or irregular work hours, and other stressors that may make it difficult to participate in a program like LIP. The purpose of this document is to highlight some feedback from LIP staff, parents, and adolescent participants, to learn how LIP can improve outreach to families.

This report begins with a description of the LIP program (Chapter 2). We then discuss risks and protective factors for suicidal behavior, and benefits and challenges of parental engagement (Chapters 3-6). For each of these chapters, we first discuss relevant findings in the academic literature, and then report results from a survey conducted among LIP adolescent participants and parents in the spring of 2017. We then discuss best practices, as developed by LIP, and recommendations for future directions (Chapter 7). Finally, we provide examples of how these best practices might be implemented (Chapter 8).

Methodology

These best practices were developed based on a review of best practices in the scientific literature, which took place in March 2017, and an analysis of interviews with LIP program staff conducted in February 2014 and August-September 2016, as well as focus groups with participants and parents conducted in December 2013, July 2014, August 2014, September 2016 and January 2017.

This process also includes results from a survey of adolescent participants and parents, conducted in February and March of 2017. Forty-five adolescent-parent pairs participated. The dyads included current LIP participants, adolescents with closed cases, participants who only attended LIP once or twice, and those who had a consult but did not join. The surveys, developed by partners at New York University, covered a range of topics including history of mental health treatment, views on mental health treatment and satisfaction with LIP. Results from these surveys are included in Chapters 3-6.

Chapter 2.

Life is Precious Program Description

The Life is Precious (LIP) program model was developed by Comunilife, Inc., led by Dr. Rosa Gil, with input from Latina adolescents and parents in New York City. The program was designed to supplement outpatient mental health treatment by providing a range of services in an after-school, clubhouse program model. LIP activities are centered on several goals: promotion of family relationships, academic support, creative expression, and wellness education. LIP does not have a defined catchment area, and accepts participants from a wide range of schools and neighborhoods. Referrals can come from outpatient mental health clinics, schools, hospitals, and self-referrals from Latinas and their families (Humensky et al, 2013). All participants must be adolescent Latinas (ages 12-18). Adolescents must have experienced suicidal ideation or attempts prior to referral, and continue to experience suicidal ideation at the time of referral. Participants must be receiving mental health treatment, either at Comunilife or another clinic.

LIP currently operates in three locations in New York City (Bronx, Brooklyn, and Queens). The program runs after school (3:00pm-7:00pm) on weekdays and on Saturday mornings. Participants come on a drop-in basis and can take advantage of any or all of the services offered by LIP; there is no set curriculum or sequence in which services must be received. Communication education is designed primarily to educate the adolescent on improving communication with family members; if other family members choose to participate, they may also learn these skills. As LIP operates as an after-school program, many parents are working or otherwise not available at those hours, and so the program is designed primarily to provide adolescents with the tools and strategies that they may find beneficial, regardless of the level of participation by other family members (Humensky et al, 2016).

References

Humensky JL, Coronel B, Gil R, Cifre R, Mazzula S, Lewis-Fernández R. Title: Life is Precious: A Community-Based Program to Reduce Suicidal Behavior in Latina Adolescents. Archives of Suicide Research, 2016, doi: 10.1080/13811118.2016.1242442.

Humensky JL, Coronel B, Gil R, Cifre R, Mazzula S, Lewis-Fernández R. Life is Precious: Reducing Suicidal Behavior in Latinas. Ethnicity and Inequalities in Health and Social Care, 2013; 6(2/3).

Chapter 3.

Risks of Suicidal Behavior in Latina Adolescents

Literature Review

Historically, studies have shown that Latina adolescents consistently have higher rates of suicidal behavior compared to non-Latina black and white adolescents. Latina adolescents face risk factors confronted by all female adolescents, as well as risk factors that have been identified as unique to Latinas. General risk factors common to many populations include history of child abuse or sexual abuse; history of suicide attempt; family history of attempted or completed suicide; history of or current mental illness, especially depression; physical illness; past or current alcohol abuse and abuse of other substances; loss (relational, social, work, or financial); easy access to lethal means; impulsive or aggressive tendencies; history of being bullied and social isolation; peer suicides or local epidemics of suicide; failure in school; hopelessness; unwillingness to seek help because of stigma; and barriers to accessing mental health care (Price, 2016; Langhinrichsen-Rohling, 2009).

Additional community-level risk factors include poverty and residing in high-crime, disadvantaged neighborhoods with low-quality housing and education (Zayas and Pilat, 2008). During adolescence, girls may face developmental struggles related to identity formation, self-esteem, and body image (Zayas and Pilat, 2008).

In addition to these risk factors that are common to many populations, some risk factors have been identified as affecting Latina adolescents. *Familism* is thought to play an important role in suicidal behaviors, as it is a core system of values centered on the family, prioritizing the family over self. *Familism* calls for family unity and reverence of parents and elders. Latino adolescents struggle with their need for autonomy, which is emphasized in American culture, on the one hand, and cultural values of *familism* on the other; therefore, a family conflict may lead to suicidal behavior when autonomy begins to threaten family order (Zayas and Pilat, 2008; Langhinrichsen-Rohling, 2009). Latinas, specifically, may feel pressure to display nurturing, controlled, family-oriented behavior. This gender role tends to conflict with the values of personal autonomy and independence common in US society. Moreover, the immigration process can be traumatic for those who may be leaving important family members behind in their countries of origin (Langhinrichsen-Rohling, 2009).

An additional barrier to care is the inability to afford treatment. Latino youth made up nearly 40% of US uninsured youths in 2014, but comprise 24% of the youth population; many have long waiting periods for insurance coverage. They also face language barriers and transportation challenges coverage (Price, 2016). While Latino adolescents are less likely to die by suicide than other ethnic groups, in 2008, they reported higher rates of

suicide plans, attempts, and hopelessness; therefore, this population has a particular risk for nonfatal suicidal behavior (Langhinrichsen-Rohling, 2009).

Life is Precious aims to address these specific needs of Latina adolescents in order to reduce suicidality, with an emphasis on improving the lives of girls in the LIP community. The five core components of the LIP program are Wellness, Creative Expression Therapy, Outpatient Mental Health Services, Family Support, and Supported Education Services. These components are included to address the unique intersection in this community of the struggles that many female adolescents experience with self, family, friends and school (Zayas and Pilat, 2008; Goldston et al., 2008; Humensky et al., 2013); and the bicultural challenge balancing the push toward autonomy against the pull toward a family-centered role (Zayas and Pilat, 2008).

Survey Findings

Many participants reported that they feel that LIP provides a comfortable, safe and free space for them to express themselves and be themselves. Of 45 adolescents and 45 parents that participated in this survey, 82% of both feel that LIP was a safe and comfortable place. Of 45 adolescent respondents, 29 (64%) moderately or strongly agree that "LIP helps me cope with my problems" and 29 (64%) moderately or strongly agree that "LIP helps to prevent me from committing suicide." Of 44 participants who responded, 28 (64%) reported moderately or strongly agreeing that "LIP has helped my academic performance."

References

Goldston, D. S., Molock, S. D., Whitbeck, L. B., Murakami, J. L., Zayas, L. H., & Nagayama Hall, G. C. (2008). Cultural considerations in adolescent suicide prevention and psychosocial treatment. *American Psychologist*, *63*(1), 14-31.

Humensky, J., Gil, R., Coronel, B., Cifre, R., Mazzula, S., & Lewis-Fernández, R. (2013). Life is Precious: reducing suicidal behavior in Latinas. *Ethnicity and Inequalities in Health and Social Care*, *6*(2/3), 54-61.

Langhinrichsen-Rohling, J., Friend, J., & Powell, A. (2009). Adolescent suicide, gender, and culture: A rate and risk factor analysis. *Aggression and Violent Behavior*, *14,* 402-414.

Price, J. H. & Khubchandani, J. (2016). Latina Adolescents Health Risk Behaviors and Suicidal Ideation and Suicide Attempts: Results from the National Youth Risk Behavior Survey 2001-2013. *J Immigrant Minority Health.* doi:10.1007/s10903-016-0445-8.

Zayas, L.H., & Pilat, A.M. (2008). Suicidal behavior in Latinas: Explanatory cultural factors and implications for intervention. Suicide and Life-Threatening Behavior, 38, pp. 334-342.

Chapter 4.

Protective Factors Against Suicidal Behavior

Literature Review

Latina adolescents face multiple risk factors for suicidal behavior; however, they also experience several protective factors. A study of middle school students shows that a major protective factor is the sense of belongingness, emphasizing the impact of peer acceptance on reducing loneliness and the effect of loneliness on depression (Baskin, 2010). Additional protective factors for students include: parent connectedness, connectedness to other adults, caring friends, participation in sports, academic achievement, school pride or a fondness for school, and neighborhood safety. Of these protective factors, parent connectedness resulted in the largest effects for high school students, regardless of gender, in terms of suicidality, suicidal ideation only, and suicide attempt (Taliaferro, 2013).

Hagler (2016) found that, in addition to school, employment is a protective factor against suicidal behavior in the general population. Working results in personal development, empowerment, feelings of autonomy, generativity, and a sense of providing help to others. Financial independence helped some participants to gain autonomy; empowerment in the work led others to gain mastery and pride. Participants in Hagler's study found that working instilled important skills, lessons, and a sense of responsibility, leading to opportunities for altruism. These protective factors may serve as mediating links between employment and mental well-being (Hagler, 2016).

Survey Results

Survey responses indicate that parents and daughters are similarly satisfied with their relationships. However, parents and daughters provided significantly different responses as to other aspects of their relationship. First, 84% of parents reported feeling that there was mutual understanding about the problems and worries that daughters face, while only 38% of daughters feel that their parents understand them in this way. Parents and adolescents differed in their perception of other relational aspects of this dyad as well. While 75% of parents felt their child is comfortable asking for their help, only 53% of adolescents in this sample endorsed feeling this way. Parents also felt that they help their daughters when they have problems (84%); however, in comparison, 56% of daughters agreed. The comfort level in showing certain emotions also differed, as 62% of parents thought their child feels comfortable being upset around them, but only 48% of adolescents agreed. Lastly, while 80% of parents believed they check-in with their daughters regularly, only 51% of the adolescents agreed.

Agreement Between Parent/Youth Dyad in Appraisal of Relationship

	Adolescent's Perspective % [N]	Parent's Perspective % [N]
Overall, I am satisfied with the relationship I have with my parent/daughter.	78% [n=35]	76% [n=34]
My parent understands my problems and worries. / I understand my daughter's problems and worries.	**38% [n=17]**	**84% [n=37]***
I am comfortable asking my parent for help. / My daughter is comfortable asking me for help.	**53% [n=24]**	**75% [n=33]***
When I have a problem, my parent helps me with it. / When my daughter has a problem, I help her with it.	**56% [n=30]**	**84% [n=38]**
I feel comfortable being upset around my parent. / My daughter feels comfortable being upset around me.	**48% [n=21]***	**62% [n=28]**
My parent checks in regularly with me about what is currently going on in my life. / I check in regularly with my daughter about what is currently going on in her life.	**51% [n=23]**	**80% [n=36]**

Table 1. Percentage of the 45 adolescents and parents who indicated "Moderately Agree" or "Strongly Agree" for the given statements on the parental engagement surveys. *N=44 due to missing responses. **Bold** indicates that difference in responses is statistically significant (<0.05) (paired t-test).

References

Baskin, T. W., Wampold, B. E., Quintana, S. M., & Enright, R. D. (2010). Belongingness as a protective factor against loneliness and potential depression in a multicultural middle school. *The Counseling Psychologist, 38*(5), 626-651.

Hagler, M., Hamby, S., Grych, J., & Banyard, V. (2016). Working for well-being: Uncovering the protective benefits of work through mixed methods analysis, *J Happiness Stud, 17*, 1493-1510.

Langhinrichsen-Rohling, J., Friend, J., & Powell, A. (2009). Adolescent suicide, gender, and culture: A rate and risk factor analysis. *Aggression and Violent Behavior*, *14,* 402-414.

Taliaferro, L. A., & Muehlenkamp, J. J. (2013). Risk and protective factors that distinguish adolescents who attempt suicide from those who only consider suicide in the past year. *Suicide and Life-Threatening Behavior, 44*(1), 6-22.

Chapter 5.

Benefits of Parental Engagement

Literature Review

According to the Ontario Centre of Excellence for Child and Youth Mental Health (2011), family engagement in youth mental health services is increasingly accepted as a best practice for quality service and support, and stresses a need to train clinicians and service providers on how to effectively engage families. Parents play a critical role in care because they have expert knowledge on their children. Moreover, many parents are concerned about the challenges that adolescents face, and want to play an active, supportive role in their care. Fortunately, adolescents who report having sufficient parental connectedness, oversight, communication, or support are less likely to engage in risky behaviors. (National Alliance to Advance Adolescent Health, 2010).

Parental engagement goes beyond participation in and adherence to health care and treatment. Effective engagement works when families are empowered and motivated to recognize their needs, strengths and resources, and to take an active role in making changes and improvements. With proper training on engagement, families gain knowledge of how the healthcare system and its services work, and how they may be improved. (Ontario Centre of Excellence for Child and Youth Mental Health, 2016). Clinicians need to provide the knowledge, skills, and confidence necessary for families to be effective partners in their adolescent's care (NCIOM, 2015).

Several studies show the benefits of parental engagement. Family psychoeducation is an evidence based practice that decreases relapse rates and aids the recovery of patients who have mental illness or psychiatric disabilities (Dixon, 2001). The benefits of family engagement include improved psychological adjustment, quality of life, behavioral functioning, and adolescent and family management skills and functioning; improved patient satisfaction; shorter recovery process for mental health issues; increased medication compliance; enhanced psychological well-being and decreased stress among parents; increased caregiver feelings of competence and self-efficacy; increased caregiver knowledge about mental health issues; and reduced rates of relapse and risk of mortality (Ontario Centre of Excellence for Child and Youth Mental Health, 2016).

Beyond the family level, parental engagement also improves the effectiveness of service delivery at the individual, organizational, and system levels. Providers can meaningfully engage family members in several evidence-informed ways, including regarding families as experts, encouraging active participation in treatment; investing in relationships and improving the quality of the therapeutic alliance; addressing barriers to engagement, such as transportation issues or scheduling conflicts, and misunderstandings about services or stigma; implementing culturally-responsible services; and tailoring unique services to fit each families' needs and preferences (Ontario Centre of Excellence for Child and Youth

Mental Health, 2016). When both the patient and the family are engaged, there are fewer medical errors and serious safety events, and increased patient satisfaction scores. In addition, there are lower medical costs due to fewer hospital admissions, improved health behaviors, and increased levels of physical activity (NCIOM, 2015).

Even in a highly technical setting such as an intensive care unit, meetings between healthcare professionals and families who used a shared decision-making model resulted in reduced decision-making conflicts and unrealistic parental expectations, and improved collaboration between clinical providers and family members (Davidson, 2007).

Survey Results

According to the LIP survey on parental engagement, 10 adolescents (22%) moderately agree or strongly agree that it would be helpful if the parent were more involved in LIP, and 17 (37%), generally agree or strongly agree that they would like for the parent to participate in more LIP activities. Even among parents, there is interest in gaining a more prominent role in their adolescent's care. Twenty-seven parents (60%) want to participate more in LIP activities, and 33 (73%) think it would be helpful for the daughter if the parent were more involved with LIP. In addition, 26 (57%) believe that their daughters would like for them to participate more in LIP activities. Thirty parents (68%) agree that LIP has improved their relationships with their daughters, and 31 parents (68%) agree that LIP has taught them ways to better support their daughters.

References

Davidson, J. E., Powers, K., Hedayat, K. M., Tieszen, M., Kon, A. A., Shepard, E., … Armstrong, D. (2007). Clinical practice guidelines for support of the family in the patient-centered intensive care unit: American College of Critical Care Medicine Task Force 2004–2005. *Crit Care Med 35*(2), 605-622.

Dixon, L., McFarlane, W. R., Lefley, H., Lucksted, A., Cohen, M., Falloon, I., … Sondheimer, D. (2001). Evidence-Based Practices for Services to Families of People with Psychiatric Disabilities. *Psychiatric Services, 52*(7), 903-910.

The National Alliance to Advance Adolescent Health. (2010). *Parents' Perspectives on Health Care for Adolescents.* (Report No. 3). Fox, H. B., McManus, M. A., & Yurkiewicz, S. M.

North Carolina Institute of Medicine. (2015). *Patient and Family Engagement: A Partnership for Culture Change, 76*(3), 197-200.

Ontario Centre of Excellence for Child and Youth Mental Health. (2011). *Developing a family engagement training strategy.* Dostaler, T. & Cannon, S. Retrieved from http://www.excellenceforchildandyouth.ca/sites/default/files/family_engagement_report.pdf.

Ontario Centre of Excellence for Child and Youth Mental Health. (2016). *Evidence In-Sight: Best Practices in Engaging Families in Child and Youth Mental Health.* Retrieved from http://www.excellenceforchildandyouth.ca/sites/default/files/eib_attach/FamilyEngagement_Final_Jan2016.pdf.

Chapter 6.

Challenges in Getting Parents Involved in Programs

Literature Review
Studies of adolescent programs have found that engaging families is challenging (Ingoldsby, 2010). Low engagement can lead to low participation in treatment, which means that participants do not receive the treatment's optimal benefits (Kazdin 1996; Spoth and Redmond 2000). Moreover, individuals at greater risk for poor outcomes (i.e. participants with more severe mental health problems, those with families with low socioeconomic status, or living in high-poverty areas) may be at higher risk for disengagement (Miller and Prinz 1990; Snell-Johns et al. 2004).

Predictors of low parental engagement include factors such as single-parent status or ethnic minority status, the parent's mental health problems, and low socioeconomic status (Nock and Ferriter 2005; Snell-Johns et al. 2004, Ingoldsby, 2010). Additional barriers to treatment engagement are time demands (i.e. from work or caring for other family members) and lack of transportation to the clinic or treatment site (Garvey et al. 2006; Kazdin et al. 1997; Spoth and Redmond 2000; Stevens et al. 2006). Other barriers include poor rapport between providers and families, and program activities not seen as relevant to the family's needs (Gross et al. 2001).

Programs have identified methods for enhancing parental engagement (Ingoldsby, 2010). Improving communication by having program employees match their communication styles to that of participants has been shown to help promote engagement in some programs. For example, several programs have found it helpful to address stigma by validating participants' feelings about mental health treatment and addressing concerns that they may have (Beeber et al. 2007). Additional examples of improving communication include identifying achievable goals and clarifying reasons for treatment, ensuring that treatment plans are understood by both the participant and family, and providing positive feedback after goals are achieved (Watts and Dadds, 2007). Furthermore, programs may wish to address the needs of the family beyond mental health treatment (i.e. assisting a family with applying for public benefits or helping them escape a domestic violence situation) (Watts and Dadds 2007).

Strategies to improve engagement and retention include providing appointment reminders, addressing practical barriers (i.e. providing information about transit subsidies to reduce transportation costs) and the expectations about the goals and limitations of the intervention, and adapting service delivery based on each individual family's barriers (i.e. allowing siblings to attend the program on family days) (Ingoldsby, 2010).

Survey Results

Compared to the number of LIP participants, fewer than half of the parents are involved in LIP. According to 45 LIP participant surveys on parental engagement, in the past three months, 32 girls (71%) participated in LIP activities, and 18 parents (40%) attended LIP activities. This is confirmed by the LIP parent surveys; in the past three months, 30 of their daughters (66%) participated in LIP activities and 21 parents (47%) attended LIP activities.

A number of challenges to parent participation are noted. Challenges can be caused by lack of communication with the parents due to their being unresponsive or having a disconnected phone; loss of interest in LIP; family duties at home; care for younger children; health issues; scheduling conflicts with work; lack of Metro card funds; and the location of the LIP site. From the surveys on parental engagement, 8 parents (17%) indicated that they moderately agreed or strongly agree that it is difficult to get to a mental health counseling facility; as an LIP site may be far from the subway stop, parents may find the commute to LIP cumbersome. Most parents report that they like the LIP program; only 3 parents (6%) moderately agreed or strongly agreed that they do not enjoy being part of the LIP program, and 2 parents (4%) say that they don't enjoy the fact that their daughter is part of the LIP program.

Parental Perspective on Mental Health and Related Services

Positive Views	Moderately Agree and Strongly Agree % [N]	Negative Views	Moderately Agree and Strongly Agree % [N]
Mental health counseling can teach my daughter ways to cope with her problems.	84% [n=38]	I feel embarrassed talking about my daughter's mental health problems	15% [n=7]
I believe that mental health services can help my daughter.	84% [n=38]	I feel afraid about my daughter seeking out mental health counseling services	9% [n=4]
I trust that mental health counselors are experts that know what they are doing.	78% [n=35]	If my daughter goes to mental health counselling, she will be judged negatively.	9% [n=4]
I trust that mental health counselors have my daughter's best interest in mind.	82% [n=36]*	I feel shy talking about my daughter's mental health.	9% [n=4]
I support my daughter speaking	84% [n=38]	Mental health counselling is	11% [n=5]

to a mental health counselor.		against my cultural beliefs.	

Table 2. Percentage and number of the 45 parents who indicated "Moderately Agree" or "Strongly Agree" for the given statements on the parental engagement surveys.
*N=44 due to missing response.

References

Beeber, L. S., Cooper, C., Van Noy, B. E., Schwartz, T. A., Blanchard, H. C., Canuso, R., et al. (2007). Flying under the radar: Engagement and retention of depressed low-income mothers in a mental health intervention. Advances in Nursing Science, 30, 221–234.

Garvey, C., Julion, W., Fogg, L., Kratovil, A., & Gross, D. (2006). Measuring participation in a prevention trial with parents of young children. Research in Nursing and Health, 29, 212–222.

Gross, D., Julion, W., & Fogg, L. (2001). What motivates participation and dropout among low-income urban families of color in a prevention intervention? Family Relations, 50, 246–254.

Inglesby EM. (2010). Review of Interventions to Improve Family Engagement and Retention in Parent and Child Mental Health Programs. *J Child Fam Stud, 19*: 629-645.

Kazdin, A. E. (1996). Dropping out of child psychotherapy: Issues for research and implications for practice. Clinical Child Psychology and Psychiatry, 1, 133–156.

Kazdin, A. E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. Journal of Consulting and Clinical Psychology, 65, 433–463.

Miller, G. E., & Prinz, R. J. (1990). Enhancement of social learning family interventions for child conduct disorder. Psychological Bulletin, 108, 291–307.

Nock, M. K., & Ferriter, C. (2005). Parent management of attendance and adherence in child and adolescent therapy: a conceptual and empirical review. Clinical Child and Family Psychology Review, 8, 149–166.

Snell-Johns, J., Mendez, J. L., & Smith, B. H. (2004). Evidence-based solutions for overcoming access barriers, decreasing attrition, and promoting chance with underserved families. Journal of Family Psychology, 18, 19–35.

Spoth, R., & Redmond, C. (2000). Research on family engagement in preventive interventions: Toward improved use of scientific findings in primary prevention practice. Journal of Primary

Prevention, 21, 267–284.

Stevens, J., Kelleher, K. J., Ward-Estes, J., & Hayes, J. (2006). Perceived barriers to treatment and psychotherapy attendance in child community mental health centers. Community Mental
Health Journal, 42, 449–458.

Watts, B. D., & Dadds, M. R. (2007). Facilitating treatment attendance in child and adolescent mental health services: A community study. Clinical Child Psychology and Psychiatry, 12,
105–116.

Chapter 7.

Best Practices

I. Outreach

Parents and guardians are allowed to visit LIP any day at any time. Designated Family Days, which include activities for the parents and siblings, occurs on Tuesdays, Fridays, and Saturdays. For the parents who attend LIP regularly, or every Family Day, the case manager can maintain constant communication with them and get updates as they arise. Most families, however, do not attend LIP activities regularly. Allowing families to bring younger siblings to Family Day can make it easier for families to participate.

LIP case managers are assigned to a specific LIP site to enable clients to build relationships with adolescents and families. They make regular phone calls every week to every client on their caseload to get updates from the parents and schools. Generally, case mangers reach a parent once a month, and if case managers want to call the participant, the legal guardian must give permissions to do so. If there is a crisis, such as an open child welfare case, the case manager calls every day if needed, to help the parent and participant with whatever needs to get done.

Recommendations
LIP staff should be trained in family outreach. Family outreach can help to identify barriers that the participant had not articulated to LIP staff. For example, if a case manager finds that the family is resistant to the adolescent receiving mental health treatment, he/she can help the family to identify and address the concerns (i.e. if a family is concerned about encountering stigma, the case manager can help to identify the sources of stigma and help the family identify strategies to overcome any stigma they may face). Participants may be motivated to attend LIP if they see that LIP has helped their families resolve an issue or problem.

Staff should reach out to families at regular intervals to remind them of upcoming Family Days and particular activities that will be occurring on those days. Staff can also remind them of positive feedback that they have gotten from adolescents when their parents participated, to remind the parents that the adolescents value their participation. LIP staff can also obtain feedback from parents who participate, to share with others how parents have viewed the benefits of the activities.

II. Home visits

Case managers aim to perform an initial home visit after intake, and at regular intervals afterwards. Intervals will vary depending on the family's needs. Case managers look at the living space, availability of food, and discuss problems or changes that may have arisen

with the family. Home visits can occur either when the participant is present or not present. Usually, case managers will perform home visits during school hours because they need to be at LIP after school; thus, participants are not generally home for the visit.

Recommendations
Frequency of home visits may vary according to the needs of the family. For example, if the adolescent and family members regularly attend LIP, they may have less need for home visits, since they are in constant communication with LIP. Alternatively, if the family has extensive needs, such as an active case with child protective services, more extensive home visits may be needed. Regular communication with the adolescent and family can help the case manager to assess when home visits are needed.

III. Assistance to parents in coordination with other entities

LIP case managers assist parents in multiple facets of the participants' life. They may act as a liaison with other entities, such as school guidance counselors, public assistance agencies, and child welfare agencies; this is particularly helpful when the parent does not speak English. They can help with child welfare cases (i.e. when a complaint of abuse has been reported) and divorce cases, by taking the parents step-by-step through paperwork and administrative processes. Case managers can help families find new clinics and psychiatrists when a participant's health insurance changes, or when there are issues with Medicaid or other insurance companies. Case managers can also help the family obtain food stamps, housing, employment services, and goods such as kitchenware and furniture.

Similar to home visits, case managers conduct school visits at intake, and then at the end of each term to retrieve the marking period grades. In addition, case managers contact the guidance counselors regularly to get updates on the participant's academic performance and behavior at school. Case managers can also work with teachers as needed to help the participant.

Recommendations
Case managers should, with the participant's and parent's permission, remain in regular contact with the school. The appropriate contact person (i.e. school counselor, guidance counselor, or teacher) may vary depending on the school policies and adolescent's needs. The appropriate intervals will also vary depending on the student's needs, but should occur at least once per marking period to obtain progress reports and identify the student's progress and whether new needs have emerged.

IV. Reasons to participate

In order to increase parental engagement, staffers can provide reasons to motivate parents to participate. Examples include inviting the parent to participate in joint art and music activities with their child, to attend field trips (i.e. to the movie theater, park, museum, or local farm), or to give the parents a purpose such as helping teach the girls how to cook

nutritious meals. These activities enable parents to feel as if they are a part of the LIP community and the therapy process.

Recommendations
Parents have suggested that that LIP should publish a schedule of specific activities, so that parents can plan in advance to attend a desired activity. Parents have also suggested that LIP provide means through which parents could communicate with other parents (e.g. email list-serve). Trips—even low-cost, local trips—are very popular with parents and adolescents. Some parents also suggested making participation mandatory at least twice a month. Although the program would not want to sanction girls whose families do not participate, they may wish to offer incentives to parents who do participate.

V. When parental participation may not be warranted

During the focus groups, a few participants stated that they do not want the family to come or became more involved in LIP, particularly when they view LIP as an opportunity to escape from difficulties at home. Staffers noticed that some girls are more reserved and participate less when the parents are present.

Recommendations
Case managers should remain sensitive to participants who may not wish to have their parents attend, and perhaps reduce outreach in some cases if it seems that parental participation is not beneficial. Participants who are younger may benefit more from parental participation than those who are older. Case managers can also encourage parents to participate in separate activities if that seems preferable to adolescents or parents.

Chapter 8.

Examples of Best Practices

Note: Names and scenarios are based on an amalgamation of experiences of LIP clients, based on interviews and focus groups. However, to protect participant privacy, all cases are fictional.

Example 1: Sarah actively participates in LIP, attending both during the week and on Saturdays. Sarah's mother, Maria, is not engaged with LIP, saying that she has to take care of her two younger children and is too busy to go to LIP.

LIP staff and case manager can:

- Continue to outreach via phone calls once a week to receive updates and share Sarah's progress with Maria
- Inform Maria that she is welcome to bring her two younger children to LIP during Family Days (Tuesday, Friday, Saturday), and emphasize that the children would be able to participate in music and art activities and have snacks as well
- Initiate and conduct home visits twice a month to maintain contact with Maria and get updates on the family situation
- Offer to help with social services, housing, food stamps, and family matters, as needed
- Invite Maria and the children to LIP events such as the LIP Annual Breakfast or educational summer field trips, if possible

Example 2: Lizzy has been at LIP for over a year, and has complied with her outpatient mental health treatment plan and creative expression therapy at LIP. She has fewer behavioral problems in school and at home, her academic performance has improved, and she has ceased to self-harm. Lizzy's mother, Joan, has noticed the positive changes in her daughter and wants to contribute to LIP because she believes that the program works and is grateful for the efforts that LIP has put into helping Lizzy. Joan asks LIP how she can volunteer, and decides to cook for the LIP group one Saturday a month.

LIP staff and case manager can:

- Stay up to date on Lizzy's well-being by communicating with Joan when she comes to LIP
- Thank Joan for her help and involvement, and inquire about whether she would be interested in becoming a *madrina*, or spokesperson for LIP when there are mothers or girls who are hesitant about the program
- Encourage Joan to cook and interact with other parents who show up on Family Day
- *Ask Joan if she needs anything / any help*

Example 3: Carolina wants to receive therapy and attend LIP. Her mother Paula, however, does not want Carolina to attend LIP and believes that she does not need any mental health treatment. She says mental health problems and treatment are stigmatized and does not want her daughter or her family to be ridiculed.

LIP staff and case manager can:

- Reassure Paula of confidentiality and HIPAA regulations in place to protect Carolina's and her family's privacy
- Educate Paula on mental health issues and treatment to decrease the negative image associated with this form of disability
- Hold a conversation with Paula, the psychologist and psychiatrist, and Carolina, so that everyone understands the treatment plan and its goals and limitations
- Introduce Paula to another mother who is actively engaged in the LIP program
- Explain that the LIP program not only provides mental health treatment, but that it also incorporates family support, supported education services, creative expression therapy, and wellness
- Maintain an open line of communication so Paula can ask any questions, as needed
- *Point out the risks of declining mental health treatment, with case studies*
- *Other benefits: improving communication with your daughter*

Example 4: Anne has recently joined LIP. Her grandmother, Lola, is supportive of her attending LIP but is not engaged. Lola speaks only Spanish, and takes care of Anne who emigrated alone from the Dominican Republic. Anne is struggling in school because of her limited English fluency.

LIP staff and case manager can:

- Aide Lola with school visits and meetings with the guidance counselor and Anne's teachers to build a plan for Anne's progress in English
- Translate written material and interpret verbally for Lola in matters related to Anne, Anne's clinical services, and social services, as needed
- Encourage Lola to attend LIP at least once a week, possibly on Saturdays, where Lola can also build a support network with other legal guardians who also speak Spanish
- Ask Lola to share her culture and cuisine with the girls on a given Family Day
- *Investigate what other supports and resources the grandma has*