Engaging Youth and Families in School Mental Health Services

Kimberly D. Becker, PhD[a,*], Sara L. Buckingham, MA[b], Nicole Evangelista Brandt, PhD[c]

KEYWORDS

• Engagement • Barriers • School mental health • Families • Youth

KEY POINTS

- Engaging youth and families in children's mental health treatment is challenging.
- School mental health services increase access to care for youth; however, there are unique barriers to engaging families in treatment.
- Strategies to effectively engage families have been identified based on a review of the extant literature and findings from focus groups with consumers.
- Providers can thoughtfully decide which engagement strategies will address their clients' barriers.

Estimates suggest that 20% to 40% of youth have a psychiatric disorder[1] and may be in need of mental health services. Yet, national survey data show that as many as 75% of youth in need of mental health services do not enroll in treatment.[2,3] Schools are the primary entry point for children and adolescents who receive mental health services,[4] and more youths receive mental health services in schools than in any other setting.[5] Across school and specialty mental health settings, treatment engagement remains low relative to the needs of youth. Of those few children and adolescents who enroll in services, approximately 55% do not attend the first session,[6,7] and 50% to 70% terminate treatment prematurely.[8,9]

Funding Source: 1915c Demonstration Waiver: Community Alternatives to Psychiatric and Residential Treatment Facilities Demonstration Waiver Program Management, Workforce Development and Program Evaluation.
Conflict of Interest: The authors have no conflicts of interest to report.
[a] Division of Child and Adolescent Psychiatry, University of Maryland School of Medicine, 737 West Lombard Street, Room 424, Baltimore, MD 21201, USA; [b] Human Services Psychology Program, University of Maryland, Baltimore County, 1000 Hilltop Circle, Math/Psych Room 312, Baltimore, MD 21250, USA; [c] Department of Psychology, Columbus State Community College, 550 East Spring Street, Room 335B, Columbus, OH 43215, USA
* Corresponding author.
E-mail address: kbecker@psych.umaryland.edu

Child Adolesc Psychiatric Clin N Am 24 (2015) 385–398
http://dx.doi.org/10.1016/j.chc.2014.11.002 **childpsych.theclinics.com**
1056-4993/15/$ – see front matter

Abbreviations

BSPS-DV	Barriers to Service Participation Scale for Caregivers and Children Who Experience Domestic Violence
BTPS	Barriers to Treatment Participation Scale
SMH	School mental health

Many factors influence youth and family engagement in mental health services.[10–13] One of the most obvious factors is the availability and accessibility of services. The delivery of mental health services in schools has the potential to fundamentally enhance treatment engagement by increasing access to care for youth in need.[14–16] Such accessibility allows for children's mental health problems to be identified early by school personnel (ie, problems often manifest as poor academic or behavioral performance in the classroom), who can provide more efficient referrals for school mental health (SMH) treatment. Mandatory school attendance and the naturalistic setting of SMH services may mitigate both practical (eg, transportation issues, scheduling conflicts) and psychological (eg, stigma) barriers.[17–20] Further, youth who receive SMH treatment learn skills that may be better generalized, because the skills are taught in a natural, social setting.[21]

Although there are certainly advantages to SMH services related to better access to care and follow through with referrals, there are unique barriers to engagement.[6,22] Enrollment in SMH services requires identification of youth who could benefit from mental health services, and many teachers report a lack of training and experience in this area.[23] Adolescents in particular have many issues that may prevent them from seeking care, such as perceiving that they should handle mental health problems on their own, failing to recognize that their mental health problems require treatment, not believing that mental health services would be useful, and paying greater attention to peers' views and worrying about stigma, privacy, and confidentiality.[22,24] Although housing mental health services in schools increases accessibility for youth, it can hinder families from engaging in treatment. For example, the timing of the services often coincides with caregivers' work schedules.[25] In addition, caregivers vary in the extent to which they are involved with or connected to their children's schools; thus, SMH may not be desirable for all caregivers.[26,27] Hence, SMH services cannot fully mitigate all barriers to treatment engagement. It therefore falls within the role of the mental health provider to use additional strategies to manage the many obstacles that youth and families continue to face. In our own work as scientist-practitioners, we have taken a 2-pronged approach to identifying strategies to enhance treatment engagement by (1) reviewing the empirical literature (ie, Refs.[28,29]) and (2) querying consumers of mental health services (ie, Brandt NE, Buckingham SL, Becker KD, et al. Youth and family perspectives about children's mental health services: barriers to and facilitators of engagement, manuscript in preparation).

There is a burgeoning literature that can guide providers on how to reduce barriers and enhance treatment engagement. Over the past decade, multiple investigators (eg, Refs.[30–34]) have published qualitative reviews of engagement intervention studies, presenting strategies for better engaging families in services. Another approach to reviewing the literature involved a quantitative review of 40 randomized controlled trials testing engagement interventions in child and adolescent mental health services using a distillation method[35] to identify practices commonly used in effective engagement interventions (eg, appointment reminders, reinforcement, motivational enhancement). Lindsey and colleagues[28] concluded that the practices most frequently used in effective engagement interventions include assessment,

accessibility promotion, psychoeducation about services, homework assignment, and assessing barriers to treatment.

Expanding on this work, Becker and colleagues[29] examined whether practices varied according to the engagement outcome of interest in the study: attendance, cognitive preparation (eg, understanding of and expectations for treatment, motivation for change), and adherence (eg, session participation, out-of-session practice, contact with referrals; **Fig. 1** shows engagement practices mapped onto the outcomes). Results showed that certain practices, such as accessibility promotion, assessment, and psychoeducation about services, were frequently used across multiple outcomes.[29] In contrast, assessment of barriers to treatment was frequently used in interventions successful at increasing attendance. Homework assignment was common in interventions targeting adherence, whereas modeling and instilling hope were used in interventions targeting cognitive preparation. This comprehensive literature review suggests that certain engagement practices were more frequent than others and that their use varied according to the engagement outcome of interest. Armed with this knowledge, providers can make decisions to use more strategies that work to strategically enhance cognitive and behavioral domains of treatment engagement that are tailored for each client.

To explore the validity of these engagement practices, our team conducted focus groups to examine youth's and families' experiences with children's mental health

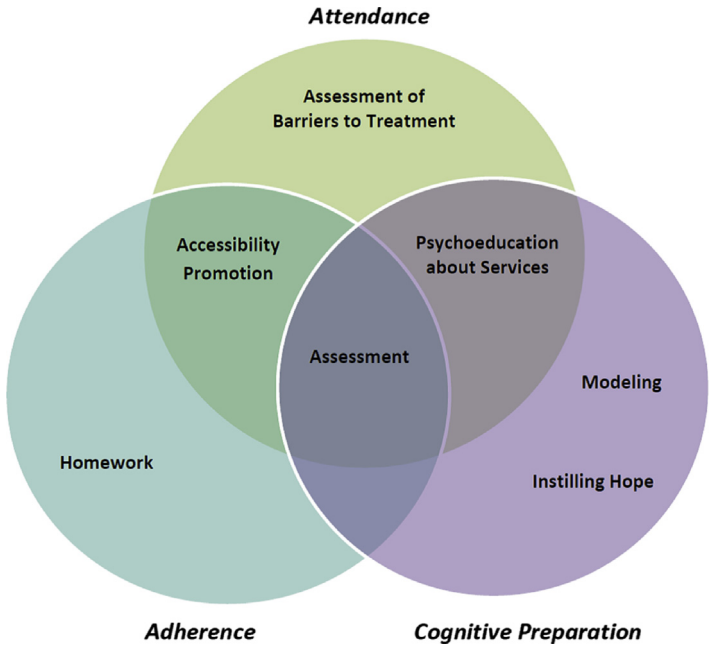

Fig. 1. Engagement practices by engagement outcome. A literature review[29] identified adherence (*lower left*), attendance (*top*), and cognitive preparation (*lower right*) as 3 frequent engagement outcomes measured in children's mental health services research. Some engagement practices (eg, assessment of barriers to treatment) situated within 1 circle in the figure were uniquely associated with a particular engagement outcome (eg, attendance). In contrast, other practices (eg, psychoeducation about services) situated within overlapping circles in the figure were associated with multiple engagement outcomes (eg, attendance, cognitive preparation).

treatment, and perspectives on providers' engagement techniques (Brandt NE, Buckingham SL, Becker KD, et al. Youth and family perspectives about children's mental health services: barriers to and facilitators of engagement, manuscript in preparation). During 4 focus groups, consumers of children's mental health services (ie, youth and young adults [$n = 11$]; caregivers [$n = 20$]) described their involvement in treatment, challenges to their participation in treatment, and strategies that providers had used or could use to engage them in services. Participants reported many attitudinal and practical barriers to treatment engagement (eg, poor relationship with provider, perceptions that therapy was unfocused, location). They noted several strategies that providers had used to address these barriers and improve engagement. Although these strategies frequently coincided with the literature (**Table 1**), participants recommended additional engagement strategies. For example, they recommended that providers connect and empathize with their clients, strive to truly understand their clients, and build a relationship with their clients to encourage the families to have a strong voice and choice in treatment (ie, rapport building, cultural acknowledgment, compassion, empowerment, and youth-directed and family-directed services). Focus group participants also suggested that providers use a collaborative approach to goal setting, coordinate with other service providers to achieve treatment goals, continually assess progress toward treatment goals, and provide consumers with clear expectations for treatment (ie, goal setting, progress monitoring, service coordination, managing expectations). Brandt and colleagues (Brandt NE, Buckingham SL, Becker KD, et al. Youth and family perspectives about children's mental health services: barriers to and facilitators of engagement, unpublished data, 2015) concluded that although there is significant alignment between the extant engagement literature and consumer recommendations, there seems to be a gap in provider use of these strategies in clinical settings.

This empirical work laid the groundwork for the creation of professional development workshops on engaging youths and families in children's mental health services (Becker KD, Buckingham SL, Brandt NE, et al. Training therapists in evidence-based family engagement practices, unpublished data, 2015), as well as the development of resources for providers seeking to assess treatment engagement and incorporate engagement techniques into their clinical practice. The Strategic Engagement Checklist (Appendix 1) guides providers through a series of questions to reflect on a youth's or family's treatment engagement. Indicators of low engagement are linked to specific engagement practices that a provider could implement to address that particular engagement issue. This checklist can be used at the beginning of treatment to promote engagement or throughout the course of treatment to monitor engagement and manage new issues that arise.

Questionnaires are available in the literature to assist providers with determining what barriers are likely to impede treatment engagement, including the Barriers to Treatment Participation Scale (BTPS)[36–40] and the Barriers to Service Participation Scale for Caregivers and Children Who Experience Domestic Violence (BSPS-DV) (Becker KD, Mueller CW, Kanuha VK. Barriers to service participation scale for mothers and children who experience domestic violence, unpublished data, 2012).[41] The BTPS is completed by caregivers and assesses barriers to treatment, whereas the BSPS-DV includes both caregiver and youth versions, consisting of items measuring barriers to and facilitators of treatment engagement. With knowledge of the barriers facing youth and their families in treatment, a provider can use the Strategic Engagement Checklist (Appendix 1) to further consider what engagement strategy might be used to address one of several common barriers. The 4 case vignettes that follow show the integration of these resources and the application of engagement practices within the context of SMH services. At the end of each case vignette is a corresponding checklist of engagement strategies.

Table 1
Engagement strategies

Commonly Suggested By	Strategy	Definition
Literature review	Homework assignment	Therapeutic tasks given to youth/families to complete outside sessions to reinforce/facilitate knowledge and skills
	Modeling	Demonstration of a desired behavior to promote imitation and performance of that behavior by client
	Motivational enhancement	Exercises designed to increase readiness to participate in additional therapeutic activity or programs
Focus groups	Compassion	Expression of empathy for the youth/family and their situation
	Cultural acknowledgment	Asking questions designed to explore the client's culture; adapting therapeutic practices to incorporate youth/family's culture (eg, race/ethnicity, age, sexual orientation, religion)
	Empowerment and youth-directed/family-directed services	Validation of youth/family experiences, roles, and perspectives; supporting self-efficacy by providing opportunities for choice and involvement in decisions; collaboration with the family
	Goal setting	Selection of a therapeutic goal for the purpose of working toward achieving that goal
	Managing expectations	Discussion or provision of corrective information to help the family have realistic expectations for treatment (pace, duration, improvement progress)
	Progress monitoring	Repeated review of a target process or behavior throughout treatment to regularly assess progress, homework completion, satisfaction with services, or youth/family's perception of therapeutic relationship, with the goal of eliciting feedback or information so that the provider can address potential problems
	Rapport building	Enhancement of the quality of the relationship between the youth/family and the provider
	Service coordination	Coordination and oversight of formal supports; communication with the youth/family's other providers
Literature review and focus groups	Accessibility promotion	Any strategy used to make services convenient and accessible (eg, offering evening hours, transportation, coming to the house, child care, reduced fees); providing around-the-clock access to services
	Assessment	Information gathering about the youth's strengths and needs through the use of a variety of methods (including interviews, questionnaires, observations) at the beginning of treatment
	Assessment of barriers to treatment	Open discussion about barriers to participation in treatment (eg, practical issues, previous experiences, stigma)
	Instilling hope	Facilitation of positive expectations for change
	Psychoeducation of services	Review of information about services or the service delivery system (eg, session frequency/content, roles of provider and youth/families)

Case Vignettes

VIGNETTE 1: PROMOTING ENGAGEMENT FOR ALL YOUTHS AND FAMILIES

Case Background

Mr Hart was the first SMH provider at his school, and found that most students and families did not understand his role as an SMH provider and the services that he could provide. In addition, his impression was that the families and surrounding community were distrustful of mental health providers. Several teachers had approached Mr Hart and informed him that several students were showing severe disruptive behaviors; the teachers wanted him to help immediately. Although Mr Hart knew that many students could benefit from mental health services right away, he had been unsuccessful reaching caregivers to schedule an intake and enroll them in services. To identify the most appropriate engagement strategies, Mr Hart used the Strategic Engagement Checklist (see Appendix 1) and determined that he would use school-wide engagement strategies to increase the visibility of his services in the school and to build rapport with school staff, students, and families.

Rapport Building and Psychoeducation About Services

Mr Hart capitalized on opportunities to make connections and build rapport with all youths, families, and school staff during school-wide events. To develop these relationships, he attended school-sponsored family events, such as back to school night or a science fair, and participated in parent-teacher organization meetings. During these events, he had an informational table on hot topics that concerned caregivers, were not stigmatizing, and were culturally appropriate (eg, stress management for parents, tips for Internet safety and children, how to manage homework time). Mr Hart also attempted to reduce mental health treatment stigma by showcasing and providing information about SMH services during these school-wide events and alongside other school programs (eg, band, chess, athletic teams). These outreach efforts allowed him to build relationships with all families (regardless of their need for SMH services), reduce stigma about mental health, connect with families who may be interested in SMH services, and provide education about SMH services. By showing that he was committed to the students and families at the school, Mr Hart forged strong relationships with other school staff. When Mr Hart was unable to reach a caregiver whose child could benefit from SMH services, he reached out to his colleagues on the school staff to help facilitate communication with the family. In these ways, Mr Hart earned a reputation among the school staff and community members that he was kind, sincere, and trustworthy, which helped caregivers to feel comfortable enrolling their child for SMH services.

*In addition to connecting with caregivers, Mr Hart also conducted classroom-wide prevention activities to reach many students in the school. The prevention activities introduced the students to Mr Hart, reduced the stigma of mental health, and provided an entry into future services. In these ways, Mr Hart proactively built rapport and engaged youths and families before connecting with them about SMH services (**Box 1**).*

Box 1
Tips for promoting engagement for all youths and families

- Attend school-sponsored family events
- Organize an informational table showing parenting topics or strategies
- Provide information about SMH services in a nonstigmatizing manner
- Participate in school-wide events with youth
- Conduct classroom-wide prevention activities
- Collaborate with school staff to facilitate communication with families

VIGNETTE 2: FOSTERING ENGAGEMENT WHILE CONDUCTING BUSINESS

Case Background

Maria, a 13-year-old Latina student nearing the end of eighth grade, was referred by the art teacher for depressed mood and decreased performance. Ms Boyd, the SMH provider, scheduled an intake with Maria and her mother.

Empowerment

Ms Boyd knew that it was easy to fall into using an expert approach and not be collaborative with families. This approach might negatively affect the family's engagement in treatment. Expert and noncollaborative approaches often lead families to feel misunderstood, devalued, and unimportant. Instead, Ms Boyd used a collaborative approach during the intake and worked carefully to let the family take the lead and tell their story. Ms Boyd briefly discussed her experience in working with youth to improve emotional and behavioral functioning; yet, she emphasized that Maria and her mother were experts on their family (as opposed to Ms Boyd being the expert). She explained that they would work as a team to help improve Maria's mood and academic performance. This approach empowered the family by encouraging their voice to be heard and allowing them to guide treatment from the beginning.

Assessment

As requested by Ms Boyd, Maria and her mother completed questionnaires to assess Maria's mood and related concerns. Although Ms Boyd did not have time to score all of the questionnaires, she provided initial feedback and discussed how some of the family's responses might suggest depression and anxiety that would benefit from treatment. She informed the family that comprehensive feedback about the assessment would be presented at the next meeting.

Psychoeducation About Services

At a meeting after the assessment, Ms Boyd provided comprehensive psychoeducation about the services, including information about the nature of services (eg, theoretic approach, availability of psychiatry services), treatment demands (eg, frequency, cost, activities), and the responsibilities of the provider, Maria, and her mother. Ms Boyd educated the family about issues particularly relevant to the school setting. For example, she discussed confidentiality issues, highlighting the fact that the family could complete a release of information form that allowed school staff and Ms Boyd to exchange information. She also reassured them that therapy sessions would be short (ie, 30 minutes) and missed instruction time in classroom would be minimized. She discussed scheduling and availability of services during the summer. Ms Boyd comprehensively described her role, Maria's role, and her mother's role in treatment, emphasizing the importance of Maria's mother's engagement. During this conversation, Ms Boyd solicited their feedback regarding their role in treatment, helped to establish reasonable expectations, and provided flexible options for the mother's participation and engagement. For example, she offered flexible scheduling, home visits, and telephone sessions. Toward the end of the session, she elicited the family's understanding of treatment, corrected any misperceptions, and provided ample time for their questions to be answered.

Assessing Barriers to Treatment, Instilling Hope, and Coordination

While providing psychoeducation about services, Ms Boyd elicited the family's perspective about treatment and their previous experiences with SMH services. She learned that Maria received SMH services in elementary school, but the family discontinued services. Ms Boyd probed about why they terminated services and learned that it was because of high provider turnover (ie, 3 providers in 2 academic years). Ms Boyd responded by providing empathy and communicating her genuine interest in helping Maria and her family. She proactively discussed Maria's transition to high school, the services available there, and how she could coordinate services with a new provider. Ms Boyd then explained that she had successfully helped youth with similar problems and conveyed her belief that Maria would also improve. By eliciting the family's perspective about treatment, providing ideas about coordinating future care, and being hopeful, Ms Boyd improved the family's attitude about treatment.

Using several engagement strategies, Ms Boyd created a safe and empowering environment for Maria and her mother to share their perspectives, yet she also accomplished the business aspects of conducting an intake. Through dialogue, Ms Boyd helped the family gain hope and clarity about SMH services (Box 2).

Box 2
Tips for fostering engagement while conducting business

- Use a collaborative approach
- Use active listening skills
- Allow youths and families to guide treatment
- Collect data to inform treatment and provide feedback to families
- Instill hope, provide empathy, and show genuine interest
- Coordinate care after school transitions or transfers
- Provide psychoeducation about services, particularly focusing on issues unique to mental health services provided in school
- Provide flexible scheduling, such as evening hours
- Offer home visits and telephone sessions

VIGNETTE 3: CONNECTING AND MOTIVATING TO PROMOTE BEHAVIOR CHANGE

Case Background

Jim, a 15-year-old Native American student in ninth grade, was referred by the principal for suspected marijuana use. Jim and his grandfather (his legal guardian) attended an intake with Mr Tom and were beginning treatment. Mr Tom sensed that the family had several barriers to engagement, which they were uncomfortable sharing.

Assessing Barriers to Treatment

Mr Tom normalized barriers, noting that all families have things that get in their way of participating in treatment from time to time. Although Jim and his grandfather initially denied any obstacles, Mr Tom encouraged them to complete the BTPS to explore possible barriers.[38] *Jim and his grandfather endorsed items related to the relevance of treatment, suggesting that they perceived that treatment might not be necessary or useful. Mr Tom completed the Strategic Engagement Checklist (see Appendix 1) to reflect on the family's treatment engagement. The checklist suggested that Mr Tom had neither a strong therapeutic alliance with the family nor a thorough understanding of how their identity, beliefs, and values related to their participation in treatment. Based on this information, Mr Tom created a plan to enhance engagement.*

Cultural Acknowledgment

Mr Tom understood the impact of cultural values and beliefs on a family's engagement. He asked the family about their roles at home, and how race, ethnicity, age, and other aspects of culture affected their lives. In addition, he asked curious, open-ended questions to determine how these factors might influence treatment. He encouraged them to let him know if anything during treatment went against their beliefs. Mr Tom was aware of his own personal biases related to culture and race, particularly because Mr Tom and Jim's family were of different cultural and racial backgrounds.

Motivational Enhancement

Mr Tom knew that Jim in particular remained reluctant to enter treatment. To address this attitudinal barrier, Mr Tom avoided passing judgment about Jim's marijuana use. Instead of trying to persuade Jim that he should make better lifestyle choices, Mr Tom used an open and genuine approach to ask Jim what he found appealing about using marijuana.

Mr Tom enhanced Jim's motivation for change by helping him explore the benefits as well as the drawbacks of reducing his marijuana use. Mr Tom did not impose his own treatment goals on Jim; instead, Mr Tom emphasized the student's autonomy and used Socratic questioning to guide Jim toward small changes that he might consider making with regard to his marijuana use (eg, smoking only on the weekends as opposed to daily). Initially, Jim asserted that he was not ready to reduce his use, but he agreed to continue the conversation over the next few sessions. Through further motivational enhancement and Socratic questioning, Mr Tom helped Jim reflect on how marijuana use might affect his ability to achieve his life goals. Over the course of treatment, Mr Tom continued to use motivational enhancement along with goal setting and monitoring to empower Jim to make his desired changes, which were necessary for his success at home and school.

Goal Setting and Monitoring

As Mr Tom enhanced the family's motivation, he guided Jim and his grandfather to develop goals that were specific, measurable, attainable, relevant, and timely (ie, SMART goals) along with a method for measuring progress toward goals on a regular basis. Goal setting cemented the family's commitment to behavior change and provided a focus for treatment. During each meeting, they reviewed progress toward treatment goals. Through monitoring, Mr Tom used data to prompt reinforcement for treatment progress or modifications of the treatment plan in the absence of improvement.

Engagement Changes

Although Mr Tom developed a plan tailored to the family to foster their engagement, this plan would likely need to be updated throughout the course of treatment. Mr Tom knew that it was important for him to keep a watchful eye on the family's motivation for behavior change throughout treatment. It is common for youth and families to make progress but experience obstacles and setbacks along the way. Mr Tom realized that he must consistently monitor treatment progress, periodically reset goals, and continually assess new barriers to treatment. Mr Tom would readminister the BTPS in approximately 3 months to reassess for additional barriers and develop solutions to any new or continuing obstacles as well as when changes in treatment engagement were noted in terms of attendance, adherence, or attitudes (Box 3).[38]

Box 3
Tips for connecting and motivating to promote behavior change

- Assess for barriers to treatment
- Normalize and problem solve barriers
- Consider impact of culture, race, ethnicity, age, and so forth
- Be open and genuine when assessing current behaviors
- Use Socratic questioning
- Collaboratively set SMART goals
- Develop a method for measuring progress
- Reassess barriers later in treatment
- Maintain a positive attitude toward the family
- Send positive notes home or call caregivers to provide praise about their child

VIGNETTE 4: PROMOTING BEHAVIOR CHANGE THROUGH CONSISTENT PRACTICE

Case Background

Sam, a 10-year-old girl in fourth grade, was referred by her teacher for anxiety and mood dysregulation. Sam had been in treatment with Ms Smith for 3 months, and her parents attempted to attend a session at least once a month.

Facilitating Skill Mastery and Homework

Ms Smith wanted Sam to learn some social skills to reduce the anxiety she felt during social interactions. However, Ms Smith knew that it was difficult for someone to learn a new skill from just oral instruction. Thus, Ms Smith facilitated Sam's parents' mastery of skills through multiple avenues by (1) providing a rationale for exposure to clear up any misconceptions, (2) teaching them each step, (3) modeling each step, (4) eliciting the parents' perspective about the skills, (5) instructing them to practice the steps during the session, (6) eliciting their reactions to practice, (7) providing them with feedback, (8) collaborating with them to identify practice situations outside sessions (ie, homework), and (9) working to anticipate and resolve barriers to homework completion. Ms Smith always checked in regarding the use of the skill at subsequent sessions to reinforce participation and problem-solving issues that arose. She used these same steps for other skills (eg, behavior charts, effective instructions, labeled praises) to increase engagement and facilitate skill mastery.

Related to facilitating skill mastery for Sam, Ms Smith sent home handouts describing the skills that Sam was working on during therapy (eg, problem-solving skills). This strategy provided opportunity for the family to learn and reinforce the skills at home. Ms Smith strove to have a session with Sam's parents to review skills, but when face-to-face meetings were not possible, sending notes home or having brief telephone sessions were effective alternatives (Box 4).

Box 4
Tips for promoting behavior change through consistent practice

- Provide instruction and model new skills for caregivers during the session
- Allow caregivers time to practice the skills in session and provide feedback
- Discuss practicing skills at home and problem solve anticipated barriers
- Process experience with homework and problem solve challenges
- Praise caregivers for their participation, no matter how engaged they are
- Communicate with caregivers regularly via brief telephone calls, texts, or emails
- Send home information about topics covered during therapy

SUMMARY

Engaging youth and families in treatment is critical for providing effective mental health services and achieving successful treatment outcomes. Although SMH services significantly increase the accessibility of care and decrease the stigma associated with treatment, there are unique and significant barriers to engaging youth and families in care. The empirical literature has identified practices that might help enhance engagement in treatment. In this article, how the empirical literature laid the foundation for the development of resources to enhance provider reflection on and decision making about treatment engagement is described, and the application of these resources and practices is shown in a series of case vignettes. The relative contribution of these

resources and individual practices to treatment engagement remains to be determined by future studies that examine providers' decision-making processes about levels of treatment engagement, selection of engagement strategies, and the impact of selected strategies on engagement. Until such research is conducted, weaving the science of engagement interventions with SMH care has the potential to enhance the treatment participation of youth and families in need.

APPENDIX 1: STRATEGIC ENGAGEMENT CHECKLIST

Ask Yourself	Answer		If "No," Try This
Do you regularly communicate and interact with youths and families (not enrolled in SMH services) in your school?	Yes	No	Rapport building Psychoeducation about services
Do you have a strong relationship with school staff/families/students?	Yes	No	(school-wide activities)
Do school staff/families/students recognize you as someone who can help?	Yes	No	
Do school staff/families/students understand the range of services you provide?	Yes	No	
Do school staff/families/students know how to identify a student in need and make a referral?	Yes	No	
Does your program have policies around scheduling, transportation, or childcare that aid families with getting to treatment?	Yes	No	Accessibility promotion
Does the youth/family display open body language?	Yes	No	Rapport building
Does the youth/family openly share information with you?	Yes	No	
Do you think you have a strong therapeutic alliance with the youth/family?	Yes	No	
Do you have a thorough understanding of all components of the youth/family's identity and how their beliefs influence treatment?	Yes	No	Cultural acknowledgment
Is the youth/family in agreement with all of the interventions you suggest?	Yes	No	
Do you have a clear idea of what needs to change for treatment to be successful?	Yes	No	Assessment
Have you provided the youth/family information about assessment results?	Yes	No	
Can the youth/family describe what treatment involves and how it will address their needs?	Yes	No	Psychoeducation about services
Can the youth/family describe their roles in treatment?	Yes	No	
Does the youth/family attend treatment consistently?	Yes	No	Assess barriers
Does the youth/family follow through with recommendations/homework?	Yes	No	Motivational enhancement
Has the youth/family identified the changes they need to make?	Yes	No	
Has the youth/family mentioned barriers to making changes?	Yes	No	
Does the youth/family believe that change is possible and that they have the capacity to change?	Yes	No	Instilling hope
Does the youth/family believe that others with similar problems have got better?	Yes	No	

(*continued on next page*)

Ask Yourself	Answer		If "No," Try This
Are there specific goals for treatment?	Yes	No	Goal setting
Did the youth/family help create treatment goals?	Yes	No	
Can the youth/family articulate those goals?	Yes	No	
Do you know if treatment is working?	Yes	No	Monitoring
Do you have a way of tracking goal progress and sharing that information with the youth/family?	Yes	No	
Has the youth/family recognized that they have made progress?	Yes	No	
Are you the only provider the youth/family is seeing for treatment?	Yes	No	Coordination
Does it seem like services in the youth/family's life complement, rather than compete with or duplicate, one another?	Yes	No	
Do the youth/family's problems involve academic issues?	Yes	No	
Does the youth/family easily implement the skills learned in session in other settings?	Yes	No	Skill mastery Homework
Has the family dropped out of treatment?	Yes	No	Reengage (positive notes/calls, assess barriers)
Has the family stopped answering your phone calls?	Yes	No	

REFERENCES

1. Costello E, Copeland W, Angold A. Trends in psychopathology across the adolescent years: what changes when children become adolescents, and when adolescents become adults? J Child Psychol Psychiatry 2011;52:1015–25.
2. Merikangas K, He J, Burstein M, et al. Service utilization for lifetime mental disorders in US adolescents: results of the National Comorbidity Survey-Adolescent supplement (NCS-A). J Am Acad Child Adolesc Psychiatr 2011; 50:32–45.
3. Ringel J, Sturm R. National estimates of mental health utilization and expenditures for children in 1998. J Behav Health Serv Res 2001;28:319–33.
4. Farmer E, Burns B, Phillips S, et al. Pathways into and through mental health services for children and adolescents. Psychiatr Serv 2003;54:60–6.
5. Burns B, Costello E, Erkanli A, et al. Children's mental health service use across service sectors. Health Aff 1995;14:147–59.
6. Guo S, Kataoka S, Bear L, et al. Differences in school-based referrals for mental health care: understanding racial/ethnic disparities between Asian American and Latino youth. School Mental Health 2014;6:27–39.
7. McKay M, McCadam K, Gonzales J. Addressing the barriers to mental health services for inner city children and their caretakers. Community Ment Health J 1996; 32:353–61.
8. Nock M, Kazdin A. Randomized controlled trial of a brief intervention for increasing participation in parent management training. J Consult Clin Psychol 2005;73:872–9.
9. Pellerin K, Costa N, Weems C, et al. An examination of treatment completers and non-completers at a child and adolescent community mental health clinic. Community Ment Health J 2010;46:273–81.
10. Ajzen I. The theory of planned behavior. Organ Behav Hum Decis Process 1991; 50:179–211.

11. Jaccard J, Dodge T, Dittus P. Parent-adolescent communication about sex and birth control: a conceptual framework. In: Feldman D, Rosenthal A, Damon W, editors. Talking sexuality: parent-adolescent communication. San Francisco (CA): Jossey-Bass; 2002. p. 9–41.
12. Morrissey-Kane E, Prinz R. Engagement in child and adolescent treatment: the role of parental cognitions and attributions. Clin Child Fam Psychol Rev 1999;2:183–98.
13. Staudt M. Treatment engagement with caregivers of at-risk children: gaps in research and conceptualization. J Child Fam Stud 2007;16:183–96.
14. Adelman H, Taylor L. Mental health in schools and system restructuring. Clin Psychol Rev 1999;19:137–63.
15. President's New Freedom Commission on Mental Health. Achieving the promise: transforming mental health care in America. Final Report for the President's New Freedom Commission on Mental Health (SMA Publication No. 03–3832). Rockville (MD): New Freedom Commission on Mental Health; 2003.
16. Weist M. Expanded school mental health services: a national movement in progress. Adv Clin Child Psychol 1997;19:319–52.
17. Catron T, Harris V, Weiss B. Posttreatment results after 2 years of services in the Vanderbilt School-Based Counseling project. In: Epstein MH, Kutash K, Duchnowski AJ, editors. Outcomes for children and youth with emotional and behavioral disorders and their families: programs and evaluation best practices. Austin (TX): PRO-ED; 1998. p. 633–56.
18. Catron T. The Vanderbilt School-based counseling program: an interagency, primary-care model of mental health care. J Emot Behav Disord 1994;2:247–53.
19. Stephan S, Weist M, Kataoka S, et al. Transformation of children's mental health services: the role of school mental health. Psychiatr Serv 2007;58:1330–8.
20. Weist M. Challenges and opportunities in expanded school mental health. Clin Psychol Rev 1999;19:131–5.
21. Masia C, Klein R, Storch E, et al. School-based behavioral treatment for social anxiety disorder in adolescents: results of a pilot study. J Am Acad Child Adolesc Psychiatr 2001;40:780–6.
22. Lindsey M, Chambers K, Pohle C, et al. Understanding the behavioral determinants of mental health service use by urban, under-resourced black youth: adolescent and caregiver perspectives. J Child Fam Stud 2013;22:107–21.
23. Reinke WM, Stormont M, Herman KC, et al. Supporting children's mental health in schools: teacher perceptions of needs, roles, and barriers. Sch Psychol Q 2011;26:1–13.
24. Thompson R, Dancy B, Knafl K, et al. African American families' expectations and intentions for mental health services. Adm Policy Ment Health 2013;40:371–83.
25. Shucksmith J, Jones S, Summerbell C. The role of parental involvement in school-based mental health interventions at primary (elementary) school level. Adv Sch Ment Health Promot 2010;3:18–29.
26. Ceballo R, Maurizi L, Suarez G, et al. Gift and sacrifice: parental involvement in Latino adolescents' education. Cultur Divers Ethnic Minor Psychol 2014;20:116–27.
27. DeMoss S, Vaughn C. Reflections on theory and practice in parent involvement from a phenomenological perspective. Sch Community J 2000;10:45–59.
28. Lindsey M, Brandt N, Becker K, et al. Identifying the common elements of treatment engagement interventions in children's mental health services. Clin Child Fam Psychol Rev 2014;17:283–98.

29. Becker KD, Lee B, Daleiden EL, et al. The common elements of engagement in children's mental health services: which elements for which outcomes? J Clin Child Adolesc Psychol 2013. [Epub ahead of print].
30. Gopalan G, Goldstein L, Klingenstein K, et al. Engaging families into child mental health treatment: updates and special considerations. J Can Acad Child Adolesc Psychiatry 2010;19:182–96.
31. Ingoldsby E. Review of interventions to improve family engagement and retention in parent and child mental health programs. J Child Fam Stud 2010;19:629–45.
32. Lefforge N, Donohue B, Strada M. Improving session attendance in mental health and substance abuse settings: a review of controlled studies. Behav Ther 2007; 38:1–22.
33. McKay M, Bannon W. Engaging families in child mental health services. Child Adolesc Psychiatr Clin N Am 2004;13:905–21.
34. Snell-Johns J, Mendez J, Smith B. Evidence-based solutions for overcoming access barriers, decreasing attrition, and promoting change with underserved families. J Fam Psychol 2004;18:19–35.
35. Chorpita B, Daleiden E, Weisz J. Identifying and selecting the common elements of evidence based intervention: a distillation and matching model. Ment Health Serv Res 2005;7:5–20.
36. Kazdin A. Perceived barriers to treatment participation and treatment acceptability among antisocial children and their families. J Child Fam Stud 2000;9: 157–74.
37. Kazdin A, Holland L, Crowley M. Family experience of barriers to treatment and premature termination from child therapy. J Consult Clin Psychol 1997;65: 453–63.
38. Kazdin A, Holland L, Crowley M, et al. Barriers to treatment participation scale: evaluation and validation in the context of child outpatient treatment. J Child Psychol Psychiatry 1997;38:1051–62.
39. Kazdin A, Wassell G. Barriers to treatment participation and therapeutic change among children referred for conduct disorder. J Clin Child Psychol 1999;28: 160–72.
40. Kazdin A, Wassell G. Therapeutic changes in children, parents, and families resulting from treatment of children with conduct problems. J Am Acad Child Adolesc Psychiatr 2000;39:414–20.
41. Becker KD, Mathis G, Mueller CW, et al. Barriers to treatment in an ethnically diverse sample of families enrolled in a community-based domestic violence intervention. J Aggress Maltreat Trauma 2012;21:829–50.