

## Are we skipping a step? Engaging youth and families in mental health treatments and services

Mary M. McKay, Ph.D.  
Professor of Social Work in Psychiatry  
& Community Medicine  
Mount Sinai School of Medicine

## Acknowledgements

This line of research has been supported by:

- talented research staff (R. Hibbert, W. Bannon, D. Kerkorian, M. Harrison, K. Hoagwood, J. Rodriguez, J. Legerski, L. Murray), consumers (A. Miranda, R. Lawrence, H. Osuji, R. Powell) and providers
- Funding from the National Institute of Mental Health

## Why study engagement?

- U.S. Surgeon General identified meeting the mental health needs of youth a **national priority** (U.S. Department of Health & Human Services, 1999; 2001; 2002).
- In the early 1980s, the child mental health service delivery system was described as failing to respond to youths in serious need of mental health care.

## Background (continued)

- Rates of child mental health difficulties at alarming levels (17 to 26% of youths in need) (Brandenburg, Friedman, & Silver, 1987; McCabe et al., 1999; U.S. Department of Health & Human Services, 2000; Tuma, 1989).
- Within low-income, urban communities, rates of child mental health need as high as 40% (Tolan & Henry, 1996; Tolan et al., 1998).

## Background (continued)

- Yet, 75% of children with mental health needs do not have any contact with the child mental health service system (National Institute of Mental Health, 2001).
- Disparity between need and use of services was found to be highest for minority youth.
- These rates are identical to those reported in the mid 1980's. The level of need for services remains unchanged despite advances in developing evidence-based assessments, treatments and services for these children (OTA, 1986).

## Implications

- There is a significant need to understand and enhance the ability of the child mental health system to reach out effectively to youth and their families and engage them in acceptable and effective child mental health care.

### Empirically supported engagement interventions

- Reminders reduced missed appointments by 32% (Kourany et al., 1990; McLean et al., 1989; Shivack et al., 1989; & Sullivan)
- Intensive family-focused telephone engagement intervention associated with 50% decrease in initial show rates and a 24% decrease in premature terminations (Szapocznik, 1988; 1997)
- Combined telephone and first interview engagement interventions associated with attendance rates of 74%, representing a 16 to 25% increase above the clinic comparison families (McKay et al., 1998).

### The CATS Opportunity: Combining engagement interventions with evidence-based care

- Child and Adolescent Trauma Services Project, funded by SAMSHA, overseen by the New York State Office of Mental Health under the direction of Dr. Kimberly Hoagwood
- Primary goal is to examine the impact of cognitive-behavioral trauma treatments for children and youth experiencing distress associated with the 9/11 terrorist attack or other traumatic events.

### CATS Concern

- Disseminating evidence-based services has proven difficult with multiple obstacles encountered with “real world settings”
- An important goal of the CATS project was to intervene with “real world” organizations and providers to enhance implementation of CATS evidence-based interventions in order to increase ability to test outcomes.

### Evidence-informed engagement training for CATS providers

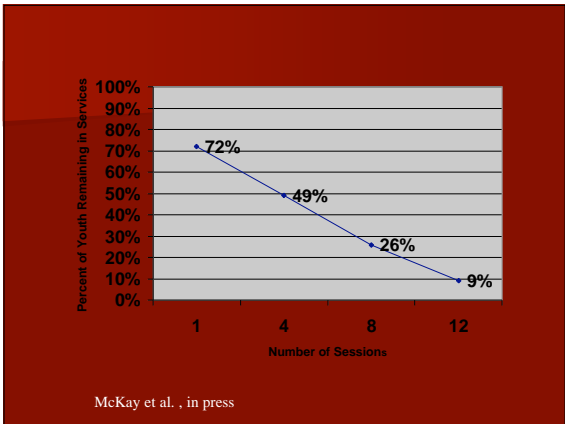
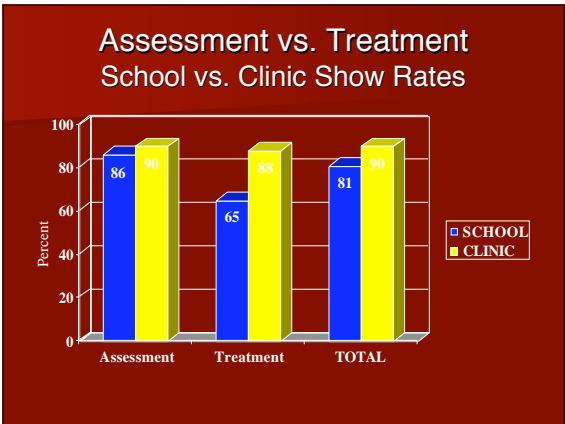
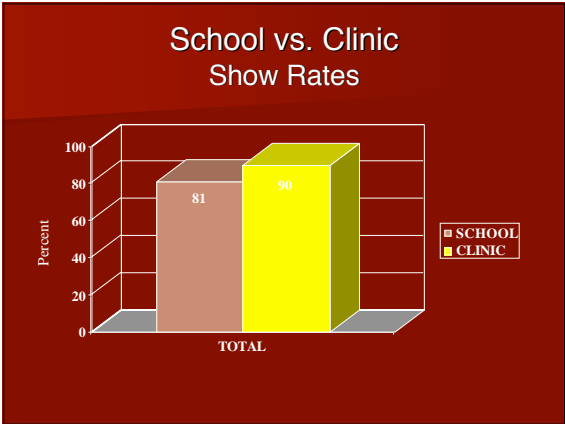
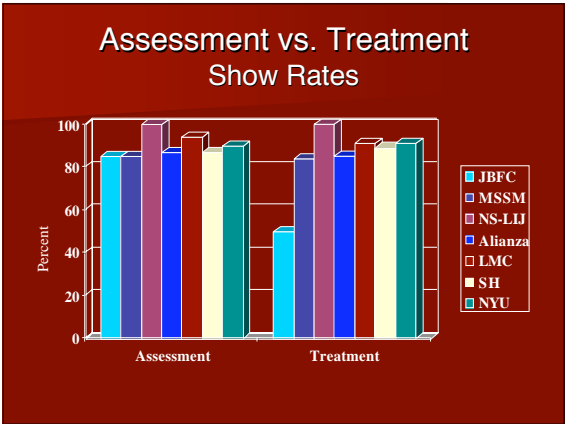
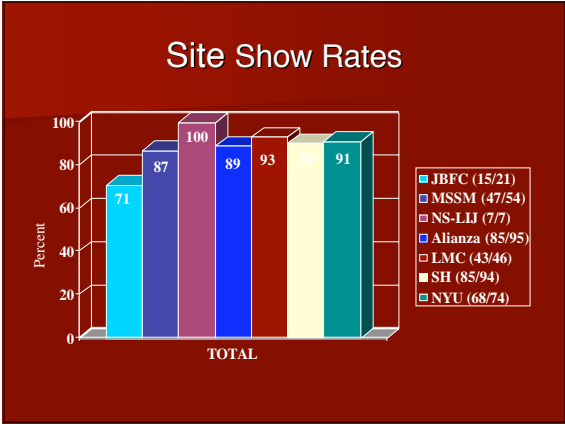
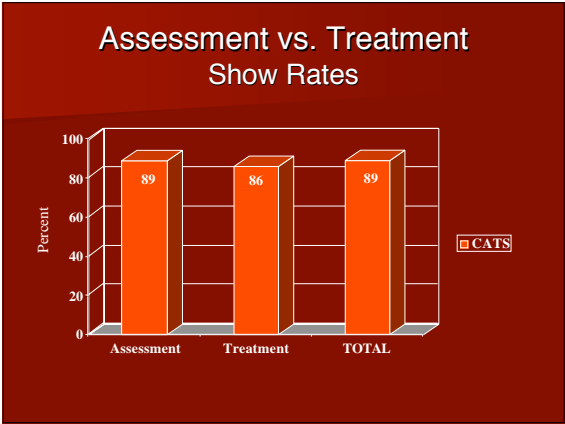
- 8 hour intensive workshop
- Primary goals are to help CATS providers: 1) understand child, family, community and system level barriers and; 2) develop a set of strategies to overcome these barriers.
- Training is divided into two parts: 1) first contact engagement skills and; 2) initial interview engagement skills.
- Providers learn ways to discuss “difficult to talk about” barriers with adult caregivers (e.g. stigma, mistrust of professionals, fear of being blamed) and enhance proactive problem solving around concrete obstacles to care.

### Key training elements

- Review evidence based engagement interventions.
- Identify and practice telephone engagement skills.
- Help providers examine their perceptions of barriers
- Practice skills related to the initial face-to-face interview with a child and their family.
- Support providers' abilities to form collaborative working relationships with adult caregivers and youth.
- Help providers identify an immediate and practical concern that can be addressed rapidly in the first interview.
- Learn skills related to the development of a shared commitment, language and understanding with the family.

### Training activities

- Designed to elicit innovative approaches to real situations that providers encounter.
- The “realness and authenticity” of the activities benefited from the input of parent consumers.
- “I went for an intake and never came back” video tool.
- The video of “real” parents voicing their concerns about the care that they or their child received in the “helping” system allows providers the opportunity to discuss and respond to parent concerns within an atmosphere that promotes self examination and reduces defensiveness. In addition, discussions allow providers to offer recommendations of ways to engage the parents in the film and address their prior negative experiences.



## Implications & Next Steps

- Findings don't convey difficulty or obstacles encountered
- Leadership must be "ready" to examine rates of engagement and develop "engagement teams" and methods of data collection.
- Engagement goes beyond contact with providers and involves training of administrative staff.
- Intervening with providers belief systems is critical.
- Helping providers and support staff to think innovatively about the way they approach engaging clients is a central theme in the training.
- Providers examine barriers they set up (i.e. 'tried everything', blaming, labeling as "resistant client") and look at agency barriers (i.e. crowded waiting room, lengthy intake processes).