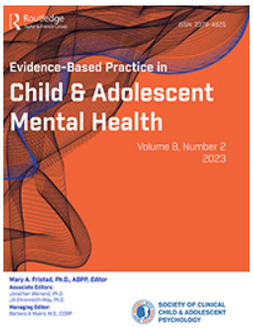

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Promoting Positive Mental Health Outcomes for Black Youth of African Descent: Applying the Family as Host Model for Culturally Responsive Practice

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ABSTRACT

For Black youth of African descent and their families, the pathways to effective support and intervention for mental health are complex andchallenging to navigate. Research continues to highlight the need to achievehealth equity, eliminate disparities, and improve mental health access and careof all groups. Thus, there is a need for strategies that are culturally responsive for promoting positive mental health outcomes for Black youth of African descent. In this paper, a new perspective that promotes access to non-stigmatizing, culturally responsive supports for Black youth of African descent across all socio-economic status is presented. This innovative framework for culturally responsive treatment engagement is called the Family as Host (FAH) model. This model positions Black youth and their family as primary initiators, acting as "Host" and clinical care providers as facilitators, acting as "Guest" during treatment engagement. Implications for practice and research are discussed to promote positive psychological health outcomes for Black youth of African descent.

Engagement is critical for reducing disparities in mental health treatment and improving care outcomes. Of utmost public health importance are strategies to improve treatment engagement and intervention for culturally diverse and underserved populations who seek mental health and behavioral intervention services (Ofonedu et al., 2017). Black youth of African descent are among the underserved groups who experience many disparities, including disparities in engagement with mental health care (Breland-Noble et al., 2011; Breland-Noble & Board, 2012; Mojtabai et al., 2011; Ofonedu et al., 2013; Turner et al., 2016). It is this recognition of disparities in mental health care that necessitates the development of culturally responsive practice models for providing psychological assessment and intervention to racially and ethnically diverse populations. This is particularly important when working with individuals who identify with and share a heritage or historical connection to the greater African Diaspora.

Negative life events and experiences significantly affect one's emotional sense of self. For Black youth of African descent, an awareness of the changes to one's sense of self may elicit different feelings that include unremitting sadness, helplessness, erratic emotional states, self-blame, and guilt (Ofonedu et al., 2013). Adverse childhood experiences (ACEs) have been linked to an increase in unhealthy psychological adjustment among youth. According to Wolff et al. (2018), higher ACEs scores are associated with negative short- and long-term consequences on domains such as health, neurological development, achievement, and involvement with the juvenile justice system. One study found that Black children and children with mothers from low education backgrounds were particularly likely to have been exposed to multiple ACEs (Hunt et al., 2017). Despite the array of mental health stressors, Black youth of African descent seek psychological treatment less often due to stigma associated with mental illness and treatment, distrust of providers, poorer quality of care, greater likelihood of clinical misdiagnosis, and culturally encapsulated attributions of disease etiology (Breland-Noble et al., 2011; Mojtabai et al., 2011; Ofonedu et al., 2017; Turner, 2019; Turner & Mills,

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2016). Research shows that social and psychological adversities contribute to barriers underserved families experience seeking mental health services for their children (Ofonedu et al., 2017). Additionally, current mental health care systems add to the complexities of providing high quality care for vulnerable and underserved families seeking child mental health treatment (Gross et al., 2018). For example, for underserved families seeking mental health services, perceived barriers to treatment include long wait times, concerns about the child's diagnosis, scheduling conflicts, unavailability of appointments, limited service locations, competing demands, and levels of adversity (Ofonedu et al., 2017). Research supports that culturally relevant practices help to increase treatment engagement and reduce treatment drop-out (American Psychological Association [APA], 2017; Ofonedu et al., 2017; Turner, 2019). Given the disparities in access to and utilization of mental health treatment, it is necessary to implement intervention programs and strategies that are culturally relevant.

Treatment engagement in the mental health realm focuses primarily on two areas, attendance at the first treatment session and ongoing participation in mental health services (Breland-Noble & Board, 2012; Breland-Noble et al., 2011; Lizardi & Stanley, 2010). Initially, treatment engagement models failed to account for cultural diversity and racial/ethnic differences in perceptions of mental illness and the type of care desired by clients. Whereas these previous theoretical models are helpful for understanding treatment with youth, there is a gap in applying these to Black families. One theoretical model discusses considerations for culture and context (Cauce et al., 2002), outlining how pathways to engaging in treatment among diverse families consist of three stages: problem recognition, the decision to seek help, and selecting a help provider. Other scholars have identified frameworks and models of treatment initiation and engagement across diverse groups. Some of these early models of treatment engagement for Black people are grounded in African principles, mores and values beginning with the works of scholars like Linda James Myers (Myers, 1993) and Carl Bell (Bell, 2001). Seminal work in this area also includes treatment engagement models tested by scholars like Lindsey and Breland-Noble with positive outcomes (See Breland-Noble, 2004) – grounded in the Transtheoretical Model of Change (Prochaska & DiClemente, 1992; Prochaska et al., 2013). The work of Breland-Noble (2004) further incorporates Community-Based Participatory Research principles through the Seven Field Principles (i.e., rebuilding/supporting the village; providing access to health care; improving bonding, attachment and connectedness; improving self-esteem; increasing social skills of target recipients; reestablishing/strengthening the adult protective shield; and minimizing residual effects of trauma) as presented by Dr. Carl Bell and colleagues (Bell et al., 2009). Building on the prior work of Cauce and other disparities scholars, this work is some of the earliest that directly addressed the process of encouraging Black families to recognize problems and seek mental health care for Black youth. More recently, scholars (Turner, 2019; Turner et al., 2019) have described a conceptual model of treatment initiation that builds upon the early seminal work of Black scholars. The Model of Treatment Initiation (MTI; Turner, 2019) identifies four major areas that influence treatment seeking: accessibility factors (structural variables that may influence an individual's ability to access treatment), availability factors (examines access to culturally competent services), appropriateness factors (examines how individuals view mental health problems as requiring treatment), and acceptability factors (captures variables such as stigma and cultural mistrust). These pathways may be particularly important for Black youth of African descent. For example, studies suggest the need to consider cultural and psychosocial influences on the presentation of depression and other psychological symptoms of distress in Black youth of African descent during assessment and treatment (Breland-Noble et al., 2016; Lindsey et al., 2006; Ofonedu et al., 2013). Overall, these earlier models demonstrated how cultural values and beliefs play an important role in decisions to seek and engage in mental health treatment. Therefore, it is imperative that the field considers how to integrate culture into assessment and treatment for Black families.

Interventions that are grounded in equitable partnerships foster engagement and strong working relationships that promote health outcomes. Research on treatment engagement and initiation

for culturally diverse and marginalized groups highlights equitable relationships and power-sharing as central to the promotion of health equity for this population (Butler, 2014; Reschly & Christenson, 2012; Reupert et al., 2015). Partnerships and treatment engagement processes that promote cultural humility are also central to the successful engagement of Black youth in mental health treatment. Cultural humility helps to establish strong working relationships and to overcome power imbalances that may exist in client-clinician relationships (Mosher et al., 2017; Owen et al., 2016; Tervalon & Murray-García, 1998). Having an attitude of humility allows clinicians to partner with their clients and respect their perspectives and worldviews. Conceptually, the Family as Host (FAH) model of engagement to facilitate successful treatment evolves from this perspective and clinical practice.

The current paper seeks to advance the literature by offering a new perspective, the Family as Host (FAH) model of treatment engagement. This perspective promotes access to non-stigmatizing and culturally responsive support for Black youth and their families seeking mental health treatment services. The FAH model is rooted in a person- and family-centered approach to treatment wherein the perspectives of the youth and their families are elevated in the early phases and throughout the assessment and treatment processes. The model adds to the literature on conceptualizations of treatment engagement of culturally diverse and underserved populations.

Family as Host (FAH) model of treatment engagement: a new framework

The Family as Host (FAH) model of treatment engagement is a six-step culturally responsive approach for engaging Black youth of African descent and their families in health treatment services. This framework positions Black youth of African descent and their families as primary *initiators*, acting as "*Host*," and clinical care providers as *facilitators*, acting as "*Guest*." The FAH model allows both the family and the clinician to travel *far* during the treatment journey. It provides an opportunity for clinicians to view treatment initiation and engagement from the client's perspective as opposed to the clinician's experience. FAH is an orientation to positionality rather than manualized use of language. The clinician's orientation is understanding the position of the family as *host* in the family's engagement of the therapeutic process. Unlike the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) Cultural Formulation Interview (CFI), which is structured for clinicians to implement at the beginning of diagnostic evaluation (American Psychiatric Association, 2013), the FAH model is a framework that extends beyond the intake stage and through the end of treatment. The model is organized into six stages: (1) problem identification and help seeking; (2) intake process; (3) treatment assessment; (4) treatment intervention; (5) acceptance of recommendations; and (6) treatment outcome (see Figure 1).

The following case example will be used to illustrate the application of the FAH model in working with Black youth of African descent and their families.

Case example: 13-year-old male school referral

Udo is a 13-year-old African American male who has been referred to the clinic for truancy, teacher and peer confrontations, and academic underperformance. The school counselor and principal have advised his mother to seek help for Udo before he gets into worse trouble. They believe Udo has attention and anger management issues and is depressed. Udo has an 11-year-old sister and 8-year-old brother. He lives with his single mother, a hospital cafeteria worker, in public housing which has neighborhood gang activities. His mother has variable work shifts that sometime require her to leave home before her children go to school or return well after school ends, depending upon the week. She relies upon Udo to help with his younger siblings, which include being responsive to his next-door neighbor, who is considered like an aunt, and his mother's sister who lives in the nearby public housing. His mother has enlisted both her neighbor and sister in monitoring her children's activities. Udo has become resentful of the monitoring and what he considers intrusive inquiries by his mother's co-parents.

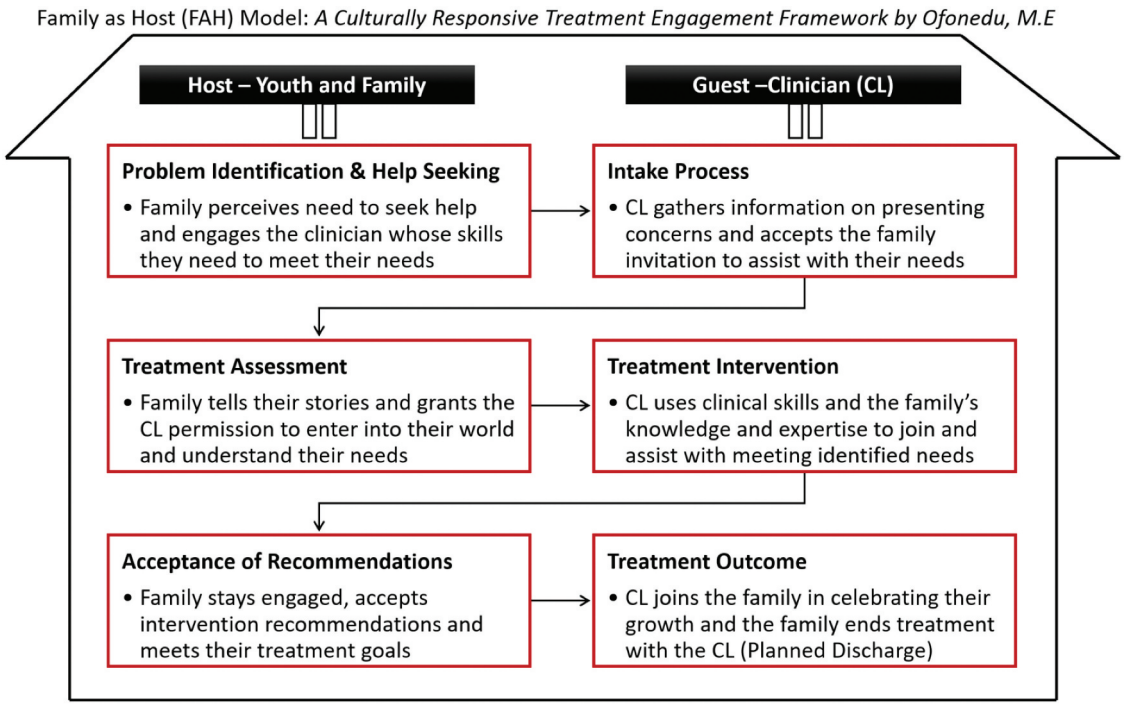

Figure 1. Family as Host (FAH) treatment engagement process map: a framework for culturally responsive treatment engagement.

Udo's mother is not convinced that he is as bad of a child as represented by the school. She is aware of how Black male children are labeled by schools and has gone to battle for Udo with his teachers and schools in the past. She does not see the same behavior in Udo as the school and suspects their motives. Her conversations with other parents and friends support her justification for suspicion of school motives. It is conventional wisdom in the community that Black male children are targeted by greater school expulsions. Moreover, the moodiness and oppositional behaviors she has observed in Udo in her opinion is justifiable by his adolescence and life circumstances. He is a Black male adolescent trying to survive the streets with limited family, school, and community resources. "Whose mental health wouldn't be challenged by these living conditions?," she exclaimed in a brief initial conversation with outreach staff from the community clinic where the family was referred.

Family as Host (FAH) model application

First stage of the FAH model: problem identification and help seeking

Engagement is a necessary component toward the achievement of positive treatment outcomes. Strategies that aim at targeting engagement early and throughout the treatment process for underserved Black youth and families are of critical importance to reducing health disparities (Ofonedu et al., 2017). Treatment engagement begins well before the family and clinician have contact with each other. It starts with the family's perception of the need to seek help for an identified problem and continues through the assessment and intervention process until treatment is completed (Boyd-Franklin, 2003; Franklin, 2018; Ofonedu et al., 2017). Helping clinicians understand this process is useful in decreasing the failure to attend the intake appointment and staying engaged in treatment.

The treatment entry door experience of a particular youth or family may influence their attitudes about engaging in treatment. Many racial and ethnic underserved populations, including African Americans, are less likely to seek psychological help (Anglin et al., 2008; Turner et al., 2015) and are more likely to end treatment prematurely (Arnow et al., 2007; Fortuna et al., 2010; Terrell & Terrell, 1984). Among Black people, fear of oppression in mental health settings, exposure to racial micro-aggressions, and mistrust in mental health systems might cause avoidance of care (Alang, 2019). While behavior problems are an important

motivator for families to seek help, many other factors interfere with them being able to get the mental health care they need for their children (Gross et al., 2018). According to research (Boyd-Franklin, 2003; Franklin, 2018; Gross et al., 2018; Ofonedu et al., 2017), several factors have been identified to affect treatment initiation and engagement, including practical factors (e.g., schedule conflicts, childcare issues, lack of transportation, and/or difficulties juggling competing demands) and perceptual factors (e.g., stigma, concern that child will be placed on medication, prior negative experiences with mental health care, feeling judged, and/or thoughts and beliefs about problems and ambivalence to change).

In the first stage of the FAH model, *problem identification and help seeking* process are important determinants of a client's engagement in the first phase of connecting to treatment services. At this stage, youth and their family perceive the need to seek help for their concerns and reach out to a qualified clinician whose skills they need to address those concerns. This is a very important step because failure to effectively respond to the outreach by the family will block the next stage (i.e., the *intake process)*. An example of disconnect in the case of Udo is in problem identification and the competing views of the parent and clinic staff as manifested in the intake person's report of the clinic's outreach to Udo's mother. The outreach staff noted in their initial report that the mother was resistant to having her son come in for treatment and she did not seem to understand the gravity of the referral. They also noted that she was not responsive to their outreach and that she was difficult to reach. Research cites competing demands and levels of adversity as barriers to treatment engagement (Ofonedu et al., 2017). The outreach staff had done little to understand the mother's work schedule and how that made it difficult for her to call back. Their brief conversation did not disclose how her perspective on seeking help for her son was greatly influenced by her community's conventional wisdom about treatment of Black males by schools and society at large. She felt they were also not sufficiently sensitive to her circumstances as a working single mother in the service industry where time off and work hours often are not as flexible and can prove consequential to her employment. Udo's mother, like many parents in her line of employment, consider clinicians' understanding and responsiveness to their work circumstances (as well as the clinic protocols) when they seek help. Within the FAH model, it is important for clinicians to properly assess the impressions molded by the client/family's first contact with their services. Clinicians should seek to learn the genuine context of the family's view of problem identification that guides their help-seeking behaviors. This will help facilitate the later stages of assistance, such as intake or assessment. During this initial stage/contact, it is also important for the clinician to explore the family's perspective without judgment. In the case of Udo, it would have been helpful for the staff to validate his mother's concerns (i.e., balancing her work and parent life) and to work together as a team to identify the service and therapy goals. By working from an egalitarian perspective, it could help to improve the alliance and engagement of the family in treatment (Turner & Mills, 2016).

Second stage of the FAH model: intake process

The second stage of the FAH model is the *intake process*. At this stage, the family, literally or by their presence invites the clinician to assist them with their concerns. Through their disclosure of family life and personal issues, the family opens their sacred space to the clinician. If the clinician feels qualified to assist the family with their concerns, as reflected in their ability to be empathic and skilled in joining with the family, they will accept the family's invitation and begin to nurture a clinical bond. The case of Udo is an example of elements within the first two stages of the FAH model (problem identification and help-seeking and intake process) that are essential in the help-seeking and engagement process. As a working single mom, if Udo's mother does not feel understood early at the problem identification and intake process stages, she may likewise suspect the provider's ability to understand her son's problems, much less her dilemma to manage them given her work and life circumstances. Despite the high levels of social adversity that underserved families endure, they still recognize the need for help and initiate mental health and behavioral intervention services for their

children (Ofonedu et al., 2017). For example, many families may seek informal help after they recognize that a problem may be psychological in nature. They may consult with family members, faith leaders, and other community members before seeking formal help (Belgrave & Allison, 2014; Boyd-Franklin, 2003). In addition, they may have experienced multiple unanswered phone calls or transfers that resulted in having to retell reasons for seeking help at each phone call. For a responsive engagement at this stage, the clinician needs to be skilled in interviewing and understand the service-seeking journey that many underserved families go through before making it to the intake process stage. Therefore, it is crucial to have an effective intake process that provides an opportunity to develop and build trust while learning why a family is seeking support. This will facilitate how the clinician conceptualizes treatment needs and possible treatment goals. Failure associated with a poor intake process can negatively impact the next stage (i.e., *the treatment assessment process*). An effective initial intake session, whether in-person or over the phone, is very important. For example, a parent may not be alone at home during a phone intake and as a result, they may not share all of their concerns. They may also be selective in what they disclose because of confidentiality and privacy concerns, fear that they may be judged, or not been able to secure an initial assessment appointment. Providing families with options, such as in-person follow up meeting, a call back, or the use of a secure and encrypted intake portal online are important intake process and engagement strategies. Close monitoring and evaluation of the intake process is necessary for effective triage of clients and families, assessment referrals, and management of waitlists. It is also important to engage in continuous needs assessment of the clinic and population served and addressing the structural barriers that go beyond attitudes. For example, lack of evening or weekend clinic hours, inflexible appointment times, long waitlist, cost, lack of virtual appointment, and limited staffing should be addressed. Lack of continuous assessment of the clinic and population it serves may hinder initial treatment engagement. For example, a parent's motivation to seek help for their child could be to consult with a mental health professional within a few days or week. If the clinic waiting period between initial contact and the first appointment is too long, the parent may be discouraged and may not follow through with their decision to seek professional help. Addressing these barriers and engaging in culturally relevant and responsive communication, especially during these early stages of treatment, can increase families' motivation and engagement in treatment and improve quality care and positive treatment outcomes (Ofonedu et al., 2017).

Third stage of the FAH model: treatment assessment

The third stage of the FAH model is the *treatment assessment* process. Assessment is an essential part of any treatment or intervention. At this stage, the family grants the clinician permission to enter into their world and understand their needs. This is another level of client/family investment in the clinical process and belief that there will be positive returns from engaging in the process. The client and their family tell their story and provide an in-depth description of their subjective lived experiences. In the case of Udo, this would be represented by the mother acknowledging that her son does have behaviors of concern and being comfortable aligning her perspective about her son's needs with the problem identified by the school. This may then result in her accepting or at least beginning to accept that the clinic is a safe place to seek help. It is important for clinicians to acknowledge and not outright dismiss youth and families' theory of the problem, or rather "informal versus professional formal reasons" for the problem during assessment, as it may inform the clinician's work with the family. While a clinician learns to apply theories to practice, a family uses their own learned theory to inform the clinician's work. For example, according to Udo's mother, his behavior is in part justifiable given his adolescence and life circumstances. During assessment, identification of possible strengths and building on them should serve as the core for efforts to promote positive emotional, social, behavioral, and academic outcomes for Black youth of African descent. For example, Udo's mother has managed family life as a single mom with a degree of success that can be mined for strengths to help with Udo. Her resilience should

be assessed with clinical acumen to integrate her strengths into the treatment intervention with her son. Her son, Udo, has likewise managed family life (e.g., helping with his younger sibling) and peer life (which the clinician should equally be assessing) in ways that represent strengths that should be incorporated into his treatment intervention.

It is important to obtain well-informed and accurate information during treatment assessment as it will inform treatment intervention. The use of treatment screening questionnaires that are not culturally relevant (for example omit identifying individual, extended family, and community strengths) may be inadequate to assess cultural factors that influence the mental health of underserved ethnic families and children (Ofonedu et al., 2017). Every family has a history that must be gathered and taken into account by the clinician as they strive to explain any of its members' behavior. Every family also has privileged access to the body of knowledge that is needed to guide any intervention. As a result, the family should have an active voice at every phase of the treatment assessment. Not including family voices during assessment minimizes the opportunity for an engaged and positive treatment outcome. The need to include and honor family voices in the mental health system of care has led to the family movement, which resulted in the adoption of the goal that mental health care should be consumer and family driven (Spencer et al., 2010). Black youth and their families need to tell their stories during treatment assessment. Therefore, it is critical that clinicians allow time for families' in-depth description of their experiences and sharing of their family theory of the problem and network of social supports that could be drawn upon to address their problems. Creating opportunities for families to openly express their thoughts and feelings during assessment and to access or to be exposed to enriched experiences and resources based on their needs, are critical to positive health outcome and equity. Adopting practices such as mutual respect, tolerance for differences of opinion, and respectful curiosity (Kirmayer, 2013) could facilitate the treatment assessment process. Lack of time leads to rushed assessments that are overly dependent upon clinician's experiences or clinic protocol. Allowing time for information gathering and engaging in collaborative decision-making will allow the clinician to engage in the process of *experiencing* (i.e., active listening and understanding of the presenting concerns) before *explaining* (i.e., sharing of diagnostic impressions). Efforts should be made to address any constraints to diagnostic assessment practice. Such efforts should include continuous quality improvement and ensuring a functional, unified, collaborative team; providing organizational support for staff training, education, and advocacy and addressing service billing concerns and insurance coverage restrictions. For example, a client's health insurance type and coverage may influence their treatment access and care quality and the non-reimbursement of service concerns can undermine a clinician's effort in providing comprehensive assessment. Poor treatment assessment will maximize misdiagnosis, minimize client/family engagement, and block the next stages (i.e., *treatment intervention and acceptance of treatment recommendations*).

Fourth stage of the FAH model: treatment intervention

The fourth stage of the FAH model is the *treatment intervention* process. With an understanding that the family holds the key to unlock the door to their recovery process through full engagement, the clinician uses their clinical skills and knowledge gained from the family to establish a solid therapeutic relationship with the family and assist them with addressing their concerns. Research notes that the therapeutic relationship is the building block that unites clients and their clinicians as they work to achieve mutually agreed upon treatment goals (Oddli et al., 2021). Although walking into the unfamiliar world of Black youth and families may be challenging for some clinicians, it is important to allow time to establish a therapeutic alliance early in treatment that will facilitate the clinician's entry into the family's world. Black youth and families must grant the clinician permission to enter into their world for a successful intervention and outcome. Having a strong therapeutic relationship makes being on the treatment intervention journey together possible. In the case of Udo, this would be represented by the clinician validating the mother's feelings (e.g., about work and parent life), and

showing genuine concern and respect. At this stage, it is important that the clinician recognizes and draws from the assets and strengths within the family system and tailor their intervention recommendations to match resources available to the family (Chung et al., 2016; Garg et al., 2016; Turner, 2019). Healing should not be considered as an individual process but that which includes the family as a whole (Reupert et al., 2015). This means that the clinician should consider the role of extended family and their collective definition of the problem and possible solutions to them during treatment intervention. For example, Udo's mother noted that conventional beliefs among African Americans in many communities are that Black boys in schools are often disproportionately labeled as behavior problems, more unfairly expelled from school, and being tracked into schools and classrooms with less educational opportunities. African American mothers within her close circle of friends whom she relies upon for social support and advice cautioned her about the information she receives from school administrators as well as school counselors and other providers about how to handle Udo. This advice from her close friends is consistent with a narrative she has heard before from other people within the African American community, which is: counselors, psychologists, physicians, social workers and other allied health and mental health professionals are part of a health care system of providers that should be viewed with skepticism. That skepticism has been socialized by anecdotes shared between African Americans for generations about historical health care mistreatment (e.g., Tuskegee Experiment) and underserving of the community (Boyd-Franklin, 2003; Franklin, 2018).

Culture plays a role in the healing process. The healing process can be facilitated when clinicians show cultural sensitivity by holding their clients' culture in high esteem and with appreciation. According to Sue et al. (2013), clinicians who are culturally sensitive are aware of their own cultural heritage and are comfortable with the differences that may exist across the client-clinician dyad. Also, clinicians who understand their own cultural identities, biases, and power, and who can communicate cultural empathy and facilitate clients' feelings of empowerment, are better able to facilitate cultural competency and effective treatment assessment, intervention and engagement (Chu et al., 2016).

A culturally sensitive and responsive clinician should not begin treatment thinking exclusively about what strategy they should use to address a particular client/family concern. Instead, they should allow time for the strategy to present itself by allowing the client and their family to take them into their world, which will help to reveal, collaboratively, the best strategies for addressing the family problems. A clinician's knowledge, beliefs, and attitudes can affect their sensitivity to Black youth's needs and their intervention approach selection. Therefore, it is important to consider how the clinician's personal values may influence the way they practice, how they view the presenting concerns, their perceptions of Black families, and the goals for treatment. For example, if the clinician acknowledges Udo mother's work circumstances, time demands, job security, and her community views of parenting, it can influence the mother's ability to participate in and be effective in her son's treatment. These are attributes of cultural sensitivity and responsiveness by the clinician. Clinicians working with Black youth and their families should frequently engage in critical self-reflection and utilize culturally competent supervision. Cultural competence in practice entails the recognition of the client's diversity including their gender identity, age, sexual orientation/identity, socioeconomic status, ability status, religious and spiritual beliefs, national origin, immigration status, level of acculturation, educational level, and historical life experiences (Turner, 2019). When working with clients of African descent, spirituality, religious orientation, values and belief system, family orientation, perception of self as a member of a clan or cultural group, and cultural and psychosocial influences should be explored and considered during treatment intervention (e.g., Ofonedu et al., 2017; Reupert et al., 2015; Turner et al., 2016). A critical reflection by the clinician using the following questions: (1) how do I connect with Black youth, their families, and communities? (2) how do I engage and support the experience described by Black youth and their families? (3) how do I build and sustain Black youth and their families' protective factors that promote their resilience?, could help to unpack the clinician's own intersectional identities

and how they relate to their client/family that they serve.

Black youth, their families, and clinicians who work with them each bring unique perspectives and expertise into the treatment intervention process. The importance of family partnering and collaborative decision-making is well established in the literature (Charles et al., 1997; Reschly & Christenson, 2012). Evidence suggests that racial and ethnic underserved families seeking help, especially for child mental health conditions, have fewer opportunities to engage in shared decision-making with providers because it is not usually offered as an option (Butler, 2014). Although an equal partnership in the decision-making process is highly recommended, power is usually concentrated in the hands of the clinician. It is a violation of human rights when Black youth and their families are not included in the treatment decision-making process. Clinicians should not just *involve* families in treatment, they should *engage* families and invite them to serve as partners and care collaborators at all stages of the treatment process. Clinicians should also plant themselves as partners with families and not as advisers. Engaged partnership allows the clinician to support the client and their family members and organize referrals as appropriate. They should prioritize shared decision-making over information sharing with families. Ensuring the full inclusion of Black youth and their families in the treatment intervention process will help facilitate the next FAH model stage –i.e., acceptance of treatment recommendations.

Fifth stage of the FAH model: acceptance of treatment recommendations

The fifth stage of the FAH model is the *acceptance of treatment recommendations*. Acceptability of treatment recommendations leads to positive treatment outcomes. This stage requires the clinician to draw from the solid therapeutic relationship that has been established. This allows for the family to stay engaged in treatment and accepts the clinician's recommendations that will help to meet their treatment goals. This also means, on some level, that the client/family has to believe that the treatment being recommended makes sense to them independent of how much it makes sense to the clinician in their professional opinion. Engaging in a nonhierarchical therapeutic relationship that is based on mutual respect helps to bring the needs, assets, and capabilities of the client and the family into alignment with the demands and resources of the social system in which they are embedded. The family draws from their social support, encouraged by the clinician, as they navigate the school, mental health, and other service systems. For a Black youth, to heal from emotional distress often involves having strong social and family support and to be shielded by family and friends (Ofonedu et al., 2013). Drawing from the family's social capital can facilitate acceptance of treatment recommendations and help improve engagement.

In the case of Udo, this would be represented by the family accepting the clinician's recommendations. For example, if part of the identified problem is Udo's resistance to his mother utilizing both her neighbor and nearby sister in monitoring and parenting her children, an element of treatment intervention is helping Udo to understand, in greater depth, his mother's reasons for this arrangement and how that serves as a family strength and asset. Part of his mother's practice is determined by her fears for their safety and welfare when she is required to be at work and cannot monitor them, how she views herself as a "good-enough parent," and what family/friends say parents must do. Udo's mother has not fully shared or explained her motivations, much less fears, to Udo. This is in part her personal philosophy that children do not need reasons for parental behavior. Part of the intervention is to have mother and son discussion in sessions to help Udo understand his mother's reasons behind her behavior and to help Udo's mother to understand his resistance. A goal of the intervention is to reduce his resistance to monitoring and perhaps solicit from him strategies for allaying both his and his mother's concerns. The intervention could also include bringing in both the neighbor and his mother's sister into the mother-son discussions to further expand understanding among all parties and to evolve strategies to reduce resistance and maximize comfort about safety while recognizing Udo's evolving autonomy. These efforts as well as the cultural competence and sensitivity of the clinician, facilitate efficacy outcomes. Acceptance of the intervention recommendations is

paramount to the last stage of the FAH model – i.e., the treatment outcome.

Sixth stage of the FAH model: treatment outcome

The sixth and last stage of the FAH model is the *treatment outcome*. At this stage, a mutual agreement on whether the family's treatment goals have been met is discussed. When there is an agreement, the clinician joins the family in celebrating their growth and treatment accomplishments. The family as *host*, ends treatment by discharging the clinician, whom they have invited as *guest* into their world. In the case of Udo, this would be represented by the family perceiving themselves to have met their treatment goals and the clinician acknowledges that there has been clinically significant change. It is important to avoid labeling a family as "dropping out" when the family believes that they have met their goals or when they may not have accomplished all the goals prescribed by the intervention. For example, Udo and his mother may only come to a limited understanding and acceptance of his mother's need and arrangement for parental monitoring. It may mean that Udo has acquired greater knowledge, reducing some of his resistance, if not complete acceptance of his mother's practice.

The following four engagement principles should be considered when applying the FAH model: (1) *Therapeutic alliance*: (i.e., joining with understanding and acceptance and engaging in relationships based on mutual respect that enables the family to allow the clinician into the their world) takes into account the positionality of families in the therapeutic relationship and recognizes how the clinician positionality may impact treatment engagement and the experience clients and families report. Similarly, to the CFI that has been found to improve a client's communication and rapport with the clinician (Aggarwal et al., 2015; Lewis-Fernández et al., 2017), the FAH model positions the clinician as a learner who is open to what clients and families are thinking and feelings about their situations. This helps to establish a solid therapeutic alliance early in treatment that will facilitate full engagement. (2) *Strength-based*: (i.e., drawing from and building upon youth and family strengths and assets) seeks to obtain insider's perspective that captures the individualistic experiences that made each Black youth and family unique and distinctive from each other. (3) *Family and person-centered care*: (i.e., considering the heterogeneity among Black people of African descent and recognizing how within group differences impact client and family characterization and description of experiences, relationships and interpretation of presenting concerns) uses culturally-informed linguistic practices that support the youth and family's preferred learning and communication styles and modifies approaches to match their available resources and other preferences and needs. Adopts a flexible conversational style and understands the colloquialisms of the community and how the client and family contextualized their experiences. (4) *Engaged partnership and collaboration*: (i.e., partnering with youth and families and positioning them as "*host*" [i.e., primary initiators with lived experience and expert knowledge] with the clinician as "*guest*." [i.e., facilitators who gained their expertise from academic and practice trainings])helps to counter the power imbalances that exist in therapeutic relationships and moves mental health care of Black people of African descent toward equity. Table 1 identifies some practice goals and questions that can be used to guide reflective deliberation at each of the FAH stages. The questions are meant to drive discussion and should be understood within the context of how Black people of African descent attach meaning to their experiences. They offer ways to approach discussion with sensitivity to understand individual needs. Although there is complexity with understanding each family's experience, it is important for clinicians to understand that how they engage with clients and their families plays a vital role in facilitating trust and a strong therapeutic relationship to strengthen treatment outcomes. The FAH model of treatment engagement provides the pathways for promoting the positive mental health outcomes of Black youth of African descent and serves as an important practice framework when working with culturally diverse groups.

Discussion

Research demonstrates that Black youth of African descent are disproportionately impacted by mental

Table 1. Practice goals and questions to support application of the Family as Host (FAH) model.

FAH Stages	Practice Goals	Questions
Problem Identification and Help Seeking	Assess the impressions molded by the client/family's first contact with your services and learn the genuine context of the family's view of problem identification that guides their help-seeking behaviors.	What were your individual, family or friends' views that influenced your help seeking and keeping this appointment?
Intake Process	Learn why a family is seeking support while providing opportunities to develop and build trust.	What would you like help with? What has been your experience with seeking help about this problem?
Treatment Evaluation	Explore youth and families' theory of the problem or the informal versus professional formal reasons for the problems while acknowledging and honoring their voices.	How do you view the problems? What are your family and friends' opinions of the problems?
Treatment Intervention	Explore the family's experience in trying to address the problems while recognizing and drawing from the assets and strengths within the family system.	What has helped and did not help you and your family as you try to address the problems?
Acceptance of Recommendations	Explore what would help to facilitate the family's acceptance of recommendations and improve engagement and do so while engaging in a non-hierarchical therapeutic relationship that is based on mutual respect.	What do you think would work best for your family? How can we help each other and partner on these treatment recommendations?
Treatment Outcome	Explore whether a mutually agreed upon treatment goals have been met while respecting the family's decision to end treatment without labeling them as "drop out" when the family believes that they have met their goals.	How would you describe what a successful treatment outcome would be for you and your family?

health disparities (Breland-Noble et al., 2011; Breland-Noble & Board, 2012; Mojtabai et al., 2011; Ofonedu et al., 2013; Turner et al., 2016), therefore it is imperative to identify ways to improve treatment engagement and intervention. This paper articulates the FAH model as an innovative approach to increase cultural responsivity and sensitivity when working with Black families and underserved ethnic groups. Whereas several approaches and methods could be helpful to address disparities in care when working with this community, existing models lack attention to cultural considerations such as allowing the family to lead and take ownership of the process. For example, some models emphasize the importance of context or community, but the clinician is still the primary agent to guide the session(s).

The FAH model proposes that an effective intervention model is one that attempts to increase the clinicians' awareness of factors that contribute to the intra- and interpersonal difficulties of Black youth and improve their understanding of factors to consider when the goal is to increase adaptive functioning. For example, within stage 1 and 2 (problem identification and intake process), an opportunity for the clinician to gather information and question their own assumptions about the clients presenting concerns and how the environment contributes to the client and family's functioning was provided. While the impact of historical events and experience of oppression should be considered when assessing mental health functioning (Adewale et al., 2016; Franklin, 2018), it is recommended that no assumption should be made that all Black clients and their families will experience these events in the same way. Some scholars note that although individuals may experience racial discrimination, how they interpret those events and how their coping resources play a role in their psychological reaction to those events may differ (Carter, 2007; Turner, 2019). Western trained clinicians should also recognize that avoiding discussions around negative life events and experiences that are influenced by racial and colonial oppression during treatment assessment and intervention could obstruct one's ability to provide culturally responsive care (Rosen et al., 2019). These experiences are foundational to understanding the social and cultural context to engage Black youth and their families in treatment (Boyd-Franklin & Bry, 2019; Ofonedu et al., 2013; Rosen et al., 2019). While the discussion of colonial oppression and racial factors in treatment can instigate negative reactions, such as feelings of anxiety, anger, confusion, distress, or tension, on the part of the clinician and the client, such a discussion has the potential to facilitate the engagement and healing process. To increase cultural responsivity and become an antiracist clinician, it is necessary that Western trained clinicians learn how to manage conversations around race with Black families (Rosen et al., 2019) and not avoid such conversations. Furthermore, clinicians need to be aware of how their behaviors shape the families' engagement during assessment and treatment. If clinicians are not aware of cultural mistrust or reluctance by clients to open up, it could lead to inaccurate

assessment and to difficulties implementing interventions (Ofonedu et al., 2013; Turner & Mills, 2016; Turner et al., 2019).

Research consistently shows that having an accurate understanding of a client's cultural system contributes to better treatment outcomes (Belgrave & Allison, 2014; Ofonedu et al., 2013; Turner et al., 2019). The Family as Host model provides a framework for clinicians to apply when working with youth of African descent and their families (see Figure 1). Central to this process is recognizing the importance of culturally relevant care and communications. To effectively navigate the complexities of ethnic heterogeneity and understand the community contexts that inform family life for Black people of African descent and other ethnic groups, it is important for clinicians to participate in multicultural courses and training in professional development. This specific training furthers the acquisition of knowledge in FAH concepts and practices. Consistent with an African-centered perspective, the FAH model encourages clinicians to allow the family to guide assessment and treatment which can improve the therapeutic relationship and engage families in the process (e.g., Boyd-Franklin, 2003; Franklin, 2018; Ofonedu et al., 2017; Turner & Mills, 2016). From a Western perspective, the family is not always considered as having agency to determine the flow of assessment or treatment. The proposed FAH model urges clinicians to view their perspective as being secondary, or at least complementary to the expertise of the family. This idea also supports a more egalitarian process in treatment which may be particularly important when working with Black families. To improve engagement throughout assessment and treatment, it is critical that the family unit is fully involved and that the clinician is intentional about supporting the family throughout the process (Ofonedu et al., 2013; Turner, 2019). Given the importance of integrating different cultural practices in healing, Western medicine should not be promoted as the only legitimate approach to assessment and intervention. For example, prayer and faith healing practices such as the use of oils, incense, or holy water, should not be considered primitive or dismissed, as they represent culturally accepted forms of healing practice or alternative healing practice for mental health in most communities of African descent. It is important for clinicians to validate these approaches even when they may not be utilizing them in treatment. The field of psychology, social work, and other health professions that are interested in African culture and traditional beliefs and healing practices should increase their efforts to conduct and better disseminate psychological research in communities of African descent. As a field, training regarding other forms of healing is significantly limited. Therefore, efforts that focus on African-centered mental health treatment approaches and healing practices is necessary. To advance research and practice with this population, it is necessary to continue to expand these efforts that contribute to and improve culturally responsive care. Engaging Black youth and their families in these efforts are critical to promoting their engagement in care and for positive treatment outcomes. Sustaining these efforts requires ongoing opportunity to engage this population in shared leadership and decision-making. When we respectfully engage, affirm, and listen well enough to Black youth of African descent and their families, they will allow us to enter into their world and show us where the solutions to their concerns lie.

Disclosure statement

"Udo" and his family are a composite case example of a typical adolescent/family presenting to our clinic.

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