North American Association of Christians in Social Work
A Vital Christian Presence in Social Work

PO Box 121
Botsford, CT 06404
www.nacsw.org
888.426.4712

CONCEPTUALIZING ENGAGEMENT: ENHANCING YOUR PRACTICE TO OBTAIN BETTER OUTCOMES

By: Angela R. Tyler, MSW

Presented at:
NACSW Convention 2011
October, 2011
Pittsburgh, PA

Abstract

The Christian social worker, must allow creativity to emerge through tradition. Continuing with "business as usual" is not effective. Taking the initiative to utilize traditional concepts and enhance them to fit the changing landscape of service delivery, will allow for better therapeutic outcomes; and better outcomes provide for more sustainable programs.

This paper will review many traditional methods of engagement, as well as offer additional strategies that may be utilized to insure active participation from key stakeholders and clients. Engagement is key to obtaining buy-in and buy-in is necessary to achieving favorable outcomes. Social workers will be encouraged to "think outside of the box" and allow their faith and conscience to address the needs of those that they serve, fulfill the mission of their agency, while maintaining appropriate ethical boundaries.

Our presence as service providers is not enough to make a difference. Compassion must meet our service in tangible ways that engage our clientele in treatment; create therapeutic alliances and increase the sustainability of effective programs. Historically, grass roots Christian social workers have been the extension of Christ's hands in the community. The profession has worked very diligently towards professionalizing the field and improving the quality of service. We as Christians while maintaining our professionalism must also be attentive in retaining what has always been the foundation of our service.

Our communities are facing great economic challenges. Public Mental health recipients have grown exponentially, as a result of our country's economic recession. Funding sources are leaning towards wanting better outcomes for fewer dollars. Our federal government faces a national debt of over 14 trillion dollars. State and county governments are working judiciously to balance their budgets. As a result, practitioners, have to do more with less. Decisions on whether to spend public money and on how to spend it are ideally based on criteria related to economic efficiency, ethics and political considerations (e.g. demand by the populace). (Musgrove, 1999).

Mental health providers, must ask themselves, how can they improve services and retain funding for programs that are essential. This indeed is not just an obstacle for the programs, but for the individual clinicians as well, as they are the ones that are charged with engaging consumers in treatment. The primary focus of these strategies are in a therapeutic setting. However, these strategies are generalizable to other areas of treatment, such as case management, social services, juvenile justice, or the school setting. As Christian social workers, we are to be reminded that we fulfill two roles, that of a helper and as a disciple of Jesus Christ. This has been a longstanding quandary for those that have come before us and it still exists. Christian social workers must be ethical in balancing both roles, yet strategic in fulfilling

James 1:27 (New King James Version):

Pure religion and undefiled before God and the Father is this, To visit the fatherless and widows in their affliction, and to keep himself unspotted from the world.

When we visit the widows and fatherless in their affliction, we are displaying the love of Jesus and we need to do so in tangible ways, not being the person that says, "go be warmed and be filled" (James 2:14-16). Mental Health professionals in an effort to remain objective and keep professional boundaries can at times, come off as un-empathetic and irrelevant to the needs of their clients. Contrary to traditional methods of practice, Christian social workers, can take their cue from evidence based practices, such as Multi-systemic Therapy (MST), which has achieved, high engagement and treatment completion rates (Stern, 1999). Clients are not seen as resistant to treatment. "Resistance" is a cue for the therapist to work harder at engagement. MST assumes that therapist empathy is critical for engaging clients. (Cunningham & Henggeler, 1999) Therefore, therapists take the responsibility for engaging those clients that are more challenging. Multi-systemic Therapy is a family oriented treatment model that has shown long term success in engaging youths and their families who present serious clinical difficulties. Strategies are developed to access the client's strengths to make change a more palatable consideration. The promotion and dissemination of evidence based practices (EBP), has become the standard in

mental health care. EBP increases the value gained from dollars spent in healthcare.(Lehman, Goldman, Dixon & Churchill, 2004). MST is based on the work of Bronfenbrenner (1979) and the socio-ecological model of behavior.

The responsibility to provide education to our clients must be held in colligation with the act of collaborating with them on their treatment. When we begin to see ourselves as co-collaborators with those that we serve instead of their teachers, we allow them to rise above negative circumstances. Social workers value the dignity and worth of every person (NASW Code of Ethics). As Paulo Freire (1970) stated when a banking concept of education is adopted, knowledge becomes a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing. Thus, projecting an absolute ignorance onto others, a characteristic of the ideology of oppression. Adopting a varied approach to treating clients, involves clinicians to "think outside the box" when designing engagement strategies.

It is imperative that evidence of successful engagement be provided to agency administration and key stakeholders, to achieve their buy-in. Engaging this particular group is equally as important as engaging clientele.

Engagement in Treatment:

Treatment doesn't progress, unless the client is engaged and actively participates in his or her treatment. (Cunningham & Henggeler, 1999) This is the basis of effective interventions. Social workers by definition work with the most vulnerable and oppressed, in our communities.

The factors that drive them to need services are also concomitant barriers to engagement. High drop-out rates are common in the field of substance abuse, as well as other outpatient services. Family based outpatient programs have higher completion rates, 50% in contrast to 10-18% amongst substance abuse programs. (Henggeler, Pickrel, Brondino & Crouch, 1996) More information is needed to reduce program attrition rates. A recent review of 39 articles designed to reduce or prevent treatment drop-out revealed that only 15 of the articles were research studies of targeted interventions; which primarily focused on pre-session preparation, instead of specific approaches to avoid treatment drop-out (Barrett, Chua, Crits-Christoph, Gibbons, Casiano & Thompson, 2008).

Engagement can be divided into two specific steps: initial attendance and ongoing engagement (McKay & Bannon, 2004). Maintaining engagement through each step is crucial to a successful outcome. Barriers must be assessed on an ongoing basis; literal and perceptual barriers, have to be considered. It does not matter, if the obstacle is real or perceived, it must be addressed in order to obtain the buy-in of the client, thus accelerating treatment progress.

In practice, pejorative language is often used to describe poor engagement. When clients do not show for scheduled appointments, or does not complete treatment, they are often described as "non-compliant". As practitioners, we must move beyond a surface assessment and consider every alternative. There are three primary domains, by which barriers are classified. Concrete, contextual and agency related (McKay & Bannon, 2004). We will discuss each one briefly.

Concrete Barriers: e.g., lack of time, lack of transportation and basic needs are not met. Most families that enter treatment are experiencing a variety of challenges. This would include working multiple jobs, low wage positions, housing issues and relying on public transportation. Sometimes these individuals are the only wage earner and cannot afford to take time off for mental health treatment. Although in the long term, obtaining appropriate treatment, might bring some stability, it is counterintuitive to expect those facing concrete barriers, to be focused on treatment, when these particular needs are so pressing. Maslow's Hierarchy of Needs (1943), provides us a framework for sequentially addressing barriers to treatment. Addressing one layer of need, allows for dialogue regarding the others, physiological, safety, social, esteem and self-actualization, respectively.

Contextual Barriers**:** e.g., community violence and lack of social support. Having the support of someone in your natural environment provides motivation. People with serious mental illness, report spending the majority of the time alone, dissatisfaction with the social support they receive and social networks consisting of mental health or social service professionals and peers with psychiatric conditions. In the general population, it is recognized that social support acts as a protective factor against stressful life events and improves recovery from health conditions. The literature has established that there is a positive correlation between social support and health, functioning and quality of life. (McCorkle, Rogers, Dunn, Lyass & wan, 2008). Mental health professionals can sometimes, increase the effectiveness of their treatments, by

inviting the client's family or friends to a session. This of course, occurs only if evidence in the client's clinical assessments supports the need. Appropriate releases should be signed and the client adequately prepared, so that this intervention does not produce a relapse of symptoms. Natural supports, can provide the therapeutic process with additional insight and resources, that may not have been considered previously.

Agency related: e.g. Slow access to services, length of intake process, therapist related barriers, employee policies and ineffective training of staff. In low income communities, 40% of youth display mental health difficulties (McKay and Bannon, 2004). Some of the typical challenges faced, with this particular population, include the barriers mentioned above. Simple strategies, such as toys or books in the intake room, increased staff training on customer service, enlisting the help of a volunteer to assist with younger siblings during the intake process, seeking out alternatives to completing all of the paperwork at the first visit, such as beginning the process via phone or possibly offering a home- based service are strategies that can be utilized. There is strong evidence that supports, when intensive engagement efforts are made at the initial contact and it becomes more than just an information gathering session, service use is increased dramatically. (McKay, Hibbert, Hoagwood, Rodriguez, Murray, Legerski & Fernandez (2004).

Few studies have examined predictors of non-attendance in mental health settings. This gathering together of hypotheses, add to traditional theories of engagement, enhancing the therapeutic framework. (Mitchell & Selmes, 2007)----Box 1

PATIENT FACTORS: **Box 1**

- Forgetting, oversleeping, getting the date wrong
- Being too psychiatrically unwell
- High trait anxiety
- Lower social desirability scores
- Dismissing attachment styles

MEMORY /COGNITIVE PROBLEMS

- Dementia

INFORMATION AND HEALTH BELIEFS

- Poor insight into illness

ILLNESS FACTORS

- Personality disorder
- Substance misuse
- Neurotic disorders
- Diagnosis unclear or cannot be established

CLINICIAN AND REFERRER FACTORS

- Poor communication between the referring practioner and the patient
- Patient's disagreement with the referral
- Referrer's skepticism about the value of psychiatry
- Poor quality referral letter
- Longer delay between the referral and the appointment (or between assessment and treatment)
- Early stages of treatment
- Quality of therapeutic alliance
- Non-collaborative decision making

STRATEGIES FOR SUCCESS

When a client presents as challenging or “resistant”, negotiation can be used to engage them. It is an influential method that has been shown to decrease resistance. Murdach (2008) defines negotiations as a bargaining interaction characterized by the exchange of social resources between two or more people to gain a mutual adjustment beneficial to all parties involved. Negotiation assumes both the practitioner and client possess valuable resources to assist one another.

Negotiation enhances the therapeutic alliance. Research demonstrates that the therapeutic alliance is essential to successful outcomes. Therapist’s relationship skills predict treatment outcome, 45% of the time (Alexander, Schiavo, & Parsons, 1976). The hierarchal top down approach of mental health practitioners as “experts” is being challenged and replaced with a paradigm that esteems clients as collaborators in their treatment. Collaboration can be evidenced by signs of engagement measured by a high rate of attendance at sessions, progress being made towards treatment goals, completion of homework assignments and emotional involvement in sessions (Cunningham, et.al., 1999). Assessing for barriers to engagement, should be an ongoing process.

Core clinical skills are the foundation for strengthening engagement, such as empathy and warmth. Providers must recognize specific treatment barriers and be willing to make reminder phone calls, provide snacks during sessions, or at times, a full meal. Clients appreciate when a

mental health practitioner, asks about the things that interest them, such as hobbies or what they do at their job. If there is a particular barrier centered around access to services, involve administrative staff and develop a plan to address this issue. Front line staff have the benefit of direct observation. We must keep in mind, when a client begins to lose buy-in, they are at risk for terminating treatment, prior to its completion. Therapist should facilitate active participation in sessions. Positive interactions create an environment that elicits communications that are affirming (Thompson, Bender, Windsor & Flynn, 2009). Games and activities allow clients to focus on the activities themselves, while still learning valuable tools to attain their goals.

FAITH IN PRACTICE

Christian social workers most often enter the field, out of a sincere desire to help; to improve the quality of life for those that are having difficulty managing circumstances on their own. We must continually find the balance between being a mental health professional, keeping appropriate boundaries and showing empathetic care and concern. Engagement is costly, not from a financial perspective, but certainly when it comes to paradigm shifting. We can see throughout the life of Jesus, who often said, “come follow me.” (Mark 8:34). It cost him time and energy. Jesus used some very strategic engagement strategies and they were effective.

Food- We see many instances in scripture where food was provided to those who were following him, such as in Mark 6:30-34. However, the emphasis was not on the food. Food meets a basic need, and relaxes the atmosphere, allowing people to feel more comfortable.

Miracles- Jesus's miracles, met an urgent need. We may not be able to perform miracles on behalf of our clients, but we can help them meet urgent needs. For example, you have a client who frequently misses appointments, because she works all day, picks the kids up from school, prepares dinner and then has her scheduled therapy session. A simple engagement strategy, might be to provide this mom with a gift card for pizza, or if you are providing services in the home, bring pizza to the session. You have met an "urgent need", and removed a stressor, that might distract from treatment.

Acknowledging People: Recognizing that our clients are more than just the problem that brought them into treatment. Mental health practitioners must take the time, to understand their clients in whole and not just in part. This can be done, by showing interest in their hobbies or special activities; such as discussing sports, or scrapbooking and truly allowing yourself to "learn" from your clients.

Strength focused- Mankind is created in the image of God (Gen 1:27). Although our sinful nature dictates many of our actions, strengths reside in all of mankind. Focusing on these

strengths as leverage for change is another key strategy. Clients often times have negative cognitions towards themselves, thus finding it difficult to feel motivated for change.

Avoiding labels- Jesus saw the person, not the disease (Matthew 8:1-5). Research implies that many do not pursue mental health treatment, because they do not want to be labeled "crazy". Sometimes, those negative beliefs are internalized and they feel less valued or "worthy", as a result of their psychiatric disorder. Theorists in this area of study, believe that diagnosis, has unintentionally, reinforced the stigma that many face. (Reference #10) Recognizing the presence of stigma, as a barrier, means efforts must be made, to re-enforce individual strengths. When initiating treatment, reframe symptoms and help the person not feel that he or she is their diagnosis. Frontline staff must be proactive in avoiding labels and insuring that support staff do this as well. (e.g. a person with schizophrenia is preferable to "a schizophrenic").

Ethical considerations:

Approaches that deviate from typical standards of practice should be discussed with the clinical supervisor in your respective practice setting to insure the approach is compliant with agency policy. Social workers are never to participate in an activity that violates the NASW code of ethics or that meets the practitioner's own needs. (e.g.- taking a client to the grocery store, so that you can get your grocery shopping done or taking a client to church, because you

are going for you and not to develop their social support network). Proper supervision, agency policies and the NASW code of ethics continue to guide our decision making processes.

CONCLUSION:

The life of Jesus offers us many examples of how to interact with people and "meet them where they are", instead of requiring them to come to "where we are at", when they may not have the capacity to follow through.

Agency administrators, supervisors and those that are key stakeholders, have a duty to continually be informed regarding what is working in the clinical arena. Allowing some fiscal resources to be allocated to the engagement of clients will empower staff to fully utilize available resources in the agency and in the community. This lessens the burden on clinical staff and eliminates a powerful administrative barrier to engagement. More research will need to be conducted, to determine a cost-benefit analysis of the allocation of agency resources as best practice.

References

Corrigan, P. (2007) How Clinical Diagnosis might Exacerbate the Stigma of Mental Illness.

Cunningham, P.B., & Henggeler, S.W. (1999). Engaging Multiproblem Families In Treatment: Lessons Learned Throughout The Development Of Multisystemic Therapy. Family Process. 38, 265-286.

Freire, Paulo. Pedagogy of the oppressed. New York: Herder and Herder, 1970.

Hennggeler, S.W., Pickrel, S. G., Brondino, M. J., & Crouch, J. L. (1996). Eliminating (almost) treatment dropout of substance abusing or dependent delinquent through home-based multi-systemic therapy. American Journal of Psychiatry, 153, 427-428

Lehman, A., Goldman, H., Dixon, L., Churchill, R. (2004). Evidence Based Mental Health Treatment and Services. Examples to Inform Public Policy.

Maslow, Abraham (1954). Motivation and Personality. New York: Harper. pp. 236

McCorkle, B., Rogers, S., Dunn, E., Lyass, Wan, Y. (2007) Increasing Social Support for Individuals with Serious Mental illness: Evaluating the compeer Model of Intentional Friendship

McKay, M., Hibbert, R., Hoagwood, K., Rodriguez, J., Murray, L., Legerski, J., Fernandez, D. (2004). Integrating Evidence-Based Engagement Interventions Into "Real World" Child Mental Health Settings.

McKay, M., & Bannon, W., (2004). Engaging Families in Child mental health services.

Mitchell, A. & Selmes, T. (2007). Why Don't Patients Attend Their Appointments? Maintaining Engagement With Psychiatric Services. Advances in psychiatric treatment, 13, 423-434.

Musgrove, P. (1999). Public Spending on Health Care, How are different criteria related. 47, 207-223.

Thompson, S., Bender, K., Windsor, L., & Flynn, P. (2009) Keeping Families Engaged: The effects of Homebased Family Therapy Enhanced With Experiential Activities.

Workers, N. A. (2008). NASW Code of Ethics (Guide to the Everyday Professional Conduct of Social Workers). Washington, DC: NASW.