Evidence-Based Solutions for Overcoming Access Barriers, Decreasing Attrition, and Promoting Change With Underserved Families

By: Jessica Snell-Johns, Julia L. Mendez, Bradley H. Smith

Various definitions exist for what constitutes family therapy (e.g., Haley, 1976; Minuchin, 1974; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). In this article, we consider family therapy to encompass any intervention that targets family interactions and conceptualizes problems as existing beyond individual clients (Gurman, Kniskern, & Pinsof, 1986; Hazelrigg, Cooper, & Borduin, 1987). Numerous individual studies and several quantitative reviews have established family therapy as an effective treatment modality and the treatment of choice for many disorders (Kazdin, 1987; Shadish et al., 1993; Weisz & Hawley, 1998). However, critiques of existing service provision highlight the unfortunate fact that numerous barriers to treatment exist at multiple levels of the broader ecology, preventing many families from benefiting from these services (Imber-Black, 1988).

Underserved Families: Concerns of the Surgeon General
The 2000 Report of the Surgeon General's Conference on Children's Mental Health concludes that undertreatment of children constitutes a major public health crisis and access barriers to effective treatments are a pressing concern that should be confronted with the vigor equivalent to efforts undertaken to eradicate polio (U.S. Public Health Service, 2000). This report identifies several goals related to developing a reasonably effective system of mental health care for children in the United States, including reducing stigma associated with mental illness, eliminating racial/ethnic and socioeconomic disparities in access to mental health care, and increasing access to and coordination of quality mental health services. The report reveals two mechanisms through which a family can be viewed as underserved. The first and most basic definition is when a person/family with an identifiable disorder is not receiving any type of service. Seventy percent of youth who are in need of care do not receive mental health services (Kazdin, 1996; U.S. Congress, 1986). The second and more subtle definition for being underserved is when a family is receiving services, but the services lack scientific support. An intervention may have demonstrated success with middle-class Caucasian families, but modifications are often necessary before the treatment is a best practice for families from other cultures or ethnic backgrounds (Surgeon General, 1999). In this article, family, community, and service provider variables are all conceptualized as contributing to families being underserved.

Given the dramatic changes in family composition and structure, there is an increasing need for programs that are effective in reaching all types of families (U.S. Public Health Service, 2000). Demographic characteristics often describe certain child-family patterns that may place a family at-risk for receiving treatment that does not reflect their unique family needs. For example, the number of divorced persons has quadrupled since 1970, and only 7 out of 10 children live with two parents (U.S. Department of Commerce, 1997). The percentage of racial/ethnic minority families in this country is dramatically expanding (U.S. Department of Commerce, 1997), yet only 5% of articles published before 1997 on marriage and family therapy research focused on ethnic minority populations (Bean & Crane, 1996).

A Social-Ecological View: Understanding the Underserved

Families are underserved for many reasons beyond their control. Service providers often work from the assumption that if a family truly desires change, the family will seek treatment. This assumption ignores the multiple issues (e.g., child care, cost of treatment) that many families must address before they can access services (Kazdin, 1996). Families living in poverty often have limited access to telephones for scheduling appointments or for arranging transportation. Poor verbal or social skills can also make it difficult for families to access services (Suarez, Smokowski, & Wodarski, 1996). Clearly, a model for assessing and understanding the complex interplay among risk factors is necessary in order to improve service delivery.

Accordingly, this article employs a social-ecological framework (Bronfenbrenner, 1979; Cicchetti & Lynch, 1993) for understanding factors that place a family at risk for being underserved. Risk factors can exist at four levels: (a) the ontogenetic or individual level, (b) the microsystem level (e.g., family, home, school, or clinic settings), (c) the exosystem or community level, and (d) the macrosystem or cultural level. Ecological theorists conceptualize risk factors as existing within individuals as well as within and between social-ecological systems. Individual factors include variables such as race, gender, age, and symptom severity. Individuals, however, directly participate in microsystems, which are immediate environments that influence behavior and well-being. Bronfenbrenner (1979) described the links between microsystems as the mesosystem, which represents the degree of overlap or congruence between portions of a person's environment. The exosystem or community level typically encompasses broader community characteristics, like availability of educational and recreational resources, that affect individual and family life (Levine & Perkins, 1997). Finally, the most distal portion of the environment involves the macrosystem beliefs and values that influence both the person and the therapist (e.g., attitudes and expectations related to race/ethnicity).

The purpose of this article is not to place families in categories or to conclude that if a family fits one or more of these characteristics, they will be underserved. However, certain family characteristics are repeatedly cited in the literature as factors associated with being underserved. Empirical studies have not definitively disentangled the complex relationships among economic disadvantage, level of symptom severity, and ethnic minority status (Allen & Mitchell, 1998). Although risk factors are generally presented as separate characteristics, in reality they are often found in constellations (e.g., a single parent may be heading a low-income, minority family), which can have compounding effects.

At the ontogenetic (individual) and microsystem levels, a number of factors have been found to be related to mental health service delivery and outcomes, including single-parent status, socioeconomic disadvantage, symptom severity, social isolation, distressed social relationships, and maternal depression. Single-parent status is associated with an increased likelihood of premature drop out and poor treatment outcomes (Kazdin & Mazurick, 1994; Miller & Prinz, 1990; Taylor & Biglan, 1998). Socioeconomic disadvantage is also related to negative treatment outcomes (Kazdin & Wassell, 1999; McKay, Gonzales, Quintana, Kim, & Abdul-Adil, 1999; Webster-Stratton & Hammond, 1990). Families residing in low-income neighborhoods are less likely to receive services and are more likely to drop out (Bischoff & Sprenkle, 1993; Kazdin, 1996; Kazdin & Mazurick, 1994; McKay et al., 1999).

Symptom severity also predicts attrition such that the more severe a child's problems, the less likely a family is to stay in therapy (Kazdin & Mazurick, 1994; McKay et al., 1999; Miller & Prinz, 1990). Youths with serious behavioral and emotional disturbances are also less likely to be served by innovative mental health services (Henggeler & Santos, 1997). Engaging families with drug-abusing children has been identified as one of the most urgent obstacles to treating this prevalent disorder (Stanton & Todd, 1981; Szapocznik et al., 1988). Dadds and McHugh (1992) concluded that social isolation is a risk factor for families failing to respond to behavioral family therapy, one of the most successful treatments for families with children diagnosed with a behavioral disorder (Kazdin, 1987). Maternal depression and marital distress are also predictive of families dropping out or having fewer treatment gains (Bischoff & Sprenkle, 1993; Dadds & McHugh, 1992; Kazdin & Mazurick, 1994;

Taylor & Biglan, 1998; Webster-Stratton, 1994; Webster-Stratton & Hammond, 1990). Overall, the level of parental psychopathology and stress are inversely related to therapeutic change (Kazdin & Wassell, 1999).

Community factors at the exosystem level can interfere with access and utilization of services. For example, rural areas often have fewer specialized resources (Connell, Sanders, & Markie-Dadds, 1997; Sayger & Heid, 1990) and have difficulty attracting well-trained professionals (Connell et al., 1997). Families living in rural areas are more likely to have problems with insurance coverage (DeLeon, Wakefield, Schultz, Williams, & VandenBos, 1989), must travel further to receive services, and are more likely to be socially isolated, increasing the likelihood that they will not initiate treatment or will drop out of treatment (Connell et al., 1997; Kazdin, 1996; Sayger & Heid, 1990). Within inner cities, a clear gap exists between children's and families' needs and provision of services. Urban children living in impoverished communities are up to twice as likely to have a conduct problem than children living in other urban communities, and prevalence rates of childhood disruptive disorders in inner cities range from 24% to 40% (Tolan & Guerra, 1994). Children who face high rates of crime, violence, and lack of infrastructure are described as coping with the "social toxicity" of neighborhoods (Garbarino, 1995).

With regard to the macrosystem or cultural variables, the 1999 Surgeon General's Report on Mental Health concluded that the U.S. Mental Health System is not currently equipped to meet the needs of racial and ethnic minority groups. The Surgeon General also concluded that on account of the dramatically increasing number of minority groups, the lack of culturally competent treatments is becoming an ever more serious problem. Minority families are more likely to drop out early in treatment (Kazdin & Mazurick, 1994) and are less likely to have positive treatment outcomes (McKay et al., 1999; Webster-Stratton & Hammond, 1990). Although stress and socioeconomic disadvantage account for much of the difference between ethnic groups in terms of dropping out (Kazdin, 1996), there are additional reasons minority families are at risk for being underserved. Because of the experience of racism and blocked mobility, minority members face different life experiences than do low-income, Caucasian Americans (LaVeist, 1993). Finally, attitudes toward receiving therapy from professionals have been shown to differ across cultural backgrounds, particularly among immigrant families (Surgeon General, 1999).

Review of Empirical Studies
The review of studies for this article was limited to empirical studies that explicitly examine a specific strategy (e.g., use of the telephone) designed to overcome an access barrier, decrease attrition, and/or promote change in families defined as at risk for being underserved. For the purposes of this article, strategies are defined as methods used to enhance or adapt programs and curricula so that they are accessible and appropriate for families who are typically underserved. This focus on (a) underserved families and (b) empirically supported interventions is a response to the Surgeon General's reports on children's mental health (Surgeon General, 1999; U.S. Public Health Service, 2000), which identify numerous barriers to children and families receiving appropriate therapeutic services and call for greater emphasis on evidence-based interventions.

This review focuses largely on interventions that examine a clearly identified problem and does not cover universal prevention programs. Thus, to use the contemporary language of prevention science (Mrazek & Haggerty, 1994), the implications of this review are most relevant to families targeted for treatment (i.e., for a child with a diagnosed problem) or indicated prevention interventions (e.g., prevention services for a family with a child identified as having an elevated risk for developing a problem). It is likely that there are important differences between engaging underserved families in a relatively high-level, focused treatment compared with a less intensive prevention program. Unfortunately, this important issue, though central to the field of prevention science, is beyond the scope of the current review.

Tables 1–3 provide detailed information about each empirical study, including the target population served by each program, the criteria for participation, the process for recruiting or referring participants, and the length of the intervention. Table 1 includes empirical studies that investigated strategies for overcoming access barriers; Table 2 includes empirical studies that investigated strategies for decreasing attrition; and Table 3 includes an

empirical study that investigated a strategy for promoting change. If reported in the study, the tables include the access and completion rates for the treatment and comparison groups. Because the desired outcomes and methods for reporting results varied dramatically across studies, they were not included in the tables. It is important to remember that many of the studies examining access and completion rates are comparing treatments that have better-than-average results with underserved families. Furthermore, a few studies examined a cost-effective strategy. Therefore, it is a significant finding if the more cost-effective version of the treatment achieves outcomes similar to the more costly, traditional approach.

Table 1
Empirical Studies That Investigated Strategies for Overcoming Access Barriers

Study	Strategy	Risk factors	Sample/design	Criteria and recruitment	Length	Tx. access	Comp. access	Tx. complete	Comp. complete
	Telephone								
McKay et al. (1996)	Use telephone to help families overcome access barriers	IC, LI, M	108 families who requested child mental health services were randomly assigned to: (a) 30-minute intensive telephone-engagement strategy or (b) control condition, which used routine telephone screening.	Any parent calling clinic requesting child mental health services was assigned to one of two conditions.	Not a tx	73%	45%	Not a tx	Not a tx
Santisteban et al. (1996)	Use intensive phone-based intervention to engage families in between initial contact and first session	DA, M	193 Hispanic (54% Cuban, 46% non-Cuban Hispanic) families with youths (ages 12–18 years) were randomly assigned to: (a) engagement family therapy (EFT), which is brief strategic family therapy plus strategic structural systems engagement (SSSE), (b) family therapy without SSSE, (c) group therapy without SSSE.	Families who called the Spanish Family Guidance Center seeking services were screened with the Drug Abuse Syndrome List. To be eligible, adolescent had to be suspected of or at risk for drug abuse.	Not reported	81%	60%	69%	67%
Szapocznik et al. (1988)	Use the telephone to engage families and to help them get to their first session	DA, M	108 Hispanic families with a drug-using adolescent (ages 12–21 years) were randomly assigned to: (a) SSSE plus brief strategic family therapy or (b) engagement-as-usual plus brief strategic family therapy.	Families only included if parent reported direct knowledge of adolescent using drugs or confirmed four or more behaviors from Drug Abuse Syndrome List.	3 weeks for engagement through use of telephone	93%	42%	77%	25%
	Home-Based Services								
Henggeler et al. (1996)	Provide substance abuse tx through home-based services, have therapist readily available, and focus on strengths	DA, LI, M	118 teens (mean age = 15.7 years) and their families were randomly assigned to: (a) home-based multisystemic therapy (MST) or (b) treatment as usual in community.	All youths were on probation and met *DSM-III-R* criteria for psychoactive substance abuse or dependence.	20 weeks of tx for MST 78% of control did not receive any tx	Not reported	Only 22% of youth received any tx	98%	Could not be assessed due to nature of services in tx as usual in community
	Self-Directed								
Connell et al. (1997)	Use the telephone to facilitate self-directed, behavioral family intervention	RL	24 preschool children (ages 2–6 years) and families living in rural, remote parts of Australia were randomly assigned to: (a) wait-list control or (b) telephone-based, parent-directed, behavioral family intervention.	Families were recruited through media releases in rural newspapers, school brochures, and general practitioners. Children scored in the clinical range for the Eyberg Child Behavior Intensity scale.	10 weeks	60%	Wait list	100%	Wait list

Table 1 (continued)

Study	Strategy	Risk factors	Sample/design	Criteria and recruitment	Length	Tx. access	Comp. access	Tx. complete	Comp. complete
	Videotapes								
Kacir & Gordon (1999)	Use video-based, self-directed, parent training program	LI, RL, SI	38 mothers and children (ages 12–18 years) living in rural Appalachia were randomly assigned to: (a) parent training using the Parenting Adolescent Wisely video disk program or (b) a no-treatment control group.	38 mothers volunteered for the program after learning about the study through a letter that was mailed or sent home with children from area middle and high schools. The program was for parents who were experiencing difficulties parenting their teenager. No diagnostic criteria for the teen.	2 weeks	Not reported	No-tx control	Not reported	No-tx control
Webster-Stratton et al. (1988)	Provide parent training through use of video-tape, self-directed program	LI, PD	114 mothers and 80 fathers of conduct-problem children (ages 3–8 years) were randomly assigned to: (a) self-administered videotape modeling program, (b) group discussion videotape modeling program, (c) group discussion program, or (d) wait-list control.	Parents only included if they rated children as having a clinically significant number of behavior problems according to the Eyberg Child Behavior Inventory. 43% of parents were self-referred, and 57% were professional referred.	10–12 sessions	Not reported	Not reported	92%	98%
	Multiple Family Groups								
Cunningham et al. (1995)	Provide parent training in the format of multiple family groups	BP, M	150 Canadian families were randomly assigned to: (a) clinic-based, individual parent training, (b) large group community-based parent training, or (c) a wait-list control condition. Both conditions were available at day and evening times.	Teachers of all junior kindergarten students in several schools were sent the Home Situations Questionnaire (HSQ). Teachers were asked to distribute the HSQ to each parent in their class. Sealed questionnaires were returned to school and forwarded unopened to research team. Children rated at least 1.5 standard deviations above the mean were selected.	12 weeks	49%	31%	76%	76%
McKay et al. (1999)	Provide psychosocial intervention through the use of multiple family therapy groups	IC, LI, M	34 families with children (mean age = 9.9 years) referred for disruptive behaviors were assigned to Multiple Family Therapy (MFT) Group, and 54 families were assigned, based on availability, to individual child therapy or family therapy.	Families came to university-based clinic and were referred to the program if they had children with disruptive behavioral difficulties.	16 weeks	100%	95%	59%	39%
Stone et al. (1996)	Use multiple family groups to reduce stigma and increase access for low-income families	IC, LI, M, SP	22 urban families and their 32 children (modal age = 10 years) with behavioral difficulties participated in 8-week multiple-family group treatment.	Families were recruited from outpatient, child mental health agency. Families were referred if children were displaying aggressive or inattentive behavior at home or school.	8 sessions	81%	No comp. group	100%	No comp. group

Note. Tx = treatment; comp. = comparison. The following abbreviations were used to report risk factors: BP = child with severe behavioral problems; DA = drug-abusing child; IC = inner city/urban living; LI = low income; M = minority; PD = parental depression; RL = rural living; SI = social isolation; SP = single parent. DSM-III-R refers to Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev; American Psychiatric Association, 1987).

Table 2
Empirical Studies That Investigated Strategies for Decreasing Attrition

Study	Strategy	Risk factors	Sample/design	Criteria and recruitment	Length	Tx. access	Comp. access	Tx. complete	Comp. complete
Financial Incentives									
Fleischman (1979)	Give an incentive for attendance	LI, SP	17 families with one or more aggressive children (mean age 6.7 years) randomly assigned to: (a) social learning–based tx with "parenting salary" ($1 for each day of tx compliance) or (b) social-learning based tx without parenting salary.	Participants were families already in treatment at a family treatment center. They were referred into the study because each family had one or more children who were aggressive, acting out.	10 sessions	Families were already part of clinic	Families were already part of clinic	100%	0%
Stanton et al. (1982)	Pay families for attending sessions	DA, LI	64 families with a son (mean age 25.3 years) enrolled in a methadone program randomly assigned to: (a) Paid family therapy, (b) Family Movie Treatment, or (c) Unpaid family therapy.	Son had to be addicted to heroin for at least 2 years and be in regular contact with parents or parent-surrogates.	10 sessions	Not reported	Not reported	86%	44%
Address Parent Need									
Dadds & McHugh (1992)	Provide socially isolated parents with social support while they are also receiving child management training	LI, SI	22 single parents and their kids (mean age of 54.8 months) were randomly assigned to: (a) child management training or (b) child management training with adjunctive ally support.	TV, newspaper, and radio announcements were made offering assistance to single parents who were experiencing child management problems and who felt isolated and without support in their role as parent. Children had to meet *DSM-III-R* criteria for oppositional or conduct disorder.	8 weeks	Use of media made this hard to assess	Use of media made this hard to assess	100%	100%
Prinz & Miller (1994)	Enhance family treatment by focusing on parents' concerns	LI, MP, PD	147 families with an aggressive boy (ages 4–9 years) were randomly assigned to: (a) standard family treatment or (b) an enhanced family treatment focusing on parent management and other adult concerns.	609 families sought tx and 160 (26%) met criteria of Child Behavior Checklist–Teacher Report Form Aggressive scale T score above 66.	12 sessions	92%	92%	71%	53%
Webster-Stratton (1994)	Enhance parent training by addressing other parent concerns	PD, MP	78 families with a child (ages 3–8 years) were randomly assigned to: (a) group discussion with videotaped parent-skills training (GDVM) or (b) GDVM plus teaching family communication, problem solving, and coping skills.	Child had to be diagnosed as oppositional defiant or conduct disordered. 50% of parents were self-referred, and 50% were professional referred.	Tx with strategy was 14 additional 2-hr sessions	Not reported	Not reported	92%	91%

Note. Tx = treatment; comp. = comparison. The following abbreviations were used to report risk factors: BP = child with severe behavioral problems; DA = drug-abusing child; IC = inner city/urban living; LI = low income; MP = marital problems; PD = parental depression; SI = social isolation; SP = single parent. *DSM-III-R* refers to *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., rev; American Psychiatric Association, 1987).

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Study	Strategy	Risk factors	Sample/design	Criteria and recruitment	Length	Tx. access	Comp. access	Tx. complete	Comp. complete
Maldgady et al. (1990)	Adapt intervention to make it culturally relevant	M, LI	210 Puerto Rican children (mean age 7.45 years) and their mothers were randomly assigned to: (a) folktale therapy with stories originating from Puerto Rican folklore, (b) folktale therapy with stories bridging Puerto Rican and American cultures, (c) art/play therapy, or (d) no therapy. Sessions were held at public school.	Children were screened for behavior problems in school and at home (by teacher and parent ratings) and were classified as at risk of developing a mental disorder.	20 weeks	Not reported	Not reported	Not reported	Not reported

Note. The strategy for this study was to provide culturally sensitive services. Tx = treatment; comp. = comparison. The following abbreviations were used to report risk factors: LI = low income; M = minority.

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Maldgady et al. (1990)	Adapt intervention to make it culturally relevant	M, LI	210 Puerto Rican children (mean age 7.45 years) and their mothers were randomly assigned to: (a) folktale therapy with stories originating from Puerto Rican folklore, (b) folktale therapy with stories bridging Puerto Rican and American cultures, (c) art/play therapy, or (d) no therapy. Sessions were held at public school.	Children were screened for behavior problems in school and at home (by teacher and parent ratings) and were classified as at risk of developing a mental disorder.	20 weeks	Not reported	Not reported	Not reported	Not reported

Note. The strategy for this study was to provide culturally sensitive services. Tx = treatment; comp. = comparison. The following abbreviations were used to report risk factors: LI = low income; M = minority.

A variety of strategies are reviewed in order to illustrate the range of strategies innovative researchers have tested as part of their effort to reach underserved families. The discussion of studies has been organized according to whether the study's greatest contribution was to methods for overcoming access barriers, decreasing attrition, or promoting change, although several strategies relate to all three objectives. This is because the solutions often cut across the full range of therapeutic considerations related to recruitment, engagement, and positive therapeutic outcomes. Thus, the categories are used to provide a heuristic for facilitating discussion of a complicated literature and should not be construed as a rigid set of independent considerations.

Strategies for Overcoming Barriers to Access
In the Report of the Surgeon General's Conference on Children's Mental Health (U.S. Public Health Service, 2000), and in many other places, researchers and clinicians have suggested solutions for reducing access barriers and increasing retention. Our review focuses primarily on factors that can be directly and immediately manipulated by service providers, including the following: (a) offering transportation, child care, and low-cost services; (b) using the telephone; (c) providing home-based services; (d) facilitating self-directed and video-based interventions; and (e) using the format of multiple family groups. Whereas all of these suggested strategies have theoretical support, they vary in the extent to which they have empirical support.

Offer Transportation, Child Care, and Low-Cost Services
Several studies suggest that offering transportation, child care, and low-cost services will reduce barriers to access and increase service providers' ability to reach underserved families (Miller & Prinz, 1990; Sayger & Heid, 1990; Taylor & Biglan, 1998). The fact that these strategies are included in several effective interventions, including Homebuilders (Kinney & Dittmar, 1995) and Families and Schools Together (McDonald, Billingham, Conrad, Morgan, & Payton, 1997), provides some support for these strategies, even though the unique contributions of these strategies have not yet been assessed. However, several other solutions for access barriers have direct support and are reviewed below.

Use the Telephone
Some assert that treatment begins with the first phone contact between a family and a therapist (Szapocznik, Perez-Vidal, Hervis, Brickman, & Kurtines, 1990). A telephone call can create a positive mesosystem by increasing the congruence between a family's home microsystem and the way the family perceives the treatment microsystem. During a telephone call, a therapist can clearly define the process of obtaining services, invest the family in the help-seeking process, and explore other access barriers the family may be facing (McKay, McCadam, & Gonzales, 1996).

Three empirical studies were identified that examined the effectiveness of telephone-based strategies (McKay et al., 1996; Santisteban et al., 1996; Szapocznik et al., 1988). Szapocznik et al. (1988) created and evaluated a telephone strategy, which they call Strategic Structural Systems Engagement (SSSE). A therapist using this strategy calls a family in between the initial request for services and the first therapy session. During this phone contact, the therapist works to restructure any family interaction that would prevent the family from coming into therapy. SSSE is based on the rationale that the families most in need of services are the ones most likely to have patterns of interacting that make them resistant to change (Szapocznik, Brickman, Hervis, & Perez-Vidal, 1989; Szapocznik, Perez-Vidal, et al., 1990). In two studies, therapists used the SSSE strategy with Hispanic families with drug-abusing adolescents (ages 12–18 years). Compared with families who did not receive this telephone strategy, families that received the SSSE strategy were much more likely to attend (Santisteban et al., 1996; Szapocznik et al., 1988) and complete (Szapocznik et al., 1988) family therapy. McKay et al. (1996) also used a telephone-engagement strategy and found that this increased first-appointment attendance. Seventy-three percent of families who received the telephone intervention, compared with 45% of control families, came to their first appointment or called ahead to reschedule (McKay et al., 1996). Considering this evidence, telephone strategies are a promising strategy for helping families overcome access barriers.

Provide Home-Based Services
Researchers and practitioners stress the need for home-based services (e.g., Miller & Prinz, 1990; Sayger & Heid, 1990; Surgeon General, 1999; Szapocznik & Kurtines, 1989; Webster-Stratton & Hammond, 1990) and suggest that many families are underserved because they lack reliable transportation or have inconsistent or late work schedules, which interfere with therapy attendance. Intervention in the home microsystem, compared with intervention in the clinic microsystem, is also believed to increase the likelihood that the skills families learn will generalize to other natural settings (Kinney & Dittmar, 1995).
The Homebuilders Program in Tacoma, Washington has demonstrated great success with home-based services in treating and reunifying abused or neglected children with their parents (Kinney & Dittmar, 1995). Outcome studies have shown that 70% to 90% of the children and adolescents who participate in home-based, family

preservation programs do not need to be placed outside of the home (Surgeon General, 1999). The Triple P—Positive Parenting Program also uses home-based services and has demonstrated positive outcomes with hard-to-reach families (Sanders, 1999). Findings from these studies demonstrate that multiproblem families can be engaged and effectively treated, often using strategies that simultaneously target multiple levels of the ecology (Sanders, Markie-Dadds, Tully, & Bor, 2000). However, because of the comprehensive nature of these effective programs, it is difficult to determine the unique contribution of providing home-based services. The findings do, nevertheless, provide indirect support for the provision of home-based services.

Henggeler et al. (1996) examined whether Multisystemic Therapy (MST), which incorporates home-based services, would have better results than treatment-as-usual for increasing therapy completion rates among substance-abusing delinquents from disadvantaged, multiproblem families. When MST was provided through home-based services, 98% of youths and their families completed a full course of treatment that lasted an average of 130 days. This finding is even more impressive when compared to the fact that only 22% of comparison families received any type of treatment. Furthermore, the fact that 98% of families completed the therapy is in stark contrast to the high drop-out rates documented in numerous studies (e.g., Bischoff & Sprenkle, 1993; Kazdin, 1990). Although home-based services are clearly an effective strategy for serving families, more research is needed to understand which situations and what kinds of families require the use of this strategy and when this complicated and expensive treatment modality is cost-effective.

Facilitate Self-Directed and Video-Based Interventions
Facilitating self-directed treatments and using videotapes to communicate information and model skills are other strategies for decreasing barriers to access. A study conducted by Connell et al. (1997) examined the effectiveness of a self-directed family intervention for families with children (ages 2–6 years) who were recruited through media releases in rural newspapers and brochures distributed through schools and general practitioners. This intervention involved providing parents with reading materials and a workbook, scheduling weekly phone consultation, and prompting parents to self-monitor and self-select goals. This minimal-contact, telephone-based intervention was specifically designed for families living in a rural environment who had limited access to treatment centers. Although only 60% (n = 24) of the families that expressed an interest and completed the 30-min intake telephone interview actually completed the pre-assessment package, 100% (n = 12) of the families assigned to the self-directed treatment group completed the 10-week program. Pretreatment, posttreatment, and follow-up evaluations revealed that this intervention was effective at decreasing disruptive child behaviors and increasing mothers' sense of competence and satisfaction (Connell et al., 1997).

Use of videotaped programming with families offers privacy, self-pacing, and flexible scheduling (Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). Families who are intimidated or have had negative experiences with service providers in traditional face-to-face settings may be willing to use video-based programming (Kacir & Gordon, 1999). Although videos have been used in supervision and for providing feedback to families (e.g., Ray & Saxon, 1992), few empirical studies have examined the use of interactive video as a strategy for reducing access barriers. Kacir and Gordon (1999) conducted an empirical investigation of their Parenting Adolescents Wisely (PAW) program, a 3-hr parent program presented through an interactive videodisk. This study was designed to accommodate families living in rural Appalachia, an area where children have been identified as in need but are not receiving services (Kacir & Gordon, 1999). Poverty, mistrust of service providers, and lack of transportation were all identified as access barriers the PAW program would attempt to overcome through the use of this low-cost, self-directed, and short-term video-based strategy. Kacir and Gordon (1999) found that approximately half of their participants used the PAW program during times that a therapist would normally be unavailable. This study did not employ a control group design or report dropout rates; therefore, conclusions regarding efficacy are not warranted at this stage of research.

Webster-Stratton et al. (1988) found that multiproblem families with conduct-problem children (ages 3–8 years) responded almost as well to a self-administered videotaped program as they did to a group discussion, videotape-modeling program. Families in both groups had significant improvements in parent and child behaviors as measured by self-reports, teacher reports, and home observations (Webster-Stratton et al., 1988),

and these outcomes were maintained at a 1-year follow-up (Webster-Stratton, Hollinsworth, & Kolpacoff, 1989). The group discussion, videotape-modeling program had slightly higher consumer satisfaction scores, higher attendance, and a high completion rate (98%); however, the use of the self-directed intervention was supported by the fact that 92% of these parents completed the program, and families in this group made significant behavioral changes. The finding that multiproblem families with conduct-disturbed children can make significant improvements by self-administering a video program is noteworthy given the extremely low cost and flexibility of this strategy.

The self-administered videotape treatment did not involve any therapist time and only required 1 hr per week of parents' time, compared with the 2 hr required for the group format (Webster-Stratton et al., 1988). Thus, the self-administered program may be more cost effective. However, there may be a gender by treatment interaction that should enter into cost and feasibility calculations. Whereas mothers preferred the group administration, fathers did not indicate a preference for the group over the self-administration. One hypothesis for this gender difference is that fathers feel more comfortable with the privacy and self-control allowed by the self-administration, whereas mothers feel they benefit more from group discussion and sharing with other parents. More research needs to be conducted in order to determine potential gender differences related to access barriers.

Use the Format of Multiple-Family Groups
Based on the success of multiple family therapy groups (MFT) with schizophrenic patients (e.g., McFarlane, 1994), MFT groups have been highlighted as a potential strategy for serving low-income, multiproblem families living in inner-city environments. MFT groups are thought to decrease the stigma associated with receiving mental health services, which has been identified as a significant barrier to the utilization of services by minority families (Aponte, Zarski, Bixenstine, & Cibik, 1991; McKay, Gonzales, Stone, Ryland, & Kohner, 1995; U.S. Public Health Service, 2000). This method of service delivery builds on the traditions of self-help, mutual support, and informal social support that can be culturally relevant when providing services to an African American community (Stone, McKay, & Stoops, 1996). Other barriers to access, like cost and need for child care, are also addressed because several families can be served by one therapist, and child care can be provided to several children at one time.

Multiple-family therapy groups include children, parents, and a facilitator. They are problem focused and facilitate interaction between and within family units (McKay et al., 1995; O'Shea & Phelps, 1985). The goals of MFT groups are to decrease families' social isolation, expose parents to new skills, and provide opportunities for families to receive feedback from multiple sources. The presence of other families is hypothesized to motivate and encourage change in a nonthreatening manner (McKay et al., 1995).

The Families and Schools Together (FAST) program is designed to reduce substance abuse, violence, delinquency, and school failure through early intervention with at-risk children in stressed, isolated, and low-income families (McDonald et al., 1997). The FAST program provides services in the format of multiple-family groups. Evaluations conducted at 53 national replication sites have consistently found positive outcomes (McDonald et al., 1997). Of the families who attended one multiple-family group, 88% completed the program (McDonald et al., 1997). FAST uses multiple strategies to promote attendance that include transportation, hot meals, child care, and prizes. The combination of the MFT group modality and the inclusion of attendance incentives makes FAST effective at recruiting, retaining, and treating low-income families. However, because FAST is a comprehensive intervention, conclusions cannot be made from this study regarding the unique impact of using an MFT group format.

Three studies have evaluated MFT groups as a specific strategy for decreasing barriers to access (Cunningham, Bremner, & Boyle, 1995; McKay et al., 1999; Stone et al., 1996). McKay et al. (1999) evaluated the effectiveness of a 16-week MFT group specifically designed to serve minority families living in a low-income, urban community. The 34 families that participated had children (mean age of 9.9 years) demonstrating disruptive behavior problems. Compared with individual child/family therapy, the MFT strategy resulted in

increased therapy completion and significant decreases in children's externalizing behaviors (McKay et al., 1999).

In a study conducted by Cunningham et al. (1995), 150 Canadian families with preschool-age children were randomly assigned to clinic-based individual parent training, a large group community-based parent training, or a wait-list control. Parents were recruited through the school, and parents who rated their children as 1.5 standard deviations or more above the mean on the Home Situations Questionnaire were selected. The study found that demographic variables predicted rates of attendance in clinic-based treatment but not in community-based treatment. Although Stone et al. (1996) did not have a comparison group, 81% of the families referred attended the first group, and 100% of the families that came to the first group completed the program. Findings from these empirical studies suggest that factors typically placing families at risk of being underserved can effectively be addressed by the MFT format.

Strategies for Decreasing Attrition

In order for a therapist to keep a family in therapy and generate change, a therapist must create a delicate balance between using forms of interaction that are comfortable to a family while at the same time helping a family create new patterns of interaction (Jackson & Chable, 1985; Szapocznik et al., 1989). There is a plethora of suggested strategies for facilitating engagement and creating a strong mesosystem between the activity in the clinic and the home environment. For example, Stanton and Todd (1981) defined 20 principles and techniques for recruiting and engaging "resistant" families, and Carr (1990) described a catalogue of engagement mistakes. However, empirical investigations of these suggested strategies are sparse. The most commonly suggested strategies for increasing engagement include the following: (a) decrease the amount of time families have to spend on the waiting list, (b) monitor therapists' behaviors and expectations, (c) offer incentives for attendance, (d) conduct brief interventions, (e) make therapists readily available, and (f) address parents' needs.

Decrease Time Families Spend on the Waiting List

Decreasing the time between when a client seeks treatment and the first appointment is hypothesized to reduce dropout rates (Henggeler, Pickrel, Brondino, & Crouch, 1996; Kazdin, 1996; Stanton & Todd, 1981; Stark, 1992; Szapocznik et al., 1988). A few studies have examined the connection between waiting time and adult dropout rates (e.g., Salta & Buick, 1989; Stasiewicz & Stalker, 1999). However, only one study since 1975 was located that empirically examined whether waiting time is related to families dropping out of treatment. This study concluded that time spent on the waiting list was not associated with families dropping out (Russell, Lang, & Brett, 1987). Unfortunately, this study was retrospective, and one of the agency's goals was to screen families that were likely to drop out. Well-designed studies are needed to specifically investigate the impact of waiting time on therapy engagement. At this time, no conclusions can be made about the relationship between waiting lists and dropout rates for underserved families.

Monitor Therapists' Behaviors and Expectations

Research regarding the process of family therapy and how therapists' behaviors and expectations influence drop out and outcomes is in its infancy (Gurman et al., 1986). Solutions for preventing dropout may be revealed in the interaction between client demographics and therapist behaviors. Unfortunately, there is a dearth of research examining strategies for monitoring therapists' behaviors and expectations. Shields, Sprenkle, and Constantine (1991) reviewed transcripts from initial intake interviews and used a coding system to measure therapists' behaviors and examine whether therapists' behaviors influenced attrition rates. This study is highlighted because of its pioneering effort to code family therapists' behaviors and its implications for future family therapy research. Therapists' expectations regarding the likelihood that families will complete treatment also need to be examined. Research has shown that therapists are quite adept at predicting which families will drop out (Bischoff & Sprenkle, 1993; Russell et al., 1987). Bischoff and Sprenkle (1993) hypothesize that therapists' expectations may establish a self-fulfilling prophecy. This is another example of how macrosystem variables, such as service provider or agency attitudes, may influence a family's experience in therapy.

Offer Incentives for Attendance

One type of incentive for attending therapy is to require that clients deposit money at the start of therapy that will not be returned unless the family successfully completes therapy (Aragona, Cassady, & Drabman, 1975). However, this strategy is generally inappropriate for low-income families who may not have cash available to deposit. Alternatively, Stanton, Steier, and Todd (1982) designed and tested a monetary incentive strategy for low-income, working class families with a son (mean age 25.3 years) enrolled in a methadone program. Families in two experimental conditions received money for attendance, whereas the comparison group did not. Eight-six percent of the families receiving payment and participating in structural/strategic family therapy completed the treatment, compared with 44% of families who participated in the treatment but did not receive payment. The second treatment group received payment for attendance, but their treatment consisted only of weekly viewing of anthropological movies of families from different cultures. Seventy-eight percent of these parents completed therapy but achieved less positive outcomes than did parents in the two groups who received structural/strategic family therapy. Stanton et al. (1982) concluded that whereas reimbursement influences attendance rates, it does not directly impact outcomes.

Fleischman (1979) explored the use of incentives by paying families with aggressive children (mean age 6.7 years) one dollar for each day they complied with social learning-based treatment assignments. By randomly assigning 18 families to treatment with and without "parenting salaries," Fleischman (1979) investigated whether offering attendance incentives increased parents' cooperation and decreased attrition. Although Fleischman's sample was small, positive results were found. Low-income parents who received the salary were cooperative 85% of the time, compared with control parents who were only cooperative 50% of the time. All four of the low-income families receiving parenting salaries completed treatment, whereas all four of the low-income control families dropped out. Parenting salaries did not have any influence on middle-class families' cooperation or attrition rates, thus suggesting that incentive strategies may only be necessary for certain families. Future research should further explore the use of incentives by examining whether there is a critical period during which a family's behavior is or is not influenced by the provision of incentives. After some time, families may gain more intrinsic rewards and may no longer need these external incentives.

Conduct Brief Interventions
Kinney and Dittmar (1995) theorized that the brevity of services enhances therapy completion and goal attainment. Therapists who provide families with an expected date for therapy completion communicate that change can be achieved in a reasonable time frame. Brevity also helps therapists and families focus on specific goals and make rapid, targeted progress toward goal attainment (Kinney & Dittmar, 1995). This approach may be especially important for families who have multiple demands placed on them or who need concrete responses to immediate problems (Gwyn & Kilpatrick, 1981). Whereas positive outcomes from short-term interventions demonstrate that brief interventions can be effective (e.g., multisystemic therapy, structural family therapy), no study has held all variables except length of service provision constant. This strategy is particularly difficult to analyze.

Make Therapists Readily Available
Several studies have suggested that therapist availability and the frequency of client contact can decrease dropout rates for substance-abusing individuals (Henggeler et al., 1996; Stark, 1992; Szapocznik et al., 1988). Availability means being willing to work with the family anytime, thus departing from the traditional and limited weekly therapy hour at the clinic. Therapist availability is consistent with the notion that treatment providers assume the responsibility of engaging families (Henggeler, 1999; Szapocznik, Brickman, et al., 1989). Research suggests that families with multiple needs are best served by therapists who are persistent and have the time to understand and treat families in holistic ways (Henggeler & Borduin, 1995; Kinney & Dittmar, 1995). Many comprehensive treatment approaches with well-established effectiveness have service providers who are available 24 hours a day (e.g., Henggeler, 1999; Kagan, Reid, Roberts, & Silverman-Pollow, 1987; Kinney & Dittmar, 1995), but no empirical studies were located that held all variables except the degree of therapist availability constant.

Address Parents' Individual Needs

Parents who face multiple problems, in addition to parenting issues, are more likely to drop out of treatment (Prinz & Miller, 1994; Webster-Stratton & Hammond, 1990). Thus, researchers and service providers are recognizing the need to broaden the scope of parent training programs. In order to specifically assess whether promoting discussions related to adult issues would decrease parent dropout, Prinz and Miller randomly assigned 147 families with an aggressive child (ages 4–9 years) to either standard family treatment or enhanced family treatment. Enhanced family treatment included discussions related to adult issues outside of parenting and produced significantly lower dropout rates (29% versus 47%). By conducting phone interviews with parents who dropped out, Prinz and Miller were able to determine that dropouts from standard family treatment were more dissatisfied with the intervention than were enhanced family treatment dropouts (26% vs. 6%). Because the only difference between treatment conditions was that the enhanced treatment addressed additional parent concerns, Prinz and Miller asserted that ignoring other parent concerns may be the mechanism by which parents become dissatisfied and drop out of therapy. Furthermore, the findings indicate that the strategy of enhancing parent training allowed these parents to address situational demands that otherwise might have caused them to drop out.

Webster-Stratton's (1994) analysis of 218 families who participated in a therapist-led group treatment revealed that the most powerful predictor of child behavior problems at follow-up was marital distress and lack of a supportive partner. Because of this finding, Webster-Stratton developed a program for serving multiproblem families. ADVANCE is a treatment that uses videotape modeling plus therapist-led discussion to improve families' communication, problem solving, and coping skills (Webster-Stratton, 1994). ADVANCE was tested in a study with 78 families with a child (ages 3–8 years) diagnosed as oppositional defiant or conduct disordered (Webster-Stratton, 1994). Results regarding the benefits of addressing parents' needs through ADVANCE were mixed. Parents in ADVANCE demonstrated improvements in communication, problem solving, and consumer satisfaction beyond those achieved by parents in the therapist-led group discussion. However, no significant changes in marital satisfaction, anger, or stress levels were reported, and children of ADVANCE parents did not demonstrate greater improvements in behavior (Webster-Stratton, 1994). Long-term follow-up is needed in order to examine whether improved parent communication and problem solving has delayed benefits for children.

More recent work by Webster-Stratton (1997, 1998) has specifically examined whether parent training in communication and problem solving would decrease feelings of isolation among low-income parents. Examination of clinic-based services led to the discovery that one third of families in standard parent training for children referred for conduct disorder were not responding to treatment (Webster-Stratton, 1997). In response, the parent programs initially developed for clinic-based settings are now being delivered as prevention programs within community settings. One study evaluated the effectiveness of a parenting program offered to 264 parents whose children were attending Head Start, an early intervention program for children living in poverty (Webster-Stratton, 1998). Results revealed that mothers in the community-based program demonstrated more positive parenting and more parent involvement, and their children exhibited fewer conduct problems. This study is highlighted as an example of how clinic-based services can be modified not only to promote access but to decrease attrition by addressing parents' needs within natural settings that concurrently address children's mental health and educational needs. Other notable prevention programs, including an ongoing prevention trial for conduct disorder, Fast Track (Conduct Problems Prevention Research Group, 2002), are also contributing data suggesting that community-based services can be a cost-effective complement to family therapy.

Socially isolated parents often lack opportunities for receiving empathy or for learning how to problem solve (Dadds & McHugh, 1992). Realizing that socially isolated, single parents may need extra assistance, Dadds and McHugh used the television, newspaper, and radio to offer assistance to single parents experiencing child management problems and feeling isolated and without support in their role as parent. Eleven of 22 single parents were randomly assigned to child management training. The remaining 11 parents were asked to select an "ally" to provide support throughout the 8-week program. The parent allies participated in Adjunctive Ally Support Training (AST), but AST produced no treatment gains over the original parent-training program.

Although Dadds and McHugh offered several hypotheses for the lack of differences between the groups, they failed to address whether they were in fact reaching "socially isolated" parents. Because of their emphasis on the concept and benefits of natural support, only parents having a person who could function as an ally were allowed into the program. However, these parents may not in fact be socially isolated, given that they knew a person who was willing to participate as an ally. Future research can address this limitation by more clearly defining and measuring inclusion criteria.

Strategies for Promoting Change

Miller and Rollnick (1991) defined motivation as the probability that a person will enter into and continue to adhere to a specific change strategy. Whereas hundreds of theoretical articles discuss the phenomena of motivation and resistance, only a handful of empirical studies have actually investigated specific strategies for promoting therapeutic progress. Most of these studies include adult individuals and not families at risk of being underserved. There is a great need for research regarding evidence-based solutions for promoting change. Minuchin (1974) and Haley (1976) emphasized "joining" techniques and the use of paradoxical approaches, such as prescribing the symptom, but little data has been collected regarding the effectiveness of these techniques (Allgood, Bischoff, Smith, & Salts, 1992). Prochaska and DiClemente's (1982) Stages of Change framework asserts that effective treatment strategies match individuals' readiness for change. Although this is a useful descriptive theory, no published empirical studies have examined the application of this theory as a strategy for treating families at risk of being underserved. Other suggested strategies for promoting change include (a) preparing families for therapy and addressing family expectations, (b) providing culturally sensitive services, (c) giving family task assignments, (d) focusing on families' strengths, and (e) conducting motivational interviewing.

Prepare Families for Therapy and Address Expectations

The more parents perceive a treatment as relevant to their family's needs, the more likely it is that positive change will occur (Kazdin & Wassell, 1999). Therefore, in addition to actual access barriers, perceived barriers are also significantly related to treatment outcome. If there is a mismatch between a family's expectations of treatment and the actual treatment, either the expectations, the intervention, or both need to be modified. A clash in expectations is especially likely to occur when a therapist prescribes treatment for someone from another cultural background, and modifications of therapeutic methods are often necessary (Gwyn & Kilpatrick, 1981; Santisteban & Szapocznik, 1994). In order to promote change, parents' expectations must be addressed. Morrisey-Kane and Prinz (1999) examined the role of parental cognitions and concluded that parents' positive attitudes toward treatment are critical to retention and outcomes. However, actual strategies for addressing parent expectations need to be examined. Walitzer, Dermen, and Connors (1999) conducted a review of strategies for preparing individual clients for treatment and found that therapists can have a great impact on whether or not clients stay in therapy and whether therapeutic progress is achieved.

Provide Culturally Competent Services

Several studies suggest that family resistance will be strong unless therapists and treatments are sensitive to cultural variations in family structure, coping style, and problem expression (Brondino et al., 1997; Prinz & Miller, 1994). When treatments are designed by people who have never experienced minority status or by people unfamiliar with different cultural norms, a mismatch is likely to occur (Cheung & Snowden, 1990; Surgeon General, 1999). For example, religion, prayer, and spirituality can be of varying importance to a family's coping style depending on their ethnic, regional, or generational backgrounds. If a family-based treatment does not encourage or respect families' coping styles, families may not feel accepted and may resist treatment.

Other studies recommend creating a therapeutic atmosphere where cultural values are accepted and introduced directly into the therapeutic modality (Malgady, Rogler, & Costantino, 1990). Brondino et al. (1997) suggested that the traditional treatment paradigm, which emphasizes "therapeutic boundaries," often fails to address the stressors many minority families face. A traditional approach limits clinicians from engaging in behaviors (e.g., consultation with families' informal support networks) that might help establish trust and form a positive

therapeutic relationship. If clinicians fail to help families address their most basic needs, families' beliefs that service providers cannot help may be reinforced, thereby slowing or halting therapeutic progress (Brondino et al., 1997).

Training service providers to be culturally competent is critical, and ongoing supervision is necessary to bring into practice what mere didactic teaching cannot accomplish (Stevenson, 1994). More research is needed in order to determine the most effective methods for training clinicians and supervisors about what it means to employ culturally competent strategies (Brondino et al., 1997). For example, studies of Asian American families explain that "saving face" is especially important to the Asian culture and suggest that therapists be particularly careful to avoid embarrassing family members. Positive reframing and reinforcement through compliments are thought to be more effective with these families than confrontation or shaming (Berg & Jaya, 1993). Without appropriate training, a well-intentioned clinician may not be able to encourage progress and may unintentionally leave a family feeling blamed.

Malgady et al. (1990) examined whether making an intervention more culturally relevant for Puerto Rican children (mean age = 7.5 years) and their mothers would achieve better outcomes. Children screened and classified as at risk of developing a mental disorder were referred into the school-based treatment. Two approaches were used to make the intervention culturally appropriate. One treatment used original Puerto Rican folktales, and the other used folktales adapted to bridge Puerto Rican and American (U.S.) values. The families in the control group participated in art/play therapy. There were mixed results regarding the superiority of the folktale modality over the art/play control group, depending on the type of outcome measured. Although the results do not provide clear support for the strategy of making interventions more culturally relevant, the methodological design is one to be repeated; the design allows an empirical investigation of two types of culturally relevant interventions. The mixed findings illustrate the complex relationship between culture and therapy outcomes.

Give Family Task Assignments
Numerous articles suggest that family task assignments are critical for overcoming resistance and are thought to be particularly useful when working with minority or low-income families (Gwyn & Kilpatrick, 1981; Szapocznik, Perez-Vidal, et al., 1990). Family task assignments strengthen a family's ability to resolve their own problems and provide families with a sense of power to accomplish something positive and meaningful (Gwyn & Kilpatrick, 1981). The appropriateness of family task assignments, especially for families facing multiple problems, has strong theoretical backing but no direct empirical support.

Focus on Families' Strengths
Researchers have emphasized the importance of treatments that are strength focused (e.g., Henggeler & Santos, 1997). Although evaluations of multisystemic therapy have not specifically examined the strategy of focusing on families' strengths, MST is explicitly a strength-focused approach and has achieved tremendous outcomes with families at risk of being underserved (Henggeler et al., 1996). Kagan et al. (1987) emphasized the importance of not blaming families and attributed lack of therapeutic progress or premature dropouts to families feeling blamed. Their work with court-mandated youths and their families also provides indirect support for the effectiveness of focusing on families' strengths (Kagan et al., 1987).

Ray and Saxon (1992) suggested nonconfrontational use of video playback as a strength-focused strategy for promoting change. This nonthreatening approach is thought to be particularly useful with families who did not change in other types of therapy. Only one empirical study has evaluated the effectiveness of this strategy (Weiner, Kuppermintz, & Guttmann, 1995). The Orion Video Home-Training Project is a short-term, home-based treatment that attempts to strengthen positive communication between preschool children and their parents. The intervention was specifically designed for disadvantaged Israeli families receiving financial assistance from the government. Video playback of family interactions is used to highlight and reinforce positive parent behaviors. The evaluation of this project did reveal significant increases in Orion families'

positive parent-child interactions and no significant changes in control families, although there were several methodological limitations.

Conduct Motivational Interviewing

Miller and Rollnick (1991) developed a brief intervention known as motivational interviewing, which they define as a directive, client-centered approach to increasing clients' motivation by helping them explore and resolve ambivalence. Unfortunately, most of this literature on motivational interviewing has focused on individual clients (e.g., DiClemente, Bellino, & Neavins, 1999) and not on families. Although this article only reviewed published studies, an unpublished dissertation investigated the effects of the Family Check-Up, a brief, motivational intervention for at-risk families. Results indicated that this intervention significantly decreased problem behaviors among treatment families, indicating that motivational interviewing was effective in helping parents improve their family management skills, thereby influencing adolescent problem behaviors (Rao, 1999). These findings support the need for additional research on this potentially cost-effective strategy.

Strengths and Limitations of Existing Research

In order for important questions to be answered, certain methodological weaknesses in family therapy literature with underserved families must be addressed. One limitation is that many of the studies do not have sufficient sample sizes (Connell et al., 1997; Dadds & McHugh, 1992; Fleischman, 1979; Kacir & Gordon, 1999; Stone et al., 1996). Another common weakness is the use of inadequate methodological designs, which in this case, limits the ability to make conclusions regarding individual strategies. The methodological designs used by Santisteban et al. (1996), Szapocznik et al. (1988), and Webster-Stratton et al. (1988) are positive examples of researchers using multiple conditions to isolate the strategy of interest.

An especially problematic issue revealed by this review is the failure of several studies to report recruitment or dropout rates. In their review of family therapy, Hazelrigg et al. (1987) asserted that future research needs to evaluate family therapy from multiple change indices and from multiple perspectives (e.g., parent, teacher, therapist, and observer). Only a few studies in this review adhere to this recommendation. Although the dropout rate could be calculated for most of the studies, several studies did not specifically report completion rates, and few studies reported access rates. The studies included in this article are united in that they are all interested in developing strategies that increase the likelihood that traditionally underserved families will be served by effective, culturally relevant treatments. Despite this common goal, few of the studies explicitly discussed whether their measurement approaches were culturally appropriate.

Collecting follow-up data was a strength of several of the studies (e.g., Connell et al., 1997; Kacir & Gordin, 1999; Webster-Stratton et al., 1989), although one limitation was the low percentage of families reached at follow-up (e.g., Weiner et al., 1995). Another strength of this literature is the importance placed on treatment fidelity. Several studies promoted treatment integrity by having therapists receive ongoing supervision, training, and feedback (Henggeler et al., 1996; Webster-Stratton, 1994; Webster-Stratton et al., 1988), and by using the same therapists in all treatment conditions (e.g., Webster-Stratton, 1994; Webster-Stratton et al., 1988). Studies that report effect sizes and discuss clinical significance make an important contribution to the literature. For example, because Kacir and Gordon (1999) calculate effect sizes, they are able to conclude that the Parenting Adolescents Wisely (PAW) program has a larger effect size than family enrichment programs, but a smaller effect size than psychotherapy in general (Smith & Glass, 1977). Yet, even with sophisticated statistical analyses, their conclusions are limited by small sample size. A final strength of the literature to date is that several studies discussed cost-benefit ratios, helping the reader to understand the financial benefits of using a particular strategy (e.g., Fleischman, 1979; Kacir & Gordon, 1999; Kagan et al., 1987; Webster-Stratton et al., 1988, 1989).

Conclusions

On the basis of the empirical studies that were reviewed, several conclusions can be made. Providing home-based services, using MFT groups, and facilitating self-directed or video-based treatments have empirical support for being effective strategies for diverse families. Especially with the technological strides that have

occurred in the past decade, the use of videotaped programming or Internet-based communication is of particular interest. Replication of findings (Kacir & Gordon, 1999; Webster-Stratton et al., 1988, 1989) suggests that videotaped instruction is an effective strategy for successfully reaching and treating families who might otherwise be underserved. Videotaped instruction and MFT groups help families overcome cost, stigma of receiving mental health services, and limited availability of therapists.

The question of whether providing transportation, child care, and low-cost services significantly increases underserved families' use of services remains to be answered. Indirect support indicates that these strategies are crucial in helping families overcome access barriers. Future research regarding the influence of these strategies will guide service providers in making outcome-oriented and cost-effective decisions. Enhancing parent training by addressing parents' emotional and/or marital distress has preliminary evidence for being an effective strategy; however, additional effects may not be evident until follow-up (Prinz & Miller, 1994; Webster-Stratton et al., 1988, 1989). Empirical findings also suggest that offering incentives for attendance is a promising strategy with low-income families (Fleischman, 1979; McDonald et al., 1997). The influence of therapists' behaviors and expectations on family dropout remains relatively unexplored in family therapy literature. Other strategies in this area (i.e., decreasing waiting time, brief interventions, and making therapists readily available) have mixed or only indirect support.

Strategies for promoting change among families have even less empirical support. Recent reviews (Morrisey-Kane & Prinz, 1999; Walitzer et al., 1999) have increased awareness of the need for addressing parents' expectations and preparing families for treatment. The Surgeon General's Report on Mental Health also calls for the immediate development of culturally competent strategies (Surgeon General, 1999). Strength-focused strategies have direct and indirect support for being effective at promoting change (Henggeler et al., 1996; Weiner et al., 1995). The dearth of empirical studies related to strategies for promoting therapeutic change may, at least in part, be attributed to the challenges of coding and rating family and therapists' behaviors. Future research is needed to understand the most effective ways to promote change.

Recommendations and Future Directions for Family Therapy With Underserved Families
Given the limited number of empirical studies related to each strategy, final conclusions regarding the effectiveness of each strategy cannot be made until findings are further replicated with enhanced methodology. Specific recommendations for future research include the following:

1. Independent of the specific outcomes being measured, report the percentage of families that improved, got worse, or stayed the same to allow comparison of outcomes across different designs and target groups.
2. Offer an operational definition and clear guidelines for measuring "dropping out."
3. Conduct and disseminate research examining strategies for overcoming access barriers, decreasing attrition, and promoting change. Recruitment and dropout rates need to become routine outcome measures.
4. Consider and discuss whether interventions have achieved clinically significant outcomes. Use measures that provide a priori normative cutoffs for meaningful or nonmeaningful change, allowing researchers to compare the outcomes of their interventions (Webster-Stratton & Hammond, 1990).

Implications for Application and Public Policy
The strategies reviewed provide encouragement that service providers can work with families to overcome access barriers, decrease attrition, and promote change. These overall findings have important implications for application and public policy. Agencies charged with serving families that may be at risk for being underserved should consider adopting a social-ecological view when assisting families in addressing barriers and maintaining engagement. This perspective would entail training of service providers that includes the teaching and practice of specific strategies. Too often trainees are only asked to record time spent in a clinic-based session with families. Asking therapists to document time spent calling, visiting, or engaging families in nontraditional ways communicates to trainees that this time is well spent and is part of their job. Beyond the

training of service providers, public policy changes related to insurance and managed-care stipulations are needed to produce reimbursement for these professional activities. Cost-benefit analyses demonstrate that the costs of implementing many of the strategies discussed in the article are minimal in comparison to the costs of untreated psychological distress within families and communities.

This paper, the Surgeon General's (1999) Report on Mental Health, and the Report of the Surgeon General's Conference on Children's Mental Health (U.S. Public Health Service, 2000) share the perspective that the gap between families and service providers is nested in a social ecology that influences service delivery. This paper has focused on factors that are most easily changed and immediately controlled by service providers. However, an even broader, ecological approach is necessary to overcome the many access barriers, premature attrition, and limited change experienced by so many families. These problems have reached crisis proportions. About 70% of families in need are not receiving services (Kazdin, 1996; U.S. Congress, 1986) despite ample scientific evidence that many treatments work.

Service providers must advocate for a new perspective that considers multiple levels of the ecology in order to engage and motivate families to successfully complete treatment. Society must be careful to avoid stigmatizing families and withholding resources for treatment that, in the long run, may be very cost effective. The vision of a society in which children and families receive appropriate mental health services seems to be in focus thanks to the Surgeon General's reports. The goals of this report may seem daunting, but they are no less daunting than the vision from 50 years ago of controlling infectious diseases such as polio and small pox. Fifty years ago, the proper resolve and resources were applied. Hopefully, the retrospective view from 2050 will reveal a similar level of national pride regarding how this society decided to intervene to support child and family mental health.

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