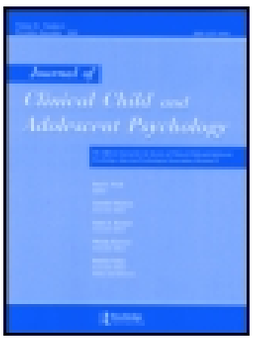

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Forty Years of Engagement Research in Children's Mental Health Services: Multidimensional Measurement and Practice Elements

Kimberly D. Becker
Department of Psychiatry, University of Maryland, Baltimore

Maya Boustani, Resham Gellatly, and Bruce F. Chorpita
Department of Psychology, University of California, Los Angeles

Poor engagement in child and adolescent mental health services is a significant public health concern. The purpose of this study was to synthesize the engagement literature using a multidimensional measurement framework to identify practice elements that are associated with improved engagement. We examined 50 randomized controlled trials of interventions targeting treatment engagement in youth mental health services published between 1974 and 2016. We utilized a multidimensional measurement framework that includes five engagement domains (i.e., *Relationship, Expectancy, Attendance, Clarity, Homework* [REACH]). We also used a distillation method (Chorpita & Daleiden, 2009; Chorpita, Daleiden, & Weisz, 2005) to identify specific practices common to interventions that were effective at increasing engagement within each REACH domain. Engagement was most frequently operationalized in intervention studies as Attendance. Individual practices distilled from effective interventions were successful when used with participants with diverse characteristics in a wide variety of contexts. Importantly, we found unique practice patterns associated with outcomes from each REACH domain. Findings suggest that practices such as *assessment, psychoeducation, accessibility promotion, barriers to treatment*, and *goal setting* might be used with all youth and families to promote engagement and that other practices could be introduced on an as-needed basis to target specific engagement domains (e.g., *modeling* to promote Clarity about therapy; *therapist monitoring* to promote Homework/participation). A substantial evidence base demonstrates that engagement can be improved through specific interventions, and findings highlight opportunities to advance the field's understanding of engagement through multidimensional measurement in future studies.

An estimated 20% to 40% of youth have a psychiatric disorder (Costello, Copeland, & Angold, 2011) and may need mental health services. However, youth and families utilize services at an alarmingly low rate. For example, national survey data show that as many as 50% of youth in need do not enroll in treatment (Merikangas et al., 2010), and more than 50% of those who do enroll terminate treatment early (Nock & Ferriter, 2005; Pellerin, Costa, Weems, & Dalton, 2010). Poor engagement in child and adolescent mental health services is a significant public health concern, given that poor engagement is associated with worse treatment outcomes (Danko, Garbacz, & Budd, 2016; Haine-Schlagel & Walsh, 2015; Karver, Handelsman, Fields, & Bickman, 2006; Kazdin & Wassell, 1999).

The scope and impact of poor engagement have likely been underestimated due to the historical emphasis on testing treatments within the context of efficacy trials, which typically have explicit structures and resources to maintain treatment participation for study participants (Clarke, 1995; Marchand, Stice, Rohde, & Becker, 2011). In contrast, publicly referred youth served in routine practice settings often experience psychosocial stressors (e.g., *Diagnostic*

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Correspondence should be addressed to Kimberly D. Becker, Department of Psychology, University of South Carolina, 1512 Pendleton Street, Barnwell College, Suite #220, Columbia, SC 29208. E-mail: beckerkd@mailbox.sc.edu

and Statistical Manual of Mental Disorders, 4th ed. [American Psychiatric Association, 1994] Axis IV stressor, low socioeconomic status, caregiver symptomatology; Marchand et al., 2011; Southam-Gerow, Chorpita, Miller, & Gleacher, 2008) that make it more difficult for these clients to participate in treatment (Gopalan et al., 2010).

As the field transports evidence-based treatments (EBTs) to community settings, significant engagement challenges are to be expected. For example, in an efficacy trial of Coping Cat (a cognitive behavioral therapy [CBT] program for childhood anxiety), engagement was high, with 90.9% treatment completion (defined as 16 sessions) for the individual child CBT condition and 87.5% for the family-based CBT (Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008). However, when Coping Cat was tested in a community setting, engagement was much lower, with only 54.2% of youth meeting the treatment completion standards of the 2008 trial (Southam-Gerow et al., 2010). Some scholars have suggested that engagement might improve as EBTs are incorporated into a stable routine of established service delivery systems, rather than delivered within the nonestablished framework of a randomized controlled trial (RCT; Michelson, Davenport, Dretzke, Barlow, & Day, 2013). At present, however, the field still faces significant challenges with maximizing the public health impact of EBTs (Kazdin & Blase, 2011), and thus, researchers have increasingly focused on improving engagement in mental health service settings as one key strategy.

We believe that one way to improve engagement is by enhancing its measurement in research and practice. Operational definitions of engagement in the treatment literature rely on attendance as the primary indicator of engagement. For instance, a recent review of 262 studies testing behavioral parent training interventions revealed that only 10% of studies measured an engagement-related outcome other than attrition or attendance (Chacko et al., 2016). Attendance is the most commonly measured outcome even within studies testing interventions designed to improve engagement (Lindsey et al., 2014). Reliance on attendance as the primary indicator of engagement is problematic for two reasons. First, there is the possibility that consistent attendance might overrepresent the strength of an individual's engagement in treatment because attendance alone is not sufficient to ensure positive treatment outcomes, particularly in skills-based therapies (Nix, Bierman, McMahon, & The Conduct Problems Prevention Research Group, 2009; Nock & Ferriter, 2005). Second, by the time engagement problems manifest themselves as low or inconsistent attendance, it may be too late to address their underlying cognitive or social barriers (Kazdin & Wassell, 1999, 2000; Spirito, Boergers, Donaldson, Bishop, & Lewander, 2002).

We assert that engagement represents an individual's multidimensional (e.g., social, cognitive, affective, and behavioral) commitment to treatment, whereby these dimensions exert reciprocal influence upon one another. We also contend that engagement is a dynamic process that involves the interplay among individual, familial, professional (i.e., provider–client), service organization, and ecological (e.g., availability of services in the community, sources of help typically sought by members of a group) factors. In short, engagement is multifaceted, dynamic, and transactional.

Our definition draws from other conceptual models (e.g., Haine-Schlagel & Walsh, 2015; King, Currie, & Petersen, 2014; Lindsey, Chambers, Pohle, Beall, & Lucksted, 2013) that consistently identify multiple dimensions of engagement. Cognitive dimensions (e.g., attitudes, self-efficacy, locus of control, understanding of treatment, readiness to change) often vary substantially across models, whereas behavioral dimensions tend to emphasize treatment enrollment, attendance, session participation, and homework completion. Social dimensions (e.g., quality of the therapeutic alliance) also are included explicitly in some models (e.g., Staudt, 2007), whereas other models have conceptualized them as primarily cognitive phenomena (e.g., perceived norms about help-seeking behavior: Ajzen, 1991; perceptions of provider efficacy: King et al., 2014).

To facilitate the alignment of research with the multidimensional conceptualization of engagement in the field, we propose a measurement framework that comprises five domains of engagement, as exemplified by the REACH acronym (Becker & Chorpita, 2016): *Relationship* (e.g., therapeutic alliance; Shirk & Karver, 2011); *Expectancy* (e.g., beliefs that treatment will be helpful and that one can participate successfully in treatment; Nock & Kazdin, 2001); *Attendance* (e.g., presence at treatment sessions; Nock & Ferriter, 2005); *Clarity* (e.g., understanding about the treatment approach or the roles of each person involved in treatment; Shuman & Shapiro, 2002); and *Homework*, which reflects multiple adherence/participation dimensions (e.g., homework completion, in-session participation; Nock & Ferriter, 2005). REACH is not offered as a definitive model, and it will likely require expansion as new engagement domains are identified, measured, and refined. Instead, REACH is proposed as an organizing framework that can put a lens on the literature to determine what we know and what we do not know about key intervention outcomes and their interrelations across multiple domains (cf. Hoagwood, Jensen, Petti, & Burns, 1996).

This review highlights more than 40 years of pioneering science. Innovations in the measurement, understanding, and resolution of treatment barriers led by McKay (e.g., McKay, McCadam, & Gonzales, 1996), Kazdin (e.g., Kazdin, Holland, & Crowley, 1997), and their respective colleagues invigorated the field's efforts to design and test engagement interventions. Over the past decade, multiple qualitative and systematic reviews have been undertaken to determine what works to engage youth and families in services (see Table 1). Historically, most literature reviews either have taken a generalist approach (i.e., grouping all engagement constructs together) to summarizing effective

interventions for engagement (e.g., Lindsey et al., 2014) or have focused on a single engagement domain (e.g., attendance; Lefforge, Donohue, & Strada, 2007), although there are exceptions. For example, Nock and Ferriter (2005) reviewed strategies designed to target both attendance and adherence, and Snell-Johns, Mendez, and Smith (2004) presented strategies for reducing *barriers to treatment* participation, decreasing attrition, and promoting behavioral change.

For the current review, we took a different approach, by using a "distillation" method (Chorpita & Daleiden, 2009; Chorpita, Daleiden, & Weisz, 2005). Distillation involves identifying a sample of effective interventions and then labeling the discrete clinical procedures (i.e., "practice elements") within those interventions, as a way to summarize the common and unique procedures across the entire literature. In the engagement literature, these procedures include *appointment reminders, psychoeducation*, and *goal setting*. As a literature synthesis approach, distillation offers multiple potential benefits. First, distillation promotes a common language across a taxonomically diverse literature, both in terms of classification of practices used and outcomes achieved (Chorpita et al., 2005). Second, distillation helps identify the practices common among all effective interventions, which is a complementary view to levels of analysis that focus on specific programs and their discrete lines of supporting research (cf. Rogers & Vismara, 2008). Early summaries of effective treatments focused on determining the value of broad treatment approaches (e.g., Is CBT for depression effective? Weisz, Doss, & Hawley, 2005), but over time, reviews (and policy) increasingly emphasized a level of analysis involving specific manualized interventions (e.g., Is *Adolescent Coping with Depression* effective? Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999). A benefit of distillation is that its level of analysis is the clinical procedures of an intervention; thus, it provides a single framework for describing the clinical features of each intervention in a chosen literature. Then, this information can be aggregated across all studies to expose specific clinical procedures of effective interventions. Extending our depression example, 71% of effective interventions for youth depression include cognitive procedures (PracticeWise, 2017).

Thus, this review is organized around a structured distillation analysis of practice elements across all effective engagement interventions, summarized to show how commonly those elements occur within those specific interventions and to look at the aggregated data within the context of a multidimensional measurement framework (i.e., REACH). Two articles demonstrated that engagement practice elements could be reliably coded using a distillation approach (i.e., Lindsey et al., 2014) and provided preliminary evidence that certain engagement practices might be associated with different engagement outcomes (i.e., Becker et al., 2015). The current review expands upon this earlier work by including 10 additional studies, demonstrating reliable coding of additional engagement practices, examining five engagement outcomes, and presenting unique analyses to highlight the co-occurrence of practices and their presence across settings and populations. For example, because individual elements are typically employed in the context of other engagement practices, we calculated conditional probabilities to show which practice elements were most likely to co-occur in order to identify patterns in the delivery of engagement practices. In these ways, we are beginning to answer questions about what works; in what context; for what purpose; and, just as important, what still warrants further study within the context of engagement in child and adolescent mental health services.

METHOD

Selection Criteria and Literature Search

We used multiple methods to identify published RCTs testing psychosocial interventions aimed at enhancing the engagement of youth or families in children's mental health services. First, we searched electronic databases (i.e., PsycINFO and SocINDEX) using the following terms: engagement OR retention OR attrition combined with an exploded "mental health services" term to facilitate the retrieval of results that contain the term "mental health services" in combination with each of its narrower forms. This method yielded 93 articles from PsycINFO and 238 articles from SocINDEX. Second, a medical librarian conducted structured searches of three databases: PubMed, PsycINFO, and SocINDEX. Search words contained at least one engagement term (e.g., *retention, participation*) and one mental health services term (e.g., *psychotherapy*). This method identified an additional 76 potentially relevant articles. Third, we reviewed the citing articles and reference lists of other published literature reviews (e.g., Ingoldsby, 2010; Staudt, 2007) as well as engagement RCTs, a strategy that yielded 10 additional articles. Fourth, personal communication with national scholars in engagement research identified three additional articles. Fifth, we identified four RCTs on family engagement through the PracticeWise Evidence-Based Services Database for children's mental health (PracticeWise, 2012). Together, these search strategies produced 424 articles that were screened for inclusion in the present review. Inclusion criteria required that each study (a) employ an RCT design, (b) test an intervention with the specific purpose of engaging youth or families in children's mental health treatment, (c) report outcomes for at least one measure of treatment engagement (e.g., attendance, adherence, knowledge about therapy), and (d) include a sample with a mean age of 21 years or younger. Studies of engagement interventions targeting the caregivers of children with mental health needs were included if they met the other eligibility criteria.

Our final sample included 48 articles published between 1974 and 2016. A single article could contain multiple

studies, all of which were coded if they met the aforementioned inclusion criteria and included independent samples. Two articles met these conditions; thus, our final sample included 50 studies. Coded studies included 117 study groups (i.e., a set of participants who were randomized to a specific treatment or control condition within that study), of which 114 (97.4%) were active intervention conditions (including services as usual) and three (3.6%) were waitlist controls.

Coding and Reliability

Study coding was guided by a modified version of the PracticeWise Clinical Coding System (PracticeWise, 2008), which summarizes multiple variables related to study design, sample characteristics, treatment group characteristics, treatment interventions, and results. The modified coding system included prompts to code engagement outcome indicators (e.g., attendance at first treatment session, client understanding of treatment), as well as practice elements (e.g., *appointment reminders, assessment of barriers to treatment, psychoeducation*) that are common to engagement interventions. This coding system has been used successfully in prior engagement reviews (i.e., Becker, Buckingham, Rith-Najarian, & Kline, 2015; Becker et al., 2015; Lindsey et al., 2014).

Each study was coded by two coders who received extensive training in the coding system and who used our detailed coding manual. Interrater reliability among coders was calculated for an initial set of 31 practice element codes. Kappas could not be calculated for five codes (i.e., *cognitive, monitoring, rehearsal, response cost, self-monitoring*) due to low base rates of those practices. For the remaining 26 codes, kappas ranged from .26 to .95 and were above published standards (at least .40; Fleiss, 1981) for 22 (84.6%) of the codes. Kappas were below published standards (i.e., < .40; Fleiss, 1981) for four codes (i.e., *psychoeducation about the problem, psychoeducation about services, reinforcement*, and *therapist monitoring*).

We examined the codebook definitions of *psychoeducation* about the problem (i.e., formal review of information about the development of a problem and its relation to a proposed intervention) and *psychoeducation* about services (i.e., providing information about services or the service delivery system, such as content and frequency of sessions, roles of treatment participants, and agency policies regarding attendance), and found definitional overlap. We also reviewed study descriptions and found that many studies did not specify this level of detail for *psychoeducation* procedures. For these reasons, we combined the two codes into a single *psychoeducation* code, which improved its reliability to .39 and reduced our total codes to 30. As part of our standard procedures, a third coder (i.e., the first author) resolved all coding discrepancies and inspected all data for accuracy.

Practice Elements

Practice elements relevant to engagement were identified using an iterative process that began with reading the empirical literature on engagement, drafting an initial list of elements and their definitions, and soliciting feedback from four experts on engagement outside of the study team who reviewed the elements and definitions. Revisions and piloting occurred following expert feedback. Table 2 provides abridged definitions of the 30 practice elements that were identified in the empirical literature. Practices employed by service agencies (e.g., *accessibility promotion*) were included along with more traditional clinical (i.e., *provider-delivered*) practices to capture the full range of strategies tested in these interventions. Note that *communication skills* refers to the clinical procedure of teaching a client *communication skills* to effectively engage other family members, as opposed to the quality of the *communication skills* or the mental health provider. Additional coding information is available from the authors.

Engagement Domains

Coding procedures were applied to outcomes across all reported engagement domains (i.e., Relationship, Expectancies, Attendance, Clarity, and Homework). Relationship outcomes were those that reflected the therapeutic alliance (Shirk & Karver, 2011), typically assessed by questionnaires such as the Working Alliance Inventory (Horvath & Greenberg, 1989), or other aspects of relationship quality. Expectancy outcomes were those that reflected expectations about the eventual outcome of treatment or one's own readiness and motivation to participate successfully in treatment (Nock & Kazdin, 2001), typically assessed by measures such as the Parent Motivation Inventory (Nock & Photos, 2006) or the Expectations of Therapy Outcome Scale (Bonner & Everett, 1986). Attendance outcomes reflected the presence and timeliness of expected participants at a therapeutic session (Nock & Ferriter, 2005). Attendance was operationalized in multiple ways, including attendance at first treatment session, attendance over time, treatment completion, cancellations, no-shows, and punctuality. Clarity outcomes reflected an understanding about the treatment approach and its rationale, the structure and goals of treatment, or the roles of each person involved in treatment (Shuman & Shapiro, 2002) and were typically assessed using a questionnaire designed to test an individual's understanding of therapy (e.g., Holmes & Urie, 1975; Weinstein, 1988). The Homework domain included outcomes that reflected an individual's active participation in collaboratively determined activities (e.g., participating in treatment session discussions and exercises, out-of-session practice; Nock & Ferriter, 2005). Examples included the number of homework assignments completed and provider-rated quality of session participation.

TABLE 1
Literature Reviews of Effective Engagement Interventions

Study	*Review Type*	*Study* N *and Years*	*Inclusion Criteria*	*Engagement Domain(s)*	*Key Findings*
Becker, Buckingham, Rith-Najarian et al. (2015)	Systematic	*N* = 31 2002–2015	(a) Studies about effective engagement strategies for clinically high-risk or first episode psychosis youth. (b) RCTs evaluating treatments for clinically high-risk or first episode psychosis youth	General	Practices (e.g., psychoeducation, rapport building, support networking, accessibility promotion) are available to engage clinically high-risk youth. However, RCTs included only a small number of these practices in their interventions.
Becker et al. (2015)	Systematic	*N* = 40 1974–2011	RCTs testing an engagement intervention that also reported engagement outcomes	Attendance; Adherence; Cognitive preparation	Specific engagement practices differed depending on whether attendance, adherence, or cognitive preparation was the target outcome.
Gopalan et al. (2010)	Qualitative (Update of McKay & Bannon, 2004)	*N* not reported 2004–2010	Criteria not reported, but findings were organized children's mental health service engagement interventions	General	Promising interventions included (a) technology, (b) paraprofessionals, (c) school- and home-based delivery, (d) strength-based approaches, and (e) considerations for special populations (e.g., trauma, disruptive behaviors).
Haine-Schlagel and Walsh (2015)	Systematic	*N* = 23 1974–2013	Studies that measured one of the following: (a) specific parent participation behaviors in the clinic, (b) homework completion, or (c) global parent participation	Participation; Homework completion	Interventions that increased parent participation included practices such as reinforcement, assessment of barriers, accessibility promotion, psychoeducation, and positive expectation setting.
Ingoldsby (2010)	Systematic	*N* = 17 1980–2009	RCTs testing an engagement intervention targeting attendance and completion	Ongoing attendance and treatment completion	Early engagement strategies included reminders, addressed barriers, and adopted a family systems approach. Continuous strategies included incentives, family support, and motivational interviewing.
Kim, Munson, and McKay (2012)	Systematic	*N* = 13 1988–2010	RCTs testing an engagement intervention	Initial and ongoing attendance	Individual- (e.g., reminder, reinforcement) and family-level approaches increased attendance at first appointment. Service delivery level approaches (e.g., addressing barriers, case management) improved ongoing engagement.
King et al. (2014)	Scoping review	*N* = 58 2000–2012	Articles focused on (a) predictors of engagement, (b) effectiveness of engagement interventions, and (c) interpersonal aspects of care	General	Engagement is a motivational framework by which providers foster client optimism, self-efficacy, and conviction about the relevance of treatment and treatment goals.
Lefforge et al. (2007)	Systematic	*N* = 43 1965–2000	Controlled studies testing interventions to improve first session attendance	Attendance	Effective strategies included reminder phone calls, letters, prompt scheduling, soliciting commitment, and resolving obstacles to attendance.
Lindsey et al. (2014)	Systematic	*N* = 38 1974–2011	RCTs testing an engagement intervention that also reported engagement outcomes	General	22 engagement practices identified, including assessment, accessibility promotion, psychoeducation, homework assignment, modeling.

(*Continued*)

TABLE 1
(Continued)

Study	*Review Type*	*Study* N *and Years*	*Inclusion Criteria*	*Engagement Domain(s)*	*Key Findings*
McKay and Bannon (2004)	Qualitative	*N* not reported 1982–2003	Criteria not reported, but findings were organized children's mental health service engagement interventions	Initial and ongoing attendance	Effective strategies included appointment reminders, addressing barriers to treatment, increasing perceptions of self-efficacy, problem solving, case management, and peer navigation.
Nock and Ferriter (2005)	Systematic	*N* = 12 1974–2002	Controlled trials testing an intervention aimed at increasing attendance and/or adherence at treatments with a parent training component	Initial and ongoing attendance; Adherence	Brief, informational preparatory strategies increased initial attendance. Financial contingency contracting and caregiver support were related to ongoing attendance and adherence.
Snell-Johns et al. (2004)	Systematic	*N* = 16 1979–1999	Studies testing engagement interventions within the context of children's mental health treatment	Treatment barriers; Attrition; Behavioral change	Effective strategies included: home-based services, multi-family groups, and facilitating self-directed treatments. Indirect or preliminary support for transportation, childcare, low-cost services, addressing parental needs, and incentives for attendance.
Staudt (2003)	Qualitative	Not reported	Studies testing engagement interventions for children and families	Initial and ongoing attendance	Individual interventions (e.g., appointment reminders) increased attendance to the first appointment; however, only total service delivery approaches reduced dropout rates.

Note: RCT = randomized controlled trial.

TABLE 2
Practice Elements and Abridged Definitions

Practice Element	*Definition*
Accessibility Promotion	Using strategies to make services convenient and accessible (e.g., on-site child care, taxi vouchers, bus tokens)
Appointment Reminder	Providing information about the day, time, and location of next therapeutic contact via mail, text, phone, e-mail, etc.
Assessment	Gathering information about the client's strengths and needs, such as by interviews, questionnaires, observations, etc.
Barriers to Treatment	Eliciting factors that might interfere with treatment (e.g., transportation, scheduling, previous experiences with services, stigma, etc.)
Behavioral Contracting	Eliciting commitment to a course of action as denoted by a contract or agreement
Case Management	Coordinating and overseeing multiple therapeutic supports
Change Talk	Probing disadvantages of the status quo, advantages of change, optimism, and intention to change
Cognitive	Altering an individual's interpretation of events through examination of thoughts, typically through the generation and rehearsal of more realistic, alternative counter-statements
Communication Skills	Training in how to communicate effectively with others to encourage treatment engagement
Crisis Management	Approaches for immediately resolving urgent or dangerous events
Cultural Acknowledgment	Using strategies designed to explore an individual's culture (e.g., race/ethnicity, age, sexual orientation, etc.).
Expectation Setting	Instilling hope and facilitating positive expectations for change
Goal Setting	Explicitly selecting a therapeutic goal for the purpose of making a plan toward achieving that goal
Homework Assignment	Providing therapeutic tasks to an individual to complete outside of session to reinforce/facilitate knowledge and skills
Insight Building	Using specific activities to help a youth or family achieve greater self-understanding
Modeling	Demonstrating a desired behavior to promote imitation and performance of that behavior by an individual
Monitoring	Training someone in the youth's ecology (e.g., caregiver) in the repeated measurement of the youth's target mood or behavior
Motivational Enhancement	Targeting readiness to participate in therapeutic activities or programs through the use of cost-benefit analysis, Socratic questioning, or a variety of other approaches
Parent Coping	Enhancing a caregiver's ability to deal with stressful situations
Peer Pairing	Pairing an individual with another similar individual, such as for skill development or information sharing
Performance Feedback	Providing information about performance to an individual based on assessment and observation
Problem Solving	Using techniques (e.g., brainstorming, choosing a solution, evaluating results) designed to solve targeted problems
Psychoeducation	Reviewing information about treatment, its relation to the presenting problem, or service delivery (e.g., session content/frequency, roles of the provider and youth/families, expectations for attendance)
Rapport Building	Strategies to increase the quality of the relationship between an individual and the provider
Rehearsal	Creating opportunities for an individual to practice a skill during session
Reinforcement	Using reinforcers (e.g., monetary incentives, attention) to promote a desired behavior
Response Cost	Delivering a loss or penalty (e.g., termination) based on unwanted behavior (no-showing appointments)
Self-Monitoring	Training a youth or caregiver in the repeated measurement of their own target mood or behavior
Support Networking	Including informal helpers (e.g., relatives, friends, neighbors, faith leaders) in service planning and delivery
Therapist Monitoring	A provider's repeated collection of data related to a target process or behavior (e.g., alliance, homework, participation)

Indicators of Effectiveness

The primary indicator of effectiveness was examined at the study group level: Specifically, we coded how each study group fared relative to comparison groups on the engagement outcomes reported within a particular study. A study group was assigned a "win" for engagement if it was statistically significantly better than one or more other conditions on any engagement measure, as indicated by a Group × Time interaction or a between-group difference observed at the postengagement assessment for measures that were not collected at baseline (e.g., attendance at the first session, homework completion over the course of treatment; Chorpita et al., 2005). Wins serve as an index of the reliability of support in the research literature, such that more wins across studies generally reflect greater confidence about the observed difference between study conditions (i.e., analogous to conceptual replication or reproducibility, given that our analyses aggregated across independent experimenter teams).

We also assigned wins to study groups for a particular REACH domain if a group was statistically significantly better than one or more other conditions in the same study on any measure reflecting that domain, as indicated by a Group × Time interaction or a between-groups difference observed at the postengagement assessment for measures that were not collected at baseline (e.g., a win on attendance at the first session was considered a win for the Attendance domain; a win for homework completion over the course of treatment was considered a win for the Homework domain). To reduce the influence of the variability in the number of measures included in each domain across studies (e.g., some studies included multiple measures of Attendance, whereas other studies included only one), each study group could earn only up

to one win within each of the REACH domains. Furthermore, we calculated the frequencies with which each practice element was included in a winning intervention for each REACH domain. The graphical depiction of these results in "practice element profiles" highlights patterns of practices characterizing effective interventions within multiple engagement outcomes, as well as practices that have unique associations with one particular outcome (Becker et al., 2015).

We coded indicators of feasibility and generalizability, including information about the most recent publication year for winning interventions, study sample (i.e., presenting problem, age, gender, race/ethnicity), and the delivery context (i.e., provider education level, setting, format, audience; cf. Chorpita et al., 2011).

We also calculated conditional probabilities to show which practice elements were most likely to co-occur with each index practice element among all effective engagement interventions in order to understand how elements are paired together (or not) in the research literature.

Our results are aggregated across the winning study groups that included each element and are presented according to each of the 30 practices. However, a practice element is usually part of a larger engagement intervention; hence, these results should not be interpreted as describing the precise delivery of any particular element in isolation. For example, *appointment reminders* were included in engagement interventions that were delivered by phone, with written materials, in person, and using audiovisual technology, but one should not infer that *appointment reminders* themselves were administered in all of these formats. It is quite possible those reminders were delivered primarily by phone but that other elements in those same engagement protocols made use of the other formats reported. Because almost no studies reported findings by element (as opposed to by study group), we have no definitive way of knowing the format, setting, or other such characteristics at the element level.

Review of Moderators and Mediators

Finally, we examined each of the 50 studies for moderation and mediation analyses. Three studies (i.e., Fleischman, 1979; Santisteban et al., 1996; Watt, Hoyland, Best, & Dadds, 2007) examined moderators of engagement outcomes. Two studies (i.e., Mendenhall, Fristad, & Early, 2009; Nock & Kazdin, 2005) conducted mediation analyses.

RESULTS

Participant Characteristics

The total number of participants across all studies was 5,323 youth/young adults between the ages of 0 and 21. Of the 50 studies reviewed, studies had at least one participant between the ages of 0 and 5 (46.0% of studies), 6 and 12 (80.0%), 13 and 18 (46.0%), and 19 and 21 (12.0%). Across 39 studies (78.0%) that reported participant gender, study samples included slightly more male (52.4%) than female participants (47.6%). Across 34 studies (68.0%) that reported participant race/ethnicity, study samples included at least one participant who self-identified as Black/African American (70.6% of studies), White/Caucasian (70.6%), Hispanic (58.8%), multiethnic (35.3%), Asian (17.6%), or American Indian (8.8%). Half the studies (50.0%) reported participants of "other" ethnicities and 11.8% reported including participants whose racial/ethnic backgrounds were unknown. Study samples included youth seeking help for diverse problems, including conduct problems (52.0% of studies), inattention/hyperactivity (28.0%), depression (26.0%), anxiety (18.0%), substance use (18.0%), trauma (8.0%), suicidal ideation (6.0%), and autism (4.0%). Thirty studies (60.0%) reported a specific geographic location; of those, 25 (83.3%) were conducted in the United States.

Intervention Delivery Characteristics

All 50 studies reported at least one intervention setting, the most common of which were as follows: clinics (68.0%[1]), homes (44.0%), hospitals (4.0%), and the community (4.0%). In the 48 (96.0%) studies that reported delivery format, the most frequently reported formats were in-person dialogue (64.0%), telephone (46.0%), written communication (26.0%), and audiovisual materials (14.0%). In the 39 (78.0%) studies that reported provider (i.e., individuals who implemented the engagement intervention), most frequently reported in studies were evenly divided among graduate students (24.0%), a professional with a master's degree (24.0%), or a doctoral degree (24.0%), and at times (20.0%) the intervention was self-administered by the youth or caregiver themselves. Across all studies, the intended recipients were the youth (54.0% of the time) or caregivers (52.0% of the time).

We identified three manualized engagement protocols that were tested in multiple studies in their original form or in an adapted form. McKay, McCadam, and Gonzales's (1996) *addressing barriers to treatment* protocol was tested in six studies. *Motivational Interviewing* (W. R. Miller & Rollnick, 2013) was tested in four studies, although additional studies tested interventions including motivational procedures but did not report using "motivational interviewing." Finally, *Strategic Structural Engagement* (Szapocznik et al., 1988) was tested in three studies. Taken together, these three protocols were tested in 13 (26.0%) studies included in this review, corroborating our decision to use a methodology to aggregate across all protocols and thus include a much larger literature.

[1] Categories are not mutually exclusive; therefore, percentages do not equal 100%.

Winning Interventions

Of the 117 study groups included in the review, 51 (43.6%) demonstrated a positive outcome for any engagement outcome relative to a comparison condition and thus were assigned a "win." Discrete practice elements were distilled from the interventions tested in these 51 study groups to provide a description of the features of winning interventions. Table 3 presents these practice elements in alphabetical order, along with the number of winning groups in which that element was included. For example, *accessibility promotion* was included in 25 of the 51 study groups using an engagement intervention that outperformed another group on any engagement measure. The way to interpret these data is that 49.0% of winning interventions included *accessibility promotion*.

The five practice elements most frequently included in effective engagement interventions were *assessment* (68.6% of winning interventions), *psychoeducation* (66.7%), *accessibility promotion* (49.0%), *barriers to treatment* (45.1%), and *goal setting* (43.1%). In contrast, the least frequently included practice elements were *communication skills* (3.9%), *crisis management* (3.9%), *response cost* (3.9%), *support networking* (3.9%), *cognitive* (2.0%), *insight building* (2.0%), *monitoring* (2.0%), and *self-monitoring* (2.0%).

Table 3 also provides information about the most recent supporting evidence for interventions including each practice element (e.g., *accessibility promotion* was most recently included in a winning intervention tested in a paper published in 2014). Nearly all practice elements were included in winning interventions that appeared in papers published in the past 10 years, with the exceptions of *communication skills*, *crisis management*, and *response cost*.

As one indicator of generalizability, Table 3 also provides information about the presenting problems of the samples with which interventions including each practice element were effective. For example, *accessibility promotion* has been included in interventions that effectively have engaged families seeking help for youth conduct problems, attention problems, substance use, anxiety, depression, and trauma. Therefore, in clinical practice, the use of *accessibility promotion* as one component of an engagement intervention delivered to clients seeking help for traumatic stress is consistent with the evidence base. In contrast, the use of *parent coping* as a component of an engagement intervention delivered to these same clients is not consistent with findings in the evidence base. The majority of practice elements were included in engagement interventions that were effective with individuals seeking help for any number of problems, whereas there were some elements (e.g., *parent coping, communication skills, peer pairing*) whose appearance was limited to engagement interventions effective primarily with individuals seeking help for externalizing problems.

In general, the patterns showed that most practice elements were included among effective engagement interventions, whose collective use was not restricted to particular youth developmental levels, genders, or ethnicity (Table 3). For example, interventions that included *accessibility promotion* were effectively used across samples that spanned youth ages 0 to 21, of male and female gender, from any one of multiple ethnic backgrounds. However, practice elements with few wins (e.g., < 4) tended to appear among effective engagement interventions the use of which was restricted to samples with specific characteristics (e.g., the use of *communication skills* was limited to winning interventions for Hispanic youth ages 12–21 seeking help for substance use), some of which may simply be an artifact of the size of the underlying supportive literature.

Table 4 provides information about the delivery context of effective engagement interventions, including provider background, setting, format, and audience. For example, *accessibility promotion* has been included in winning engagement interventions alternately delivered by graduate students, doctoral- and master's-level providers, and the clients themselves. *Accessibility promotion* has also been included in engagement interventions delivered across a variety of settings and formats, with youth and caregiver audiences. One way to interpret this finding is that using *accessibility promotion* as part of an engagement intervention delivered by a social worker is consistent with the evidence base. As an alternative example, a practice such as *parent coping* appears to have been used in effective engagement interventions that featured doctoral level providers and in-person delivery to youth and/or caregivers within a clinic setting only. Thus, delivery of *parent coping* by a social worker or in a school setting would be inconsistent with the evidence base for this practice.

Similar to the results presented in Table 3 regarding sample characteristics, Table 4 suggests that most practice elements appeared in a set of effective engagement interventions that, across all studies, were delivered by providers from diverse educational backgrounds (i.e., graduate student, M.A.-level provider, M.D., Ph.D./Psy.D., self), across various settings (i.e., clinic, community, day care, home, hospital, residential), using different formats (i.e., audiovisual, in person, phone, written,), and targeting various audiences (i.e., caregiver, family, youth).

REACH Domain Measurement and Practice Profiles

Table 5 presents the frequency with which any outcomes (i.e., whether winning or not) within each REACH domain were reported across the 50 studies. Attendance was by far the most frequently reported outcome, appearing in 47 (94.0%) studies. Outcomes for each of the other domains were reported in less than 25% of studies. Table 5 also presents the number of study groups with reported outcomes and wins for each REACH domain. For example, outcomes for at least one Relationship measure were reported for 13 (11.1%) study groups out of the 117 study groups in this review, and two of these 13 groups (15.4%) were superior to a control group on at least one Relationship outcome measure.

TABLE 3
Study, Clinical, and Demographic Characteristics of Winning Treatment Groups Using Specific Practice Elements

Practice Element	*Wins*	*Most Recent Year*	*Problem Focus*	*Age*	*Gender*	*Ethnicity*
Accessibility Promotion	25	2014	Conduct, attention, substance, anxiety, depression, trauma	1–21	male, female	White, Black, Latino/a, Asian
Appointment Reminders	11	2016	Conduct, attention, depression, adjustment, anxiety, autism, substance	2–20	male, female	Black, White, Latino/a
Assessment	35	2015	Conduct, attention, depression, substance, trauma, anxiety, suicide, adjustment	1–21	male, female	White, Black, Latino/a, Asian, Native American
Barriers to Treatment	23	2016	Conduct, depression, attention, anxiety, substance, trauma, suicide	1–21	male, female	Black, Latino/a, White, Native American
Behavioral Contracting	9	2016	Conduct, depression, substance, anxiety, attention, suicide	1–21	male, female	Latino/a, Black, White
Case Management	3	2006	Anxiety, depression, substance, conduct, attention, trauma	12–18	male, female	Black, Latino/a, White
Change Talk	8	2016	Conduct, substance, anxiety, depression	2–21	male, female	Latino/a, Black, White
Cognitive	1	2011	Conduct, suicide	12–18	male, female	Asian, Black, White
Communication Skills	2	1996	Substance	12–21	N/A	Latino/a
Crisis Management	2	1998	N/A	N/A	N/A	Black, Latino/a, White
Cultural Acknowledgment	11	2014	Conduct, anxiety, depression, attention, substance	1–18	male, female	Latino/a, Black, White, Asian
Expectation Setting	10	2009	Conduct, attention, adjustment, anxiety, substance	1–17	male, female	White, Black, Latino/a
Goal Setting	22	2016	Conduct, attention, depression, anxiety, substance, suicide, trauma	1–21	male, female	Black, Latino/a, White, Asian
Homework Assignment	18	2016	Conduct, attention, depression, substance, suicide, anxiety	2–20	male, female	White, Black, Latino/a, Asian
Insight Building	1	2011	Conduct, suicide	12–18	male, female	Asian, Black, White
Modeling	9	2016	Conduct, attention, adjustment, anxiety, depression	3–16	male, female	White, Black, Latino/a
Monitoring	1	2006	Anxiety, conduct, depression, attention, substance, trauma	12–17	male, female	Black, Latino/a, White
Motivational Enhancement	6	2016	Conduct, depression, anxiety, attention, suicide, trauma	2–18	male, female	Black, White, Asian, Latino/a
Parent Coping	3	2009	Conduct, attention	4–12	male, female	White, Black, Latino/a
Peer Pairing	2	2009	Attention, conduct	5–12	male, female	Black, White, Asian, Latino/a
Performance Feedback	6	2014	Conduct, anxiety, depression, attention, substance, suicide, trauma	3–18	male, female	Black, White, Latino/a, Asian
Problem Solving	6	2016	Conduct, trauma, depression, attention, anxiety, substance	3–18	male, female	White, Black, Latino/a, Native American
Psychoeducation	34	2016	Conduct, attention, depression, anxiety, substance, trauma, suicide, adjustment	1–21	male, female	White, Black, Latino/a, Asian, Native American
Rapport Building	10	2016	Conduct, depression, anxiety, attention, substance, trauma	1–21	male, female	Latino/a, Black, White
Rehearsal	8	2016	Conduct, attention, anxiety, depression	2–13	male, female	White, Black, Latino/a, Asian
Reinforcement	10	2016	Conduct, attention, anxiety, depression, substance	2–20	male, female	White, Black, Latino/a
Response Cost	2	1998	Conduct, substance	2–20	male, female	Black, Latino/a, White
Self-Monitoring	1	2006	Anxiety, conduct, depression, attention, substance, trauma	12–17	male, female	Black, Latino/a, White
Support Networking	2	2009	Attention, conduct	5–12	male, female	Black, White, Asian, Latino/a
Therapist Monitoring	16	2016	Conduct, attention, depression, anxiety, substance, suicide, trauma	2–18	male, female	White, Black, Latino/a, Asian

Note. The number of possible wins is 51. Problem Focus and Ethnicity are listed in decreasing order of frequency for which each value appears in winning study groups. N/A = not available.

Figure 1 presents the practice element profiles for each REACH domain. Each profile shows the frequency with which each element occurred in engagement interventions that were superior to a control group on at least one measure for a particular REACH domain.

Relationship

As reported in Table 5, only two study groups (15.4%) achieved a win for Relationship outcomes. Nine practices (30.0% of the 30 elements coded in this review) were included in the set of practices present in these two winning interventions (see Figure 1). *Assessment* was the most frequent practice element, used in both effective study groups.

Expectancy

Five study groups (35.7%) achieved a win for Expectancy outcomes (Table 5). Seventeen elements (56.7%) were included in the set of practices present in these winning interventions (Figure 1). The most frequent elements were *assessment* (80.0%), *psychoeducation* (80.0%), *barriers to treatment* (60.0%), and *goal setting* (60.0%). Elements that were comparatively more common within this domain relative to other domains included *goal setting, rehearsal* (40.0%), *behavioral contracting* (40.0%), *change talk* (40.0%), and *motivational enhancement* (40.0%).

Attendance

Thirty-seven study groups (33.6%) outperformed another study group on at least one measure of Attendance (Table 5). All 30 practice elements coded in this review (100%) were included in the set of practices in these winning interventions (Figure 1). *Psychoeducation* was the most common practice element across effective study groups (73.0%), followed by *accessibility promotion* (59.5%), *barriers to treatment* (59.5%), and *goal setting* (54.1%). *Appointment reminders* (27.0%) were more frequent among the interventions having superior outcomes for Attendance relative to the sets of interventions representing superior outcomes for other domains.

Clarity

Six study groups (46.1%) achieved a win for a Clarity outcome (see Table 5). Five of the 30 practice elements (16.7%) were included in the set of practices present in interventions effective for this domain. *Psychoeducation* (83.3%) and *modeling* (83.3%) were the most frequent practice elements for this domain. Compared with the sets of interventions that achieved superior outcomes for other domains, *modeling* was unique to interventions effective for improving Clarity. (Figure 1).

Homework

Thirteen study groups (48.1%) achieved a win for a Homework outcome (see Table 5). Twenty-two practice elements (73.3%) were represented among the set of interventions that demonstrated superiority over a control group for this domain (Figure 1). *Homework assignment* was the most common practice element (84.6%), followed by *accessibility promotion* (69.2%), *therapist monitoring* (69.2%), and *assessment* (61.5%). *Rehearsal* (38.5%) and *reinforcement* (38.5%) were more frequent in the Homework profile relative to the profiles for the other domains.

Associations Among Practice Elements

Table 6 presents each practice element, along with its most common co-occurring elements in winning study groups, as indicated by conditional probabilities for their pairing. The table displays only those elements that co-occurred in at least 50% of winning interventions for each practice element. For example, when *accessibility promotion* appeared in a winning intervention, *assessment* was the most frequent other practice element, appearing in 72% of the winning interventions in which *accessibility promotion* appeared. *Psychoeducation* was the next most frequent pairing (64% of the winning interventions), followed by *barriers to treatment* (52%), *goal setting* (52%), and *homework assignment* (52%). A more extreme example of co-occurrence of practices involved *response cost*. When this practice was used in a winning intervention, it always included *appointment reminders* and *psychoeducation*. Thus, *response cost* has never been included in a winning intervention that did not also include both *appointment reminders* and *psychoeducation*.

Moderators and Mediators of Engagement Outcomes

Only three studies examined diagnosis, socioeconomic status, culture, or similar variables as potential moderators of engagement outcomes. Specifically, Watt et al. (2007) found that receiving a reminder call significantly improved treatment attendance for youth with conduct problems but not for youth without conduct problems, relative to a no-call comparison condition. In a small study, Fleischman (1979) determined that a parent salary ($1 for every day that parents cooperated with treatment assignments) significantly improved cooperation with at-home treatment assignments for low income and/or single-parent families but not for middle-income and/or two-parent families, relative to a no-salary comparison condition. Finally, in a Miami-based study of Hispanic families of youth at risk for substance abuse, Santisteban et al. (1996) found that culture was a significant moderator of treatment effectiveness in the experimental condition of Brief Strategic Family Therapy, such that 97% of non-Cuban-Hispanic families were successfully engaged compared with 64% of Cuban-Hispanic families.

Only two studies in this review (i.e., Mendenhall et al., 2009; Nock & Kazdin, 2005) conducted mediational analyses. The temporal sequencing of measurement was explicit in only one study (i.e., Nock & Kazdin, 2005), in which

TABLE 4
Provider, Setting, and Format Characteristics of Winning Treatment Groups Using Specific Practice Elements

Practice Element	*Provider*	*Setting*	*Format*	*Audience*
Accessibility Promotion	Graduate Student, PhD/PsyD, MA-Level Provider, Self	Clinic, Home, Community, Daycare, Residential, School	In Person, Phone, Written, AV	Youth, Caregiver
Appointment Reminders	Graduate Student, Self, Clinic Staff, PhD/PsyD, MA-Level Provider	Home, Clinic	Phone, Written, In Person, AV	Youth, Caregiver
Assessment	Graduate Student, MA-Level Provider, PhD/PsyD, MD, Self	Clinic, Home, Hospital, Community, Daycare, School	In Person, Phone, Written, AV	Youth, Caregiver, Family
Barriers to Treatment	Graduate Student, MA-Level Provider, PhD/PsyD, MD	Clinic, Home, Community, Hospital	In Person, Phone, AV, Written	Youth, Caregiver, Family
Behavioral Contracting	MA-Level Provider, PhD/PsyD, MD, Graduate Student	Clinic, Home, Community, Hospital	In Person, Phone, Written	Youth, Caregiver, Family
Case Management	MA-Level Provider, Graduate Student	Clinic, Home, Residential	In Person	Youth, Caregiver
Change Talk	PhD/PsyD, Graduate Student, MA-Level Provider, MD, Self	Clinic, Home, Community	In Person, Phone, Written	Youth, Caregiver, Family
Cognitive	MA-Level Provider, MD, PhD/PsyD	Hospital	In Person, Written	Family
Communication Skills	MA-Level Provider, Graduate Student	Clinic, Home, Community	In Person, Phone	Caregiver, Family
Crisis Management	MA-Level Provider, Graduate Student	Clinic, Home	In Person, Phone	Youth, Caregiver
Cultural Acknowledgement	Graduate Student, MA-Level Provider, Self, Clinic Staff, PhD/PsyD	Clinic, Home, Daycare, School	In Person, AV, Phone, Written	Youth, Caregiver, Family
Expectation Setting	MA-Level Provider, Self, Graduate Student	Clinic, Home	In Person, Written, AV, Phone	Youth, Caregiver
Goal Setting	MA-Level Provider, PhD/PsyD Graduate Student, MD	Clinic, Home, Community, Hospital, Residential	In Person, Phone, Written, AV	Youth, Caregiver, Family
Homework Assignment	Graduate Student, PhD/PsyD, MA-Level Provider, MD	Clinic, Home, Hospital, Daycare, School	In Person, Phone, Written, AV	Youth, Caregiver, Family
Insight Building	MA-Level Provider, MD, PhD/PsyD	Hospital	In Person, Written	Family
Modeling	Self, MA-Level Provider, Graduate Student	Clinic, Home	AV, In Person, Phone, Written	Youth, Caregiver
Monitoring	MA-Level Provider, PhD/PsyD, Graduate Student, MD	Home, Residential	In Person	Youth, Caregiver
Motivational Enhancement	PhD/PsyD, MD	Clinic, Home, Hospital	In Person, Phone, Written, AV	Youth, Caregiver, Family
Parent Coping	PhD/PsyD	Clinic	In Person	Youth, Caregiver
Peer Pairing	Graduate Student, MA-Level Provider, MD, PhD/PsyD	Clinic	In Person	Youth, Caregiver, Family
Performance Feedback	MA-Level Provider, Graduate Student	Clinic, Home, Hospital, Residential	In Person, AV, Phone, Written	Youth, Caregiver, Family
Problem Solving	Self, MA-Level Provider, Graduate Student	Home, Clinic, Community, Residential	Phone, In Person, AV, Written	Youth, Caregiver
Psychoeducation	Graduate Student, MA-Level Provider, PhD/PsyD, Self, MD	Clinic, Home, Community, Daycare, Hospital, Residential, School	In Person, Phone, Written, AV	Youth, Caregiver, Family
Rapport Building	PhD/PsyD, Graduate Student, MA-Level Provider, MD	Clinic, Home, Community	In Person, Phone, AV, Written	Youth, Caregiver, Family
Rehearsal	MA-Level Provider, PhD/PsyD, Graduate Student	Clinic, Daycare, Home, School	In Person, Written, AV, Phone	Youth, Caregiver, Family
Reinforcement	Graduate Student, MA-level Provider, Self	Clinic, Home, Daycare, School	In Person, Phone, Written, AV	Youth, Caregiver
Response Cost	Graduate Student, Self	Clinic, Home	Phone, Written	Youth, Caregiver
Self-Monitoring	PhD/PsyD	Home, Residential	In Person	Youth, Caregiver
Support Networking	Graduate Student, MA-Level Provider, PhD/PsyD	Clinic	In Person	Youth, Caregiver, Family
Therapist Monitoring	PhD/PsyD, Graduate Student, MA-Level Provider, MD	Clinic, Home, Hospital, Residential	In Person, Phone, AV, Written	Youth, Caregiver, Family

Note. Provider, Setting, and Format are listed in decreasing order of frequency for which each value appears in winning study groups. AV = audiovisual.

TABLE 5
Counts and Percentages of Studies and Groups Across Outcome Domains

	Studies With Outcome Data		*Groups With Outcome Data*		*Winning Groups*	
Outcome	*N*	%[a]	*N*	%[b]	*N*	%[c]
Relationship	6	12.0	13	11.1	2	15.4
Expectancy	7	14.0	14	12.0	5	35.7
Attendance	47	94.0	110	94.0	37	33.6
Clarity	6	12.0	13	11.1	6	46.1
Homework	12	24.0	27	23.1	13	48.1

[a]The percentage of the 50 studies in this review that reported any outcomes on at least one measure for that domain.

[b]The percentage of the 117 study groups in this review that reported any outcomes on at least one measure for that domain.

[c]The percentage of groups with outcome data for that domain that outperformed another group on at least one measure for that domain.

the authors found that parent readiness and perceived ability to change (parent motivation) did not mediate the association between treatment condition and the number of sessions attended.

DISCUSSION

The primary aim of this review was to summarize information regarding what clinical practices characterize successful engagement interventions for which outcomes, for which youth, and in which contexts, using a distillation method to summarize engagement procedures within a multidimensional framework. This review points to a growing body of support for the notion that it is possible to achieve improvements in mental health treatment engagement using interventions designed for that purpose.

Clinical Application of Findings

We found that 30 practice elements were featured in varying clusters within 51 study groups that outperformed their respective control groups in the literature. The analysis of these 51 interventions at the level of elements has important implications for clinical practice when addressing engagement, which we have explicitly defined at the outset as both dynamic and transactional in nature. Unlike clinical symptoms, by which a population is initially defined (e.g., depressed youth) and then a fitting intervention is selected (e.g., manualized CBT), engagement challenges are variably present across youth and families seeking treatment for their primary concern, and even in such cases where those challenges are present at all, they may not be present at the outset but rather emerge and even evolve over time. Thus, a level of analysis that is suited to selection of specific practices that might fit particular engagement outcome domains (e.g., returning to *psychoeducation* in the middle of treatment to improve Clarity or increase Expectancy) is well positioned to inform decisions made as treatment unfolds (i.e., a "run time" vs. "design time" decision; Chorpita & Daleiden, 2014). The findings in this review, particularly the practice profiles, offer ideas for how a provider might select and coordinate specific procedures to use in clinical practice.

Assessment and *psychoeducation* appear to be promising candidates for promoting engagement universally across domains (i.e., "big bang for the buck"; see also Becker et al., 2015), given their frequent presence in effective engagement interventions nearly across the board. When used at the outset of services, *assessment* guides case formulation and clinical decision making (Mash & Hunsley, 2005). Through dialogue, a provider also learns the client's story and the client learns the provider's style (Stattler, 2002). By demonstrating warmth and genuine respect, a skilled provider can use *assessment* to build a relationship and to instill positive expectations about the provider's efficacy for helping the client and general hopefulness regarding the situation (Stattler, 2002). By its nature, assessment prompts client participation (an important indicator in the Homework domain) and so creates an explicit expectation of participation in the therapy that follows. In addition, *assessment* can pave the way for *psychoeducation*, whereby the provider shares information about the nature of the problem, treatment options, treatment features (e.g., session frequency, therapy activities), and the roles and responsibilities of the provider and client. Notably, the most common co-occurring practice for *psychoeducation* is *assessment*, as well as the other way around, consistent with the idea that these skills may frequently be meaningfully linked, with information from a carefully performed *assessment* being used as a context for introducing the treatment rationale and logic that are central to *psychoeducation*. A skilled provider delivers *psychoeducation* in a conversational style, creating opportunities to check in with the client about their understanding about what the provider has shared (and to provide corrective information when necessary; Shuman & Shapiro, 2002), as well as about how well this information fits with the client's expectations and previous experiences in treatment. In these ways, a provider can use *psychoeducation* to build rapport by eliciting the client's perspectives, to set positive expectations about treatment success, to increase the client's clarity about treatment, to encourage attendance, and to facilitate session participation. In these ways, the skilled implementation of *assessment* and *psychoeducation* is consistent with engagement as a dynamic and multidimensional construct.

Much in the way that *assessment* and *psychoeducation* co-occur across domains, certain pairs or groups of practices are especially common within domains, and their pairings make theoretical sense. These practices could be used to

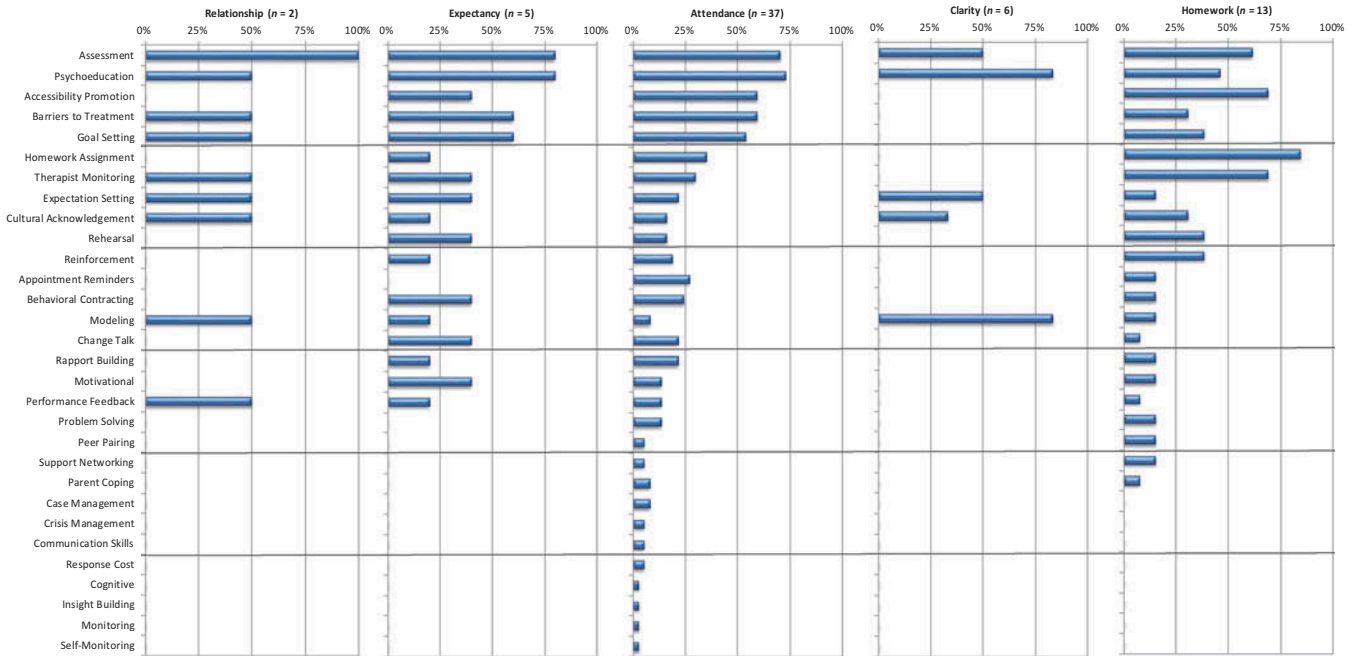

FIGURE 1 Practice element profiles showing element frequency (% of winning groups) for each REACH domain. *Note*: The order of elements on the vertical axis is in descending order of element frequency among all winning groups, regardless of REACH domain. Motivational = *Motivational Enhancement*.

facilitate engagement in a particular domain, either proactively or in response to interference. For example, in addition to *assessment* and *psychoeducation*, *accessibility promotion* and *barriers to treatment* are also common in interventions that improve Attendance outcomes. When a youth or family wants to schedule an appointment, service agencies are often concerned about getting the client in the door (i.e., attendance at first session). *Accessibility promotion*, which involves considerations such as providing treatment at a location convenient to the youth and family, transportation, or child care, can promote attendance by reducing practical barriers. By structuring convenient access to services, *accessibility promotion* helps create the opportunity for a provider then to use *assessment* and *psychoeducation* to engage the client in treatment. Its impact might even extend beyond getting clients in the door, because initiating and attending a session might enhance a client's expectancies about their self-efficacy to participate in treatment and the general hopefulness of their situation (Ajzen, 1991).

Barriers to treatment involves addressing obstacles that might get in the way of a youth or family's treatment participation. Barriers are often conceptualized as concrete obstacles that interfere with treatment, such as lack of transportation and other logistical challenges. However, it is important to note that research indicates that perceptual barriers (e.g., stigma, poor experiences with prior treatment, beliefs about acceptable treatments for mental health issues) are critical to treatment engagement (e.g., Kazdin et al., 1997; Kerkorian, McKay, & Bannon, 2006). Barriers to treatment is frequently included in interventions effective for Attendance and Expectancy outcomes and present to a lesser extent in interventions effective for Relationship and Homework outcomes. Although the *barriers to treatment* element can directly facilitate conversation between a provider and client about potential obstacles and how to reduce their interference, it is also possible that normalizing the experience of perceptual barriers such as stigma or prior experiences and showing a willingness to collaboratively develop solutions builds the therapeutic relationship and promotes positive expectations that obstacles are resolvable, thereby providing hope. There also appears to be a uniquely common pairing between *psychoeducation* and *modeling* for enhancing Clarity outcomes. In the literature, *modeling* often takes the form of an audio- or videotape that demonstrates how a provider and client interact during a therapy session (e.g., Weinstein, 1988) or during which a prior youth or parent client describes their experiences in the current therapy to facilitate role induction for a current client (e.g., Shuman & Shapiro, 2002). Certainly, both *psychoeducation* and *modeling* could be used to enhance a client's understanding of services at the outset of treatment, or could be introduced over the course of services to address misperceptions when necessary.

To improve skill acquisition and generalization outside of session (i.e., *Homework domain*), there appears to be a uniquely common pairing between *homework assignment* and *therapist monitoring*. *Homework assignment* involves collaboratively developed out of session practice, goals for skill practice, and in some cases resolution of barriers to out

TABLE 6
Most Common Co-Occurring Elements for Winning Groups

Practice Element	*Co-occurring Elements*
Accessibility Promotion	Assessment (.72)[a], Psychoeducation (.64), Barriers (.52), Goal Setting (.52), Homework Assignment (.52)
Appointment Reminders	Psychoeducation (.64), Accessibility Promotion (.55)
Assessment	Psychoeducation (.77), Barriers (.63), Goal Setting (.57), Accessibility Promotion (.51)
Barriers to Treatment	Assessment (.92), Psychoeducation (.88), Goal Setting (.79), Accessibility Promotion (.54)
Behavioral Contracting	Goal Setting (1.0) Assessment (.90), Barriers (.90), Psychoeducation (.80), Change Talk (.50), Rapport Building (.50)
Case Management	Accessibility Promotion (1.0), Goal Setting (1.0), Psychoeducation (1.0), Assessment (.67), Barriers (.67), Cultural Acknowledgement (.67)
Change Talk	Psychoeducation (.88), Accessibility Promotion (.75), Assessment (.75), Barriers (.75), Goal Setting (.75), Behavioral Contracting (.63), Rapport Building (.50)
Cognitive	Assessment (1.0), Goal Setting (1.0), Insight Building (1.0), Motivational Enhancement (1.0), Performance Feedback (1.0), Psychoeducation (1.0)
Communication Skills	Assessment (1.0), Barriers (1.0), Behavioral Contracting (1.0), Change Talk (1.0), Goal Setting (1.0%), Psychoeducation (1.0), Rapport Building (1.0), Accessibility Promotion (.50)
Crisis Management	Accessibility Promotion (1.0), Assessment (1.0), Barriers (1.0), Cultural Acknowledgement (1.0), Goal Setting (1.0), Psychoeducation (1.0), Rapport Building (1.0), Behavioral Contracting (.50), Case Management (.50), Expectation Setting (.50)
Cultural Acknowledgment	Assessment (.73), Psychoeducation (.55)
Expectation Setting	Assessment (.91), Psychoeducation (.82), Accessibility Promotion (.55), Barriers (.55)
Goal Setting	Assessment (.87), Barriers (.83), Psychoeducation (.78), Accessibility Promotion (57)
Homework Assignment	Accessibility Promotion (.72), Therapist Monitoring (.72), Assessment (.67), Barriers (.50), Goal Setting (.50), Psychoeducation (.50)
Insight Building	Assessment (1.0), Cognitive (1.0), Goal Setting (1.0), Motivational Enhancement (1.0), Performance Feedback (1.0), Psychoeducation (1.0)
Modeling	Psychoeducation (.78), Assessment (.56)
Monitoring	Accessibility Promotion (1.0), Case Management (1.0), Goal Setting (1.0), Performance Feedback (1.0), Problem Solving (1.0), Psychoeducation (1.0), Self-Monitoring (1.0), Therapist Monitoring (1.0)
Motivational Enhancement	Psychoeducation (1.0), Barriers (.83), Goal Setting (.83), Assessment (.67), Change Talk (.50), Rapport Building (.50), Therapist Monitoring (.50)
Parent Coping	Assessment (1.0), Barriers (1.0), Homework Assignment (1.0), Psychoeducation (1.0), Rehearsal (1.0), Accessibility Promotion (.67), Expectation Setting (.67), Goal Setting (.67), Reinforcement (.67), Therapist Monitoring (.67)
Peer Pairing	Accessibility Promotion (1.0), Assessment (1.0), Goal Setting (1.0), Homework Assignment (1.0), Rehearsal (1.0), Support Networking (1.0), Barriers (.50), Cultural Acknowledgement (.50), Expectation Setting (.50), Parent Coping (.50), Psychoeducation (.50), Reinforcement (.50), Therapist Monitoring (.50)
Performance Feedback	Assessment (.83), Goal Setting (.83), Psychoeducation (.83), Therapist Monitoring (.83), Barriers (.67), Accessibility Promotion (.50), Modeling (.50)
Problem Solving	Psychoeducation (1.0), Barriers (.83), Assessment (.67), Accessibility Promotion (.50), Goal Setting (.50), Rapport Building (.50), Therapist Monitoring (.50)
Psychoeducation	Assessment (.79), Barriers (.62), Goal Setting (.53)
Rapport Building	Psychoeducation (1.0), Barriers (.90), Assessment (.80), Goal Setting (.80), Accessibility Promotion (.50), Behavioral Contracting (.50)
Rehearsal	Assessment (.88), Homework Assignment (.88), Psychoeducation (.88), Accessibility Promotion (.75), Barriers (.63), Goal Setting (.63), Reinforcement (.63), Therapist Monitoring (.63)

(*Continued*)

TABLE 6
(Continued)

Practice Element	*Co-occurring Elements*
Reinforcement	Psychoeducation (.80), Assessment (.70), Homework Assignment (.70), Accessibility Promotion (.60), Rehearsal (.50), Therapist Monitoring (.50)
Response Cost	Appointment Reminder (1.0) Psychoeducation (1.0), Accessibility Promotion (.50), Assessment (.50), Change Talk (.50), Expectation Setting (.50), Reinforcement (.50)
Self-Monitoring	Accessibility Promotion (1.0), Case Management (1.0), Goal Setting (1.0), Monitoring (1.0), Performance Feedback (1.0), Problem Solving (1.0), Psychoeducation (1.0), Therapist Monitoring (1.0)
Support Networking	Accessibility Promotion (1.0), Assessment (1.0), Goal Setting (1.0), Homework Assignment (1.0), Peer Pairing (1.0), Rehearsal (1.0), Barriers (.50), Cultural Acknowledgement (.50), Expectation Setting (.50), Parent Coping (.50), Psychoeducation (.50), Reinforcement (.50), Therapist Monitoring (.50)
Therapist Monitoring	Homework Assignment (.81), Accessibility Promotion (.69), Assessment (.56), Goal Setting (.56), Barriers (.50), Psychoeducation (.50)

[a]Conditional probability of an element being part of the intervention tested in a winning treatment group given the presence of the element in column 1. Only those elements that co-occurred in at least 50% of winning study groups are shown.

of session practice either at the point of *homework assignment* or between treatment sessions (e.g., Nock & Kazdin, 2005). Then, a provider can *monitor* or review homework completion at the next therapeutic contact to reinforce skill use and address any questions or issues that arose during practice (e.g., Nock & Kazdin, 2005).

With so few study groups that demonstrated superiority relative to a control group for Relationship outcomes, it is not possible to draw similar inferences for uniquely common pairings for this domain. The appearance of *cultural acknowledgment* is noteworthy in the set of winning interventions in this domain, often involving either cultural adaptations to an established EBT (e.g., McCabe & Yeh, 2009) or elicitation of client perspectives about how culture influences their views of the problem (e.g., Yasui & Henry, 2014). Both approaches allow a provider to demonstrate value and respect for a client's culture, thereby helping to bridge distance that might otherwise occur when sociocultural differences between a client and provider are present.

Lower frequency elements might be useful when they complement higher frequency elements or when higher frequency elements are not feasible or successful. For example, *performance feedback* was included in 20% of effective interventions for Expectancy. The use of *performance feedback* to enhance Expectancy might not be one's first choice, but its pairing with other elements such as *assessment, goal setting*, or *motivational enhancement* might be worthy of future study, as in one study conducted by Smith, Davis, Ureche, and Tabb (2015).

Regarding the issue of "for whom" these interventions work, the majority of practice elements were included in interventions that were shown to be effective at engaging individuals seeking help for youth of different ages, genders, ethnic backgrounds, and clinical concerns. With regard to "in what context," it is encouraging to see that many interventions were effective when delivered by providers without doctoral-level training, in settings other than clinics (particularly home), in a variety of formats, and to youth, caregiver, and family audiences. These results underscore the generalizability of effective interventions across a variety of clinical applications.

Limitations

These results provide a descriptive characterization of the clinical practices and contextual features of effective interventions. However, one can draw conclusions neither that any practice element on its own is itself "evidence-based" nor that practice elements that appear more frequently in winning treatments are necessarily better or more effective than those that appear less frequently (Chorpita, Becker, & Daleiden, 2007). Similarly, one cannot infer that those practices that appear more frequently in effective interventions for a particular REACH domain are more effective at yielding positive outcomes within one domain relative to another (Becker et al., 2015). Finally, although the distillation method focuses on engagement practices, one should not interpret this to mean that the practices themselves are the most importance features of engagement interventions, or that they would provide greater certainty of a desired engagement outcome relative to formal manualized protocols that have been subjected to empirical tests (Chorpita et al., 2007).

This review did not evaluate studies according to quality indicators (e.g., replication by independent research teams, fidelity checks) established in the field (e.g., Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009). Our review is meant to offer a novel and complementary view of the literature that could yield ideas about how to enhance engagement interventions in the future, rather than to prescribe a definitive set of practices. Similarly, effect sizes, which are an important indicator of treatment efficacy (Jacobson, Roberts, Berns, & McGlinchey, 1999), were not considered in this review. Instead, practice element profiles were based on determination of winning interventions as indicated by statistical significance. Interventions that outperformed another intervention on one measure within a domain were treated similarly to interventions that outperformed another intervention on multiple measures within a domain. Thus, future studies may examine these data in a different way that somehow weights interventions based on their replication of effects.

This review was based on information reported in published manuscripts. There were no efforts to obtain documentation (e.g., manuals) of the protocols from study authors. Omissions regarding engagement practices by study authors might influence the results of this study. These omissions might be due to space limits in journals, author emphasis on the active practice ingredients rather than the nonspecifics of engagement, or an artifact of the assumption that engagement strategies are a standard component of quality care.

Finally, four practices yielded kappas below published standards; thus, the codebook would benefit from closer examination of their definitions relative to study descriptions.

Future Directions for Research

Over the past 40 years, scholars have been designing, testing, and refining engagement interventions with success. The accelerating trend of new studies appearing during this time frame speaks to a growing recognition in the field of the value of understanding treatment engagement and how best to improve it. Given this accumulation of supportive literature, the field is now poised to move from merely identifying best engagement interventions to advancing the theory of how those approaches work while they are tested.

In terms of opportunities, the engagement intervention literature currently has a significant imbalance that

prioritizes measurement of Attendance over other domains. This imbalance has likely occurred in part because attendance data are easily collected as part of the routine business procedures at most service agencies, whereas the measurement of other domains might require clients or providers to complete questionnaires or additional interviews. Further, attendance is typically of genuine interest to researchers because it directly relates to treatment dose and is therefore critical to the evaluation of treatment acceptability, feasibility, and effectiveness.

The field will benefit from further alignment of research operations with the conceptualization of engagement as a dynamic, multidimensional, and transactional construct. A simple step toward enhancing engagement theory is to include measures representing each domain when testing engagement interventions (cf. Hoagwood et al., 1996, in the context of mental health services). As a consequence of this pursuit of informing theory, multidomain measurement will also inform basic intervention-outcome relations for those domains in which the science is particularly underdeveloped, such as for Relationship outcomes. For this domain in particular, although correlational studies suggest that the therapeutic alliance is important to treatment outcome (Karver et al., 2006; Shirk & Karver, 2011), we still have limited evidence that demonstrates our ability even to modify the Relationship-related indicators, let alone impact outcomes through the therapeutic relationship.

Through multidomain measurement within the same trial we can also begin to understand what measures are well suited to assess different types of engagement problems, how early we can detect different types of engagement problems, how different facets of engagement change over time, what strategies bring about change on different dimensions, how engagement domains relate to one another over the course of services, and how engagement domains relate to treatment outcome. Few studies in this review had the capacity to conduct mediational analyses, yet multidimensional measurement and attention to temporal sequencing of *assessment* would allow sophisticated analyses of mediation effects that are hypothesized in the literature (e.g., cognitions mediate the association between an engagement intervention and attendance).

Aside from its implications for engagement outcome measurement, this review points to other opportunities to enhance the impact of engagement research. For example, distillation of practices at the level of elements seems to be a useful strategy for summarizing this growing literature. Despite a sizable literature of 50 RCTs, the current review identified only three manualized engagement protocols that had been tested in more than one study, which together were tested in 26% of the RCTs. We considered this a "tip of the iceberg" phenomenon, such that if we were to focus our review exclusively on formal manualized engagement approaches, we would forfeit a sizable evidence base with clear and potentially valuable implications for clinical practice. Supplementing a traditional review of manualized approaches, a distillation review can aggregate a literature that is nearly four times the size and allow new inferences across different contexts and investigator teams.

There exist research opportunities to further study the context of engagement. More attention is needed with regard to engaging ethnic minority youth and families, given that ethnic minority youth and families are generally more likely to drop out of treatment than are non-Hispanic White clients (Kazdin & Whitley, 2003). However, developing culturally responsive EBTs for each minority group and unique target problem may not be feasible and so far is not borne out by the evidence (Huey & Jones, 2013). Consistent with other research (e.g., Huey, Tilley, Jones, & Smith, 2014), our review found that culturally neutral engagement strategies such as phone reminders, addressing *barriers to treatment*, and motivational interviewing were effective with minority populations. Hence, at least in the short term, using culturally anchored, EBT-independent interventions that facilitate client engagement through enhancing therapeutic alliance (Yasui & Henry, 2014) may be a more feasible and effective approach to increasing engagement and improving outcomes among ethnic minority youth and families, as well as those who might be marginalized from mental health services due to socioeconomic status, sexual orientation, military affiliation, political leanings, religion, or education (e.g., Firestein, 2007).

Future research could examine how the extended community might enhance engagement for individual youth and families, especially in communities where distrust of the mental health system is prevalent or where mental illness is stigmatized (e.g., Breland-Noble, 2012). Community education and awareness of mental health has the potential to increase knowledge about mental health and mental health treatments, as well as normalize and support treatment participation of youth and families (Becker, Buckingham, Rith-Najarian et al., 2015). The science of engagement could be enhanced by expanding the literature to test strategies designed to enhance help-seeking in these communities, given that many youth in need never participate in the help-seeking process (Merikangas et al., 2010). Community-level interventions that increase awareness and literacy about mental health issues, service options, and pathways to access services may be particularly effective (Jorm, 2012; Wright, McGorry, Harris, Jorm, & Pennell, 2006).

Finally, novel service delivery models have shown some potential to enhance treatment engagement. For example, difficult-to-reach populations have been engaged through technology such as *appointment reminders* sent by text message (Downer, Meara, Da Costa, & Sethuraman, 2006), avatars to deliver therapy (Pagliari et al., 2012), web-based self-help (Possemato et al., 2015), and phone applications to increase therapy homework adherence (Jones et al., 2015). However, as Kazdin and Rabbitt (2013) pointed out, our current system of care (one-on-one therapy with a highly trained provider) is not adequate to

meet the mental health need of the population worldwide, even when incorporating technology (which is often unavailable or unreliable in some parts of the world). Other novel delivery strategies that might help improve treatment engagement include leveraging existing resources to provide mental health in a variety of community settings such as schools (e.g., Becker, Buckingham, & Brandt, 2015; Weist et al., 2014), pediatrician offices (e.g., Gadomski et al., 2014), park and recreation programs (e.g., Frazier et al., 2015), or extracurricular activities (e.g., Rotheram-Borus, Swendeman, & Becker, 2014), as well as capitalizing on the role of task shifting parts of therapy to nonprofessionals in these settings (e.g., Nadkarni et al., 2015; Singla et al., 2017).

In summary, interest and developments in the field related to treatment engagement provide tremendous opportunity for advancing the science of engagement to enhance its practice. We contend that enhanced measurement will yield greater understanding of engagement as a dynamic, multidimensional, and transactional construct and will inspire new discoveries.

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REFERENCES

References marked with an asterisk indicate studies included in the meta-analysis.

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, *50*, 179–211. doi:10.1016/0749-5978(91)90020-T

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Becker, K. D., Buckingham, S. L., & Brandt, N. E. (2015). Engaging youth and families in school mental health services. *Child and Adolescent Psychiatric Clinics of North America*, *24*(2), 385–398. doi:10.1016/j.chc.2014.11.002

Becker, K. D., Buckingham, S. L., Rith-Najarian, L., & Kline, E. R. (2015). The Common Elements of treatment engagement for clinically high-risk youth and youth with first-episode psychosis. *Early Intervention in Psychiatry*, *10*(6), 455–467. doi:10.1111/eip.12283

Becker, K. D., & Chorpita, B. (2016, August). Enhancing the design of engagement interventions to enhance the public health impact of mental health treatments for youth. In K. Becker (Chair), *Extending the reach and impact of science on clinical care for youth and families: Looking for new models for the old challenges*. Symposium conducted at the NIMH Conference on Mental Health Services Research: Harnessing Science to Strengthen the Public Health Impact, Bethesda, MD.

Becker, K. D., Lee, B. R., Daleiden, E. L., Lindsey, M., Brandt, N. E., & Chorpita, B. F. (2015). The common elements of engagement in children's mental health services: Which elements for which outcomes? *Journal of Clinical Child and Adolescent Psychology*, *44*(1), 30–43. doi:10.1080/15374416.2013.814543

*Bonner, B., & Everett, F. (1986). Influence of client preparation and problem severity on attitudes and expectations in child psychotherapy. *Professional Psychology: Research and Practice*, *17*(3), 223–229. doi:10.1037/0735-7028.17.3.223

*Breland-Noble, A. (2012). Community and treatment engagement for depressed African American youth: The AAKOMA FLOA pilot. *Journal of Clinical Psychology in Medical Settings*, *19*(1), 41–48. doi:10.1007/s10880-011-9281-0

Chacko, A., Jensen, S. A., Lowry, L. S., Cornwell, M., Chimklis, A., Chan, E., … Pulgarin, B. (2016). Engagement in behavioral parent training: Review of the literature and implications for practice. *Clinical Child and Family Psychology Review*, *19*(3), 204–215. doi:10.1007/s10567-016-0205-2

*Chacko, A., Wymbs, B. T., Wymbs, F. A., Pelham, W. E., SwangerGagne, M. S., Girio, E., … O'Connor, B. (2009). Enhancing traditional behavioral parent training for single mothers of children with ADHD. *Journal of Clinical Child and Adolescent Psychology*, *38*(2), 206–218. doi:10.1080/15374410802698388

Chorpita, B. F., Becker, K. D., & Daleiden, E. L. (2007). Understanding the common elements of evidence-based practice. *Journal of the American Academy of Child & Adolescent Psychiatry*, *46*(5), 647–652. doi:10.1097/chi.0b013e318033ff71

Chorpita, B. F., & Daleiden, E. L. (2009). Mapping evidence-based treatments for children and adolescents: Application of the distillation and matching model to 615 treatments from 322 randomized trials. *Journal of Consulting and Clinical Psychology*, *77*(3), 566–579. doi:10.1037/a0014565

Chorpita, B. F., & Daleiden, E. L. (2014). Structuring the collaboration of science and service in pursuit of a shared vision. *Journal of Clinical Child & Adolescent Psychology*, *43*, 323–338. doi:10.1080/15374416.2013.828297

Chorpita, B. F., Daleiden, E. L., Ebesutani, C., Young, J., Becker, K. D., Nakamura, B. J., … Starace, N. (2011). Evidence based treatments for children and adolescents: An updated review of efficacy and clinical effectiveness. *Clinical Psychology: Science and Practice*, *18*(2), 154–172. doi:10.1111/j.1468-2850.2011.01247.x

Chorpita, B., Daleiden, E., & Weisz, J. (2005). Identifying and selecting the common elements of evidence based interventions: A distillation and matching model. *Mental Health Services Research*, *7*(1), 5–20. doi:10.1007/s11020-005-1962-6

Clarke, G. N. (1995). Improving the transition from basic efficacy research to effectiveness studies: Methodological issues and procedures. *Journal of Consulting and Clinical Psychology*, *63*(5), 718–725. doi:10.1037/0022-006X.63.5.718

Clarke, G. N., Rohde, P., Lewinsohn, P. M., Hops, H., & Seeley, J. R. (1999). Cognitive-behavioral treatment of adolescent depression: Efficacy of acute group treatment and booster sessions. *Journal of the American Academy of Child & Adolescent Psychiatry*, *38*(3), 272–279. doi:10.1097/00004583-199903000-00014

*Coatsworth, J. D., Santisteban, D. A., McBride, C. K., & Szapocznik, J. (2001). Brief strategic family therapy versus community control: Engagement, retention, and an exploration of the moderating role of adolescent symptom severity. *Family Process*, *40*(3), 313–332. doi:10.1111/j.1545-5300.2001.4030100313.x

*Coleman, D. J., & Kaplan, M. S. (1990). Effects of pretherapy videotape preparation on child therapy outcomes. *Professional Psychology: Research and Practice*, *21*(3), 199–203. doi:10.1037/0735-7028.21.3.199

Costello, J., Copeland, W., & Angold, A. (2011). Trends in psychopathology across adolescent years: What changes when children become adolescents, and when adolescents become adults? *Journal of Child Psychology and Psychiatry*, *52*(10), 1015–1025. doi:10.1111/j.1469-7610.2011.02446.x

Danko, C. M., Garbacz, L. L., & Budd, K. S. (2016). Outcomes of Parent–Child Interaction Therapy in an urban community clinic: A comparison of treatment completers and dropouts. *Children and Youth Services Review*, *60*, 42–51. doi:10.1016/j.childyouth.2015.11.007

*Dean, S., Britt, E., Bell, E., Stanley, J., & Collings, S. (2016). Motivational interviewing to enhance adolescent mental health treatment engagement: A randomized clinical trial. *Psychological Medicine*, *46*(9), 1961–1969. doi:10.1017/S0033291716000568

*Donohue, B., Azrin, N., Lawson, H., Friedlander, J., Teichner, G., & Rindsberg, J. (1998). Improving initial session attendance of substance abusing and conduct disordered adolescents: A controlled study. *Journal of Child & Adolescent Substance Abuse*, *8*(1), 1–13. doi:10.1300/J029v08n01_01

*Dorsey, S., Pullmann, M. D., Berliner, L., Koschmann, E., McKay, M., & Deblinger, E. (2014). Engaging foster parents in treatment: A randomized trial of supplementing trauma-focused cognitive behavioral therapy with evidence-based engagement strategies. *Child Abuse & Neglect*, *38*(9), 1508–1520. doi:10.1016/j.chiabu.2014.03.020

Downer, S. R., Meara, J. G., Da Costa, A. C., & Sethuraman, K. (2006). SMS text messaging improves outpatient attendance. *Australian Health Review*, *30*, 389–396. doi:10.1071/AH060389

*Dumas, J. E., Begle, A. M., French, B., & Pearl, A. (2010). Effects of monetary incentives on engagement in the PACE parenting program. *Journal of Clinical Child and Adolescent Psychology*, *39*(3), 302–313. doi:10.1080/15374411003691792

*Eyberg, S. M., & Johnson, S. M. (1974). Multiple assessment of behavior modification with families: Effects of contingency contracting and order of treated problems. *Journal of Consulting and Clinical Psychology*, *42*(4), 594–606. doi:10.1037/h0036723

*Fabiano, G. A., Chacko, A., Pelham, W. E. J., Robb, J., Walker, K. S., Wymbs, F., … Pirvics, L. (2009). A comparison of behavioral parent training programs for fathers of children with attention-deficit/hyperactivity disorder. *Behavior Therapy*, *40*(2), 190–204. doi:10.1016/j.beth.2008.05.002

Firestein, B. A. (2007). *Becoming visible: Counseling bisexuals across the lifespan*. New York, NY: Columbia University Press.

*Fleischman, M. J. (1979). Using parenting salaries to control attrition and cooperation in therapy. *Behavior Therapy*, *10*(1), 111–116. doi:10.1016/S0005-7894(79)80014-3

Fleiss, J. L. (1981). *Statistical methods for rates and proportions* (2nd ed., pp. 38–46). New York, NY: Wiley.

Frazier, S. L., Dinizulu, S. M., Rusch, D., Boustani, M. M., Mehta, T. G., & Reitz, K. (2015). Building resilience after school for early adolescents in urban poverty: Open trial of Leaders@ Play. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*(6), 723–736. doi:10.1007/s10488-014-0608-7

Gadomski, A., Wisslow, L., Palinkas, L., Hoagwood, K., Daly, J., & Kaye, D. (2014). Encouraging and sustaining integration of child mental health into primary care: Interviews with primary care providers participating in Project TEACH (CAPES and CAP PC) in NY. *General Hospital Psychiatry*, *36*(6), 555–562.

*Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R. R., & Passetti, L. L. (2007). The effect of assertive continuing care on continuing care linkage, adherence and abstinence following residential treatment for adolescents with substance use disorders. *Addiction*, *102*(1), 81–93. doi:10.1111/j.1360-0443.2006.01648.x

Gopalan, G., Goldstein, L., Klingenstein, K., Sicher, C., Blake, C., & McKay, M. (2010). Engaging families into child mental health treatment: Updates and special considerations. *Journal of the Canadian Academy of Child & Adolescent Psychiatry*, *19*(3), 182–196. PMCID: PMC2938751.

*Haine-Schlagel, R., Martinez, J. I., Roesch, S. C., Bustos, C. E., & Janicki, C. (2016). Randomized trial of the Parent and Caregiver Active Participation Toolkit for child mental health treatment. *Journal of Clinical Child & Adolescent Psychology*, 1–11. doi:10.1080/15374416.2016.1183497

Haine-Schlagel, R., & Walsh, N. E. (2015). A review of parent participation engagement in child and family mental health treatment. *Clinical Child and Family Psychology Review*, *18*(2), 133–150. doi:10.1007/s10567-015-0182-x

*Heinrichs, N. (2006). The effects of two different incentives on recruitment rates of families into a prevention program. *The Journal of Primary Prevention*, *27*(4), 345–365. doi:10.1007/s10935-006-0038-8

Hoagwood, K., Jensen, P., Petti, T., & Burns, B. (1996). Outcomes of mental health care for children and adolescents: I. A comprehensive conceptual model. *Journal of the American Academy of Child & Adolescent Psychiatry*, *35*(8), 1055–1063. doi:10.1097/00004583-199608000-00017

*Holmes, D. S., & Urie, R. G. (1975). Effects of preparing children for psychotherapy. *Journal of Consulting and Clinical Psychology*, *43*(3), 311–318. doi:10.1037/h0076735

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*(2), 223–233. doi:10.1037/0022-0167.36.2.223

Huey, S. J., Jr., & Jones, E. O. (2013). Improving treatment engagement and psychotherapy outcomes for culturally diverse youth and families. In F. A. Paniagua & A. Yamada (Eds.), *Handbook of multicultural mental health: Assessment and treatment of diverse populations* (2nd ed., pp. 427–444). San Diego, CA: Elsevier Academic Press.

Huey, S. J., Jr., Tilley, J. L., Jones, E. O., & Smith, C. A. (2014). The contribution of cultural competence to evidence-based care for ethnically diverse populations. *Annual Review of Clinical Psychology*, *10*(1), 305–338. doi:10.1146/annurevclinpsy-032813-153729

Ingoldsby, E. (2010). Review of interventions to improve family engagement and retention in parent and child mental health programs. *Journal of Child and Family Studies*, *19*(5), 629–645. doi:10.1007/s10826-009-9350-2

Jacobson, N. S., Roberts, L. J., Berns, S. B., & McGlinchey, J. B. (1999). Methods for defining and determining the clinical significance of treatment effects: Description, application, and alternatives. *Journal of Consulting and Clinical Psychology*, *67*(3), 300–307. doi:10.1037/0022-006X.67.3.300

*Jensen, S. A., & Grimes, L. K. (2010). Increases in parent attendance to behavioral parent training due to concurrent child treatment groups. *Child & Youth Care Forum*, *39*(4), 239–251. doi:10.1007/s10566-010-9101-y

Jones, D. J., Anton, M., Gonzalez, M., Honeycutt, A., Khavjou, O., Forehand, R., & Parent, J. (2015). Incorporating mobile phone technologies to expand evidence-based care. *Cognitive and Behavioral Practice*, *22*(3), 281–290. doi:10.1016/j.cbpra.2014.06.002

*Jones, D. J., Forehand, R., Cuellar, J., Parent, J., Honeycutt, A., Khavjou, O., … Newey, G. A. (2014). Technology-enhanced program for child disruptive behavior disorders: Development and pilot randomized control trial. *Journal of Clinical Child and Adolescent Psychology*, *43*(1), 88–101. doi:10.1080/15374416.2013.822308

Jorm, A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *American Psychologist*, *67*(3), 231. doi:10.1037/a0025957

Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2006). Meta-analysis of therapeutic relationship variables in youth and family therapy: The evidence for different relationship variables in the child and adolescent treatment outcome literature. *Clinical Psychology Review*, *26*(1), 50–65. doi:10.1016/j.cpr.2005.09.001

Kazdin, A. E., & Blase, S. L. (2011). Rebooting psychotherapy research and practice to reduce the burden of mental illness. *Perspectives on Psychological Science*, *6*(1), 21–37. doi:10.1177/1745691610393527

Kazdin, A. E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology*, *65*(3), 453–463. doi:10.1037/0022-006X.65.3.453

Kazdin, A. E., & Rabbitt, S. M. (2013). Novel models for delivering mental health services and reducing the burdens of mental illness. *Clinical Psychological Science*, *1*(2), 170–191. doi:10.1177/2167702612463566

Kazdin, A., & Wassell, G. (1999). Barriers to treatment participation and therapeutic change among children referred for conduct disorder. *Journal of Clinical Child Psychology*, *28*(2), 160–172. doi:10.1207/s15374424jccp2802_4

Kazdin, A., & Wassell, G. (2000). Predictors of barriers to treatment and therapeutic change in outpatient therapy for antisocial children and their families. *Mental Health Services Research*, *2*(1), 27–40. doi:10.1023/A:1010191807861

Kazdin, A. E., & Whitley, M. K. (2003). Treatment of parental stress to enhance therapeutic change among children referred for aggressive and antisocial behavior. *Journal of Consulting and Clinical Psychology*, *71*(3), 504–515. doi:10.1037/0022-006X.71.3.504

Kendall, P. C., Hudson, J. L., Gosch, E., Flannery-Schroeder, E., & Suveg, C. (2008). Cognitive-behavioral therapy for anxiety disordered youth: A randomized clinical trial evaluating child and family modalities. *Journal of Consulting and Clinical Psychology*, *76*(2), 282–297. doi:10.1037/0022-006X.76.2.282

Kerkorian, D., McKay, M., & Bannon, W. M. (2006). Seeking help a second time: Parents'/caregivers' characterizations of previous experiences with mental health services for their children and perceptions of barriers to future use. *American Journal of Orthopsychiatry*, *76*(2), 161–166. doi:10.1037/0002-9432.76.2.161

Kim, H., Munson, M. R., & McKay, M. M. (2012). Engagement in mental health treatment among adolescents and young adults: A systematic review. *Child and Adolescent Social Work Journal*, *29*(3), 241–266. doi:10.1007/s10560-012-0256-2

King, G., Currie, M., & Petersen, P. (2014). Review: Child and parent engagement in the mental health intervention process: A motivational framework. *Child and Adolescent Mental Health*, *19*(1), 2–8. doi:10.1111/camh.12015

*Kourany, R. F., Garber, J., & Tornusciolo, G. (1990). Improving first appointment attendance rates in child psychiatry outpatient clinics. *Journal of the American Academy of Child and Adolescent Psychiatry*, *29*(4), 657–660. doi:10.1097/00004583-199007000-00022

Lefforge, N. L., Donohue, B., & Strada, M. J. (2007). Improving session attendance in mental health and substance abuse settings: A review of controlled studies. *Behavior Therapy*, *38*(1), 1–22. doi:10.1016/j.beth.2006.02.009

Lindsey, M. A., Brandt, N. E., Becker, K. D., Lee, B. R., Barth, R. P., Daleiden, E. L., & Chorpita, B. F. (2014). Identifying the common elements of treatment engagement interventions in children's mental health services. *Clinical Child and Family Psychology Review*, *17*(3), 283–298. doi:10.1007/s10567-013-0163-x

Lindsey, M. A., Chambers, K., Pohle, C., Beall, P., & Lucksted, A. (2013). Understanding the behavioral determinants of mental health service use by urban, under-resourced Black youth: Adolescent and caregiver perspectives. *Journal of Child and Family Studies*, *22*(1), 107–121. doi:10.1007/s10826-012-9668-z

*MacLean, L. M., Greenough, T., Jorgenson, V., & Couldwell, M. (1989). Getting through the front door: Improving initial appointment attendance at a mental-health clinic. *Canadian Journal of Community Mental Health*, *8*, 123–133. doi:10.7870/cjcmh-1989-0009

Marchand, E., Stice, E., Rohde, P., & Becker, C. B. (2011). Moving from efficacy to effectiveness trials in prevention research. *Behaviour Research and Therapy*, *49*(1), 32–41. doi:10.1016/j.brat.2010.10.008

Mash, E. J., & Hunsley, J. (2005). Evidence-based assessment of child and adolescent disorders: Issues and challenges. *Journal of Clinical Child and Adolescent Psychology*, *34*(3), 362–379. doi:10.1207/s15374424jccp3403_1

*McCabe, K., & Yeh, M. (2009). Parent-child interaction therapy for Mexican Americans: A randomized clinical trial. *Journal of Clinical Child and Adolescent Psychology*, *38*(5), 753–759. doi:10.1080/15374410903103544

*McKay, M., & Bannon, W. (2004). Engaging families in child mental health services. *Child & Adolescent Psychiatric Clinics of North America*, *13*(4), 905–921. doi:10.1016/j.chc.2004.04.001

*McKay, M. M., Gopalan, G., Franco, L., DeanAssael, K., Chacko, A., Jackson, J. M., & Fuss, A. (2011). A collaboratively designed child mental health service model: Multiple family groups for urban children with conduct difficulties. *Research on Social Work Practice*, *21*(6), 664–674. doi:10.1177/1049731511406740

*McKay, M., McCadam, K., & Gonzales, J. (1996). Addressing the barriers to mental health services for inner city children and their caretakers. *Community Mental Health Journal*, *32*(4), 353–361. doi:10.1007/BF02249453

*McKay, M. M., Nudelman, R., McCadam, K., & Gonzales, J. (1996). Evaluating a social work engagement approach to involving inner-city children and their families in mental health care. *Research on Social Work Practice*, *6*(4), 462–472. doi:10.1177/104973159600600404

*McKay, M., Stoewe, J., McCadam, K., & Gonzales, J. (1998). Increasing access to child mental health services for urban children and their caregivers. *Health & Social Work*, *23*(1), 9–15. doi:10.1093/hsw/23.1.9

*Mendenhall, A. N., Fristad, M. A., & Early, T. J. (2009). Factors influencing service utilization and mood symptom severity in children with mood disorders: Effects of multifamily psychoeducation groups (MFPGs). *Journal of Consulting and Clinical Psychology*, *77*(3), 463–473. doi:10.1037/a0014527

Merikangas, K., He, J., Brody, D., Fisher, P. W., Bourdon, K., & Koretz, D. S. (2010). Prevalence and treatment of mental disorders among US children in the 2001–2004 NHANES. *Pediatrics*, *125*(1), 75–81. doi:10.1542/peds.2008-2598

Michelson, D., Davenport, C., Dretzke, J., Barlow, J., & Day, C. (2013). Do evidence-based interventions work when tested in the "real world?" A systematic review and meta-analysis of parent management training for the treatment of child disruptive behavior. *Clinical Child and Family Psychology Review*, *16*(1), 18–34. doi:10.1007/s10567-013-0128-0

*Miller, G. E., & Prinz, R. J. (2003). Engagement of families in treatment for childhood conduct problems. *Behavior Therapy*, *34*(4), 517–534. doi:10.1016/S0005-7894(03)80033-3

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change*. 3rd edition. New York, NY: Guilford Press.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & The PRISMA Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Plos Medicine*, *6*(7), e1000097.

Nadkarni, A., Velleman, R., Dabholkar, H., Shinde, S., Bhat, B., McCambridge, J., … Patel, V. (2015). The systematic development and pilot randomized evaluation of counselling for alcohol problems, a lay counselor-delivered psychological treatment for harmful drinking in primary care in India: The PREMIUM study. *Alcoholism: Clinical and Experimental Research*, *39*(3), 522–531. doi:10.1111/acer.12653

Nix, R., Bierman, K., McMahon, R., & The Conduct Problems Prevention Research Group. (2009). How attendance and quality of participation affect treatment response to parent management training. *Journal of Consulting and Clinical Psychology*, *77*(3), 429–438.

Nock, M. K., & Ferriter, C. (2005). Parent management of attendance and adherence in child and adolescent therapy: A conceptual and empirical review. *Clinical Child and Family Psychology Review*, *8*(2), 149–166. doi:10.1007/s10567-005-4753-0

Nock, M. K., & Kazdin, A. E. (2001). Parent expectancies for child therapy: Assessment and relation to participation in treatment. *Journal of Child and Family Studies*, *10*(2), 155–180. doi:10.1023/A:1016699424731

*Nock, M., & Kazdin, A. (2005). Randomized controlled trial of a brief intervention for increasing participation in parent management training. *Journal of Consulting and Clinical Psychology*, *73*(5), 872–879. doi:10.1037/0022-006X.73.5.872

Nock, M., & Photos, V. (2006). Parent motivation to participate in treatment: Assessment and prediction of subsequent participation. *Journal of Child and Family Studies*, *15*(3), 345–358. doi:10.1007/s10826-006-9022-4

*Noel, P. E. (2006). The impact of therapeutic case management on participation in adolescent substance abuse treatment. *The American Journal of Drug and Alcohol Abuse*, *32*(3), 311–327. doi:10.1007/s10826-006-9022-4

*Ougrin, D., Zundel, T., Ng, A., Banarsee, R., Bottle, A., & Taylor, E. (2011). Trial of Therapeutic Assessment in London: Randomised controlled trial of Therapeutic Assessment versus standard psychosocial assessment in adolescents presenting with self-harm. *Archives of Disease in Childhood*, *96*(2), 148–153. doi:10.1136/adc.2010.188755

Pagliari, C., Burton, C., McKinstry, B., Szentatotai, A., David, D., Serrano, B. A., … Wolters, M. (2012). Psychosocial implications of avatar use in supporting therapy for depression. *Annual Review of Cybertherapy and Telemedicine*, *181*, 329–333. doi:10.3233/978-1-61499-121-2-329

*Parrish, J. M., Charlop, M. H., & Fenton, L. R. (1986). Use of a stated waiting list contingency and reward opportunity to increase appointment keeping in an outpatient pediatric psychology clinic. *Journal of Pediatric Psychology*, *11*, 81–89. doi:10.1093/jpepsy/11.1.81

PracticeWise. (2017, Spring). *PracticeWise Evidence-Based Services (PWEBS) database*. Satellite Beach, FL: Author.

Pellerin, K., Costa, N., Weems, C., & Dalton, R. (2010). An examination of treatment completers and non-completers at a child and adolescent community mental health clinic. *Community Mental Health Journal*, *46*(3), 273–281. doi:10.1007/s10597-009-9285-5

*Planos, R., & Glenwick, D. S. (1986). The effects of prompts on minority children's screening attendance at a community mental health center. *Child & Family Behavior Therapy*, *8*(2), 5–13. doi:10.1300/J019v08n02_02

Possemato, K., Acosta, M. C., Fuentes, J., Lantinga, L. J., Marsch, L. A., Maisto, S. A., … Rosenblum, A. (2015). A web-based self-management program for recent combat veterans with PTSD and substance misuse: Program development and veteran feedback. *Cognitive and Behavioral Practice*, *22*(3), 345–358. doi:10.1016/j.cbpra.2014.03.005

PracticeWise. (2008). *Psychosocial and combined treatments coding manual*. Satellite Beach, FL: Author.

PracticeWise. (2012, Spring). *PracticeWise Evidence-Based Services (PWEBS) database*. Satellite Beach, FL: Author.

*Prinz, R. J., & Miller, G. E. (1994). Family-based treatment for childhood antisocial behavior: Experimental influences on dropout and engagement. *Journal of Consulting and Clinical Psychology*, *62*(3), 645–650. doi:10.1037/0022-006X.62.3.645

Rogers, S., & Vismara, L. (2008). Evidence-based comprehensive treatments for early autism. *Journal of Clinical Child and Adolescent Psychology*, *37*(1), 8–38. doi:10.1080/15374410701817808

Rotheram-Borus, M. J., Swendeman, D., & Becker, K. D. (2014). Adapting evidence-based interventions using a common theory, practices, and principles. *Journal of Clinical Child & Adolescent Psychology*, *43*(2), 229–243. doi:10.1080/15374416.2013.836453

*Santisteban, D., Szapocznik, J., Perez-Vidal, A., Kurtines, W., Murray, E., & LaPerriere, A. (1996). Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness. *Journal of Family Psychology*, *10*(1), 35–44. doi:10.1037/0893-3200.10.1.35

*Saxe, G. N., Ellis, B. H., Fogler, J., & Navalta, C. P. (2012). Innovations in practice: Preliminary evidence for effective family engagement in treatment for child traumatic stress–trauma systems therapy approach to preventing dropout. *Child and Adolescent Mental Health*, *17*(1), 58–61. doi:10.1111/j.1475-3588.2011.00626.x

Shirk, S. R., & Karver, M. S. (2011). Alliance in child and adolescent psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 70–91). New York, NY: Oxford University Press. doi:10.1093/acprof:oso/9780199737208.003.0003

*Shuman, A., & Shapiro, J. (2002). The effects of preparing parents for child psychotherapy on accuracy of expectations and treatment attendance. *Community Mental Health Journal*, *38*(1), 3–16. doi:10.1023/A:1013908629870

*Sibley, M. H., Graziano, P. A., Kuriyan, A. B., Coxe, S., Pelham, W. E., Rodriguez, L., … Ward, A. (2016). Parent–teen behavior therapy + motivational interviewing for adolescents with ADHD. *Journal of Consulting and Clinical Psychology*, *84*(8), 699–712. doi:10.1037/ccp0000106

Singla, D. A., Kohrt, B., Murray, L. K., Anand, A., Chorpita, B. F., & Patel, V. (2017). Psychological treatments for the world: Lessons from low- and middle-income countries. *Annual Review of Clinical Psychology*. doi:10.1146/annurev-clinpsy-032816-045217

*Smith, D. C., Davis, J. P., Ureche, D. J., & Tabb, K. M. (2015). Normative feedback and adolescent readiness to change: A small randomized trial. *Research on Social Work Practice*, *25*(7), 801–814. doi:10.1177/1049731514535851

Snell-Johns, J., Mendez, J. L., & Smith, B. H. (2004). Evidence-based solutions for overcoming access barriers, decreasing attrition, and promoting change with underserved families. *Journal of Family Psychology*, *18*(1), 19–35. doi:10.1037/0893-3200.18.1.19

Southam-Gerow, M. A., Chorpita, B. F., Miller, L. M., & Gleacher, A. A. (2008). Are children with anxiety disorders privately referred to a university clinic like those referred from the public mental health system? *Administration and Policy in Mental Health and Mental Health Services Research*, *35*(3), 168–180. doi:10.1007/s10488-007-0154-7

Southam-Gerow, M. A., Weisz, J. R., Chu, B. C., McLeod, B. D., Gordis, E. B., & Connor-Smith, J. K. (2010). Does cognitive behavioral therapy for youth anxiety outperform usual care in community clinics? An initial effectiveness test. *Journal of the American Academy of Child & Adolescent Psychiatry*, *49*(10), 1043–1052. doi:10.1016/j.jaac.2010.06.009

*Spirito, A., Boergers, J., Donaldson, D., Bishop, D., & Lewander, W. (2002). An intervention trial to improve adherence to community treatment by adolescents after a suicide attempt. *Journal of the Academy of Child & Adolescent Psychiatry*, *41*(4), 435–442. doi:10.1097/00004583-200204000-00016

Stattler, J. (2002). *Assessment of children: Behavioral and clinical applications* (4th ed.). San Diego, CA: Jerome M. Stattler, Publisher.

Staudt, M. M. (2003). Helping children access and use services: A review. *Journal of Child and Family Studies*, *12*(1), 49–60. doi:10.1023/A:1021306125491

Staudt, M. (2007). Treatment engagement with caregivers of at-risk children: Gaps in research and conceptualization. *Journal of Child and Family Studies*, *16*(2), 183–196. doi:10.1007/s10826-006-9077-2

*Stern, S. B., Walsh, M., Mercado, M., Levene, K., Pepler, D. J., Carr, A., … Lowe, E. (2015). When they call, will they come? A contextually responsive approach for engaging multistressed families in an urban child mental health center: A randomized clinical trial. *Research on Social Work Practice*, *25*(5), 549–563. doi:10.1177/1049731514548038

*Sterrett, E., Jones, D. J., Zalot, A., & Shook, S. (2010). A pilot study of a brief motivational intervention to enhance parental engagement: A brief report. *Journal of Child and Family Studies*, *19*(6), 697–701. doi:10.1007/s10826-010-9356-9

*Stevens, J., Klima, J., Chisolm, D., & Kelleher, K. J. (2009). A trial of telephone services to increase adolescent utilization of health care for psychosocial problems. *Journal of Adolescent Health*, *45*(6), 564–570. doi:10.1016/j.jadohealth.2009.04.003

*Szapocznik, J., Perez-Vidal, A., Brickman, A., Foote, F., Santisteban, D., Hervis, O., & Kurtines, W. (1988). Engaging adolescent drug abusers

and their families in treatment: A strategic structural systems approach. *Journal of Consulting and Clinical Psychology*, *56*(4), 552–557. doi:10.1037/0022-006X.56.4.552

*Warzak, W. J., Parrish, J. M., & Handen, B. L. (1987). Effects of telephone intake procedures on initial appointment keeping in a child behavior management clinic. *Journal of Compliance in Health Care*, *2*(2), 143–154. Retrieved from http://psycnet.apa.org/psycinfo/1989-16529-001

*Watt, B. D., Hoyland, M., Best, D., & Dadds, M. R. (2007). Treatment participation among children with conduct problems and the role of telephone reminders. *Journal of Child and Family Studies*, *16*(4), 522–530. doi:10.1007/s10826-006-9103-4

*Weinstein, M. (1988). Preparation of children for psychotherapy through videotaped modeling. *Journal of Clinical Child Psychology*, *17*(2), 131–136. doi:10.1207/s15374424jccp1702_4

Weist, M., Youngstrom, E. A., Stephan, S., Lever, N., Fowler, J., Taylor, L., … Hoagwood, K. (2014). Challenges and ideas from a research program on high-quality, evidence-based practice in school mental health. *Journal of Clinical Child and Adolescent Psychology*, *43*(2), 244–255. doi:10.1080/15374416.2013.833097

Weisz, J. R., Doss, A. J., & Hawley, K. M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology*, *56*, 337–363. doi:10.1146/annurev.psych.55.090902.141449

*Wiseman, M., & McBride, M. (1998). Increasing the attendance rate for first appointments at child and family psychiatry clinics: An opt-in system. *Child Psychology & Psychiatry Review*, *3*(2), 68–71. doi:10.1017/S136064179700141X

Wright, A., McGorry, P. D., Harris, M. G., Jorm, A. F., & Pennell, K. (2006). Development and evaluation of a youth mental health community awareness campaign–The Compass Strategy. *BMC Public Health*, *6*(1), 1–13. doi:10.1186/1471-2458-6-215

*Yasui, M., & Henry, D. B. (2014). Shared understanding as a gateway for treatment engagement: A preliminary study examining the effectiveness of the culturally enhanced video feedback engagement intervention. *Journal of Clinical Psychology*, *70*(7), 658–672. doi:10.1002/jclp.22058