PARENTAL ENGAGEMENT IN CHILD AND YOUTH MENTAL HEALTH SERVICES

ORGANIZATIONAL- AND PROVIDER-LEVEL FACTORS IMPACTING PARENTAL ENGAGEMENT IN CHILD AND YOUTH MENTAL HEALTH SERVICES

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Abstract

The literature indicates that engaging parents in child/youth mental health services is crucial for achieving positive outcomes. Yet, little research exists on how providers and organizations might hinder or facilitate parental engagement. This study aims to address this gap in literature by answering three research questions: (1) how do service providers working in child and youth mental health services define parental engagement? (2) Why does engaging parents in treatment remain a challenge for service providers? (3) What organizational- and provider-level factors contribute to this challenge?

To facilitate this aim, semi-structured interviews were conducted with four service providers, including those working in community-based or outpatient child and youth mental health services. Participants were recruited using a snowball sampling recruitment method. Interviews were audio-recorded, transcribed and analyzed following principles of Constructivist Grounded Theory.

Study results highlighted system- (e.g., access), organizational- (e.g., expectations and constraints), provider- (e.g., stance) and parental-level (e.g., shame) factors impacting parental engagement in services. These findings coincide with the documented impacts of neoliberalism and New Public Management on shaping mental health services. This study thus challenges traditional conceptualizations of engagement and underscores the interplay of complex factors that occur between service-levels. An expanded definition of parental engagement is therefore warranted if providers and organizations intend on holistically engaging parents in their child/youth's care.

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In loving memory of Keith Burton (1966-2019)

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Chapter One: Introduction

I am not yet a parent, however, having parents of my own has made me deeply empathetic to the roles and responsibilities that parents have. It is no small feat to raise a child from infancy to independence, especially with the added pressures that our society and culture upholds; namely, to raise a healthy, hardworking and 'successful' individual. In my experience, our society leaves little room for error; when a child or youth is not mirroring the depiction of normalcy that our culture presents, or worse, is found to be deeply struggling with their mental well-being, it is not uncommon to fix our attention and blame to the parent or caregiver. Through first-hand experience, I have witnessed the difficulties and stressors that parents encounter, and thus have come to wonder if societal expectations are all that realistic? That is not to say that I negate parents' accountability, or even, a fair measure of responsibility. Rather, I am recognizing that parents are also human beings, and so, make mistakes, experience hardship and trauma, and may struggle with childrearing and connection, a task that is difficult to begin with. More than that, they may struggle to aid their child or youth who is found facing a mental health challenge.

My interest in child and youth mental health stems from my desire to see children well cared for and thriving. A myriad of personal family, volunteer, and work experiences have left me passionate about the safety and well-being of children and the health of families. It was not until I completed a practicum in my undergraduate degree that I realized so profoundly the importance of parental engagement, and my inability to work holistically with children in isolation from their caregiver.

As I began to read literature on engagement, it became abundantly clear that engaging parents and families in their child or youth's mental health services has a positive impact on service outcomes (Haine-Schlagel et al., 2016; Ontario Centre of Excellence for Child and Youth

Mental Health [CYMH], 2016). However, while there is a wealth of literature on the topic of parental engagement, scholars are clear that engaging parents in services continues to be a challenge (Bode et al., 2016; Gopalan et al., 2010). Based on my observation of this gap in knowledge, I became interested in this area of study and even more interested and critical of how our systems and organizations may be contributing to this identified challenge.

While the literature does present various barriers that contribute to the difficulty in engaging parents, such as structural barriers like transportation (Gopalan et al., 2010; Ingoldsby, 2010) and scheduling conflicts (Ingoldsby, 2010; CYMH, 2016); or perceptual barriers, such as opinions regarding the relevance or necessity of treatment (Gopalan et al., 2010; Staudt, 2007) and level of expectation of treatment (Staudt, 2007; Gopalan et al., 2010), a noticeable gap in literature remains. Specifically, there exists a lack of discussion on service provider- and organizational-level factors that impact parental engagement in child and youth mental health services (Haine-Schlagel & Walsh 2015; Ingoldsby, 2010; Staudt, 2007). As such, the aim of my dissertation is to contribute to this identified gap by interviewing service providers to answer three main questions:

Question one is necessary to facilitate my desired aim. It is important for me to understand how service providers are conceptualizing parental engagement, as their answers may have an impact on subsequent questions; like barriers to engagement and how they facilitate engagement in practice. The second research question encompasses the study as a whole; identifying why engaging parents in child and youth mental health services continues to be a challenge for service providers. Likewise, my third sub-question helps to narrow the focus of my study further, by aiming to uncover pertinent organizational- and provider-level factors that contribute to this challenge. Since existing literature discusses matters related to parent/family- or child-level factors that impact engagement, it was imperative that my study did not focus on duplicating existing literature. Furthermore, I wanted to avoid a form of second hand reporting where providers explain their perception of parental barriers to services. If I indeed wanted further understanding of these matters, my study would have sought the opinions of parents themselves, rather than the opinions of providers.

To this end, my aim was to produce a study that was liberating to parents and providers alike, while also working to enhance parental engagement in child and youth mental health services. Whilst this goal may indeed be lofty, I am optimistic that my research will contribute some useful knowledge and recommendations, even if small. To facilitate my desired aims, service providers who are currently working or who have previously worked in the child and youth mental health service system were interviewed. Interviews were semi-structured and were analyzed utilizing principles of Constructivist Grounded Theory (see methods section 3.3).

Dissertation Outline

This Masters thesis is comprised of seven chapters. Chapter two provides an overview of existing literature, outlining the current socio-political context of neoliberalism and New Public Management, as well as providing an in-depth conversation on what the literature currently says about parental engagement in child and youth mental health services. Chapter three will expound my theoretical frame, my methodological approach, and provide an overview of my methods. Chapter four summarizes my findings and offers a conceptual framework to guide the main themes that were identified. This leads into chapter five: where I offer a discussion and present an analysis of the abovementioned conceptual framework. Chapter six will conclude my study and outline the implications and limitations of my research, as well as pertinent areas for future research that have been identified.

Chapter Two: Critical Review of the Literature

2.1. Overview and Direction

The following chapter has three main foci: (1) our society's current socio-political context, namely, a discussion on neoliberalism; (2) a conversation surrounding principles of New Public Management (NPM) and their subsequent impact on providers and workplaces; and (3) the current state of the literature as it pertains to parental engagement within child and youth mental health services. This includes a discussion on the definition of engagement, measurement of engagement, identified barriers and facilitators, and areas for future research.

2.2. Neoliberalism: Introduction and Direction

After examining the literature outlined in this thesis, I have noticed that neoliberalism is a vast and multi-faceted concept, with several conceptualizations of this paradigm being presented. As such, this has made the scope of neoliberalism very large and its definition ambiguous. Notwithstanding, there are key proponents of neoliberal ideology that are consistent throughout the literature, and are noteworthy in my discussion and analysis of parental engagement within child and youth mental health services. Accordingly, I will explore how neoliberalism has impacted the discourse of mental health at large (as it pertains to an underlying economic motivation and individualism) as well as matters related to organizational funding. First, I will present an overview of neoliberalism, as well as a brief description of its history in Canada.

2.2.1. History and Overview

The history of neoliberalism in Canada has proven difficult to trace-back given the noticeable ambiguity within the literature. With that said, there is some consensus among scholars that neoliberalism in Canada first emerged in the mid-to-late 1900's (Carroll & Shaw, 2001; Garrett, 2019; McKenna, 2015). In keeping with this suggested time frame, Canada's shift from Keynesian economics (which emphasized government intervention and increased national spending to boost the economy) to neoliberal ideology (which drastically reduced the government's role and oversight of the economy through a laissez-faire approach) is well documented throughout the literature (Carroll & Shaw, 2001; Evans, Richmond & Shields, 2005; McKenna, 2015).

Globally, several scholars also highlight the shift to neoliberalism that took place in Britain under Prime Minister Margaret Thatcher and/or in the United States under President Ronald Reagan (Clark, 2002; Harvey, 2005; McKenna, 2015). In fact, Bashevkin (1998) argues that these governments significantly influenced Canada's shift to neoliberalism under Prime Minister Brian Mulroney (as cited by McKenna, 2015). Consistent with this argument, Coulter (2009) explains that these three governments (Thatcher, Reagan and Mulroney) were known as "the neoliberal seizure of government in the North during the 1980s" (p. 28).

This demonstrates that neoliberalism is not a Canadian-born ideology or a phenomenon found solely within our borders; rather, it has reached and significantly impacted the world on a global scale (Harvey, 2005). With this in mind, neoliberalism may be broadly understood as a "a set of political beliefs, values, and practices that valorize the private market, economic rationalism, and individual, rather than collective, responsibility for social and individual ills" (Baines, 2010b, p.11-12). Neoliberalism promotes individualism; encourages competition; makes services a commodity; and effectively implements a "free market" mentality (Connell et al., 2009, p. 331).

While it is true that neoliberalism is largely described as a political economic ideology, Coulter (2009) rightly points out that it "must [also] be understood as a multi-faceted project with real institutional and economic restructuring, coupled with reinforcing cultural and ideological processes” (p.26). In other words, while neoliberalism may have begun as a political economic ideology in the mid-to-late 1900s, now, it is a deeply ingrained and persuasive philosophy that has impacted the world; becoming “hegemonic as a mode of discourse…[and] incorporated into the common-sense way many of us interpret, live in, and understand the world” (Harvey, 2005, p.3). On this basis, I will consider the ways that neoliberalism has shaped mental health as an economic concern and individualized problem.

2.2.2. Mental Health, Consumerism and Economic Concern

At large, the literature explains how neoliberal ideology has deeply impacted the construction of mental health and illness in society today (Cosgrove and Karter, 2018; Esposito & Perez, 2014; Rizq, 2014) Referring to what some term “market fundamentalism”, Esposito and Perez (2014) describe how under a neoliberal regime, the market assumes an unchallenged vision of reality that dictates how individuals ought to behave and what they ought to prioritize. Normalcy is defined in terms of happiness and satisfaction, which is achieved through wealth and esteem in society (Esposito & Perez, 2014). That is to say, that normalcy is equated with the pursuit to come “out on top” (i.e., achieving high social status) and thus is contingent upon an individual’s ability and desire to contribute to the market and be an active consumer (Esposito & Perez, 2014, p.416). Moreover, these scholars explain, “failing to become fully integrated into this market reality is, at best, regarded as a type of irrational/unproductive idealism, or, even more typically, associated with personal deviance and/or pathology” (Esposito & Perez, 2014, p. 416). Thus, this normalcy described above, which is achieved through mental health and well-being, has become commodified and purchasable (Esposito & Perez, 2014).

Consequently, this neoliberal vision of reality turns individuals into consumers, and thus results in the commodification of mental health and individual well-being (Cosgrove and Karter, 2018; Esposito & Perez, 2014; Rizq 2014). Interestingly, in referencing the '*Improve Access to Psychological Therapist*' [IAPT] program in the UK, Rizq (2014) explains that service users are defined as "independent consumer[s]", where the ideal citizen is able to select their own mental health treatment for themselves; in turn shifting responsibility of service selection and care to the individual and making such selection a "rewarding consumer activity" (p. 213). Furthermore, other scholars rightly point out that mental health services and well-being are items that are purchased to "aid one's return to neoliberal productivity" (Cosgrove and Karter, 2018, p.671).

The underlying economic intent behind an individual's mental health state demonstrates one primary way that neoliberalism has deeply impacted the mental health discourse. For example, Cosgrove and Karter (2018) criticize the Global Mental Health (GMH) movement as an example of neoliberal impact, noting how mental health (and in this case, depression) is viewed from an economic perspective. More specifically, these scholars highlight how the GMH movement portrays the impact of depression in terms of the time that individuals 'lose' as a result of their mental health challenge (Cosgrove and Karter, 2018). They go onto describe how under neoliberalism, we apply "intra-individual interventions" to mental health, which leads to a loss of social justice ethic and ignores the social, political and economic obstacles that impact an individual's sense of well-being (Cosgrove and Karter, 2018, p. 673).

Similarly, Rizq (2014) uses the aforementioned *Improve Access to Psychological Therapist* program as an example of economic motivation; underscoring how the goal is not only to improve overall well-being but also to assist individuals who are experiencing unemployment for mental health-related reasons, to increase social inclusion, all the while cultivating economic output. Rizq (2014) goes as far as to suggest that "fragility, dependence, mental pain and poverty…have been recast by neoliberalism as an example of 'negative suffering' – something that impedes, rather than facilitates human advancement: they get in the way of activity and productivity" (p. 212).

With this in mind, much of the discussion of neoliberalism as it relates to mental health discourse takes place within the healthcare field and outside of a Canadian context (e.g., Cosgrove & Karter, 2018; Esposito and Perez, 2014). Thus, there is less attention being paid to community-based mental health. It would seem then, that a gap exists within the literature, and so, more scholarship on how neoliberalism has impacted conceptions of mental health within community-based services (and children's services) might be useful; as well as scholarship in a Canadian context. Nevertheless, overlaps within these two fields emerge, suggesting that the discussion above is relevant. Accordingly, the commodification of mental health services leads to the "responsibilization" of the individual (Teghtsoonian, 2009, p. 29). This in turn perpetrates a key function of neoliberal ideology: individualism; I will attend to this principle below.

2.2.3. Mental Health and Individualism

> *I see the global state of mental health not as a crisis of chemical imbalances but a crisis of power imbalances, requiring urgent policy responses to address the social determinants of mental health as well as the reflection of powerful stakeholders on their role in perpetuating an abusive status quo. In other words, the crisis in the field of mental health should be managed not as a crisis of individual's conditions or disorders but as a crisis of societal obstacles that hinder individual rights* (Pūras, 2017).

Dr. Dainius Pūras (2017), a medical doctor appointed by the United Nations Human Rights Council (HRC) as a Special Rapporteur, made that statement in his address during the 35th meeting of the HRC. This, along with the rest of his address rightly suggests the problem that neoliberal ideology creates and perpetuates as it pertains to the mental health of individuals. As I noted above, Cosgrove and Karter (2018) describe the "intra- individual interventions" that society applies to mental illness, which largely ignores other "societal obstacles" that Dr. Dainius Pūras (2017) acknowledges above. It is the location of the problem (namely, a 'poor' sense of mental-well being) within the individual, and the subsequent individual "responsibilization" (Teghtsoonian, 2009, p. 29) to fix that problem (namely, through the active selection and consumption of mental health services) that a neoliberal ideology projects and attends to.

Providing a helpful example from a Canadian context, Katherine Teghtsoonian (2009) analyzes British Columbia's (BC) *Provincial Depression Strategy* and *Development of a Mental Health and Addictions Information Plan for Mental Health Literacy*. In her analyses, she highlights that while these reports briefly identify the impact of harmful social structures, public policy and other outside forces on an individual's mental health, they do not undertake a fulsome discussion that would elaborate on these external factors. Rather, these reports locate the problem of depression within the individual and, for example, locate the cause of persistent depression rates as with "individuals [being] unable to identify the presence of depression and/or likely to make ineffective or inappropriate choices regarding treatment" (Teghtsoonian, 2009, p. 31). At large then, mental health and mental health strategies are thus positioned in terms of self-management and individualized coping skills, with shifts to individual, family, communal and even workplace "responsibilization" of care and well-being; all the while removing the need for government funded services (Teghtsoonian, 2009, p. 29).

Interestingly, the idea of pathologizing mental health, as a matter localized within the individual has been very well defined and explained under the term "psychocentrism"; originally coined by social scientist Heidi Rimke (Defehr, 2016, p. 20). Rimke (2016) was keenly aware of the vast social factors impacting mental health, such as unemployment, sexual and physical violence, housing insecurity, and trauma (p.9). Hence, Rimke uses psychocentrism "to study and critique the dominant Western rationality that all human problems result from individual pathologies rather than deficits in society" (Defehr, 2016, p. 20).

In keeping with neoliberal ideology, psychocentrism reduces the responsibility of the state, whilst situating individuals as responsible for their own well-being and narrowing the source of mental illness to that of personal struggles and deficiencies (Defehr, 2016). Thus, Rimke (2016) finds the growing use of psycho-pharmaceutical drugs and self-help solutions in the psych industry problematic; as well as the overall "therapeutic culture" that has emerged (p. 10). Notably, Rimke (2016) complicates the notion of 'individual as consumer' that psychocentrism puts forth, as he rightly identifies financial barriers (specifically, poverty), which prohibits many individuals from being "competent or capable 'consumers' of health and wellness" (p. 11).

Strikingly, Cosgrove and Karter (2018) go as far as to categorize the effects of neoliberal ideology as a form of "structural violence" against people's sense of mental well-being (p. 427). These scholars note the failure of medication as an effective treatment to address mental health, as well as the promotion of individualized marketed solutions and "escapism"; all of which perpetuate the idea of individual as a consumer and so continues to preserve the unchallenged vision of reality that the market projects (Cosgrove & Karter, 2018, p. 427).

While psychocentrism and the identification that medication alone is a poor way to treat mental health is indeed true and arguably quiet relevant, this discussion (as well as other scholarship [e.g., Cosgrove & Karter, 2018]) is highly situated within the psychology discipline; as such, it may ignore other relevant conversations within a community-based mental health field and disciplines such as my own (namely, social work perspectives). Nevertheless, neoliberal ideology encourages individualism in two main ways: (1) through its location of the mental health/illness and well-being at the individual level (e.g., psychocentrism [Rimke (2016)]), thereby ignoring and minimizing the effects of external factors (e.g., employment precarity, public policies, etc. [Cosgrove and Karter, 2018; Teghtsoonian, 2009]); and (2) through the abovementioned discussion of turning individuals into consumers and thus making people responsible for their own mental well-being through their active selection of services (e.g., Esposito & Perez, 2014; Rizq 2014).

Therefore, neoliberal ideology posits a value-laden discourse that implicitly defines what it means to be a "good citizen"; asserting that individuals must make active decisions regarding what services to 'purchase' in order to avoid "burden[ing] the health care system" or asking for "costly and unnecessary services" (Rizq 2014; Teghtsoonian, 2009, p.32). Consistent with this shift to individual responsibility for mental well-being is the subsequent move away from government intervention and thus, funding of social services. It is this inherent problem that I will attend to below.

2.2.4. Neoliberalism and Funding

During the Keynesian-era (the period previous to neoliberalism) the relationship between non-profit organizations (NPOs) and the government was characterized by trust and core funding that was both stable and long lasting; meaning that organizations were able to spend funds in an array of areas and thus grow services on a non-project base basis (Baines et al., 2014b; Evans et al., 2005). It was also a time where NPO were known for "fill[ing] the gap" or "complementing" the services that the Keynesian state was already providing (Baines et al., 2014b; Evans et al., 2005, p.76). While scholars point out that this relationship had its downfalls (e.g., irresponsible use of funds), they do not describe these problems at length (Evans et al., 2005). Nevertheless, bearing this history in mind, there has been a dramatic shift in the relationship between NPOs and the state, which accompanied the government's shift to neoliberalism (Baines, 2010b; Evans et al., 2005).

Several scholars document the changes to funding structures and speak openly about the negative effects that this new government ideology has on NPOs and social services (e.g., Baines, 2010b; Evans et al., 2005) For example, in multiple publications, Baines (2004, 2010b, also see Baines et al., 2014b) explains that non-profits have seen a shift from the aforementioned block and long-term funding to short-term and project-specific funding strategies. Baines (2010b) explains that this change "fails to cover the costs of overhead for most non-profits, by speeding dependence on private fund-raising and other precarious solutions to maintain facilities and operations" (p.12). Unfortunately, NPOs are significantly reliant on government funding, and so, as a result of neoliberal shifts, have faced serious funding cuts and are struggling to make-up lost funds through cooperate and independent funders (Evans et al., 2005).

The effect of these funding cuts goes beyond organizations and employees struggling to fundraise additional finances to support the provision of services. The literature highlights that funding cuts and neoliberal restructuring at large, has also lead to increased competition among agencies (Baines, 2010b; Baines et al., 2014b; Evans et al., 2005); increased organizational accountability (Baines et al., 2014b; Evans et al., 2005); increased paper work and reporting requirements (Baines, 2010b; Evans et al., 2005); spending constraints (Baines et al., 2014b); as well as low wages, reduced benefits and job instability/ precarity (Baines et al., 2014b; Evans et al., 2005). Indeed, many of the abovementioned effects are also discussed in literature on New Public Management (NPM), an ideological shift that coincides with neoliberalism and has significantly impacted the non-profit social service sector. A discussion on NPM and its effects on the public services sector, as well as service providers at large, will follow below.

2.3. New Public Management: Overview and Direction

Like neoliberalism, there is a wealth of literature on NPM; however, its conceptualization in the literature is less far-reaching and more straightforward. According to Lorenz (2012), NPM was first established in the United States during the 1980s and later seen in other countries, such as the UK, Australia and New Zealand (p. 603); other authors have noted the presence of NPM in these countries as well (Thomas & Davies, 2005). In Canada, Baines (2004) explains that NPM was first seen in Alberta in 1993 (a province well acquainted with neoliberal restructuring), and later moved to other provinces.

Broadly, NPM may be described as the implementation of private sector business models into public and/or non-profit workplaces (Connell et al., 2009, Evans et al., 2005). Thus, and in accordance with neoliberalism, NPM increases financial accountability (Evans et al., 2005; Thomas & Davies, 2005) and is concerned with efficiency of services (Baines, 2010a; Thomas & Davies, 2005). As such, this model decentralizes control (Baines, 2004; Evans et al., 2005); gives power to managers (also known as managerialism [Evans et al., 2005]); concerns itself with the quality of services (Baines, 2004; Evans et al., 2005); standardizes work practices (Baines, 2010a; Evans et al., 2005) and is concerned with risk management (Healy, 2009). These efforts have arguably led to a decrease in worker discretion and ability to engage in advocacy, and work within social work values; it has also led to a decrease in supervision for front-line staff and an increase in job insecurity and workload/ volumes (Baines et al., 2014a; Evans et al., 2005).

The work facilitated by non-profits, yet funded by the government has often been described as *contracting out* (Baines et al., 2014a; Evans et al., 2005). *Contracting out* is a competitive process by which services that were once provided by the government are downloaded to non-profit organizations and communities; thus meaning that the government minimizes support of its citizens and shifts responsibility to individuals and communities alike (Baines et al., 2014b). Indeed, some have described this as “lean work” where “advancing private market-compatible notions of cost savings and efficiency, competitive performance measures and other standardizing metrics over more open-ended, holistic, community-engaged approaches” are adopted (Baines et al., 2014a, p. 434). To facilitate a discussion on NPM I will describe three main overlapping aspects of this model: (1) inefficiencies and standardized practices (2) managerialism and (3) outcome measures and accountability.

2.3.1. Inefficiencies and Standardized Practices

As noted above, NPM is highly concerned with the efficiency of services and the removal of ‘waste’ (Baines, 2010a; Evans et al., 2005; Thomas & Davies, 2005). With this in mind, a large part of the push to make services “efficient” is also accompanied by the introduction of standardized practices (Baines, 2010b; Evans et al., 2005). Standardized practices, which may be a singularized approach to providing services, computerized documentation or paper forms, assessments, record keeping documents (etc.) may be described or at least marketed, as “best practices” (Baines, 2004; Smith, 2011, p.199). In reflecting on their experience as a mental health worker in the healthcare system, Kristen Smith (2011) explains that when their workplace introduced a form of standardized practice, “it was believed that these approaches would speed up our work in order to serve greater numbers of people” (p.200). Similarly, Baines (2004) highlights that the use of standardized work practices under NPM is a strategy used to reduce error.

Several scholars contribute to the conversation regarding the negative impact of standardized practices, noting that the use of such practices within social services creates an environment where workers’ discretion and intuitiveness is diminished (Baines, 2010a; Baines, 2004; Evans et al., 2005). Evans et al. (2005) explains, “the application of standardized, quantifiable procedures to each and every case regardless of context and without the possibility of deviation ostensibly removes the ability of workers to respond to specific cases with…creativity, discretion and sensitivity” (p.89). Indeed, in various studies, providers point out their discomfort or frustration with the standardized work practices that NPM has introduced (e.g., Baines, 2004). Overall then, the decrease in discretion and the increase in standardized or routinized work deskills the service profession, making providers feel like anyone is capable of doing their job (Baines, 2004; Baines et al., 2014a).

Another notable impact of standardized work practices is the loss of service provider relationship with clients and the overall decrease in direct client time (Baines, 2004; Baines et al., 2014b). Evans and his colleagues (2005) also speak of the reduction in client time within the context of cost-cutting measures that also accompany NPM and neoliberal restructuring. Indeed, Baines (2004) explains in her study of front-line workers in Canada that most, “blamed standardization and new technologies for removing the opportunity to build helping relationships with clients” (p. 278).

Interestingly, the literature also speaks about the effects of standardized practices on client’s lives and their overall experiences of services. In one study that interviewed practitioners, for example, participant’s suggested that standardized assessments can lead families to feel like: (1) they are “repeating themselves”, (2) sharing personal information with a new and unknown service provider, and (3) labeling children with potentially unhelpful, or even inaccurate, diagnoses (Martin, Fishman, Baxter, & Ford, 2010, p.416). These scholars explain how “practitioners [in their study] were clearly concerned about impairing their therapeutic relationships with families and burdening them with additional tasks, to the extent that some practitioners thought that some families might elect not to attend as a result" (p.417). Moreover, study participants reported that engagement might be impeded if the caregiver supporting the child cannot answer all the relevant assessment questions, and if language barriers or cultural differences exist (e.g., surrounding one's understanding of mental health) (Martin et al., 2010).

Further, in providing a case example, Smith (2010) suggests that because of standardized assessments, her client's lives are "seen through a lens that decontextualizes, individualizes, and pathologizes the social problems…[they] experience" (p. 206). The use of standardized practices and/or assessments thus perpetuates the individualized and pathologized perspective of mental illness accustomed to neoliberalism (as described above in section 2.2.2-2.2.3).

Moreover, the diminished capacity to build client relationships described above and the overall affects of NPM models often removes or compromises what some scholars term the *voluntary ethic* or *spirit* of non-profit work (e.g., Baines, 2010b; Baines et al., 2014a). Baines (2010b) describes the *voluntary spirit* as values that encompass non-profit-care-work, including advocacy, participation, service, and democracy. To this end, scholars report that the presence of NPM and neoliberal restructuring at large, makes it challenging to keep the voluntary spirit alive; some scholars highlight this reality warning against "the dangers of mission drift" (Baines, 2010b; Baines et al., 2014a, p. 473).

Indeed, Bush (1992) originally cautioned against the "inherent dangers in following blindly the growing belief that non-profits must be more businesslike in every sense of the word" (p.392). Included in these "inherent dangers" is the potential to lose and/or diminish the inherent mission that is found at the core of non-profit work; namely, what Bush (1992) describes as "the spirit of cooperation and participation" (p.392). Brainard and Siplon (2004) summarize Bush's (1992) concern well, explaining, "Bush cautioned that one of the biggest challenges facing organizations in the sector was how to retain their 'nonprofit spirit in a for profit world" (p.436). While Bush (1992) warned non-profits of these dangers nearly three decades ago, Baines (2010b, 2014a) highlights how such problems have come to fruition. Relatedly, a key-contributing aspect of NPM that also enforces standardized assessments and promotes efficiency is managerialism. I will attend to this construct below.

2.3.2. *Managerialism*

Evans and his colleagues (2005) explicitly express that the "mission of management under NPM is to standardize work processes to increase efficiency" (p. 91). That is to say that this neoliberal model urges that mangers in non-profits view their workplace like a business, and so, encourage decentralized control (Baines, 2004; Evans et al., 2005). Furthermore, and as noted above, because NPM facilitates the integration of business models (such as that found in manufacturing or commercial settings), it encourages managers to "adopt business oriented solutions" (Evans et al., 2005, p. 89).

Baines and her colleagues (2014a) also explain that with the introduction of NPM, managers and supervisors alike have seen a shift in their roles and an increase in their overall workload. These scholars specifically point out that management roles have moved towards outcome documentation, monitoring/ ensuring the compliance of policy, while also assuring that staff meet the outlined performance objectives; rather than supporting front-line staff and other programming (Baines et al., 2014a). Interestingly, Aronson and Smith (2010) highlight that the literature has dedicated less space to discuss the impact of neoliberal restructuring and NPM on managers. However, they report that managers' work is "characterized by constant change, excesses of paper and technical work, dwindling resources and the strain of being positioned as buffers between funders, more senior management, front line staff and service users" (Aronson and Smith, 2010 p. 531).

In keeping with these documented shifts, the literature also reports on the diminished supervision that front-line workers are left with (Baines, 2010a; Evans et al., 2005). In her study, Baines (2010a) not only notes the overall inaccessibility of supervisors, but also expresses that within the context of neoliberal structuring and NPM, workers were met with disapproval and sometimes consequences, with their request to undertake community work and advocacy on behalf of their client(s). Likewise, using long-term healthcare as an example, Evans et al. (2005) notes that reducing supervision is just one impact of the cost-cutting measures at large.

With this in mind, some literature (referred to as "critical management literature") does suggest ways in which supervisors engage in resistance and so mediate or disempower the effects of NPM and neoliberalism (Aronson & Smith, 2010; Baines et al., 2014a, p. 438). For example, Aronson and Smith (2010) conducted a longitudinal study of women in management in the non-profit sector. Upon analyzing their interviews, these scholars found that these managers acknowledged the diminished scope of "the social" in their work, as well as engaged in "oppositional practices aimed at expanding that scope" (Aronson & Smith, 2010, p. 535). With that said, these scholars highlight that the literature on critical management approaches is few and far between; there is little knowledge for managers to reference, thus making "improvisation" a felt reality (Aronson & Smith, 2010, p.533). Furthermore, Baines et al. (2014) also rightly suggests that while supervisors have the capability to resist NPM impacts, they also can facilitate them, and so, exacerbate their effects.

2.3.3. Outcome Measures and Accountability

Another significant feature of NPM that relates to both standardized practices and managerialism is the required outcome measures and heightened accountability in non-profits and/or public services (e.g., Aronson & Smith, 2010; Baines et al., 2014b; Thomas & Davies, 2005). As noted above, the shift from the Keynsian era to neoliberalism was accompanied by a decrease in government trust in social services (Baines et al., 2014b; Evans et al., 2005). Accordingly, there is an increase in funding and performance accountability, requiring social services to document outcome measures to demonstrate the success (or failure) of their programming and to "justify their service delivery" (Aronson & Smith, 2010; Baines et al., 2014b, p. 85).

With this in mind, front-line workers and managers alike are undeniably burdened and frustrated with these new requirements (Aronson & Smith, 2010; Baines et al., 2014a; Evans et al., 2005). Many scholars emphasize how providers do not feel that the required outcome measures accurately capture the benefits of the work being carried out, or measure the success of their services; they also describe how their work is altogether difficult to quantify (Aronson & Smith, 2010; Baines et al., 2014a). Baines and her colleagues (2014a) explain this reality stating, "though not entirely opposed to lean work or quantitative metrics, mainstream literature on the voluntary sector tends to argue that outcome measures fail to capture the full contributions of social advocacy, community planning and development efforts" (p.437).

Consistent with this argument, the aforementioned study conducted by Aronson and Smith (2010) highlights the perspective of a director at a women's multi-service organization, who believes that "government audit systems 'ask the wrong questions'" and suggested that accountability should stem from the "clients' experiences of services" (p.537). Furthermore, the burden of documenting is reported as decreasing the amount of time that front-line workers have to engage with clients (Baines et al., 2014a), and as structuring and/or restricting the work that service organizations can provide (Aronson & Smith, 2010).

Bearing in mind the above discussion on the current socio-political climate that neoliberalism and NPM have created, my subsequent review of the literature will transition to examine matters related to engagement within child and youth mental health services. Given that the objective of my dissertation is to highlight provider- and organizational-level factors that are impacting parental engagement within child and youth mental health services, the importance of the persuasive neoliberal ideology and the consequent impact of NPM cannot be overstated; and must be rightly regarded as impactful to the ability for parents to engage in services and to the ability of service providers and organizations alike to facilitate engagement in practice. Accordingly, below I will discuss the literature's conceptualization of engagement, including its definition, measurement, identified barriers and facilitators, as well as areas for future research.

2.4. Parental Engagement

2.4.1. Defining Engagement

In order to measure, foster and develop practices that facilitate engagement within services, it is crucial to have a clearly outlined definition. While the literature presents various definitions and uses a variety of terms to capture engagement, notable themes emerge. For example, scholars agree that describing engagement in terms of mere service attendance rates does not elicit a comprehensive definition (Gopalan et al., 2010; Stadnick et al., 2016; Staudt, 2007). A person may indeed be physically present in a session, but this does not necessarily mean that they are truly engaged in the service they are attending (Staudt, 2007). As a result, scholars suggest a far more nuanced definition of engagement, which is achieved through the delineation of "attitudinal" and "behavioral" components (e.g., Gopalan et al., 2010; Stadnick et al., 2016; Staudt, 2007).

2.4.1.1. Attitudinal Engagement. Gopalan et al., (2010) describes attitudinal engagement as “the emotional investment and commitment to treatment resulting from clients’ belief that treatment is worthwhile and beneficial” (p. 183). That is to say that if an individual is to be attitudinally engaged they must perceive that the prospective benefits of treatment outweigh the costs that may accompany accessing services (Haine-Schlagel et al., 2016; Stadnick et al., 2016; Staudt, 2007). Some scholars have used to the term “buy-in” to describe the concept of attitudinal engagement (Gopalan et al., 2010; Yatchmenoff, 2005).

2.4.1.2. Behavioral Engagement. In contrast, Staudt (2007) explains that behavioral engagement “consists of client performance of the tasks that are necessary to implement treatment and to ultimately achieve outcomes” (p.185). These tangible tasks or behaviors that demonstrate engagement may include keeping and attending appointments (Staudt, 2007) completing assigned homework (Gopalan et al., 2010; Haine-Schlagel et al., 2016; Staudt, 2007;), discussing feelings (Gopalan et al., 2010; Staudt, 2007), actively participating in session (Gopalan et al., 2010; Stadnick et al., 2016), sharing one’s own opinions (Haine-Schlagel et al., 2016; Stadnick et al., 2016) and the continuation of therapy at home (Gopalan et al., 2010; Stadnick et al., 2016), such as facilitating games with children to help develop emotional regulation (Haine-Schlagel et al., 2016).

Encompassing similar principles, some scholars have described behavioral engagement in terms of three main steps that clients complete. Firstly, an individual must seek out or begin treatment; secondly, they must attend sessions; and thirdly, they must meaningfully participate in treatment, both in and out of session (Haine-Schlagel et al., 2016; Haine-Schlagel & Walsh, 2015; Stadnick et al., 2016). Accordingly, these three main actions involve many of the above-mentioned behaviors (e.g., sharing one’s opinion, completing homework), and so, broadly capture what a service provider would see from an actively engaged client.

Many scholars are quick to point out the importance of both attitudinal and behavioral components of engagement (Gopalan et al., 2010; Staudt, 2007). Indeed, this delineation is not arbitrary, but rather necessary to fulsomely capture the construct of engagement. Staudt (2007) explains this well, stating, "clients may keep appointments (or perfunctorily perform other tasks) for many different reasons, but this does not necessarily mean that they are engaged in the therapeutic enterprise" (p. 186).

2.4.1.3. Terminology. Bearing these concepts in mind, it is also noteworthy to discuss the various terms used in the literature to capture the construct of engagement; a notable issue also identified by scholars (e.g., Becker et al., 2015; Haine-Schlagel and Walsh, 2015). In fact, Becker et al. (2015) argues that the use of terminology in the literature "lacks precision" which makes summarizing the literature and pinpointing helpful practices to facilitate engagement in services difficult (p.32). Similarly, Haine-Schlagel and Walsh (2015) maintain that future researcher should employ a consistent term when capturing behavioral engagement; they recommended the terms "participation" or "participation engagement" (Haine-Schlagel & Walsh, 2015 p.146).

This inconsistency in terminology remains heavily debated amongst scholars; however, the literature also outlines how terms are used interchangeably despite their various nuances. For example, in reports released in 2016 and 2017, the Ontario Centre of Excellence for Child and Youth Mental Health (CYMH) discuss the terms *involvement* and *participation* in relation to engagement. To begin, they argue that the term *participation* does not holistically capture family engagement, noting that "a family may very well show up for appointments without feeling empowered to take an active role in their child's treatment" (CYMH, 2016, p.5). They likewise argue that the term *involvement* does not adequately capture family engagement (CYMH, 2017, p.5), upholding that, "families can be involved and compliant without being engaged. Engagement is about motivating and empowering families to recognize their own needs, strengths, and resources, and to take an active role in changing things for the better" (Steib, 2004, p.15, as cited by CYMH, 2017). Accordingly, in order to capture engagement holistically, this paper will use the term *engagement* to capture the constructs described above; namely, both attitudinal and behavioral components.

2.4.2. Measuring Engagement

Another theme found throughout the literature is the lack of and/or over-simplified measurement of engagement (Haine-Schlagel et al., 2016; Haine-Schlagel & Walsh, 2015; CYMH, 2017). Scholars report that a common way that engagement is measured is through attendance (e.g., Becker et al., 2018; Stadnick et al., 2016; Yatchmenoff, 2005;) or homework completion (e.g., Haine-Schlagel et al., 2016; Stadnick et al., 2016). As such, the attitudinal components of engagement discussed above remain largely unexamined (Becker et al., 2015; Staudt, 2007). This is problematic for several reasons; perhaps most obvious is the highly nuanced and emerging definition of engagement that constitutes far more than the behavioral component of attendance. Hence, as mentioned previously, scholars agree that defining engagement in terms of attendance is insufficient (e.g., Gopalan et al., 2010; Staudt, 2007).

Another point of contention regarding the measurement of engagement surrounds whom the measures are targeting (Haine-Schlagel et al., 2016; Yatchmenoff, 2005). Researchers note that limited measures include multiple reporters (Haine-Schlagel et al., 2016) and Yatchmenoff (2005) argues that client-perspectives of engagement are rarely ever measured. Instead, measures assessing quality of engagement focus heavily on providers' perspectives (Yatchmenoff, 2005).

As such, Yatchmenoff's (2005) work is an example of a study that seeks to bridge this gap by focusing on the development of a client-perspective measure within the child protection sector amongst non-voluntary clients.

Subsequently, scholars note the impact of cultural diversity and the overall need to increase research within this subset of families (Becker et al., 2018; Haine-Schlagel et al., 2016). Haine-Schlagel et al. (2016) specifically discuss the lack of attention that cultural diversity has received in studies that examine what they term "parental participation engagement" (p.3). Likewise, Becker et al. (2018) argues that "more attention is needed with regard to engaging ethnic minority youth and families, given that ethnic minority youth and families are generally more likely to drop out of treatment" (p. 18). Furthermore, the limited availability of measurement tools in different languages is also noted in the literature and demonstrates the need to improve assessment tools for culturally diverse families (Haine-Schlagel et al., 2016).

To this end, scholars have developed several different tools to measure engagement; which arguably makes comparisons difficult (Haine-Schlagel & Walsh, 2015). Some examples of measures include: the *Parent Participation Engagement Measure* (PPEM), which utilizes youth and parents as reporters and was designed with culturally diverse families in mind (Haine-Schlagel et al., 2016); a scaling tool developed by Diane Yatchmenoff, which measures client perspectives of engagement across five domains within the context of child protection services (Yatchmenoff, 2005); the *Public and Patient Engagement Evaluation Tool* (PPEET), which uses three questionnaires targeting different individual groups (namely, patients, project managers, and organizational leaders), which is more specifically used in the healthcare sector (Abelson et al., 2015, p.824); and the *Measure of Processes of Care* (MPOC) in Ontario, which uses scales to measure parental perspectives on the services received, as well as parental perspectives on the "family-centered behaviors" from their service providers (CYMH, 2017, p.16).

Therefore, measurement tools vary widely in terms of measuring client, parent and/or family engagement in child and youth mental health services. However, Yatchmenoff 's (2005) perspective on measuring engagement is simple but noteworthy; she says that "no single measure is likely to suffice, nor a single method" (p.93). Thus, while the measurement of engagement in child and youth mental health services can and should be improved upon, it is significant to reflect upon what developed measures can be used in tandem with one another to better the measurement of parental or family engagement in services. Likewise, in developing measures, it is prudent that scholars pay attention to if their measure is quantifying engagement (e.g., in terms of attendance rates or homework completion) or measuring the overall quality of one's engagement. Likewise, as previously noted, it will be important to consider from whose perspective engagement is being measured.

2.4.3. Barriers to Engagement

Barriers to engagement are categorized in several ways within the literature. For example, some scholar's categorize barriers as logistical (involving concrete, contextual and agency barriers), and perceptual (McKay & Bannon, 2004 as cited by Gopalan et al., 2010). Likewise, in their discussion of at-risk children, Staudt (2007) identifies cognition and belief barriers, barriers involving the family's relationship with the clinician, and barriers that surrounds the stress that occurs in everyday life. Similarly, in regards to access to child and youth mental health services, Owen and colleagues (2002) organize barriers as (1) structural, (2) perceptual concerning the mental health problem, and (3) perceptual concerning mental health services.

In terms of structural or logistical barriers, the literature suggests that families are hindered from service utilization or meaningful engagement as a result of transportation difficulties (e.g., Becker et al., 2018; Kruzich et al., 2003; Walter et al., 2019;); lack of available providers (Walter et al., 2019); financial constraints/ the inability to pay for services (Ingoldsby, 2010; Walter et al., 2019); agency waitlist (Bornheimer et al., 2018; Gopalan et al., 2010); and scheduling conflicts (Gopalan et al., 2010; Ingoldsby, 2010).

Another potential barrier to engagement is parental/family stress or strain (e.g., Bode et al., 2016; Staudt, 2007; Wang et al., 2017). In their article on parental empowerment in children's mental health services, Bode et al. (2016) consider the impact of parenting stress. Despite describing "elevated rates of parenting stress" (p.3045) as a barrier to engagement and suggesting that asking parents to be involved in treatment may actually produce additional parenting strain; these authors state that "increased involvement . . . may result in reducing the experience of strain associated with parenting a child with significant mental health symptoms" (p.3055). Thus, there appears to be an inverse relationship between parenting stress and engagement in service; where encouraging parents to be engaged in services may increase stress, but a lack of engagement perpetuates the stress a parent or family experiences. Conversely, while being asked to engage in services may feel initially stressful, doing so may reduce the parenting strain that is acting as a barrier to meaningful engagement. Further research and reflection on these matters may be worthwhile, as finding strategies to encourage parental engagement in order to reduce the barrier of parenting strain may be helpful.

Another form of barrier discussed in the literature is perceptual (e.g., Bornheimer et al., 2018; Staudt, 2007; Walter et al., 2019). Perceptual barriers may include beliefs about the cause of the problem (Gopalan et al., 2010); level of expectation of treatment (Gopalan et al., 2010; Staudt, 2007); denial regarding mental health severity (Owens et al., 2002); perceptions regarding if treatment is necessary or relevant (Gopalan et al., 2010; Staudt, 2007); and stigma (e.g., Bornheimer et al., 2018; Stadnick et al., 2016; Walter et al., 2019).

Furthermore, Owens et al. (2002) explain that parents and families might decide not to seek out or engage in treatment because they believe that they are equipped to handle the problem on their own. Likewise, Staudt (2007) describes how "client attitude toward services and the perceived relevance of services also affect engagement" (p.187); her research found that parents were more likely to keep initial mental health appointments if they had a positive outlook towards treatment. In contrast, parents who had low confidence and expectation regarding their capacity to foster change in their child were less likely to pursue/engage in treatment.

Additionally, the literature also describes the role of stigma in creating a perceptual barrier. Not only do teenagers refuse mental health services due to a fear of stigma and its impact on peer relationships (Gopalan et al., 2010), but some scholars also speak about stigma more broadly as it relates to families and parents as a whole (e.g., Walter et al., 2019). Interestingly, one author mentioned the impact of stigma that comes from therapists and/or the overall service system (Stadnick et al., 2016). Relatedly, in her report released through the F.O.R.C.E society, Chovil reported that negative attitudes from staff towards families could act as a barrier to engagement (Kruzich et al., 2003 as cited by Chovil, 2009). Thus, while one might expect the source of stigma to stem from family members, friends, colleagues, or society at large, there indeed exists the possibility that service provider's contribute to a parent or youth's experience of stigma when accessing or attempting to access services. Interestingly, CYMH (2016) argues that "stigma can be reduced by using strengths-based therapeutic strategies, implementing outreach initiatives and meeting families in natural settings" such as in-home services (p. 9).

Another noteworthy barrier is the strength of the therapeutic alliance (e.g., Haine-Schlagel & Walsh, 2015; Ingoldsby, 2010; Staudt 2007). Some scholars explain that parents are more likely to continue participating in treatment if they possess a “positive relationship” with their service provider (Haine-Schlagel & Walsh, 2015, p.144). Similarly, Staudt (2007) describes a barrier for families of at-risk children as “problems in the relationship with the practitioner” (p.187). Thus, clinicians must aim to build trustful and strong relationships with their families; studies indicate that those who experience a strong connection and engage collaboratively with the provider “are more likely to engage in treatment and remain in treatment longer” (Haine-Schlagel & Walsh, 2015, p.144).

Overall, the structural or logistical and the perceptual and relational barriers discussed demonstrate that families are faced with several factors that may affect their ability to meaningfully engage in treatment. Some of these barriers are out of a family’s control (e.g. affordability of services or lack of transportation), and others speak to larger societal issues that need resolving (e.g., stigma). Moreover, some of the barriers are the responsibility of clinicians (e.g., striving for a strong therapeutic alliance), while others rest in the hands of parents and families (e.g., having a positive or optimistic attitude towards treatment). Additionally, all of these barriers exist throughout and/or at different points of the service continuum. For example, some barriers may impact a parent’s entry into services, while others may affect their retention in services; namely, their ability or desire to continue with treatment. Thus, if organizations desire to engage parents in treatment, then it is clear that providers, organizational leaders, and policymakers must work towards eliminating the abovementioned barriers.

2.4.4. Facilitators to Engagement

Scholars suggest several different interventions to increase engagement in services. One way that service providers seek to increase engagement and/or retention in services, for example, is through addressing parental concerns and identified barriers to treatment (e.g., Becker et al., 2018; Ingoldsby, 2010; Lindsey et al., 2014). Addressing barriers may take place at the beginning of treatment (CYMH, 2016) or throughout the entire course of treatment as barriers arise (Gopalan et al. 2010). For example, Becker et al. (2018) explain that in relation to attendance, service organizations are concerned with getting clients in the door, meaning clinicians and organizations can use what they term '*assessability promotion'* by taking special consideration to reduce practical obstacles to treatment. This may include securing childcare or meeting youth outside of the clinic at a more suitable location (Becker et al., 2018). Improving engagement might therefore occur when clinicians and services organizations address barriers to parental engagement on a case-by-case basis.

Another way to increase engagement is through a strong therapeutic alliance (e.g., Gopalan et al., 2010; Haine-Schlagel & Walsh, 2015; Littell et al., 2001). As noted above, when clinicians establish a bond with their clients, they will be more inclined to engage and thus benefit from services (Haine-Schlagel & Walsh, 2015; Ingoldsby, 2010; CYMH, 2016). Conversely, when clinicians have a poor working relationship with their clients or when clients start to perceive that their provider is no longer helpful, they are more likely to disengage from services (Gopalan et al., 2010; CYMH, 2016). CYMH (2016) describes how alliance or rapport is built with clients in the beginning stages of treatment and Gopalan et al. (2010) explain how problems with alliance forming may become noticeable as early as the initial sessions. CYMH (2016) also suggests that to consistently improve one's therapeutic alliance, clinicians must practice, "open communication, positive reinforcement, emphasizing family strengths, and conveying understanding and respect for families' challenges" (p.8).

A related way to increase engagement is through culturally safe or "responsive" practices (Gopalan et al., 2010; Ingoldsby, 2010; CYMH, 2016, p. 9). CYMH (2016) suggests that "service providers should be familiar with the cultural background of the families they support and be able to accommodate their diverse needs" (p.9). Overall then, providers must strive to provide culturally safe treatments that are relevant and meaningful to the diverse populations they serve. As one scholar recommends, providers must go beyond the observable characteristics of individuals (e.g., race or gender) and seek to understand the culture of the family; gathering more salient factors that may impact their understanding of the problem and their desires for treatment (Alegria et al., 2010). While scholars do highlight the intersection between race/culture and engagement (e.g., Gopalan et al., 2010; Harrison et al. 2004), a fulsome discussion on this intersection is beyond the scope of this dissertation. Nevertheless, it is noteworthy to highlight that clinicians must seek to demonstrate respect for cultural/ ethnic differences and strive to provide culturally safe services; in efforts to strengthen the therapeutic alliance and help cultivate engagement.

An additional strategy used to enhance engagement is Motivational Interviewing (MI) (Gopalan et al., 2010; Ingoldsby, 2010; CYMH, 2016). For example, Gopalan et al. (2010) propose using MI within the context of strength-based approaches to engagement and state that "MI techniques, such as the expression of empathy, development of discrepancy, rolling with resistance, and support for self-efficacy, have been integrated into a 1–2 session intervention…to increase the likelihood that adolescents…[will] successfully participate in mental health treatment" (p.188). Overall, while literature discusses the benefits of traditional MI interventions for adults (e.g., for retention or ambivalence towards change) they also agree that adaptions of MI used for families and children and youth has potential (Gopalan et al., 2010; Ingoldsby, 2010). Moreover, some scholars discuss the use of Ethnographic Interviewing (EI) in tandem with MI, and report the success of integrating these techniques together in practice (Gopalan et al., 2010; Ingoldsby, 2010).

Another common discussion point in the literature pertains to the benefit of addressing and clarifying expectations of treatment (Becker et al., 2018; Ingoldsby, 2010; Staudt, 2007). Staudt (2007) refers to *preparatory techniques* as having the capacity to increase attendance and retention, explaining that they "provide information (via videotapes or pre-therapy preparation sessions) about what to expect from treatment, client and therapist roles, and appropriate client behaviors" (p.189). Similarly, Becker et al. (2018) discuss the usefulness of what they categorize as *psychoeducation*, which allows the clinician to provide information about "the nature of the problem, treatment options, treatment features (e.g., session frequency, therapy activities), and the roles and responsibilities of the provider and client" (p.13). For example, Becker et al. (2018) describe the use of videotapes (such as those described by Staudt, 2007) as *modeling* (p.14); this scholar describes how modeling can help to explain provider-client interactions and improve the client's understanding of what treatment may look like and entail. Modeling may take place at the beginning of services, acting as a preparatory process or as needed throughout treatment sessions (Becker et al., 2018).

Moreover, engagement literature indicates the importance of ensuring that services 'fit' or 'match' the family's expectations, needs and desires (Ingoldsby, 2010; CYMH, 2016). According to CYMH (2016), when families feel that services align with their preferences, they "tend to have longer and more successful involvement in services" (p. 9). In contrast, when there is a mismatch in services and expectations, families may disengage or terminate treatment prematurely (Ingoldsby, 2010; Littell et al., 2001). Therefore, as the abovementioned strategy explains, it is important to assess the family's expectations of treatment in early stages, and then adequately match these expectations to relevant and available treatment options (Ingoldsby, 2010). In so doing, CYMH (2016) also explains that service providers should, where possible, provide options and highlight choice, working collaboratively to create treatment goals and to address problems that families have personally defined and deemed as relevant.

Other strategies used to increase engagement include telephone calls and text messages to increase attendance (e.g., reminder messages); the use of paraprofessional staff, peer youth specialists and family advocates (Gopalan et al., 2010); the use of rewards or incentives (Ingoldsby, 2010); and the provision of treatment outside agency clinics, such as in-home therapy or school-based interventions (e.g., Becker et al., 2018; Gopalan et al., 2010).

2.4.5. Identified Areas for Further Research

Bearing this above review in mind, scholars have noted gaps in the literature and areas for future research. For instance, scholars agree that future research should work towards improving the definition or conceptualization of engagement (Gopalan et al., 2010; Littell et al., 2001). There remains a need to define and study engagement more vastly, going beyond matters of just treatment attendance (Gopalan et al., 2010; Lindsey et al., 2014). One scholar rightly states, “more sophisticated conceptualizations and measures of participation are needed, for treatment participation is not a single phenomenon, but a complex set of attitudes and behaviors that vary along several dimensions and change over time” (Littell et al., 2001, p.23).

There is also a need for better measurement of engagement (Gopalan et al., 2010; Haine-Schlagel & Walsh, 2015). Scholars agree that the measurement and study of engagement should include more attitudinal components to ensure that meaningful engagement in treatment is occurring and to facilitate helpful engagement strategies (Gopalan et al., 2010; Haine-Schlagel & Walsh, 2015). Furthermore, some scholars suggest the need for more commonly used measures across studies, so as to enable adequate study comparisons (Haine-Schlagel & Walsh, 2015).

Relatedly, future research should seek to create consistency in the use of terminology across studies (Haine-Schlagel & Walsh, 2015).

Another area for future research is the study of service provider-level characteristics (Haine-Schlagel & Walsh, 2015; Littell et al., 2001; Stadnick et al., 2016) and organizational- or program-level characteristics that influence engagement (Haine-Schlagel & Walsh, 2015; Littell et al., 2001; Staudt, 2007). Haine-Schlagel and Walsh (2015) note that “the most common levels examined are child and parent/family” levels (p.135), highlighting that provider and service-level investigations (pertaining to attendance engagement) are limited and that organizational-level study is non-existent (Haine-Schlagel & Walsh, 2015). Overall, it is important to consider the perspectives of all relevant stakeholders, which underscores the importance of future work that accounts for child-, parent-, provider- and organizational-level factors alike.

With these gaps and directions in mind, my research will seek to contribute to the areas where the literature is lacking. Namely, it will examine how service providers understand parental engagement, why they think it is a challenge, and more specifically, what organizational- and service-provider level factors contribute to that challenge. The subsequent chapter will transition to discuss my theoretical frame, methodological approach and methods.

Chapter Three: Theoretical Frame and Methodology

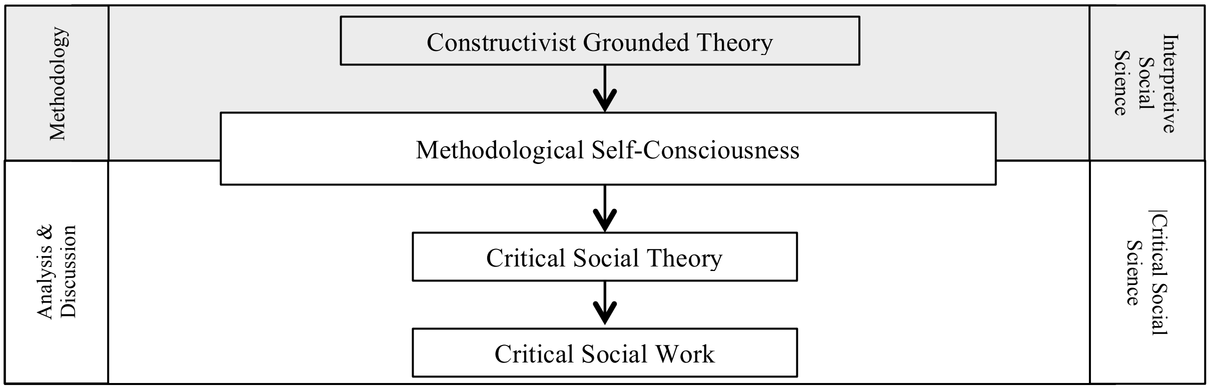
3.1. Theoretical and Methodological Overview

For this research study, I will be utilizing a combination of critical social theory and perspectives of critical social work. This theory and the associated practice modalities link to my methodology—Constructivist Grounded theory (CGT); the approach to CGT that I will draw on most significantly is that develop by Kathy Charmaz. Charmaz asserts that CGT encourages a *methodological self-consciousness* (Charmaz, 2017, p.36). As such, I have situated myself as a researcher within these frameworks and attempt to be cognizant of my situated knowledge and its effect on my data analysis, findings, and goal of my research study. In my use of these theories, frameworks and methodology, my research will apply and combine both a critical social science (CSS) and interpretative social science (ISS) research approach. For a visual representation of my theoretical framework, as it relates to my methodology, please see Figure 1.

To begin this chapter, I will outline CST and CSW and demonstrate their connection to a CSS research approach. I will also demonstrate their connection and prudence to my research study. Subsequently, I will transition to discuss CGT as my methodological approach; in doing so, I will delineate CGT from a Classical Grounded Theory methodology as developed by scholars Glaser and Strauss. To end, I will discuss the methods I took as a practical implementation of my methodology.

Figure 1

Visual Representation of Theoretical Frame



3.2. Theoretical Framework

3.2.1. *Critical Social Theory*

Arguably founded by Karl Marx, Critical Social Theory (CST) is a macro-level theory that "is motivated by an interest in those who are oppressed, is informed by a critique of domination, and is driven by a goal of liberation" (Mullaly, 2010, p.16). At large, CST challenges domination and oppression and emphasizes that knowledge is socially constructed (Fook, 2003). This paradigm also acknowledges that oppression can take place by way of "internal self-deception", where individuals internalize and thus contribute to their own oppression (Fook, 2003, p.124; Mullaly, 2010). To this end, a critical social theorist would aim to disrupt what Marx terms "false consciousness", which prohibits individuals from changing the domineering discourses, structures and ways of knowing within society (Fook, 2003; Mullaly, 2010). Relatedly, this paradigm also encourages self-reflection (Fook, 2003).

Unique to CST as it compares to mainstream social theory at large, is its commitment to social change and liberation (Mullaly, 2010). That is to say that critical social theorists are not simply concerned with acknowledging the presence of injustice, but doing something to eliminate it. Consequently, CST is not "deterministic," but "voluntaristic" in nature; meaning that it acknowledges that social action can lead to emancipation and that social action begins in the everyday lives of everyday individuals (Fook, 2003, p.125; Mullaly, 2010).

It is important to note that CST "is not a singular or unified body of thought" (Mullaly, 2010, p.18). Instead, there is collection of theories (e.g., structural social work theory, variations of feminist theory, etc.) that may be considered a CST. Critical Social Work discussed below, would likewise land within this context (Mullaly, 2010).

A key process of CST that my thesis will employ is critical deconstruction and critical reconstruction as outlined by Jan Fook (2012). Fook (2012) explains that, "the power of discourses lies in the degree to which they are unquestioned. However, simply choosing not to accept dominant ideas and pointing up contradictions can work to resist, challenge and change these dominant meaning systems" (p. 104). To this end, Fook (2012) outlines four key stages in order to engage in a critical analysis of discourse. These stages include: (1) deconstruction, (2) resistance, (3) challenge, and (4) critical reconstruction (Fook, 2012, p. 106).

Deconstruction consists of "questioning dominant discourses" and in so doing, looking for alternative perspectives and/or inconsistencies that may be present within the current way of thinking (Fook, 2012, p.106). Resistance is thus the rejection of the identified dominant discourse(s); Fook (2012) explains that the act of deconstruction alone is a viable form of resistance. In other words, simply considering the dominant discourse(s) as one perspective of many is a fundamental form of resistance as it then creates space for the conceptualization and presentation of new ideas. Subsequently, the 'challenge' stage involves labeling the dominant discourse(s) discovered in stage one, and naming the taken-for-granted knowledge or subordinated perspectives/ discourses that lay hidden. Lastly, critical reconstruction is the creation of new discourses that serve to change the dominant discourse(s) and thus elevate the voices of those who are subjugated (Fook, 2012). Fook (2012) describes the act of deconstruction and reconstruction as a useful strategy in critical reflection.

Integration into my Research Study. To begin, CST will be prudent in my research study as it not only informs my research questions at large, but also influences my data analysis and the underlying goals of my research. As noted above, CST draws attention to oppression, critiques domination and seeks social liberation for marginalized people and communities. It's overall aim to enact change within the current dominant discourses and shift the power relations that exist in society. My study takes up this theoretical frame as it endeavors to understand broader organizational- and provider-level factors and discourses that affect a parent's ability to engage in services for their child(ren) and/or youth. Therefore, my desire is to produce results and recommendations that are beneficial for parents and providers alike. In so doing, I chose to not only focus on the ways providers may be hindering (or facilitating) parental engagement, but also on the ways in which organizations are hindering (or facilitating) providers in their efforts to engage parents in treatment; thus uncovering the complex and underlying ways in which organizations impact providers and how providers thus impact parents.

Furthermore, my above review of the literature also takes a CST lens as I deliberately outlined how broader societal philosophies (namely, neoliberalism and NPM) impact the overarching discourse of mental health (e.g., the responsibilization of individuals) and constrains providers in the non-profit social service sector. Therefore, grounding my study in this socio-political reality and being critical of this reality further advances my use of CST theory as it relates to my data analysis. More specifically, CST will impact my data analysis by providing a lens through which I will look, with the particular aim of discovering what dominate discourse(s), organizational processes, and provider-level actions are contributing to the difficulty that provider's have in engaging parents in services. For example, it will seek to uncover how the power that service providers possess either hinders or facilitates engagement, and more broadly how organizational power and authority influences providers and parents alike.

In keeping with Fook's (2012) critical deconstruction and reconstruction, a portion of my research study will focus on deconstructing the dominant discourses and understanding how these discourses operate within the child and youth mental health system; thereby exposing harmful ways of thinking and/or practices, while also bringing to light taken-for-granted perspectives that may be beneficial for enhancing services. The act of deconstructing will later facilitate a discussion surrounding how service providers and parents can resist and challenge, and even more so, reconstruct dominant discourses in order to better facilitate parental engagement in practice. To this end, my hope is that this research will raise consciousness in providers and/or organizations; who subsequently have the ability to help raise consciousness in parents and families that are accessing or seeking to access services. This may thus contribute to the ability to help shift some of the detrimental feelings of shame, responsibility and self-blame that parents and families feel so deeply.

3.2.2. *Critical Social Work*

CSW is concerned with and "critical of existing systems of social arrangements" and creating a society that is just and equitable (Mullaly, 2010, p.19). CSW may be categorized as a "conflict- or changed based" approach, as it recognizes the need for progressive change within our social systems, which disrupt current ruling power relations; it thus commits to the creation of a society which is "free of dominant-subordinate relations" (Mullaly, 2010, p. 19). With this in mind, critical social workers believe that individuals experience 'reality' differently; namely that social, cultural and political contexts impact how people experience life and reality (Campbell & Baikie, 2012). Moreover, the identities that are assigned to individuals (e.g., race, gender, etc.) impact how people experience the world, which may lead to individuals holding privilege or experiencing oppression (Campbell & Baikie, 2012). Subsequently, critical social workers value diversity, human rights, equity (etc.), and they study and critique oppression, privilege, power, discourse, and more (Campbell & Baikie, 2012). CSW analyzes power in society and sees "social relationships as both personal and political" (Campbell & Baikie, 2012, p.71).

It may be argued that CSW is a practical implementation of CST. However, CSW practice may lead to further learning and development of Critical Social theories at large. Interestingly, Fook (2012) discusses this connection between critical social work practice and research and/or theory. She states,

> "the worlds of practice, theorizing and research are much less separate than perhaps more binary-based thinking has assumed…[which may allow for] using and combining methods from both practice and research discourses, in order to improve and create links between our practice, our theorizing and our research" (p.105).

Accordingly, my study will aim to connect my use of CST with my use of CSW. Bearing this in mind, below I outline how I will integrate CSW into my research study.

Integration into my Research Study. Similar to CST, CSW connects to my study's change-orientated goal and overall direction, as it aims to produce change in the child and youth mental health service system. As noted above, by focusing on organizational-level processes, my study is critical of existing systems and is therefore committed to using the voice of providers to uncover where change is necessary. This will ultimately serve to better help providers and families who are utilizing the mental health service system. Differing from CST, CSW will facilitate an increasingly pragmatic conversation within this study's discussion.

Given my educational background in CSW, I am inclined to process the information shared with/by participants in terms of how social workers or providers can utilize these understandings and implement this new knowledge into children's mental health practices and ways of doing this work. As such, CSW connects to my research, insofar as it reflects what providers and organizations can practically do to move forward. Therefore, my research will not only present a conceptual framework outlining a developing theory that explains organizational-and provider-level factors impacting parental engagement; but will aim to engage in critical reconstruction (Fook, 2012) where social work practice will be considered and suggestions and/or recommendations to better facilitate parental engagement in practice will be provided.

3.2.3. Critical Social Science

With this theory and practice modality in mind, both CST and CSW ultimately fall into a Critical Social Science (CSS) research paradigm. Like CST and CSW, a CSS paradigm is focused on creating change and so seeks to "uncover the real structures in the material world in order to help people change conditions and build a better world for themselves" (Neuman, 1997, p.74). In fact, the very purpose of CSS research is to critically analyze and change social relations (Neuman, 1997). Like CST employs, CSS aims to raise consciousness or "reduce illusion" and to liberate people from dominate and oppressive structures, discourses and the like (Sayer, 1992, p.252 as cited Neuman, 1997, p.74). As such, CSS adopts a historical realist ontological position, meaning that reality exists but is in a constant state of change as impacted by social, cultural and political (etc.) factors (Neuman, 1997, p.74).

As a result, my study adopts a CSS research approach as it examines and considers the deeply impactful historical-political context of neoliberalism and NPM. In so doing, my study locates the subjective experiences of service providers in the broader set of discourses by which their workplaces and beliefs may be shaped. Doing this may thus help to resist dominate discourses (e.g., individualism) and liberate providers and parents from their own "internal self-deception", whereby they contribute to their own oppression (Fook, 2003, p.124).

Relatedly, my research will also take a CSS approach as it conducts a broader structural analysis with the goal of creating social change. Ultimately, this change is to better facilitate parental engagement in practice for the purpose of enhancing child and youth mental health outcomes. However, more than this, the goal of this research is also to advance critical social work practice within child and youth mental health agencies; so that individuals accessing services feel better supported and so that providers are equipped to resist or disrupt the broader structures and discourses that they are working under.

3.3. Methodology

3.3.1. Methodological Overview

As mentioned above, my research study will be guided by using principles of Constructivist Grounded Theory (CGT), developed by Kathy Charmaz. CGT is an iteration of "Classical Grounded Theory" which was first developed by Barney Glaser and Anselm Strauss (Charmaz, 2006, p. 4). In order to appreciate the significance of using CGT, it will be important to understand Classical Grounded Theory first. As such, I will provide a brief overview of this methodology below, followed by an overview of CGT and discussion of my use of this methodological approach in my research study. In closing this chapter, I will discuss my data collection and analysis.

3.3.1. Classical Grounded Theory

While Classical Grounded Theory (GT) is associated with both Barney Glaser (1965) and Anselm Strauss (1967), these scholars bring two differing educational backgrounds into this methodological approach. Glaser's contributions demonstrate his roots in positivism and Strauss' reflect his education in pragmatism, informing his use of Symbolic Interactionism (Charmaz, 2006). Through the years, Classical Grounded Theory has had diverging perspectives, with Glaser's work being consistent to its original claims and Strauss developing a slightly different iteration of GT (namely, more interpretative) with Juliet Corbin (Charmaz, 2006). Nevertheless, with the history and minutiae of GT being vast, the purpose of this section will be to outline the fundamental aspects of GT as it was first developed. While the details and differences between the various iterations of grounded theory are noteworthy, they are beyond the scope and purpose of this study.

With this in mind, GT is a qualitative and inductive research approach, which aims to produce a theory grounded in the collected research data (Charmaz, 2006; Sebastian, 2019). Sebastian (2019) refers to this as "bridg[ing] the gap between research and theory" (p. 1). In so doing, GT takes a positivist ontological approach and claims to produce unbiased theoretical explanations (Sebastian, 2019). Under GT, the researcher is neutral and detached from their research, meaning their prior knowledge is not relevant; integrating such knowledge runs the risk of generating bias findings (Sebastian, 2019). In keeping with the positivist approach, GT assumes that the world is knowable, and thus, what is discovered "represents objective facts about a knowable world" (Charmaz, 2006, p.131). Hence, GT researchers become "authoritative experts" on the research that they produce (Charmaz, 2006, p.131).

Accordingly, in their original development Glaser and Strauss encourage a strict and non-flexible adherence to the methods or steps as outlined by this methodology (Charmaz, 2006, p.131). The key components or steps of GT are: simultaneous data collection and analysis; the creation of analytic codes rooted in the data; utilizing a "constant comparative method"; the continual focus of theory development throughout the entire research process; memo-writing; theoretical sampling; and a literature review conducted after analysis (Charmaz, 2006, p.5-6). Explaining each of these steps or processes is also beyond the scope of this study; moreover, not every technique of grounded theory was utilized given the scope of my research study. For clarity's sake, after providing an overview of CGT, I will discuss and expound the methods I utilized for the purpose of my research study.

3.3.3. Constructivist Grounded Theory

Although Kathy Charmaz (2006) agrees with and maintains some of the core methods of GT (such as the constant comparative method), CGT fundamentally opposes GT. The major differences stem from the philosophical paradigm in which the CGT methodology lands; namely the interpretive tradition, with theoretical roots in Social Constructivism (Charmaz, 2006; See Figure 1). Therefore, before continuing my discussion on CGT, I will briefly discuss interpretive social sciences to expound the interpretative tradition and give context to CGT.

3.3.3.1.Interpretive Social Sciences (ISS). According to Neuman (1997), interpretive social scientists seek to "develop an understanding of social life and discover how people construct meaning in natural settings" (p.69). As such, this research paradigm rejects the belief that reality exists and is waiting to be discovered. Rather, it posits that reality is relative and/ or subjective based on what individuals understand it to be, thus meaning that ISS researchers believe in the existence of multiple realties (Neuman, 1997). With this in mind, this research paradigm studies "meaningful social action" and seeks to understand the subjective meanings that individuals associate to seemingly inconsequential external human behavior (Neuman, 1997, p.69). As Charmaz (2006) explains, "interpretive theories allow for indeterminacy rather than seek causality and give priority to showing patterns and connections rather than to linear reasoning" (p. 126). Given this, ISS opposes positivism, and thus, the overall paradigm of the Classical Grounded Theory. Accordingly, this significantly impacts how Charmaz conceptualizes the goal of research, the role of the researcher and the findings research studies produce.

Therefore, this study is interpretative in nature, insofar as it examines the individual subjective experiences that service providers operating within the child and youth mental health sector present. It will consider each perspective as equal and valid as it accounts for individual's definition of engagement, experience of their workplace environment and organizational procedures and/or policies. However, ISS will be integrated with the abovementioned CSS paradigm, as I will not adopt an overly relativist ontology, but will rather ground the subjective experiences and constructed meanings of providers in a contemporary socio-political reality (namely, neoliberalism and NPM). Furthermore, my study will not merely seek to understand how my participants subjectively understand the world, but will rather aim to enact some measure of change in their workplaces, client relationships, to ultimately disrupt domineering and oppressive discourses.

CGT Continued

Bearing this in mind, CGT employs a very different perspective to GT as developed by Glaser and Strauss (1967). Firstly, rather than the researcher being neutral and detached, CGT acknowledges the researcher's positionality and thus upholds that a researcher will always enter a study with prior knowledge (Charmaz, 2008). More than this, CGT encourages researchers to understand how their prior knowledge and positionality may impact the data; this methodology does not ignore or erase ones previous knowledge, but rather implores researchers to "carefully navigate and control their perspectives" (Sebastian, 2019, p.5). Relatedly, CGT also acknowledges the positionality of the participants involved in one's study (Charmaz, 2008). Hence, while CGT emphasizes theory development as rooted in the data, it argues that the theory that emerges is simply one interpretation (Charmaz, 2006). In fact Charmaz (2006) states, "the theory depends on the researcher's view; it does not and cannot stand outside of it" (p.130).

Accordingly, CGT is highly reflexive (Charmaz, 2006; Charmaz, 2008). That is to say that this methodological approach encourages the researcher to reflect on both their participants and their own interpretations (Charmaz, 2006). Another way reflexivity has been conceptualized in CGT is as *methodological self-consciousness* (see Figure 1), which entails,

> “Examining ourselves in the research process, the meanings we make and the actions we take each step along the way…[while also] becoming aware of our unearned privileges as well as taken-for-granted privileges accompanying our positions and roles and defining intersecting relationships with power, identity, subjectivity—and marginality— for both the researcher and research participants” (Charmaz, 2017, p.36).

Furthermore, since CGT takes a relativist approach and so believes in the existence of multiple realties, reflexivity or *methodological self-consciousness* is important as it allows the researcher to reflect on how the theory they have developed has been constructed by both themselves and their participants (Charmaz, 2006).

Practically speaking, Kathy Charmaz employs many of the same methods that Glaser and Strauss developed. However, she also views these methods for data collection and analysis as flexible and not prescriptive rules to be followed (Charmaz, 2006; Sebastian, 2019). Since my study utilized a small sample size and was confined by a shorter research time frame (which will be described in more detail below), I was unable to use every principle of grounded theory; namely, theoretical sampling. Broadly, theoretical sampling allows the researcher to collect relevant data to solidify and refine categories that have arisen and that further solidify one’s emerging theory (Charmaz, 2006). The overall purpose is to develop categories that are emerging in the data until no new properties in the categories materialize; thus leading to saturation (Charmaz, 2006). As noted above, I was unable to abide by this principle of grounded theory, and do not claim that my findings are representative; rather these are emerging ideas that I argue should be further explored.

Notwithstanding, there are a few main principles of CGT that my research study abides by. These include: simultaneous data collection and analysis (see section 3.4.3.), initial and focused coding, constant comparative method and memo-writing. Below is a description of each:

3.3.3.2. Coding. GCT uses coding as a way to analyze and "ask questions of the data" (Charmaz, 2006, p. 42). In doing so, there are at least two main phases of coding: (1) initial coding and (2) focused coding (Charmaz, 2006). Initial coding entails coding everything in the data, which may include coding the data word-by-word; line-by-line; or incident-by-incident (Charmaz, 2006; Sebastian, 2019). While initial coding may feel inconsequential, it allows the researcher to remain open to the data, stay close to what the research respondents have said, and allows for multiple theoretical avenues to emerge (Charmaz, 2006). It also enables the researcher to discover gaps in the data that may need further exploration (Charmaz, 2006). Relatedly, focused coding is the second phase of analysis that allows the researcher to review the initial codes and to select the most frequently used codes to filter through large portions of data (Charmaz, 2006). This phase asks the researcher to select codes that make "most analytic sense to categorize your data incisively and completely" (Charmaz, 2006, p. 58). Focused coding thus enables the researcher to move towards theoretical development (Sebastian, 2019).

3.3.3.2. Constant Comparative Method. A key aspect of coding is the researcher's use of the *constant comparative method* (CCM). The CCM helps the researcher to make analytic "distinctions" and "comparison" at every level of data analysis (Charmaz, 2006, p. 54). Comparisons can take place within an interview, such as comparing what the participant said at the beginning of the interview versus at the end; it can also take place by comparing responses from different research participants (Charmaz, 2006). It may also take place between the data and the literature, as well as one's theoretical frame; where a researcher considers how their theory aligns with literature, expands upon it, or even contests what is being said (Charmaz, 2006). In essence, the CCM helps the researcher in their efforts to refine their codes/categories and ultimately leads to theoretical development (Charmaz, 2006).

3.3.3.3. Memo-Writing. Memos are another area where comparisons are recorded, which serve as a primary tool for analysis in CGT (Charmaz, 2006). Memos are analytic notes that are written throughout the research project (Charmaz, 2006). Charmaz (2006) describes memo-writing as an "intermediate step between data collection and writing drafts of papers" (p. 72). Fundamentally, memo-writing serves as a way to analyze your data and emerging codes, and captures the researcher's thoughts and ideas, questions about the data and helps to solidify potential research direction (Charmaz, 2006).

These abovementioned steps used to conduct GCT are not linear and below I will discuss the specific methods that I utilized for data collection and analysis. This includes providing a description of my study population, recruitment and data collection and analysis strategy.

3.4. Methods

3.4.1. Study Population and Recruitment

To facilitate this study, I sought to interview three to five service providers who were currently working (for at least two years) or had previously worked (within the past five years) in a child and youth mental health agency within the Greater Toronto Area (GTA). My inclusion criteria (see Appendix A) required that individuals held more than one individual/family on their caseload (either currently or in their previous place of employment); worked directly with children and/or youth; had some connection with the child and/or youth's parent(s) and/or caregiver(s); and whose job was to enhance or improve mental health and promote well-being.

Individuals also had to be an adult (18+) and English-speaking, and were required to have an email and telephone number to allow me to contact them.

Furthermore, individuals were excluded from my study if they worked as an independent practitioner (with no current or previous connection to an organization); if they were working within Children's Aid Society; or if they worked in the context of an inpatient child and youth mental health service. Working as an independent practitioner would not allow the participant to comment on organizational factors. Likewise, the nature of Children's Aid and inpatient work is different than that of community-based services, meaning that these service providers' responses would not lend themselves to the purpose of the study.

Participants for my study were recruited using a snowball sampling recruitment strategy (Sadler et al., 2010). The sample began by leveraging two-existing professional relationships that fit my eligibility criteria: one who worked at a community-based child and youth mental health agency and the other who was employed at an outpatient child and youth mental health service in a hospital. After receiving ethical clearance from the McMaster Research Ethics Board, I contacted these two individuals via email to send them my study's official Letter of Information (see Appendix B) and to set up an interview date. Study participants were also sent a copy of my Interview Guide (see Appendix C) to ensure they had a fulsome understanding of the questions I was asking. Consent was gathered orally at the beginning of each interview and documented in an oral consent log where participants were assigned a confidential code linking them to their answers.

After my two initial contacts were interviewed, a follow up email was sent where I asked the participants if they would be willing to forward my study invitation to eligible individuals who could provide insightful answers to my research questions. If participants' desired, I also provided a recruitment script (see Appendix D) that could be forwarded to their contacts.

Only one of my initial contacts forwarded my study, leading me to two other research participants, for a total of four individuals. Once these two additional individuals who expressed interest in my study contacted me, I repeated the abovementioned steps; namely, I provided them with the Official Letter of Information, my Interview Guide and sent them my study's eligibility criteria to confirm that they were in keeping with the requirements. After setting up an interview date, consent was gathered orally and documented in my oral consent log.

3.4.2. Data Collection

Individuals were asked to participate in a one-time telephone interview that took approximately sixty minutes; some interviews went slightly over and others slightly under. Interviews took place from a quiet and confidential space in my home office and participants were encouraged to find a confidential space of their own to complete the interview. The interviews were semi- structured referencing the abovementioned Interview Guide (Appendix C). With participant's permission, interviews were audio-recorded using a digital recorder. Recordings were then transferred to an encrypted USB and were transcribed in Microsoft word by the researcher (myself).

3.4.3. Data Analysis

Consistent with CGT, data collection and analysis took place simultaneously; after the completion of an interview, the audio-recording was transcribed and initial-analysis was conducted before transcribing and analyzing the subsequent interview. In fact, for my first two interviews, audio-recordings were transcribed and analyzed before conducting the subsequent interview. This was not possible for my third and final interview due to participant availability.

Notwithstanding, successive data analysis is still a key and prudent part of my data collection and analysis process. Doing so allowed me to slowly witness the emerging direction of my research, to make noteworthy directions for future interviews and to highlight developing questions that I had as my research unfolded.

As already outlined (in section 3.3.3.1), the first step in my data analysis was initial coding. I coded the data line-by-line, and at times, incident-by-incident; depending upon the section of data I was analyzing (Charmaz, 2006). In this first set of coding, I sought to code everything in order to remain open to what my data may have been yielding. That is, I coded in such a manner that allowed and encouraged me to truly read what participants were discussing rather than interpreting the data through what I *wanted* or *thought* it should say.

Furthermore, through refection I noticed that I was bringing my previous knowledge into my analysis, which was further exacerbated as I completed my study's literature review before collecting my data. Having a robust understanding of the impacts of neoliberalism and NPM, as well as the complex factors effecting parental engagement as described by the literature, had the ability to taint my reading of the data. As a result, I strived to gain a methodological self-consciousness to understand how my previous knowledge on this topic and my own subject positioning was impacting how I was reading the data. Thus, coding the data line-by-line helped me to stay close to the respondent's answers, to be aware of my personal impact and to stay open to potential unknown directions.

Before moving to focus coding, I participated in memo-writing. I paused to write memo's before moving onto subsequent interviews in order to capture developing thoughts, theories and questions that came up as I collected the data. My first set of memos was strictly related to my first interview; however, as the next interviews occurred my memo's expanded to include several respondents' ideas. My memo's compared what participants were saying, noting both differences and themes that emerged. They also captured aspects of my emerging conceptual framework that was later constructed as I started to fully formulate my grounded theory.

After writing memos for each interview, I moved to focus coding; which involved reviewing the initial codes I created. Since my first round of coding was quite broad, my second round of focused coding helped me to synthesize my codes, and solidify categories that could be used to begin to formulate my conceptual framework. Alike codes were grouped together, and main ideas and themes were highlighted in order to create an organized presentation of my findings. After focused coding was complete, I organized my codes and categories and constructed my conceptual framework presented in my findings and discussion. The study findings are presented in chapter five below.

Chapter Four: Findings

This chapter comprises of six sections: (1) participant demographics; (2) definitions and conceptualizations of parental engagement; and (3) system-level factors (4) organizational-level factors; (5) provider-level factors and (6) parental-level factors affecting parental engagement. Sections three to six will be accompanied by the presentation of a conceptual framework, which provides a visual representation of main themes and associated connections between each level.

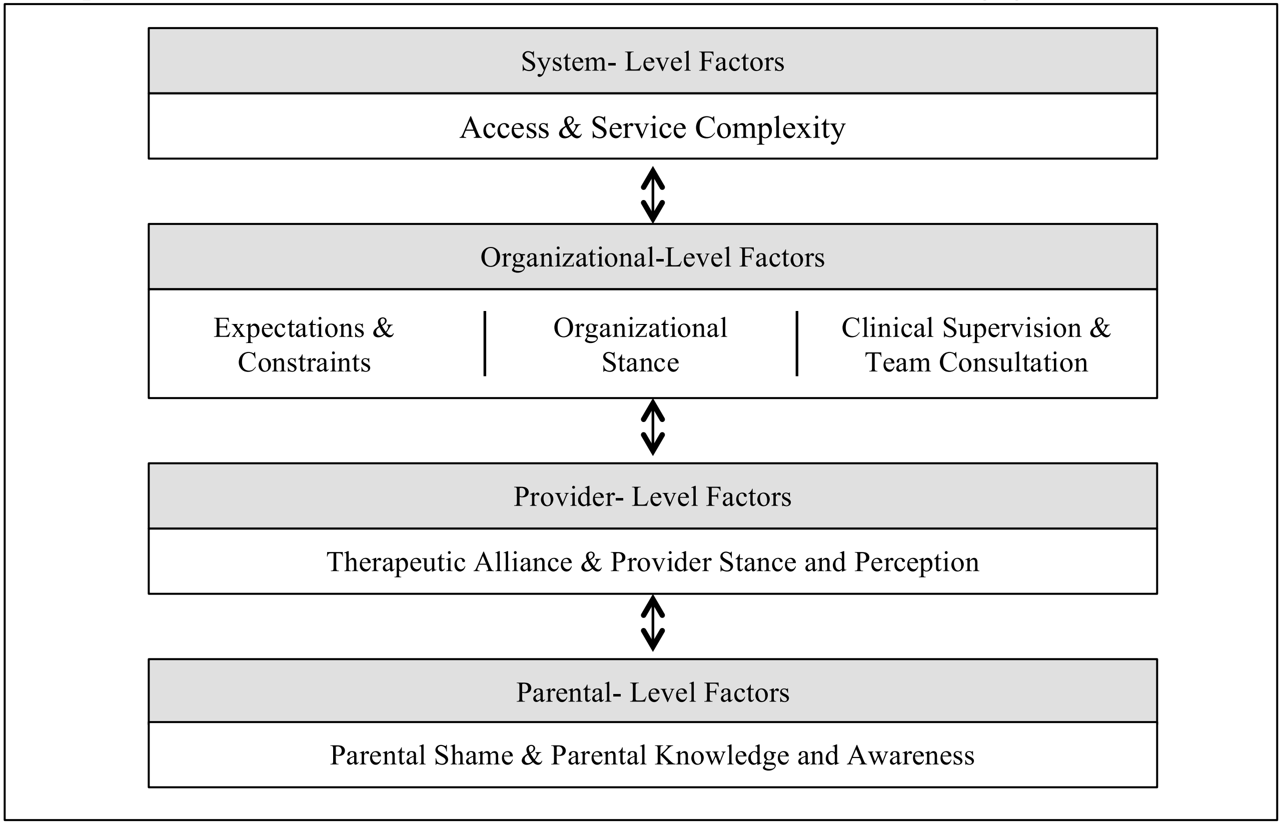
4.1. Participant Demographics

This study involved four participants, all of whom were female. Three participants work (or worked) with community-based organizations; one participant works at a hospital outpatient mental health clinic. The work experience of each participant was unique; with two participants having over thirteen years of experience with their organization of employment and the remaining two participants having around seven years of experience at their current or previous agency. Titles or roles vary by participant. One individual holds a “Family Therapist” title; another is considered a “Child and Family Therapist”; one works as a “Child and Youth Worker” but is currently working in a Master’s of Social Work (MSW) student role; and the final participant’s role is as a “Counselor”. Educational backgrounds also vary considerably; one participant has a sociology degree and is completing her MSW; another holds a Bachelor of Arts in Psychology; the third also reports having a Bachelors of Psychology and a Master’s in Spirituality and Counseling; and the final participant has her Master’s of Social Work.

4.2. Presentation of Conceptual Framework

Figure 2 below provides an overview of my findings, which demonstrates how various parent-, individual provider-, and organizational- or system-level factors interact with, inform and influence one another; with all levels having the ability to hinder or facilitate parental engagement in services. This conceptual framework will act as visual guide for the remaining findings and will be elaborated in my discussion section (see chapter five). Under each level (systems, organizational, etc.), the main themes are presented. A total of eight themes were identified, including: (1) access; (2) service complexity; (3) expectations and constraints; (4) organizational stance; (5) clinical supervision and team consultation; (6) therapeutic alliance; (7) provider stance and perceptions; (8) parental shame; and (9) parental knowledge and awareness. All nine themes will be discreetly explained below; however, it is important to note that while these themes have been organized under the appropriate headings, there are elements of this analysis that demonstrates the interconnected and interwoven aspects of these themes. Firstly, I will take a brief moment to outline the definition of parental engagement that study participants describe.

Figure 2
Conceptual Framework Overview: Barriers and Facilitators to Parental Engagement



4.3. Definition of Parental Engagement

When participants were asked to define parental engagement, common ideas emerged from all four individuals. Participants agree that parental engagement is important in child and youth mental health services and that it involves making and attending appointments. Some participants specifically allude to the importance of parents 'showing up' for meetings on time, being focused in session rather than distracted (e.g., on their phone), and having an interest and engagement in the therapeutic or treatment process that goes beyond physical presence. Some participants also add that engagement includes completing or executing tasks (e.g., homework) discussed or assigned in session. Furthermore, engagement may be defined in terms of collaboration, where parents are actively participating in session, sharing their opinions and engaging in dialogue. For example, as one provider states,

> "A parent that would be engaged would be someone who is coming to appointments, who is actively involved… they're listening, they're sharing...their perspectives, they're engaging in dialogue, that would be a parent that would be engaged for me."

Two participants use the word "buy-in" while discussing engagement. Other terms used include, "involvement," "participation", and engagement as something that is "active." Moreover, one participant describes engagement in terms of "consenting to…services," another describes the idea of "commitment" to treatment goals and a third explains the concept of parents being involved in the "understanding and treatment options [and having an]… understanding of the different resources" for their child and/or family. Interestingly, two providers also highlight engagement in terms of the parent's perception of the problem as the "child's issue" rather than a family issue. For example, one provider suggests the importance of "…seeing the therapy not just as the child's issue, but the family issue altogether and wanting to be a part of that [therapy] and wanting to learn."

4.4. System-Level Factors

While the purpose of this dissertation was to uncover organizational- and provider-level factors impacting engagement, two noteworthy themes emerged that are better described with system-level factors. These themes are (1) access and (2) service complexity. Both of these themes are impactful to organizations, providers and parents alike.

4.4.1. Access

The theme of *access* is described in a couple of ways. Most overtly, two participants speak specifically about access as directly related to parental engagement. They explain that their organizations are working to improve access, sometimes in collaboration with other organizations, to better streamline or simplify services. For example, one provider says,

> "I think the agency's trying to engage…[with regard to] clarity around how to access services, and…[ensuring] less barriers to accessing that service…So I think that we're really working on what our system looks like…and sort of shifting how that looks, in order…[to] streamline accessing those services and doing that as an entire community…[so] finding ways to confidently share information from agency to agency when clients move so they don't have to retell their story."

Similarly, one provider speaks about bettering access to services as related to increasing engagement, and describes how her organization is taking efforts to make access "simpler" for parents. The participant states:

> "So in the time that I've worked even in Halton you had many many points of entrance into a service and the services didn't necessarily coordinate or talk to each other. They did kind of individually, like on a therapist-level, but not organizationally. So I think that's gotten better, a lot better."

Access to service was also discussed as one provider talks about integrating technology into her agency's services, not only to help with documentation tasks but also as way to increase parental engagement. Technology was seen as linked to access and thus to parental engagement when it was framed as a type of flexibility. A participant presents an example of the usefulness of technology as she explains the concept of working with a parent who has multiple children at home and is unable to secure a babysitter. Having the option to engage in a Skype appointment may allow that family to access services more frequently than if they were required to come to a face-to-face meeting.

Relatedly, this provider also speaks about scheduling conflicts and the potential of these conflicts to impede access to services. For example, the participant suggests that scheduling day appointments can create conflicts for parents due to their work schedules, and notes that her organization provides evening appointments (although these appointment slots fill up quickly). She describes the challenges parents have with appointment making:

> "So a lot of these parents are having…more systemic barriers to being as available…and being as engaged. Like our clinic…offers appointments during the day and for most parents they can't make those appointments…because they're working [and so]… I've had many parents say… 'I am now…getting disciplinary letters from my place of employment because I've had to take off so much time to attend all of these appointments.' So it's not an ideal situation at all…"

Similarly, a second participant notes the importance of scheduling appointments that are convenient for parents as a way to increase engagement. All three participants allude to the availability of in-home supports as potentially increasing engagement and thus access to services. One participant notes this by saying,

> "Well I think our response to [families who were disengaged] was…the program I was with previously, where we went to people's homes. That was …where all the clients who were very difficult to engage…[but] needed supports still…were usually referred too. So I would say that has been…[our] response, which is a good program… there is no barriers per say…the worker pretty much does and accommodates whatever the family asks for. So I feel like that's a very good solution."

While providing in-home supports is acknowledged as a way to increase engagement and to reduce barriers to services, one provider also explains that in-home supports might hinder engagement if the parent and/or family are uncomfortable with having a provider in their home.

She states, “So, being able to provide services in the home—in my situation—can increase engagement. It can also hinder engagement if people aren’t comfortable having someone come in the home.”

4.4.2. Service Complexity

The second theme identified pertaining to system-level factors is service complexity. This theme encompasses the idea that navigating the mental health system is difficult for parents and that the complexity of services alone can affect a parent’s ability and/or desire to engage in services. One participant highlights this point by saying, “its tough to navigate the mental health system as a parent…which sometimes gets in the way…because it’s not straightforward.” This same participant notes resources necessary for navigating the system as expressed in the following statement:

> “[Navigating the system takes] skills or capacity, or money… [It] requires things that parents…don’t have and so we make it really challenging. So I think we always have to be thinking about…are we making this as simple as possible so people can get the help they need for their kids?”

In discussing matters related to responsibility, another participant notes all the steps parents must take in order to access services provided by her employing organization. She describes that in order to access her department, parents/ families are required to get a referral from their family doctor and then a subsequent referral to see a psychiatrist to get an assessment. Moreover, she adds that there is not only a waitlist for psychiatric assessments, but also a waitlist to enter into her specific program. Additionally, a participant also explains that some families might have “six or seven different services involved” in their care in order to get the treatment they need. This same participate explains that this can create feelings of being overwhelmed for parents, making it challenging to engage. Moreover she notes:

> "The other thing is the different services don't always really talk to each other well, they don't coordinate well, and so I think that's confusing for parents because they could get different messages depending on what service they engaged first or second."

As a way to foster engagement, this same provider talks about a program that her agency implemented where families who had multiple services involved were paired with a coordinated service planner to help mitigate some of these complexities. She states,

> "…It's almost like if we could have guides…because it's hard [for parents to navigate services]…I know the hospital does have something called navigators…to increase engagement…[and we have a program and]…they've done an amazing job…they literally match families up with a coordinated service planner and a parent support person…so these people literally…coordinate all the players and…walk them through the system and help them access what they need."

4.5. Organizational -Level Factors

4.5.1. Expectations and Constraints

Subsequently, participants allude to organizational-level factors, namely work expectations and work constraints, as hindering a provider's ability to engage parents in services. This theme is described in four main ways: (1) caseloads and volumes, (2) documentation, (3) time, and (4) flexibility of services; each sub-theme is summarized below.

4.5.1.1. Caseloads and Volumes. To begin, all participants speak to issues regarding caseload and high overall workload volumes. In particular, participants describe increases in caseload and workload demands as affecting a provider's ability to build relationship with parents. One participant explained that these demands restrict her ability to undertake therapeutic work with her clients, which she explores through the following statement:

> "Yeah, the [job] description would indicate that you should…be doing therapy, and that you should be providing that type of support and I think in an ideal world, yes, but you also have 26 kids that you're taking care of everyday, that you are responsible for everyday. So, it's just not realistic."

Likewise, another participant describes their experience with high caseloads as affecting their work with clients, suggesting that management expectations are that workers increase the number of cases they serve. This participant recalled:

> "…In the end of a meeting with my manager… [she asked] 'Can you take on more, can you take on more, can you take on more?' And I think there's a lot of pressure with an organization for me to come out with certain numbers every week but with those numbers, one of my frustrations is it takes away from the relationship building with parents that makes it easier with them to engage."

Similarly, one participant working in a community-based mental health agency relates the impact of high workload to their organization's funding structure. She explains that being funded at a ministry level creates "pressure and expectations about the outcomes of your work, and a lot of administrative and documentation tasks that you have to complete that can get in the way."

Also discussing the challenges of funding, another participant likewise describes how funding affects the scope of her work. Drawing from previous experiences, she explains how her agency was funded to work with children's mental health, and so, when parental mental health was identified as a barrier or issue to be addressed, it was challenging to know how to navigate these occurrences. This was a barrier that she identifies to parental engagement:

> "…Of course working within the confines of funding and all of that, we can't completely focus on…the parent's mental health. So ensuring that they are connected with the appropriate service would be really important as well. So, if there was anyway that I could tangibly bridge that gap so that they could access other services that would be something I would do."

This provider also describes how these challenges lead to difficulty in documentation practices. She notes that it was "tricky to separate" what information to include in the child's file and that it would be "odd" to open a parental file in a child's mental health agency. Further complicating matters, this same provider also speaks about the challenge of having several complex cases on her caseload. She suggests that providers should have lower levels of complex cases on their case list and also notes that her previous organization was working to address this concern through the use of risk measurement tools. These tools help to direct people to the appropriate services, something that she reports as “not always that seamless.” She explains,

> “I think it’s the volume but…[also] the complexity of the cases. Like there were just so many levels working with kids and families at…[my organization] whereas in private practice…it’s a little bit less complex and more straightforward. And less levels of risk. Lower risk as well I would say.”

4.5.1.2. Documentation. Similarly, other participants also describe the negative effects that documentation and administrative practices and expectations have on their work. Specifically, study participants explain how documentation and/or administrative duties limit their time with clients, add to their overall responsibilities and workload and thus impede on their ability to engage parents in services. As one provider states,

> “… On a very practical level I feel like, over the years that my time is taken up more and more and more with data... input and so less time with my ability to really engage families… I meet…every week with my manager to make sure the data’s is all in the right spot. But…less time now is spent on really understanding families, and what they need and what kind of services could we provide to engage them better.”

Likewise, another provider expresses how documentation and administrative tasks take away from direct service time with clients, and can cause providers to feel pressure and stress. One participant further describes how the use of paper charts by her organization hinders the amount of time she spends with clients:

> “So the process that I just explained [regarding documentation/administrative tasks]…can take almost half my day… If you’re expected to see six clients a day… you have to do the photocopying and filing for six clients, and then all of the documentation of what you discussed and who you refereed them to and connected them too, that’s a lot of administrative work. So, I would say that’s probably the biggest barrier for me.”

This same provider also discusses how technology might help improve documentation practices (i.e., by increasing efficiency) and increase parental engagement by offering services in more accessible means.

4.5.1.3. Time. Closely related to the abovementioned challenges (e.g., caseloads, documentation, etc.) is the issue of time—or the lack thereof—that providers have to engage parents in services. While time may be associated or directly related to the theme of *caseloads and volumes*, time was brought up specifically by participants and was therefore separated for reporting. One provider summarizes this problem saying,

> "…One of the challenges that I have...is that there's so many kind of procedural things that I have to do, so much…documentation, and it really kind of restricts my time to do the more personal engagement with parents…Cause I noticed when I have that time to really be able to meet the parents where their at and to be able to offer empathy and validation for how hard they're trying…I get way more engagement ... And I think [when I don't have time]…parents have to do more work to stay on top of their appointments, [and] stay on top of…what…they doing with [their therapy]…You know, what were they practicing at home again?"

Another participant also speaks to matters related to time as she explains that parental engagement can be achieved "through a lot of conversations, a lot of relationship building, [and] a lot of rapport." However, this same participant explains that this process takes a "takes a lot, a lot, a lot of time" and thus argues that providers do not have the capacity given the size of their caseloads.

4.5.1.4. Flexibility of services. Another topic that surfaced under organizational expectations and constraints was the flexibility of services. This sub-theme encompasses the flexibility (or lack thereof) that organizations possess in servicing parents. For example, one provider mentions her desire to see greater flexibility in services; she states:

> "I would want to have an organization that has more flexibility built into their system, so that parents could engage in the service when they need to and not be on waitlists so much and not be [told], 'well you have to do this, then this, then this, then that' you know?... I would love to see us create more flexibility and more transparency with families so they know how to navigate…[the system and so] they know how to advocate for what they need… [so] we can flex with…when and how they want to engage."

She also provides an example, describing how families who want to see a psychiatrist wait roughly six months and if a family misses their scheduled appointment they are automatically back to the waitlist, typically waiting another six months. On this point she says, "…Some of those systems don't really take into consideration some of the challenges for parents around engagement and can make it really frustrating for them."

Similarly, by way of example, another participant demonstrates the stringent rules and regulations maintained by the organization where she is employed, which may indeed affect a parent's ability to engage in services. She explains that if children/youth in her program miss five consecutive days of programming they are discharged from the service. While these rules and expectations are made clear to program participants, she also explains that families are encouraged to return to the waitlist if they are not in a place where they are ready to engage and change.

Furthermore, another provider speaks to matters related to service flexibility as she compares her experience working at a child and youth mental health agency to her experience working in private practice. She suggests,

> "…In my experience, there's greater flexibility in the ways in which I can work, with people [in private practice]. So, you know, I can use, just a variety of holistic practices and interventions, that might not be sort of, supported by an agency at this time."

In contrast, one provider describes a positive experience of flexibility within her organization. This participant describes how parental engagement may actually be a treatment goal and how this goal can sometimes take up half of the allotted therapy sessions, which is necessary in order to get to other service aims. However, this provider notes that if clinicians provides a therapeutic based reason they are able request more sessions. This participant notes that her agency is good around fulfilling these requests and desire for families to get the services that they require.

4.5.2 Organizational Stance

The second theme under organizational-level factors is organizational stance. This theme encompasses a particular organizational attitude or belief surrounding the importance of parental engagement and the organization's overall perspective on the delivery of mental health services. Overall, participants note that no formal engagement framework exists within their respective agency. However, two providers highlight their organization's approach to mental health services more generally. One participant mentions,

> "I guess it's …around… how we view the work at…[a] theoretical approaches [level]…I think the agency has a consistent approach and expectation around family engagement, so that the parents are involved with service…[For example we use]…attachment theory…[and have a] post-structuralist way of viewing clients and problems, where we externalize problems, [so] that people aren't the problem…and I think [it is also seen in] the work that we do around use of self…and [in] supervision…[and in our] trauma focused approach."

Likewise, another participant highlights the importance of organizational approaches and explains that her previous agency used an attachment framework, meaning that they understood "the significance of the parent-child relationship and of engaging parents in treatment"; something that this provider notes as fundamental to fostering parental engagement in services.

Another noteworthy aspect of organizational stance that one participant describes is the integration of parental voice and/or opinions into services. An organization's decision to include parents in this way, speaks to the organizations belief about the importance of parental engagement in services. To this end, one participant, who works in community-based mental health suggests,

> "I think there's a difference between engaging with families from an organizational-level or even from a therapist- to family-level. I think there's something pretty exciting about

> engaging parents within a group …with this understanding of… what do you want to see… for mental health services? What makes sense to you that we haven't even thought of?... [Because it] really is coming at it from a totally different end…it's like coming from the user end and saying 'what is it you want, if you could create this out of a blank slate what would you want?'…As opposed to here's our system we've been working on for years and we keep tweaking, and we really want you to fit into it."

In this way, this provider suggests that the integration of parental voice goes beyond the use prescriptive or standardized surveys and rather suggests that her organization is, "starting from a parental point of view...[and] really asking families 'what do you need?'" Moreover, she proposes that doing so may yield helpful information, such as the need for early intervention programs, which in turn may affect our communities for the better.

4.5.3. Clinical Supervision and Team Consultation

Participants also discussed clinical supervision and/or team consultation as influencing parental engagement. These themes were grouped together for the purpose of reporting since both clinical supervision and team consultation allow clinicians to collaborate and receive necessary support. Three participants speak directly to the importance and/or usefulness of these two factors in services. After explaining that their respective agency did not have an engagement framework, one participant suggests that matters related to engagement surface in supervisor and team meetings; allowing new clinicians to learn how to engage parents in services. This participant also describes how supervision and team consultation helps providers maintain an appropriate stance towards parents and families (section 4.6.2). She says,

> "…I think [a proper stance is]…always encouraged and I think that's why we have supervision. That's what good supervision…and good team consultation will get at…when we're not maintaining that stance."

A second participant likewise mentions how conversations on parental engagement surface in supervision and team consultation. While this participant notes that her organization did not have many formal parental engagement trainings, she explained, "I think we've had a few engagement [trainings] in general but I would say that for our team meetings and supervision we often are talking [about these matters]…but again not formalized."

In keeping with this idea, a third participant speaks about her experience of having a lack of supervision. She states, "I think a lack of adequate support, clinical support is a big issue, at least it was for me." When asked how clinical supervision was connected to fostering parental engagement in services she states,

> "I think clinicians need…to feel supported themselves in order to be able provide the…best quality of service and the most effective [services]… also being able to consult is important in terms of…interventions used, but also if any personal biases are coming up or anything that that may get in the way of working with the parent… even like social location, just being able to process through some of that stuff with a clinical supervisor, I think is really important for effective clinical work."

4.6. Provider-Level Factors

Two provider-level themes were identified: (1) therapeutic alliance and (2) provider stance and perception. Stance and perception have been categorized together, as a provider's perception of a parent/family and of their personal responsibilities as a clinician link to or affect the stance they may have towards the families they are working with. While these two themes (therapeutic alliance and provider stance and perception) are separated for the purpose of reporting, it important to acknowledge that without an appropriate provider stance, the ability for a clinician to build a strong therapeutic alliance would be challenging. Bearing this in mind, below I discuss these two themes in detail.

4.6.1. Therapeutic Alliance

The concept of therapeutic alliance comes up to some degree with all four participants. One provider mentions the idea of parental engagement being possible with relationship building, but argued that doing so took a lot of time, as it was necessary to develop connections.

Unfortunately this is time the participant feels that she does not have to give. Likewise, another participant also notes the influence of the therapeutic alliance on engagement:

> "I noticed when I have that time to really be able to meet the parents where their at and to be able to offer empathy and validation for how hard they're trying and those kind of…therapeutic relationship building type things, I get way more engagement."

Similarly, two participants discuss the therapeutic relationship and the idea of 'rapport'. As one participant states:

> "I think it's developing that therapeutic relationship and that ability to connect and engage, to remain non-judgmental, and curious in how we approach families, so our stance as clinicians…impacts engagement… just being able to…quickly develop that rapport with people, so that…people feel comfortable and safe…"

Interestingly, a forth study participant also utilizes the language of 'connection' as seen in the quote above. When asked about what practices or strategies she was taking to encourage parental engagement in practice, she explains that if she intended to continue working with the parent that she would "slow down and really ensure connection…ensur[ing] that…[the parent] knows that I am on their side, and that we are a team…we are collaborating." Another provider likewise alludes to the importance of collaboration as a successful way to engage parents; namely, collaborating with parents regarding what treatment will entail and what they are personally looking for in services.

4.6.2. Provider Stance/Perception

In addition to collaboration shaping a service provider's approach towards clients, study participants use and describe the word "stance" in many different ways. As noted above, a provider's perception of their clients and their role was also identified as being linked to stance. A key aspect of provider stance includes the quality of being non-judgmental. For example, one provider notes:

> "On a personal level I think I try to just be warm, friendly, curious, supportive, engaging them in their treatment, really kind of helping parents feel like they're understood, that they're doing the best they can…coming from that stance…[Also being] non-judgmental, I really try to be as non-judgmental as possible, because judgment doesn't really help anybody, as far as I can tell. And I find that if I do all those things parents are very engaged."

Moreover, the idea of providers giving validation to parents and/or acknowledging their experiences comes up with three of the four participants. On provider says, "So collaboration, validation, validating their experience of their child's behavior or whatever other concerns are going on…yeah…validation and acknowledgment would be a big one for sure." In the same vein another participant talks about the importance of, "…being able to connect with…parents and…be[ing] able to acknowledge and validate their experiences and the things that might be coming up for them in terms of blocks."

The idea of identifying "blocks" or barriers that parents might be facing in their process of engagement is likewise described by several participants. One provider in particular offers some helpful insights on this idea, saying:

> "I think really just looking at when there is a lack of parental engagement, what is underneath that lack of engagement and the assumptions that we make about what's underneath that for people, and really being able to connect with people around either some of the practical things that are leading to that lack of engagement or…[the] emotional things that are getting in the way of that lack of engagement… and being able to support people in figuring that out…and not necessarily just leaving it as a parents responsibility to figure that out on their own because if they could they would…and they need our support in being able to sort through those blocks."

A related aspect of stance is the ongoing practice of provider's looking for biases or assumptions that they may be holding in relation to the parents and families they are working with. As noted in section 4.5.3 (clinical supervision and team consultation), one provider highlights how clinical supervision was useful for providers in identifying "personal biases [that] are coming up or anything that may get in the way of working with the parent." In the same way that this provider notes the importance of having the space and support to engage in these discussions within supervision, a second study participant also discusses being aware of one's own assumptions or "blocks" that may be arising. She explains,

> "I think sometimes…we are only human…and we can have our own blocks that come up for us…. [so we need to develop] a practice where we're routinely [looking at how] we're experiencing blocks with clients first, looking at how we are feeling about those blocks and being able to address that first..."

Similarly, this provider also notes that supervision and team consultation is helpful when providers are not holding up an appropriate stance towards families. She expresses that maintaining an appropriate stance is something that clinicians strive to do, yet, as noted in the above quote, she identifies that service providers may have their own "blocks" that affect their ability to sustain the stance they desire. In describing this reality, she thus explains that "good supervision" and "good team consultation" may help provider's identify when they are not maintaining an appropriate stance towards their clients.

Another key aspect of stance pertained to the belief that providers had towards parents; namely, the provider's view that parents are *doing the best that they can* and that parents *do well when they can*. Two providers encourage this discourse. One provider explains,

> "…It's important… for us to be aware of the assumptions that we hold…when we're doing this work. So holding the assumption that people are doing the best that they can, and then working around that, to encourage engagement right? So, its our responsibility to hold that sort of assumption and approach [people]…from that position, in order that people…don't feel judged or [so they] can feel like they can have more conversation about what is getting in the way."

In holding to a belief that *parents do they best that they can* and *do well when they can*, or more than this, that "parents for the most part want there families to do well", one participant also suggests that providers should look for ways that they can make engagement easier for parents.

In contrast, another provider expresses being unsure about whether her colleagues would appreciate training on parental engagement, demonstrating a different belief towards parents and her personal responsibilities as a provider. She describes,

> "I don't know, truthfully. Only because… I feel like in a lot of ways it sounds like that's putting the onus on the care providers to engage, and I think… just truthfully, I feel like…our numbers are so high, and we are so spread thin…like you need a lot of energy to engage someone. You need a lot of energy and capacity, to do that work to go the extra mile, and just truthfully, like we don't have that extra capacity…Really where we would operate, in terms of stages of change, is that that person has to be ready for change…[and if they're not] then that person would just get discharged, because…if someone is not ready to change…then we're not going to try and force them."

Subsequently, a notable aspect of stance that one participant suggests is the idea of valuing diversity. This participant highlights the importance of creating services that are inclusive, ensuring a space where "all different groups" can access services. Furthermore, another participant notes the impact of hope (or lack thereof) on a provider's ability to engage parents in services. She describes that if a provider is loosing hope that this feeling can likewise affect the parent; potentially making them "feel like a…lost cause."

4.7. Parental-Level Factors

Two parental-level factors also emerged from the data: parental shame and parental knowledge and awareness. While the purpose of my dissertation was to uncover pertinent organizational- and provider-level factors impacting parental engagement in services, the discussion of these factors by participants warranted their inclusion as themes. Both of these factors also indirectly affect providers and thus relate to the provider-level factors that I sought to uncover.

4.7.1. Parental Shame

Three out of the four participants discuss the effects of parental shame on engagement. In their own way, these providers speak to how shame can impact a parent's ability or desire to engage in their child or youth's services. One provider explains that there are a lot of reasons why parents may not be engaging:

> "Shame's a big ones. You know like when a parent feels shame they can often shut down on us and its not because they don't love their kid or care about their kid or want the best for their family, its because their shame or what's going on for them is so big that they have a hard time engaging."

When asked about where shame came from, another provider notes,

> "Oh so many places…I think there's a lot of pressure on parents…I think it can come from expectations that parents have of themselves, I think it comes from societal expectations, I think it comes from feeling unskillful and ineffective in our relationships. I think it can [also] come from grief…from feelings of hopelessness for the dreams that you had of what you hoped life would look like when you had a child and [then] when you have a child that is experiencing mental health…[it's not what you] expect[ed]….parenting…to look like. I think parenting is hard…and sometimes…we don't realize how hard it is and we have high expectations of ourselves."

Relatedly, one of these participants also notes the effect of stigma on parental and child/youth engagement. She suggests feelings of stigma get in the way of parental engagement, noting that by accessing services parents feel like they are admitting that they cannot do it on their own and can sometimes wonder if requiring services equate to failing or doing something wrong as a parent. Interestingly, when asked where stigma stemmed from, one of the factors that this participant notes was the overall effect of our culture. She suggested that historically, our culture encourages that individuals appear like they have it "all together" and that having such appearance equates to success.

4.7.2. Parental Knowledge and Awareness

The second parental-level theme identified is parental knowledge and awareness. This theme encompasses two main aspects: the first is knowledge or awareness of mental health and illness at large, and the second is knowledge or awareness of mental health services or treatments. With regard to the first aspect, one participant suggests that some of the children and/or youth that she services do not necessarily have a mental health struggle. Rather, she argues that the problems they present result from a "loss of…common parenting skills." She describes this problem:

> "…A lot of parents when they do bring their kids to the hospital…[are] expecting you to fix them…[but] a lot of doctors…[and] a lot of psychiatrists have been saying… 'your child's not listening to you, your child's not attending school, that's not a mental health thing, that's a parenting [thing and a] child-parent conflict'…and I think a lot of that gets put…under the umbrella of mental health, when it is isn't. And for that reason, I think that our systems are strained because people are bringing [in]… children…who have not really been parented, and, they're wanting the hospital to fix their child."

In the same vein, this provider alludes to the challenges that arise when a parent's perception of the problem or solution does not align with what providers and/or organizations believe and offer (e.g., when a parent's lack of understanding about mental health results in a lack of parental engagement). She suggests,

> "… Lets say you have a kid whose anxious or depressed and the parents [are] like, 'oh just get over it, back in my day we didn't talk about these things, people just dealt with it and you just moved on' and they don't agree to bring their child in for therapy where they could… maybe get some…support to address their thought patterns and what not. And so that's where like the buy-in piece comes. Like, if the parent's not equally as on board with the treatment plan being presented or even collaborating…"

Related to a lack of awareness and/or knowledge of mental health services, another participant expresses, "I often feel like people don't really understand what I do." Cultural differences were also described as being influential to a parent's understanding (or lack thereof) of mental health and mental health services. This participant describes some families as having other remedies to 'fix' mental health difficulties (e.g., naturopathic medicine), and so when coming to Canada, the concept of psychotherapy is largely unknown. This provider went on to further discuss the importance of cultural humility.

Subsequently, another participant describes parental knowledge and awareness in terms of a parent's belief in the importance of services and the importance of their role as the parent.

She explains that a “lack of belief in the benefit of this kind of service” might surface for parents and thus affect their engagement in services. Moreover, she suggests,

> “I also think a lack of awareness and education around completely understanding their [(a parents)] impact, like the magnitude of their impact on their child’s well-being, and the importance of the relationship as well. So I think if they don’t know that, or if they don’t really believe that or see that, it’s really hard to kind of sell them on why it’s important for them to be there.”

Bearing this in mind, one participant explains how providers often take on an education role with parents by helping to teach or describe what mental health services involve. She explains,

> “…I think parents come in with…a medicalized model of how you get help. And so… a lot of…the engagement for us, is a lot of education up front…[regarding] what does it mean to get mental health services, why is it different then…how you would have gotten services for…if your child breaks their leg, or if your child has a disease…I think the whole concept of talk therapy, is very very different then say, ‘here’s the medication take this three times a week and you’ll be fine.’”

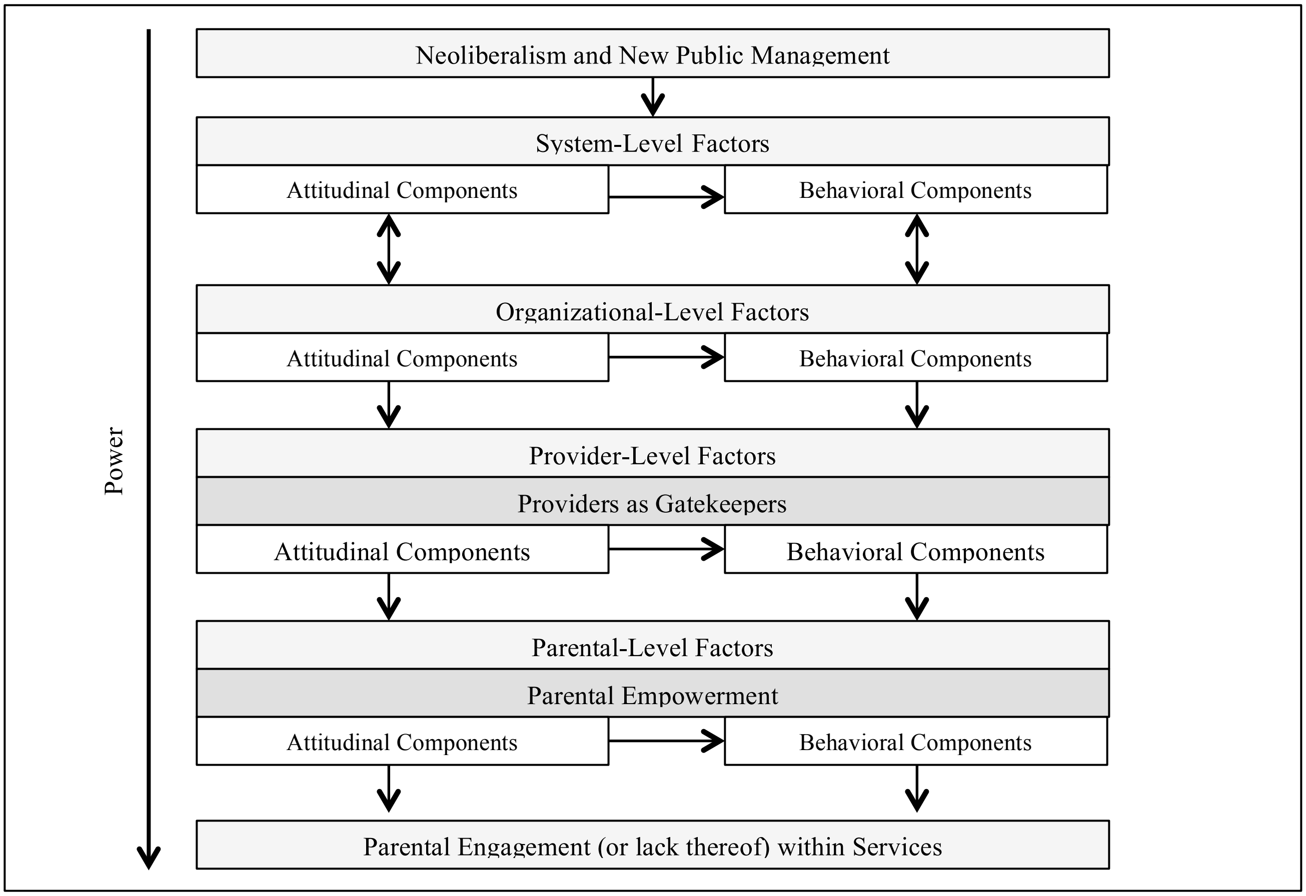
In the same way, when describing practices or strategies used to foster engagement in practice, one participant explains the need to provide families with informed consent and thus clarify the expectations of treatment from the outset. She says, “I think in the beginning it’s being very clear about the expectations around the service that you’re providing…to ensure that…[parents] know what they’re consenting [to]—[so that they are giving] informed consent.” Furthermore, this same participant also highlights a recent training that she attended, which suggests that parents attend a workshop prior to starting treatment. She explains that having parents participate in a workshop prior to staring treatment will “allow parents to have a base-level of knowledge and skill level.” Something that she believes will make a difference to engagement.

Chapter Five: Discussion

Drawing on new literature, as well as literature outlined in chapter two, the following section provides a discussion and analysis of the research findings. A conceptual framework will guide my analysis: Figure 3—as seen below. This framework differs from Figure 2, as it integrates Neoliberalism and NPM at the top of the ladder (demonstrating their influence on all following levels) and also serves to expand the definition of parental engagement by capturing the necessary components for each level of service; namely both attitudinal and behavioral components. *Providers as gatekeepers* and *parental empowerment* were added as reference to discussion that follows (see sections 5.2 and 5.4). Finally, the descending power arrow was added to serve as an analysis of the power relations that exist within a neoliberal discourse and to challenge how power is conceptualized within the child and youth mental health system.

Figure 3

Analysis of Conceptual Framework: Barriers and Facilitators to Parental Engagement



5.1. Definitions and Conceptualizations of Engagement

Interviews of service providers offered insights about the various ways parental engagement was defined. As noted in findings section 4.2, providers generally conceptualized engagement in similar ways. It is noteworthy that providers described engagement in terms of *parents making and attending appointments*. This demonstrates the tendency to define and/or measure engagement in terms of *behavioral components*, and the lack of nuance in provider's definitions as clearly described in the literature. For example, scholars agree that defining engagement in terms of attendance does not capture the concept in the fullness of its meaning (e.g., Gopalan et al., 2010; Stadnick et al., 2016).

In analyzing the information shared by the providers their responses describe aspects of both attitudinal and behavioral components described in the literature. By speaking about engagement in relation to homework completion, parents engaging in dialogue, sharing opinions, or being interested in the therapeutic process participants touched on these more nuanced understandings. Hence, while the discussion of attitudinal components was not always explicit or comprehensive, they did surface to some extent in the complexity of the discussion.

Based on these findings, the similarities in participants' responses to the literature may be explicated. On this basis, I have expanded the definition of parental engagement to include all-levels involved within the child and youth mental health service sector (as seen in Figure 3 above). Parental engagement is a multifaceted process, and thus it necessitates the involvement of several actors (e.g., systems, organizations, etc.) to be facilitated within service. As a result, focusing on the parent-level alone fails to capture other components that are necessary to foster meaningful engagement.

More specifically, in focusing solely on parents, we disregard the complex trickle down affect where our system affects organizations; organizations affect providers; and providers affect parents. Thus, I would argue that while a parent may possess both the necessary attitudinal and behavioral components, this does not equate to successful and/or meaningful parental engagement. Rather, it is necessary to, in the very least, have behavioral and attitudinal components of engagement at a provider- and parental-level, with engagement being further supported when both the system and the organization(s) also possess both components. These ideas are further expanded upon in section 5.4 on provider-level factors.

Furthermore, it is important to note that attitudinal components of engagement (e.g., the belief in the benefit of services) impact behavioral components of services (e.g., homework completion). Simply stated, meaningful behaviors will not exist without a positive belief or attitude towards services. For this reason, the developed figure above (figure 3) outlines the attitudinal components of all levels as informing the behavioral components.

Interestingly, Staudt (2007) details the same idea in her conceptual framework and outlines that attitudinal components are a precursor to behavioral components with both aspects ultimately leading to desired service outcomes. This is prudent to highlight, as one might assume that with the absence of belief, namely, the belief in the necessity/importance of parental engagement (from parents, providers, organizations and systems), that the behaviors that facilitate engagement (e.g., homework completion, non-judgmental attitude, adequate clinical supervision) may not occur; or may only occur in a "perfunctory" manner (Staudt, 2007, p. 186). Consequently, the belief in the importance of parental engagement on behalf of providers, organizations, and systems; as well as the belief in the necessity of services and the importance of their role on behalf of parents; are both fundamental if meaningful engagement is to occur.

5.2. System-Level Factors

As outlined in section 4.4, two main system-level factors were identified as influencing parental engagement: (1) access and (2) service complexity. There is a wealth of literature that identifies the difficulty that parents/families face in accessing child and youth mental health services (e.g., Davidson et al., 2010; Owens et al., 2002). With this is mind, it is important to consider the interplay between access and service complexity; namely, the reality that a fragmented and complex service system impacts a parent's ability and/or desire to access services. So, while it is reasonable to identify the connection between service complexity and access (or lack thereof) to mental health services, the connection between these two themes and parental engagement is seemingly underdeveloped and very intriguing.

In researching access and help-seeking processes in child and youth mental health services, some interesting gaps emerged revealing the need to consider the ways access, service complexity and engagement are associated with one another. For example, in their article, Logan and King (2001) point out that "most adolescents who use professional mental health services require the attention and assistance of adults to facilitate the complex process of seeking and obtaining such services" (p. 320). They argue that help-seeking is a multi-step process; first, the parent gains awareness about their child's distress; the parent identifies the severity of the distress and the need for attention and/or services; and service options are considered and intentions to seek out services are developed. Efforts are then made to seek and obtain services; help-seeking thus ends with the child and/or youth accessing the selected service (Logan & King, 2001, p.323).

Interestingly, in their proposed "parent-mediated pathway" (p.322) to services, Logan and King (2001) capture attitudinal components (e.g., the identification of the need for services) and behavioral components (e.g., seeking-out services) as well as identify barriers similar to those discussed in the engagement literature (e.g., attitudes toward services, history of service use, etc.). These scholars likewise identify that "recognizing a mental health problem…is a complex phenomenon that can be viewed as a process in itself" (p.327) and thus explain how parents can have difficulty in identifying both when and how to seek out help. Still, their article only begins to discuss the pervasive challenges that parents face in accessing and utilizing services; many of which were highlighted in my research findings and in the literature.

For example, since neoliberalism promotes consumerism (e.g., Cosgrove and Karter, 2018) and deems mental health and illness as an individual concern, parents and/or the individual are seen as responsible for their own well-being (see section 2.2). In this context, parents are left responsible to select, navigate, access, and engage in a service on their own. As noted in Figure 3 above, neoliberalism and NPM are situated at the top of the ladder in efforts to demonstrate their permeating effects on systems, organizations, providers and parents alike. Overall, neoliberal discourses of responsibilization and individualism fail to capture the ways that parents and families are impacted in their journey of accessing services. Indeed, it is important to note that the process of accessing and utilizing services is not sequential, meaning that it may not happen in the same way for each family. Hence, I believe a more robust discussion on these barriers is necessary, although some influential factors are highlighted within my findings.

In order for parents to identify the presence of psychological distress and thus begin the process of seeking out services and subsequently finding, securing, navigating and engaging in the services selected, parents/caregivers must possess a certain level of knowledge and awareness about mental health at large and the overall child and youth mental health service system. As noted in section 4.7.2 under parental-level factors, participants identified the need for knowledge and awareness in order to engage and benefit from services. To this point, participants identified a lack of knowledge and awareness as potentially impacting a parent's engagement-level. If a parent does not understand/have knowledge of mental health/illness, then, the likelihood of them successfully identifying the need for services (e.g., recognizing psychological distress in their child[ren]) is far lower, meaning that they would be unable to identify the need to access services in the first place.

Indeed, some scholars term the knowledge and skills necessary to recognize and secure resources for mental health/illness as *mental health literacy* (Kelly, et al., 2007; Mendenhall & Frauenholtz, 2013). They explain, "early recognition and appropriate help-seeking will only occur if young people and their 'supporters' (e.g., their family)… know about the early changes produced by mental disorders, the best types of help available, and how to access this help" (Kelly et al., 2007, p. 26). Thus, programs or tools aimed at increasing *mental health literacy* of parents/families may be prudent if children/youth are to be supported in recognizing their psychological distress and securing appropriate resources. Further research on these matters may likewise be warranted.

In the same vein, a lack of knowledge and awareness surrounding what mental health services entail (e.g., talk-therapy) may lead parents to feel increasingly apprehensive and uncomfortable about accessing and utilizing services. Indeed, this apprehension and lack of comfort, may lead parents to feel hesitant and to disengage from the services they have accessed. Furthermore, participants noted that shame might potentially amplify the propensity for parents to disengage from services. That is, if parents feel shame (as noted in section 4.7.1), then their willingness to access and engage in services may also decrease (e.g., if accessing services is perceived as a personal deficit or failure as a parent—a belief that likewise stems from neoliberal ideology [see section 5.5 for more detail]). Feelings of shame may thus also contribute to a parent's feeling of hesitancy, and likewise stem from a lack of knowledge and awareness of mental health/illness. Relatedly, Mendenhall and Frauenholtz (2013) argue that a lack of knowledge of children's mental health may lead to increased stigma. Therefore, given that parents play a critical role in helping their adolescent(s) (or children) navigate and access services (e.g., Logan & King, 2001), the difficulty parents may experience in accessing and navigating the complex child and youth mental health service system must also be considered.

Beyond this, it is important to consider what one participant noted, that navigating the mental health service system takes "skills or capacity, or money… it requires things that parents…don't have…". Similarly, Rimke (2016) presents this point, explaining how parents face barriers—namely financial—that inhibit their ability to be successful consumers of mental health services. Consequently, parents must not only possess a base-level of knowledge and awareness, but they must also possess skills and resources (e.g., finances) in order to successfully help their child or youth access and receive the necessary services. Moreover, if parents are tired and frustrated, unable to access services during the evening, and/or are receiving conflicting messages from different service providers (i.e., a lack of collaboration between services [as described in sections 4.4.1 and 4.4.2]), then it is reasonable to assume that their engagement in services will be lower. Indeed, scholars list scheduling conflicts as a potential barrier to engagement (Gopalan et al., 2010; Ingoldsby, 2010) and some scholars highlight the importance of "inter-agency collaboration" as enhancing service access; "by making staff in child welfare agencies, schools, and mental health agencies more aware of the service needs and barriers to service use experienced by…families" (Chuang & Lucio, 2011, p.5).

Bearing this in mind, the prudent question may now become a matter of understanding '*how can parental knowledge, awareness, and skills be increased to provide the necessary resources for parents to access, utilize and engage in services*'? Study participants provided some micro or individual-level suggestions to help increase knowledge/awareness for parents including: (1) providing parents with education "up front" in order to increase their engagement and (2) providing a parent workshop prior to beginning services.

With regard to the first suggestion, providing education on mental health and/or mental health services "up front" may indeed be a useful way to increase parental engagement, as it helps to equip families with the necessary knowledge and expectations prior to engaging in services. The second suggestion may be a considered a practical way to facilitate this aim; namely, through the delivery of a pre-service parent workshop. The literature refers to these strategies as "preparatory techniques" (Staudt, 2007), psychoeducation and/or modeling (Becker et al., 2018). For example, Staudt (2007) explain that preparatory "techniques provide information (via videotapes or pre-therapy preparation sessions) about what to expect from treatment, client and therapist roles, and appropriate client behaviors" (p. 189). Furthermore, she adds that the use of preparatory techniques is found to "increase appropriate treatment expectations and knowledge…[as well as] attendance and retention" (p.189).

While these strategies are proven to be useful, they only work to increase engagement and do not address the identified connection between access, service complexity and parental engagement in services. This is prudent to acknowledge as its implications demonstrate that preparatory techniques are found useful once services are selected and accessed by the parent. However, these strategies may be less useful when the parent is in the intermediate stage of selecting services and attempting to navigate the child and youth mental health service system on their own. Therefore, further inquiry may indeed be needed to understand how access, service navigation and engagement connect together and what strategies can be used to bridge this identified gap. Furthermore, as noted above, preparatory techniques have the ability to increase attendance and retention (Staudt, 2007) but they do not necessarily address the issue of parental shame.

Based on this analysis, a potential way to address such complexity may be through parental empowerment. Indeed, the connection between engagement and parental empowerment in the literature is intriguing and thus merits a discussion, albeit a brief one. In their article on parental empowerment in children's mental health services, Olin and colleagues (2010) draw on Gibson's (1995) description of empowerment which, for example, includes parents accepting their child's diagnosis; parents "taking stock" of their resources/skills/capabilities; advocating and collaborating with providers; and perseverance (Olin et al., 2010, p.464). Empowerment is thus viewed as a process, "through critical reflection, empowered parents channel their frustrations involved in caring for their child, enabling them to develop a sense of competence and power to face the reality of their child's diagnosis, take charge, and persevere over time" (p.464).

Furthermore, Olin and colleagues (2010) describe the creation and implementation of the Parent Empowerment Program (PEP) arguing that "to address the gap between children's mental health needs and effective service utilization and outcomes, parents must be empowered to become actively involved in the mental health care of their children" (p.4). The PEP program trains family advocates with the aim of building self-efficacy in parents, to make them capable "agents of change" (p.465). Interestingly, these scholars also suggest that parents who perceive they have skills, knowledge and/or resources to encourage success are more likely to "follow through" (e.g., with initiating services) (p.7).

Furthermore, Fitzsimons and Fuller (2002) explain that empowerment models encourage individual-choice making, acknowledge the power and skills that people possess, and take a strength-based and collaborative approach to working with people. These scholars propose that,

> The outcomes of an empowering approach include increased knowledge, skills and personal growth, a better understanding of one's position in relation to the surrounding social and political forces, and enhanced perceptions of self-efficacy, personal control, self-esteem and political efficacy. (Fitzsimons and Fuller, 2002, p.484)

It is noteworthy to highlight the potential impacts of parental empowerment on a parent's desire and ability to access, navigate and engage in mental health services for their child. If empowerment helps to build confidence, skills and knowledge, then it is reasonable to believe that empowerment can indeed address the complex web of access, service navigation and engagement.

However, while parental empowerment may offer some helpful suggestions in regards to increasing parental knowledge and awareness and providing parents and families with the necessary skills and resources to navigate, access and engage in services, there are some warranted critiques that merit discussion. Most overtly are the ways in which parental empowerment perpetuates a neoliberal discourse of mental health and illness. Namely, a discourse that promotes individualism and choice-making (e.g., Fitzsimons and Fuller, 2002) and thus the responsibilization of parents and families (e.g., Teghtsoonian, 2009). That is, by "empowering" individuals and/or parents to be choice-markers we are encouraging the consumerist approach to mental health that preserves the commodification of mental well-being and mental health services (see section 2.2.2-2.2.3).

Indeed, empowerment focuses on the individual accessing services and as a result, out rightly disregards the role that service providers, organizations, and systems have in fostering engagement and supporting parents and families in their endeavor to access services. More than this, by 'empowering' families to be responsible to select and engage in services on their own, we continue to ignore the societal obstacles and/or social factors that contribute to an individuals sense of poor mental well-being (e.g., unemployment, poverty, etc. [see section 2.2.3]); by focusing on creating capable "agents of change" (e.g., Olin et al., 2010, p. 465) that can fix their own feelings of psychological distress. With that said, I do believe that there is some merit to parent empowerment, as it enables parents to feel confident in supporting their child and/or youth and have fulsome understanding of the services that they are accessing. Therefore, further research on fostering parental empowerment to increase engagement, in such a way that does not perpetuate neoliberal discourse, may indeed be worthwhile.

5.3. Organizational-Level Factors

Through this analysis it is apparent that participants described three main organizational-level themes: (1) expectation and constraints, (2) clinical supervision and team consultation, and (3) organizational stance. Perhaps most obvious within the organizational-level findings is the connection to neoliberalism and NPM. As depicted in Figure 3, neoliberalism and NPM are placed at the top of the ladder to demonstrate their effects on all subsequent levels. However, much of what study participants described was surrounding the direct impact on their work as clinicians. For example, participants identified challenges related to growing documentation and administrative requirements and managerialism, as one provider explained how she met regularly with her manager to ensure her data was correctly inputted. Participants also described an increase in organizational outcome measures/targets, such as when clinicians expressed being responsible to see a certain number of clients/families every week. Moreover, the affect of neoliberal funding models was exemplified with one participant noting that the scope of her work was impacted as her organization was only permitted to service children/youth, without addressing parental mental health. Participants likewise discussed the results of increased caseloads, which lead to decreased time to build relationships with clients. All these above-mentioned effects are discussed heavily in the literature as being influenced by NPM's business-like models of work and neoliberal restructuring (section 2.2 for an in-depth discussion).

This reality demonstrates the trickle-down affect of neoliberalism and NPM explicating where these discourse and models affect systems, systems affect organizations and organizations affect providers (as seen in Figure 3). While these challenges are identified within the organizational-level analysis, much of the problem manifests itself at the provider-level where clinicians are forced to navigate and mitigate the demands placed on them without adequate time and resources. The effects of NPM and neoliberalism do not end with providers, as parents are also left with less effective and responsive services and clinicians. Furthermore, if the same logic is followed, it is reasonable to argue that children and/or youth who are in need of mental health services to help them cope with their psychological distress, are likewise affected. That is, the trickle-down affect outlined in Figure 3 can reasonably continue downward to include children/ youth following the parental-level. This is because children and/or youth are dependent on their parents; and so as the system, organization and providers affect parents, parents thus affect their children/youth (e.g., in their ability to access services [Logan & King, 2001]). Consequently, the child and/or youth who is most in need of services and most vulnerable, has the potential to be most negatively impacted by these broader discourses and models.

Additionally, within the entirety of this process, neoliberal discourses of individualism imply that parents/families are responsible for their child's mental health and well-being (e.g., Teghtsoonian, 2009). In so doing, the state disregards their role in caring for the well-being of their citizens, and more than this, ignores the way that systemic issues (e.g., poverty, racism, etc.) contribute to the psychological distress felt by children, youth and their families (e.g., Cosgrove and Karter, 2018; Rimke, 2016). Such discourses can lead to parents feeling shame (discussed in section 4.7.1) and cause parents to become disengaged from services that their family might benefit from. Likewise, this discussion gives space for the emergence of alternative discourses, some of which will be considered below (in section 5.4).

Subsequently, study participant's insights regarding clinical supervision and team consultation were quite fascinating. While it is commonly known that clinical supervision and/or team consultation is helpful and necessary for clinicians, the connection to parental engagement made by participants is noteworthy. In particular, participants consider clinical supervision and team consultation a place where parental engagement is discussed, a place where providers can reflect on their 'stance' or approach towards parents (e.g., processing social location or personal blocks) and as necessary for effective clinical work (see findings section 4.5.3).

In studying the effects of supervision within child-welfare practice, Collins-Camargo and Millar (2010) explain, "supervision is found in the empirical literature to affect organizational, worker, and client outcomes on many levels" (p.166). Interestingly, these scholars reported that with the use of clinical supervision, clinician's approaches toward families changed (e.g., a shift towards strength-based approaches); there was improved team work/consultation; and it also allowed for workers to spend increased time engaging families (Collins-Camargo & Millar, 2010). Likewise, at a client-level, they noted that clients were “engaged in case planning” while also feeling empowered and expressing “a desire for positive change” (p. 180).

Although the context of Collins-Camargo & Millar’s (2010) study was within child-welfare practice, the findings are noteworthy, not only because they point to the positive effects of supervision on both the provider and client or parental-level, but also because they demonstrate an explicit link to parental engagement. Moreover, it is interesting to note that clinical supervision was described as related to a parent’s feeling of empowerment (Collins-Camargo & Millar, 2010). This finding reinforces the above discussion on the potential for parental empowerment to increase parental engagement within services (see section 5.2).

Similar to this study, interview participants suggest that when clinicians are effectively supported through clinical supervision and team consultation, the work they undertake with clients and their approach towards those clients is improved. This shift in provider behaviors and attitudes thus has the ability to positively influence parents as it enables clinicians to build a strong therapeutic relationship and work more effectively with families. As noted in the above study, not only were clinicians better able to engage parents, but also parents themselves were more engaged in services (Collins-Camargo & Millar, 2010).

Beyond this, the theme of organizational stance (see findings section 4.5.2) demonstrates the need for careful consideration of attitudinal components even within the organizational-level. Thus, I maintain that the definition of parental engagement in services must include attitudinal and behavioral components at all levels (see figure 3 and section 5.1). In this context, attitudinal components may also be described as an *organizational culture;* meaning, the values, beliefs, or ‘stance’ that an organization upholds. In terms of engagement, this may include the organization’s belief in the benefit of parental engagement in services. As noted in the findings section, one participant highlights that her organization's stance was "fundamental". Therefore, if an organization is to see successful parental engagement in services, then they must first believe in the importance of the parental role, a belief that may be demonstrated through their theoretical orientation and/or approach towards families (e.g., participants suggest attachment theory, family systems approach, etc.). Once this stance and/or belief is embedded within an organizational culture, then the behavioral components (e.g., adequate team consultation/ clinical supervision, the integration of parental voice in services, etc.) can be properly attended to and implemented in services.

Organizational stance was also linked to the integration of parental voice in services. For example, the CYMH (2016) also advocates for parental voice in services explaining:

> At the organizational level, family engagement involves integrating families' perspectives across governance, programming, policy and evaluation activities in agencies. Facilitators of family engagement in this sphere include ensuring commitment from leadership to take up family engagement as a key process, [and] modifying organizational structures and processes to integrate the family voice. (p.4)

The integration of the parental voice in services demonstrates that organizations value parental insights and are willing to modify their services to meet parental needs. It is noteworthy that one provider detailed that the integration of parental voice must go beyond standardized surveys, and instead involve asking families what they need rather than asking them to fit into an existing system. Indeed, standardized evaluation surveys can easily become a 'check-list' responsibility that provides the appearance of parental engagement and voice in services, when in reality, such surveys fail to get to the root of the problem and to foster constructive feedback from parents. The use of standardized evaluation surveys also relates to proponents of NPM, as they may be used to capture necessary outcomes and statistics to secure funding (see section 2.2.3).

5.4. Provider-Level Factors

As described in findings section 4.6, two provider-level themes were identified: therapeutic alliance and provider stance and perception. Stance and perception have been categorized together because a clinician's perception of their role/responsibilities and the parent/family as a whole has the ability to affect their stance towards their clientele. Moreover, these themes (therapeutic alliance and stance/perception) are intertwined, as a therapeutic alliance between parents and providers cannot be fully achieved without a suitable provider stance (e.g., providers being non-judgmental, validating, etc.).

A working therapeutic alliance has been highlighted in the literature as being important to parental engagement in services (e.g., Gopalan et al., 2010; Haine-Schlagel & Walsh, 2015). For example, Kerkorian, McKay, and Bannon (2006) found that a parent's previous experience of feeling disrespected by a clinician made them six times more likely to (1) doubt the usefulness of services and (2) identify barriers to treatment access (as cited by Gopalan et al., 2010). Moreover, Thompson, Bender, Lantry and Flynn (2007) explain therapeutic alliance in terms *of task alliance* (e.g., agreement on treatment goals) and *relationship alliance* (e.g., the development of rapport [p.40]). These scholars note that both components of alliance are necessary and explain, "therapy devoid of a positive alliance is likely to result in a treatment interruption or termination…Alliance formation is needed to bond with each family member in a way that increases their commitment to the therapeutic interaction and enhances outcomes" (p.40-41). With that said, the above section on organizational-level factors demonstrates the ways in which providers are inhibited (e.g., as a result of NPM practices) or encouraged (e.g., through clinical supervision) to foster a positive therapeutic alliance and thus parental engagement in practice.

Bearing this in mind, a key aspect of a provider's role is being a "gatekeeper" (see Figure 3). That is to say, that service providers have the ability to resist or exasperate the effects of the organization(s), system and broader discourses in society. Thus, in section 5.1 above, I argue that in order to fulsomely capture meaningful parental engagement in services, both attitudinal and behavioral components at the parental- and provider-level must exist. While the existence of these components at the organizational- and system-level can enable providers to better foster engagement in services, I argue that their presence is not entirely necessary. This is because providers, if needed, can act as gatekeepers and strive to foster engagement regardless of the attitudes and behaviors of their organizations.

However, it is important to highlight that I identify that the act or role of being a 'gatekeeper' is a temporary solution. Indeed, if our systems/ organizations continue to act in ways that force providers to mitigate the effects of these broader discourses and/or work models, then we are creating and perpetuating a harmful work environment that has the ability to lead to burnout and increased rates of turnover. Thus, while I discuss below ways in which providers can act as gatekeepers through overt and covert resistance; I believe that it is necessary to highlight that while resistance is at times a viable action, it does not absolve organizations and systems from their need to change and resist broader discourses in their own right. Particularly, the weight of change cannot fall solely on the shoulders of front-line clinicians and staff.

Bearing this in mind, one way that service providers can act as a gatekeeper is through resistance. Fine and Teram (2013) acknowledge that resisting moral injustices in the workplace can be "complicated and risky"; doing so may require providers to risk their work status and face potential repercussions (Fine and Teram, 2013, p. 1313). With that said, in their study these scholars delineated the ways in which participants undertook both covert and overt action to address injustice in their workplaces. In delineating these two forms of actions, they explain that covert actions are often more risky and that overt actions can lead to greater change within organizations (Fine and Teram, 2013). Nevertheless, both form of actions are useful and have their place in one's effort to enact change. Interestingly, these authors also suggest that social workers taking on advocacy roles by means of covert and overt actions are important because "the social service environment appears to become increasingly neoliberal and managerial in perspective, which, by its nature, does not necessarily cater to social work values" (p. 1315). This reality was also discussed in section 2.3.

For providers working within child and youth mental health services, both overt and covert actions may be able to mitigate the affects of neoliberalism/NPM and thus shield parents and families from harmful discourses and other negative affects. For example, service providers can specifically and overtly express the burden of documentation or their need and desire for specific training material to supervisors, managers and other organizational leads; advocating for change in these areas. Alternatively, providers may choose to engage in covert actions. Fine and Teram (2010) explain that covert actions:

> …are a product of the realization by social workers that great energy and time are required to change large systems and, most importantly, the potential harm for clients waiting for the system to change. Although covert actions do not change systems, they do affect the lives of individuals who are being 'un-served' by these systems" (p. 1325).

Thus, to covertly aid families on an individual-level, providers may, for example, choose to delay their documentation duties to spend more time with families or ask for their own critical feedback of services so that they may better foster engagement in practice. Indeed, Greenslade and colleagues (2015) summarize some literature that reports on covert or "micro" actions that social workers take in resistance efforts; namely, actions that are taken when their professional values do not align with their workplace responsibilities (p. 424). These include but are not limited to, “looking the other way when clients did not comply with directives, ‘creatively’ filling out forms…being flexible with rules and laws…[and] expanding entitlements for clients who do not officially meet eligibility for services” (p. 424). While these actions may seem small and inconsequential, as Fine and Teram (2010) argue above, they have the ability to positively impact the lives of individuals who are accessing services.

Another key finding developed through my analysis under provider-level factors is the emergence of new discourses as it relates to a clinician’s stance towards parents. A few study participants talk about the perspectives that providers should have of parents, including that *parents are doing the best that they can* and that *parents do well when they can* (see finding sections 4.6.2). These findings are noteworthy because these perceptions of parents are in direct contrast to what the dominant neoliberal discourse would project. As mentioned previously (see sections 2.2.2 and 2.2.3), neoliberal ideology would promote individualism as it locates mental health and well-being within the individual, parent or family, and thus makes them responsible for the own mental health (e.g., Cosgrove and Karter, 2018; Teghtsoonian, 2009). Neoliberalism also frames mental health as an economic concern and thus pathologizes individuals who cannot contribute to the market as a result of their mental health condition (e.g., Esposito & Perez, 2014). Upholding that *parents are doing the best that they can* prevents pathologizing individuals; rather than seeing them as ‘abnormal’ this new belief demonstrates that providers understand the difficulties that parents face and thus empathize with why a family may be struggling.

Consequently, the neoliberal view of mental health and illness is focused on the individual. Through this perspective, families are seen as holding the blame for their own psychological distress and are labeled as ‘lazy’ or ‘incompetent consumers’ when they do not properly engage in mental health services for their child(ren) and/or youth(s). As such, it is prudent that these alterative discourses (that *parents are doing the best that they can* and that *parents do well when they can*) emerge, not only because they serve as an act of resistance towards the more dominant discourses (e.g., Fook, 2012), but also because they may help to change a provider's perception of parents. This change in perception may indeed have the ability to change a clinician's stance towards parents (e.g., making them increasingly non-judgment and more empathetic) while also strengthening their therapeutic alliance, which has been noted as an effective way to foster engagement in practice (e.g., Haine-Schlagel & Walsh).

Moreover, if providers are able to effectively communicate this perception (e.g., that they are doing the best that they can) to parents, then these discourses also have the power to decrease levels of parental shame that may discourage parents from fulsomely engaging in their child/youth's mental health care (see section 5.5 for more details). Accordingly, these new discourses are not only useful for providers in their efforts to deliver effective services and build a strong therapeutic alliance, but likewise in their ability to be beneficial to a parent's own perception of themselves/ their children and thus their own psychological well-being.

Bearing this in mind, it is prudent to highlight that while these emerging discourses are helpful (e.g., that *parents are doing the best that they can*); there is still a ways to go in order to further challenge the dominant neoliberal discourses surrounding mental health and illness. Though the belief that *parents are doing the best that they can* and *parents do well when they can* is an improvement and may help to elevate a measure of shame or self-blame that parents and families experience, they still persist to locate problems within the familial unit; and thus fail to capture the complex social factors that contribute to the mental well-being of children/youth and their families. Namely, the "best" the parents and families can achieve is still constrained by their personal circumstances, which point to broader societal obstacles they may experience (e.g., precarious employment and housing insecurity). Therefore, further thought regarding matters related to alternative discourses that can serve to resist neoliberal thought my indeed be prudent.

5.5. Parental-Level Factors

The final two themes categorized under parental-level factors are (1) parental shame and (2) parental knowledge and awareness. While the purpose of my dissertation was to uncover provider- and organizational-level factors that are hindering or facilitating parental engagement in services, the inclusion of these themes was necessary as they impact both providers and organizations alike. It is this connection that I aim to demonstrate in the analysis that follows.

With regard to parental shame, study participants discuss how shame might cause parents to disengage or "shut down" when accessing services and/or working with clinicians. Service providers highlight that shame comes from various places (e.g., societal expectations, feelings of hopelessness, etc.), with one participant also mentioning the concept of stigma; stigma has been included in this theme as it can produce shame in parents (see findings section 4.7). As noted in my literature review, stigma has been discussed as a perceptual barrier to engagement for children, youth and parents/families (e.g., Bornheimer et al., 2018; Stadnick et al., 2016). In contrast, parental shame has seldom been discussed in the literature as it pertains to engagement in services.

With that said, Scarnier and colleagues (2009) discuss the concepts of shame and guilt at large, describing how these emotions relate to the parent-child relationship. They explain that shame often leads to individual's distancing themselves from the event(s) or circumstance(s) that have produced these emotions (Scarnier et al., 2009). With regards to the parent-child relationship, these scholars suggest that parents can feel shame as a result of their child's wrongdoing and sense of "shared identity" (Scarnier et al., 2009, p. 206). They state, "…because [a parent's]…own sense of identity is likely to include their child and their role as a parent…their child's wrongdoings [thus] threaten this identity" (Scarnier et al., 2009, p. 206). In contrast, they explain that guilt in parents relates to the "interdependence" that exists between the parent and the child. Therefore, parents may experience feelings of guilt because there is an expectation that they control and/or influence their child's behavior; if a child acts wrongly, then the parent receives blame (or blames themselves) for their lack of intervention (Scarnier et al., 2009).

Moreover, such perception of one's self may be related to stigma, as stigma categorizes and devalues individuals in society, thus linking their identity to a "group with lower social power" (Heflinger & Hinshaw, 2010, p. 61). Since mental illness is stigmatized, parents may feel blame and thus shame and/or guilt for their child's feelings of distress.

The potential connection between stigma and shame is noteworthy, however, it is also important to consider how parental shame links to other preceding service levels outlined in Figure 3. For example, parental shame relates to neoliberalism (the top of the ladder), as stigma and shame ultimately stem from broader neoliberal discourse. This is demonstrated foremost through neoliberalism's belief in individualism and depiction of normalcy, which may be unachievable for individuals who are experiencing a mental health problem (see section 2.2.2). This is why the emergence of new discourses and counter-narratives are prudent (like those mentioned above), as they serve as a form of resistance, to mitigate the effects of broader neoliberal underpinnings, and potentially reduce feelings of parental shame or stigma that lead parents to disengage from services.

Beyond this, parental shame and/or stigma also relates to the provider-level since providers have the ability to put in place interventions that may mitigate or exasperate the effects and/or feelings of shame by parents. Indeed, Stadnick et al. (2016) highlights how stigma can arise from interactions with a therapist, with some scholars suggesting that negative attitudes from staff members can act as a barrier to engagement (Kruzich et al., 2003 as cited by Chovil, 2009, [see section 2.4.3.]). Whether perceived or actual, stigma may hinder the development of the therapeutic alliance, which is necessary for facilitating meaningful engagement in services. This discussion thus demonstrates the interconnectedness of levels (Figure 3); neoliberalism creates and projects the discourses that produce parental shame and providers are tasked with mitigating the behaviors that arise because of shame (e.g., avoidance). Thus, the complexities behind cultivating parental engagement in services are indeed multifaceted.

The final parental-level factor, parental knowledge and awareness, is likewise influential to a provider's role. As described in section 4.7.2, study participants noted that knowledge and awareness (or lack thereof) of mental health/illness and mental health services could influence whether or not a parent engages in their child/youth's care. Matters related to parental knowledge and awareness is discussed heavily under system-level factors (section 5.2). To briefly reiterate, providers and organizations must play a role in educating parents about mental illness and should clearly convey the benefits of services. In so doing, parents may feel more equipped/empowered to access services, may be able to identify mental health issues earlier on (therefore avoiding crisis later), and may feel more at ease knowing what to expect when they do indeed engage in service. Cumulatively, these changes could increase the identification rate of mental illness in children/youth and thus increase the number of individuals/ families accessing services. Both of which have been an identified issue in the literature (e.g., Pescosolido et al., 2008).

Furthermore, even when services have been accessed, parental beliefs or understanding of services may be clouded by stigma, shame or even one’s up-brining (as one study participant alludes to), heightening the need for organizations and providers to raise awareness about what mental health is and means, what services entail, and which services are available in their communities (something which some scholars note is lacking, e.g., Pescosolido et al., 2008).

5.6. Power

The final discussion I wish to outline is surrounding power. As presented in Figure 3 above, there exists a descending arrow of power pointing downward from neoliberalism and NPM to parental-level factors. The purpose of this arrow is to represent how power is traditionally *portrayed* and to facilitate a more nuanced discussion of how power is dispersed within child and youth mental health services.

As the arrow in Figure 3 demonstrates, power is traditionally viewed as being held by dominant groups in society and is something that other “subordinate groups” lack (Mullaly, 2010); a philosophy often associated with a Marxist perspective. Indeed, within the context of child and youth mental health services, our systems, organizations and providers would possess power as the dominant or “professional” care providers; whereas children/youth and/or parents would be considered subordinated and thus do not possess this same power. It is this binary view of power that keeps the system powerful and the service user powerless, that neoliberalism would endorse and aim to uphold in our society and systems.

In contrast, a post-structural perspective would argue that power is distributed among members of society and is not akin to a select few (Mullaly, 2010). For example, Foucault “argued that power is a much broader and complex phenomenon in that it is not an absolute possession of the ruling class but a result of interactions between individuals, groups, organizations and institutions" (Mullaly, 2010, p. 237). It is this understanding of power as operating at several simultaneous levels that I wish to discuss here.

Generally speaking, parents may be perceived as powerless or as possessing limited power in comparison to their service provider, the organization that they have accessed services from, and the broader mental health system. This is indeed how I was conceptualizing power, even in my previous discussion on Critical Social Theory and Critical Social Work (see section 3.2.1 and 3.2.2). However, seeing parents as powerful to change and/ or resist services may be useful when contemplating parental engagement. For example, a parent may be deemed as being 'disengaged' if they disagree with their child's treatment plan or mental health diagnosis. Conversely, such "resistance" to professional opinion may also be perceived as (1) engagement by means of resistance and/or (2) an exercise of power to challenge, for example, the standardized assessments and medicalization of a child's mental health. Indeed, adherence and engagement are two different concepts, and so what providers, organizations and systems deem as disengaged may actually be an expression of a very engaged parent. More than this, what if providers, in collaboration with parents and families, were able to identify this 'alternative' form of engagement and thus work with parents to resist against organizational expectations and broader societal discourses (e.g., neoliberalism).

Bearing this is mind, it would be interesting to further explore how parents exercise their power and how their expression of power (e.g., resistance to a treatment plan) is perceived by providers and organizations. Moreover, further research surrounding how providers can encourage and/or support parents as they exercise their power and engage in 'alternative' forms of engagement may likewise be a prudent area to investigate.

Chapter Six: Conclusion

While engaging parents and families in services may seem like a task that takes place between providers and parents, this research has uncovered the effects of various service levels (e.g., organizations, systems, etc.) and broader discourses (i.e., neoliberalism and NPM), that may impact the ability to foster engagement in practice. Indeed, this study demonstrates the system-, organizational-, provider- and parental-level factors that hinder and facilitate parental engagement in child and youth mental health services. Much of the engagement literature fails to identify these complex processes and instead focuses heavily on parent-, family- and/or child-level factors (e.g., Haine-Schlagel & Walsh, 2015). This research thus identifies the need to consider broader contexts and discourses in efforts to improve services for children, youth, parents and families as a whole.

Relatedly, this study underscores the need to further nuance the definition of engagement in a way that includes the roles of providers, organizations and systems. Indeed, definitions of engagement that focus on parental attitudes and behaviors lack depth, and thus fail to capture the components that are necessary to foster engagement within the child and youth mental health service system. To this end, it is proposed that the definition of engagement be expanded to include behavioral and attitudinal components at all-services levels (e.g., systems, organizations, etc. [see section 5.1]).

Moreover, this study highlights the need to enact change within our organizations and systems; to resist against dominant discourses that impose the responsibilization and individualization of mental well-being and/or constrain the work of service providers through NPM business models. Indeed, challenging traditional conceptualizations of engagement (e.g., adherence to professional treatment plans), power (e.g., challenging the notion that parents are powerless), and resisting the ways providers and/or our broader society perceive parents and families who utilize the mental health system (e.g., stigma), may be a prudent way to resist discourses that are restrictive and oppressive to children and families accessing mental health services.

6.1. Implications

This research has several implications for different stakeholders. At an organizational- and system-level, efforts should be taken to assist service providers in delivering effective services to better suite family needs; integrating parental voice and supporting parents in accessing services should also be considered. Policy makers are likewise encouraged to mandate the inclusion of parental voice and to better streamline access and service navigation on a broader systems-level. Similarly, service providers are urged to consider their stance towards families and to work with parents in ways that are both empowering and encouraging. Furthermore, parents are encouraged to consider how they can use their power for resistance and their voice to provide critical feedback to improve organizational and provider service delivery.

Bearing this in mind, the following sections list relevant implications of my research for (1) organizations and the mental health service system at large; (2) policy makers; (3) service providers; and (4) parents and families accessing mental health services for their children/youth.

6.1.1. Organizations and the Mental Health Service System

The children's mental health system /organizations should consider:

- How they can mitigate the impact of their current workplace exceptions (e.g., documentation requirements) on their providers
- Offering and/or requiring providers to attend parental engagement trainings on a yearly basis (i.e., to continually develop skills and knowledge)

- Developing and disseminating an organizational stance that endorses the involvement of parents in services
- Developing a formalized parental engagement framework (see section 6.3)
- Working to deliver and/or strengthen the provision of clinical supervision and team consultation to support providers in their therapeutic work with families
- Providing a parent-specific workshop previous to service access to help increase parental knowledge/awareness and provide a base-line of skills for therapy and service navigation
- Identifying ways to actively include parental voice and feedback into service delivery

6.1.2. Policy Makers

Policy makers should consider:

- Developing policy that mandates the creation and implementation of parental councils or voice into services
- Ways to improve the overall child and youth mental health system to both streamline and improve access, as well as increase the ease of service navigation

6.1.3. Service Providers

Service providers should consider:

- How to empower parents and address alternative barriers to engagement that extend beyond individual parental responsibility (i.e., thus resisting neoliberal discourses)
- How they approach parents in their work (e.g., in non-judgmental ways) and thus routinely engage in reflexive practice
- Ways to strive for and engage in cultural humility (see section 6.3)
- Ways to raise consciousness in families; so as to resist neoliberal discourses (e.g., individualism) and communicate new messages to families (e.g., that they are doing the best that they can [see section 5.4])

6.1.4. Parents and Families

Parents and families should consider:

- The ways that they can exercise their own power to resist harmful organizational expectations (i.e., adherence does not constitute engagement)
- How they can participate in providing critical feedback regarding areas for organizational and service delivery improvement (including how providers and organizations can better foster engagement in services)

6.2. Limitations

This study has several limitations worth mentioning. First, only four service providers working within child and youth mental health services were interviewed. As a result, the level of information accessed through the interviews and findings developed through analysis are limited and may not reflect the range of opinions held by an array of service providers working within child and youth mental health services. Furthermore, because of this small sample size, my study was unable to utilize all aspects of Constructivist Grounded Theory. Namely, it was unable to participate in theoretical sampling and reach saturation. Therefore, the presented conceptual frameworks in my study should not be upheld as solidified theories, but rather as emerging ideas to be studied further. Relatedly, this study employed a snowball-sampling recruitment method, which may result in sampling and confirmation bias. For example, it is possible that initial participants recruited individuals from their social circle and/or workplaces that share similar opinions and perspectives. As a result, the sample may lack diversity.

Furthermore, my sample was not homogenous as I interviewed an individual from an outpatient mental health clinic as well as individuals working in community-based mental health. In future studies, it would be interesting to interview more participants from both settings and compare results to see how parental engagement differs within each setting. This may thus provide more specific and/or contextual findings to improve parental engagement in services. Moreover, this study took place within the context of Ontario; contextual factors should thus be considered (e.g., how government funding of community-based organizations can impact caseload volumes) for the purpose of determining the relevancy of findings to other contexts.

Finally, with regards to parental-level factors and themes described by interview participants (namely, parental shame as well as knowledge and awareness), it is important to highlight that providers perceived these descriptions. Given that this study did not interview parents, it is possible that parents themselves may have differing descriptions about barriers and facilitators to parental engagement in services. Hence, in order to determine the accuracy of provider's perceptions, future research should focus on interviewing and comparing both parents and service provider responses.

6.3. Areas for Future Research

A number of other areas for future research are worthy of consideration. For example, my research yielded minimal discussion on the potential intersection between culture and engagement. Two providers vaguely discuss how a parent's/family's culture may impact how they engage in services or their understanding of what child and/or youth mental health services entail. One provider specifically notes the importance of cultural humility (rather than cultural competency) as it pertains to a provider's stance. The intersection between culture and parental engagement is indeed noteworthy and future research should seek to uncover how provider's work with families whose culture is different than their own. Research should also consider different cultural understandings of mental health at large and mental health services, as well as discover ways in which our systems and services can adapt to be more accepting and valuing of diversity in practice. Exploring matters related to cultural humility in services, rather than cultural competency is important.

Furthermore, as it relates to power (see section 5.6), further research that explores the concept of resistance and engagement may likewise be prudent. Indeed, making a clear distinction between *adherence* and *engagement* may give rise to an interesting discussion surrounding how parents can resist traditional and harmful conceptualizations of engagement. Such discussion may help to alter provider and/or organizational perceptions of a “disengaged” parent, discover ways in which providers can collaborate with parents in resistance, and so create space for change in our systems.

Beyond this, all study participants allude to their organization of practice as lacking a formal engagement framework. Regardless of the absence of formal practices, some participants believe that the development of a framework could be useful; as it can bring common understanding to providers of different training and educational backgrounds and thus foster collaboration. Thus, researchers should consider developing an engagement framework that is specific to child and youth mental health organizations.

In this context, it is prudent to highlight that the purpose of such a framework is not to standardize practice or to perpetuate NPM work models. Rather, it is to provide a tool or guide that can support providers having difficulty engaging parents in services. In conducting research in this area, matters related to standardized practices and leaving room for worker discretion and creativity should also be considered. The integration of parental voice in the development of an engagement framework should also be contemplated, as parents may have useful ideas and suggestions on how such a framework should be developed and engaging parents is after all, the over arching goal.

Another area for future research pertains to the ‘continuum of care’ or how engagement looks different or is affected differently at distinctive points of the service continuum. Considering the barriers parents face when entering services for the first time, while receiving ongoing service, and when seeking services for a second or third time may indeed be useful if our systems, organizations, and providers are to better facilitate parental engagement in service. For instance, identifying where parents/families most often disengage along the continuum of care may allow for the creation of targeted strategies to help strengthen the likelihood of retention and engagement in services.

Likewise, it would be interesting to see how parental engagement and the mental health service system as a whole is impacted by an increase of preventative (rather than crisis) work with families. One study participant notes that much of her therapeutic work is achieved only after children/youth went into crisis, and when speaking about matters related to parental voice in services, a second participant alludes to the potential usefulness of preventative work (e.g., workshops for parents of young children) on communities. As such, the connection between crisis and engagement and/or preventative work and engagement may be a fruitful area to explore. Furthermore, the connection to preventative/crisis work and neoliberal discourse should also be considered when conducting such research; neoliberalism’s discourse of individualism/ responsibilization is in direct opposition to preventative community work (i.e., collectivism) and therefore warrants discussion and exploration.

Overall, future research that seeks to answer the same questions of this study would likewise be necessary. Given that this study did not interview many participants, it would be interesting to see if the same findings would surface if more participants were interviewed. Integrating parental opinions regarding matters related to provider-, organizational- and system-level factors may also be prudent in future studies. If the overall purpose or goal of this research is to enhance parental engagement, it is important that parents/families are included in research itself so that their voices are heard.

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Appendix A
Screening Questions
A Study of Organizational- and Provider-level Factors Impacting Parental Engagement in Child and Youth Mental Health Services.

Name: ________________________

In order to determine your eligibility for my study please read the following statements. If these statements are true check 'yes', if they are not true check 'no.'

1. I hold more than one client on my caseload.
[ ] Yes
[ ] No

2. I work directly with children and/or youth and they are the primary cliental that I serve.
[ ] Yes
[ ] No

3. In my work, I have some connection with the child and/or youth's parents and/or family.
[ ] Yes
[ ] No

4. The purpose of my job is to enhance/improve mental health and to promote well-being.
[ ] Yes
[ ] No

5. I currently work or have previously worked in a community-based/ outpatient child and youth agency within the Greater Toronto Area (GTA).
[ ] Yes
[ ] No

6. I have been working at this agency for at least two years or within the past 5 years.
[ ] Yes
[ ] No

7. I am an adult (over the age of 18).
[ ] Yes
[ ] No

8. I am English-speaking.
[ ] Yes
[ ] No

9. I have an active email and telephone number I can use for this study.
[ ] Yes
[ ] No

Appendix B

LETTER OF INFORMATION

A Study of Organizational- and Provider-level Factors Impacting Parental Engagement in Child and Youth Mental Health Services

Student Principal Investigator:
Ms. Leah Burton
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Faculty Supervisor:
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Purpose of the Study
This study is being completed as part of the requirements for my Master of Social Work Degree. I am hoping to explore workers understandings and experiences of parental engagement in the context of mental health services for children and youth. Literature indicates that engaging parents in child and youth mental health services is important for achieving positive service outcomes. However, it also indicates that engaging parents in services remains a challenge for service providers. With this in mind, this study aims to discover how service providers working in child and youth mental health services define/understand parental engagement; why engaging parents in services remains a challenge; and specifically, what organizational-level factors contribute to this challenge.

Procedures Involved in the Research
In order to conduct this research you will be asked to participate in a single telephone interview. I, Leah Burton, will conduct the telephone interviews. I anticipate the interviews will be approximately 60 minutes in length. With your permission, telephone interviews will be audio-recorded and transcribed to support analysis. During the interview I will be asking you questions such as:

1. How would you define “parental engagement”?
2. What makes engaging parents in services a challenge?
3. If you could change something within your organization that would make engaging parents easier, what would you change and why?

I will also be asking you for some demographic/background information, such as the length of time you have been working for your organization and your role/title. For a full copy of interview questions please see the email attachment labeled “Interview Guide.” Further, please be aware that your participation in this study is completely voluntary and you can choose to withdraw from the study, both during and after you interview is complete. You will have up until 2 weeks after your interview date to withdraw. I describe more about your right to withdraw from my study below.

Potential Harms, Risks or Discomforts

The risks involved in participating in this study are minimal. You may feel uncomfortable answering questions related to your organization's policies, procedures, etc. if you have any negative opinions to share regarding how your work is being impacted. As such, you may find it worrying to speak openly about your work and your place of employment, as you may fear potential employment related consequences for your responses.

You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. Moreover, all of your identifying information (including your current or previous place of employment) will remain confidential and unnamed in the research study. Furthermore, telephone interviews will be scheduled at your convenience, to ensure that you can find and utilize a confidential space. It is also encouraged that you use personal contact information (i.e., phone number and email address) when participating in this study, as opposed to work related contact information. I describe below the steps I am taking to protect your privacy.

Potential Benefits

The research may benefit you as a service provider as the results may provide you with an opportunity to reflect on and share your experiences. Your knowledge may also help me to develop recommendations for organizations providing child/ youth mental health services about enhancing parental engagement in practice. With that said, there is no guarantee that you will benefit from this research study. These above mentioned benefits are only potentials, and thus, you may not benefit directly.

At large, this research also has the ability to contribute to existing literature on this topic. It may do so in such a way that begins to fill an identified gap in research, thereby contributing to knowledge that will ultimately better support children, youth, and families who are utilizing the mental health service system.

Confidentiality

You are participating in this study confidentially. I will not use your name or any information that would allow you to be identified. I will be the only person who knows about your participation in the study. When data is being analyzed and presented, all information will be de-identified so that you are not connected to the research study in any regard. A pseudonym name will be used in place of your name to ensure confidentiality. Furthermore, your place of employment will remain unnamed. I also may use direct quotes from our interview together. However, direct quotes will not include any identifiable information and a pseudonym will be attached to the quote to ensure your confidentiality.

Telephone interviews will take place from a quiet and confidential space in my home office, at a time that is most convenient for you. You are asked to consider finding a confidential space when participating in this study and you are strongly encouraged to avoid using organizational spaces, computers or telephones when completing the interview and other activities related to this research.

The information/data you provide will be kept on an encrypted USB and locked in a desk/cabinet where only I will have access to it. Information kept on a computer will be protected by a password. Audio-recordings of our interview will also be kept on this USB until I transcribe them. Once they are transcribed (for the purpose of data analysis), original audio-recordings will be destroyed and only transcription documents will remain on the encrypted USB. Oral consent logs will also be stored separately on the encrypted USB. Once the study is complete, an archive of the data with identifying information will be maintained for 1 year after my graduation date. Afterward, identifiable data will be destroyed, and only de-identified data will be maintained. De-identified data will be kept indefinitely for the purpose of potential future research.

Participation and Withdrawal

Your participation in this study is voluntary. If you decide to be part of the study, you can stop (withdraw), from the interview for whatever reason, even after giving consent, partway through the study or up until 2 weeks after your scheduled interview date; when I will have begun to analyze your interview materials and have combined your information with other participants interview results.

If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any data you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

Information about the Study Results

I expect to have this study completed by approximately September 2020. If you would like a brief summary of the results, please let me know how you would like it sent to you.

Questions about the Study: If you have questions or need more information about the study itself, please contact me at:

Burtol1@mcmaster.ca

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Secretariat
Telephone: (905) 525-9140 ext. 23142
C/o Research Office for Administrative Development and Support
E-mail: ethicsoffice@mcmaster.ca

Appendix C

Interview Questions
PARENTAL ENGAGEMENT IN CHILD AND YOUTH MENTAL HEALTH

Leah Burton, BSW (Master of Social Work Student)
(School of Social Work – McMaster University)

Information about these interview questions: This gives you an idea of what I would like to learn about parental engagement. Interviews will be one-to-one and will be open-ended (not just "yes or no" answers). Because of this, the exact wording may change a little. Sometimes I will use other short questions to make sure I understand what you told me or if I need more information when we are talking such as: "*So, you are saying that …?*, to get more information ("*Please tell me more?"),* or to learn what you think or feel about something ("*Why do you think that is…?").*

Before we get into a discussion on parental engagement, I am going to take a minute to ask a few questions about you. I am seeking this information to better understand who is taking part in my study. This information may also be used during my data analysis and be reported on in my published thesis project. However, identifiable information will be not be used in order to ensure your confidentiality.

Information about you:

1. What organization/ agency do you currently work for/did you work for in the past?
2. How long have/ did you work in this organization?
3. What is/ was your role or title within your organization (e.g., therapist, counselor, child and youth worker, etc.)?
4. What is your educational background?
5. What is your gender identity?

Definition of Parental Engagement

1. How would you define parental engagement?
2. Do you think that engaging parents in their child or youth's mental heath services is important? Why or why not?
3. What does parental engagement look like? What doesn't it look like?
    a. What behaviors and attitudes demonstrate to you as a service provider that a parent is engaged?

4. Whose responsibility do you think it is to engage parents in services? (i.e., parent's responsibility, provider's responsibility, child/ youth's responsibility). Please tell me more about why you think that?

5. Are their any practices or strategies that you implement in your practice in order to encourage parental engagement? If so, what are they?

Challenges to Engagement

1. What makes engaging parents in services a challenge?

2. Are their organizational-level factors that contribute to this challenge? Please tell me more about why you think that?

    a. Does your organization have an engagement framework or model that they operate within?

    b. Are there any particular practices that you or your organization has adopted/utilize to help foster engagement in services? If so, please tell me about them.

3. If you could change something within your organization that would make engaging parents easier what would you change and why?

4. Have you witnessed/experienced any changes within your organization that impact your ability to engage parents in services (either positively or negatively)?

5. Do you feel like you have received adequate training/education on engagement practices/strategies regarding how to engage parents in services? If so, what are these training/educational opportunities? If not, would you be interested in receiving further training/education?

6. Is there something important we forgot? Is there anything else you think I need to know about anything we discussed today?

END

Appendix D

Leah Burton BSW
Masters Candidate in Social Work
Study Title:
A Study of Organizational- and Provider-level Factors Impacting Parental Engagement in Child and Youth Mental Health Services.

Sample E-mail Subject line: McMaster study about Parental Engagement in Child and Youth Mental Health Services

Dear [insert contact name],

Leah Burton, a McMaster student, has asked me to pass along contact information of individuals who I thought would be able to provide relevant insights to a research study that she is conducting. This research is a part of her Masters of Social Work program at McMaster University.

Leah's study is aiming to discover how services providers in child and youth mental health services define and understand parental engagement; if and why engaging parents in services is a challenge for service providers; and what organizational-level factors are impacting a service provider's ability to engage parents in services. Leah is inviting you to take part in a one-time telephone interview that will take approximately 60 minutes.

If you are interested in participating in this study and for more information about it, please contact Leah Burton. You can email Leah at **burtol1@mcmaster.ca** or call her at **905-808-2492.**

Once you connect with Leah, she will provide you with more information and an official Letter of Information, which details her study in full; including information regarding risks and benefits; your right to withdraw; and information regarding confidentiality and the steps that she will take to protect your privacy.

If you have any further questions about this research study please reach out to Leah and she will be happy to answer any questions that you may have.

Sincerely,

[insert name]