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Clinician Perceptions of Barriers to Treatment and Engagement Strategies in a Community Child and Adolescent Mental Health Clinic

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Capstone Research Project

Abstract

A reported one in five children in the United States lives with a diagnosable mental illness, but only about 20% receive adequate treatment and approximately 40-60% of those drop out before achieving treatment goals and/or without the agreement of the therapist. This study examines the perceptions of clinicians working in a child and adolescent community mental health clinic regarding the barriers clients face as well the strategies they utilize to enhance engagement and treatment adherence. Results support existing literature and indicate that parents play the most significant role in treatment adherence and that logistical barriers such as transportation and finding childcare are most common. Participants also reported using several engagement strategies known to promote the therapeutic alliance and treatment adherence such as involving family in treatment planning and providing crisis intervention. Limitations to the study and implications for counseling practice are also discussed.

Keywords: adolescent, barriers, child, clinicians, community mental health, mental health treatment, parents, engagement, obstacles, strategy, therapeutic alliance, treatment

The American Academy of Pediatrics (2013) reported that approximately one in five children in the United States lives with a diagnosable mental illness, but only about 20% receive adequate treatment. Of those children and families who do seek treatment, approximately 40-60% drop out before achieving treatment goals and/or without the agreement of the therapist (Gearing, Schwalbe, & Short, 2012; Kazdin, Holland, Crowley, & Breton, 1997; Miller, Southam-Gerow, & Allin, 2008; Nock & Ferriter, 2005; Oruche, Downs, Holloway, Draucker, & Aalsma, 2014; Westmacott, Hunsley, Best, Rumstein-McKean, & Schindler, 2010). Premature termination of services weakens the potential benefits of treatment, increases the risk of ongoing psychiatric problems, (Kim, Munson, & McKay, 2012; Westmacott et al., 2010), contributes to rising costs of clinical services, and takes up appointment times that could be utilized by others (Kazdin et al., 1997). It is pertinent for mental health service providers who aid underserved youth to examine clinicians' views on the following questions: what prevents children and families from following through with treatment, what barriers do clinicians and agencies think contribute to this problem, and what strategies are utilized to engage clients throughout the course of treatment to enhance adherence? The purpose of answering these questions is to identify what could be inhibiting clients/families from attending treatment consistently and/or discontinuing therapy before meeting treatment goals. An examination of how clinicians are engaging, or failing to engage, clients serves the purpose of providing insight for agencies and clinicians to increase engagement within the therapeutic setting and improve services (Gearing et al, 2012). There are differences in the existing literature regarding clinicians' perspectives of barriers to treatment, with some claiming there is a paucity of studies examining the point of view of the therapist (Gearing, et al., 2012) and others stating that clinicians' perspectives of barriers better predict client attrition or treatment adherence (Manfred-Gilham, Sales, & Goeske,

2002). Furthermore, even fewer studies have examined the issues of barriers to treatment and engagement in the areas of child and adolescent mental health treatment (Anderson, Howey, Colbourn, & Davis, 2015; Nock & Ferriter, 2005) and in community mental health centers (Miller et al., 2008).

The main objectives in the following pages are to examine the existing literature about the barriers to treatment that clients and families face when participating in child and adolescent mental health treatment, and to identify strategies clinicians and agencies utilize to promote engagement and treatment adherence. First, the review will share the procedure for exploring current research and will define relevant key terms. Next, barriers to treatment will be discussed and include parent factors, child factors, practical obstacles, and therapist factors. Then the author will explore and describe different kinds of therapeutic engagement as well as strategies used by clinicians and agencies to enhance engagement. The review of the literature will conclude with a summary of findings before moving on to the current action research project.

Literature Review

An online search of electronic databases including EBSCO, Academic Search Complete, PsychLine, PsychInfo, Google Scholar, and MEDLINE was conducted to obtain literature relevant to the current study. Search words and phrases included “barriers to treatment,” “engagement,” “child and adolescent mental health,” “attendance,” “consistency,” “mental health,” “clinician,” “perceptions,” “perceived,” “community mental health,” “children’s mental health,” “treatment,” “psychotherapy,” and “therapist.” Reference sections of articles were also reviewed to further identify articles relevant to this study.

In the following pages several keywords and terms will be used and are further defined below. In child and adolescent community mental health treatment, although the child is the

identified client, therapy typically involves active participation by at least one parent and/or the family as a whole (Nock & Ferriter, 2005; Nock, Ferriter, & Holmberg, 2007). It may be useful to consider parents and family members not as the source of the child's problem, but as therapeutic partners (Kim et al., 2012; Oruche et al., 2014) as well as those taking on the main responsibility of major treatment decisions (Stevens, Kelleher, Ward-Estes, & Hayes, 2006) and managing participation of the entire family in treatment (Nock & Ferriter, 2005). Client(s), therefore, will be used interchangeably to refer to the identified child client as well as his or her caregiver or parent, which will also be used interchangeably when referring to the person or persons responsible for the care, well-being, and treatment adherence of the child. Other terms that will be used interchangeably are counselor, clinician, and therapist (to encompass several disciplines, which include mental health counseling, social work, case management, psychology, and psychiatry), and therapy and treatment (in reference to the remediation of mental health issues).

Engagement is another key term that will be expanded upon in later sections, but can be conceptualized briefly as attendance and commitment to the therapeutic process (Kim et al., 2012). Premature termination or dropout occurs when clients stop attending treatment before meeting agreed upon goals or without the agreement of the therapist (Westmacott et al., 2010). Finally, the concept of barriers to treatment will also be defined further, but in short, refers to factors or obstacles that keep clients from completing, or fully engaging in, treatment (Kazdin et. al, 1997).

Barriers to Treatment

The barriers-to-treatment model, developed by Kazdin et al. (1997) posited that families face many obstacles when seeking mental health treatment for their children and these barriers

have a great effect on whether or not clients participate in treatment as planned or drop out prematurely. Furthermore, the model has shown that considering barriers to treatment may predict the likelihood of dropping out of treatment. It is estimated that between 35-61% of parents seeking mental health care for their children encounter barriers that impede treatment (Nanniga, Jansen, Kazdin, Knorth, & Reijneveld, 2015). When barriers are experienced in greater number or frequency, clients tend to show less improvement and exhibit higher termination rates (Kazdin & Wassell, 1999; Westmacott et al., 2010). Several factors have been noted that contribute to early termination or inconsistent attendance, many of which can be attributed to the parent/family, such as low socioeconomic status, low levels of parental education, whether or not parents view particular interventions as relevant to the child's presenting problem, and a perception that treatment is too demanding (Kazdin et al., 1997). Barriers regarding factors related to the child, practical and circumstantial obstacles, and therapist factors, are discussed below.

Parent Factors

The impact of mental illness on family members has been shown to burden caregivers financially and socially, as well as increase the experience of difficult emotions such as grief, loss, anger, burnout, and worry for a loved one's future success (Kim & Salyers, 2008). Family/parent factors are the largest contributors to lack of attendance and premature termination (Kazdin, 2000; Nock & Ferriter, 2005; Stevens et al., 2006). When considering child and adolescent mental illness, parents not only endure the struggles mentioned above, but also have a salient role in treatment, as they are responsible for making and keeping appointments, payment, providing follow-through between sessions, and supporting the child emotionally (Nock & Ferriter, 2005). Parent factors include parental expectations of therapy, personal characteristics

(e.g. level of education), practical and circumstantial obstacles (e.g. transportation, cost), and perceptions about the therapist (Kazdin et al., 1997; Nanniga, et al., 2015), all of which may contribute to how consistently families attend appointments or the strength of their engagement in treatment.

Parental expectations. Parental expectations of potential barriers may have a greater contribution to poor outcomes and treatment adherence than the actual barriers they experience (Nanninga, et al., 2015). Kazdin, et al. (1997) found that families who perceived more barriers to treatment participation were also more likely to cancel sessions, miss appointments without notice, spend less time in treatment, and/or terminate treatment prematurely. Simply projecting that one will experience barriers throughout the course of treatment may lead to lower levels of commitment and involvement in treatment (Kazdin & Wassell, 1999). Parents often sought mental health treatment for their child without expecting to be actively involved in treatment and thus view the time and commitment required between sessions as an obstacle. Additionally, parents who perceived treatment as too demanding, rigorous, and time consuming, or did not agree with or understand the purpose of therapy, were more likely to find treatment unacceptable, or irrelevant, which contributed to poor treatment outcomes and adherence (Gearing et al., 2012; Kazdin, 2000; Nock & Ferriter, 2005; Nock et al., 2007). When considering why parents view time commitments and active participation in treatment as barriers, it is pertinent to examine personal and demographic characteristics that may also act as obstacles and contribute to lack of engagement and adherence.

Personal characteristics. Parents facing personal struggles, such as managing their own mental illness, especially depression (Kazdin & Wassell, 1999; Nock & Ferriter, 2005), and high levels of stress act as significant barriers to treatment adherence (Gearing et al., 2012; Oruche et

al., 2014). Other factors contributing to high parental stress that may inhibit engagement in therapy include poor physical health, substance use (Gearing et al., 2012), low levels of education and/or occupational attainment, socioeconomic disadvantage and poverty (Gopalan et al., 2010; Kazdin et al., 1997; Kazdin & Wassell, 1999; Miller et al., 2008; Nock & Ferriter, 2005), and being a young and/or single parent (Kazdin et al, 1997; Oruche et al., 2014). These personal characteristics and circumstances may also contribute to poor parenting skills (Gearing et al., 2012; Kazdin et al, 1997) and lack of effective discipline (Gopalan et al., 2010), which may further heighten stress and create obstacles to following through with treatment. Despite their best efforts to cope with personal stressors and characteristics, many parents also face practical obstacles that keep them from completing treatment.

Circumstantial obstacles. Although parents may have every intention of committing to the therapeutic process, circumstantial barriers can interfere making it more difficult to follow through. One such obstacle includes lack of insurance, and high cost of co-pays or private practice fees (Oruche et al., 2014). As noted above, socioeconomic disadvantage serves as a prominent barrier, and those who are struggling financially may not be able to afford the costs of treatment. Many families attempting to access services in community mental health agencies often face long waiting lists for appointments, complications with records transfer, and difficulty obtaining necessary prescriptions, which can delay the onset of services (Oruche et al., 2014). Conflicts with scheduling appointments have also been reported as substantial barriers to treatment participation and may include a parents' inability to take time off work, appointment times that interfere with a child's other activities (e.g. sports, music lessons), or trouble finding childcare for siblings (Gearing et al., 2012; Westmacott, et al., 2010). In addition to these practical obstacles, at times the circumstances and unpredictability of stressful life events

(Kazdin et al., 1997), such as divorce, death of a loved one, illness, or job loss may impact a client's ability to commit to and profit from treatment. Should parents overcome the various personal or practical obstacles that can stand in the way of treatment, their perceptions of the clinician with whom the family is working may also play an important role in whether or not they continue with treatment.

Perceptions about the therapist. It is important to consider parents' perceptions of the therapist, particularly the perceived level of the therapist's competency, when examining why some families drop out of treatment. Some parents may question the skills of the provider, experience negative interactions with agency staff (i.e. feeling treated with disrespect) (Oruche et al., 2014), or display inadequate cultural competence (Gopalan et al., 2010) leading them to doubt the usefulness and effectiveness of continuing treatment. In contrast, Oruche et al. (2014) found that parents were more likely to engage in treatment when they perceived positive qualities in the therapist, which increased motivation for participation and nurtured a positive therapeutic relationship. While it is important for parents and clinicians to build a collaborative working relationship, there are some factors that are specific to the identified client that may also act as barriers to treatment participation.

Child Factors

Children referred for mental health treatment are more likely to be male than female (Gopalan et al., 2010) and most often for externalizing disorders (e.g. conduct disorder, oppositional defiant disorder), which typically present as antisocial, chronically aggressive, and oppositional behaviors (Kazdin et al., 1997; Nanniga et al., 2015). Interestingly, children that exhibit behavioral problems have a higher risk of dropping out of treatment (Kazdin et al., 1997). In addition to a specific diagnosis relating to behavior issues, the severity of the pathology may

also serve as a barrier to treatment; the worse the problem is, the less likely the client is to follow through with treatment (Gopalan et al., 2010). The child's age is also relevant as older children, particularly adolescents, are more likely to discontinue treatment (Oruche et al., 2014). Teenagers often seek autonomy and rejecting treatment may serve as a means to assert oneself and feel in control (Block & Greeno, 2011). Regardless of age or diagnosis, clients who have a positive relationship with their therapist are more likely and willing to attend appointments regularly and engage in the process of therapy, as youth have indicated wanting to "get along" with his or her therapist (Oruche et al., 2014, p. 244).

Therapist Factors

It may be imperative in many therapeutic relationships for clinicians to work towards providing conditions in which a trusting and productive relationship can be developed. Qualities and characteristics of the clinician, such as authenticity, lack of judgment, openness, emotional availability, genuineness, and kindness are beneficial to creating a strong therapeutic alliance (Block & Greeno, 2011). Therapeutic alliance is thought of as the quality and strength of the bond between clinician and client, and to what extent a client and counselor agree upon the direction and goals of treatment (Kazdin, Whitley, & Marciano, 2006; Kim et al., 2012). Some clinicians have indicated that the most significant barrier to treatment participation involves the quality of the relationship between provider and client (Manfred-Gilham et al., 2002). Clients and clinicians who make mutual decisions regarding treatment throughout the therapeutic process are also more likely to agree upon the appropriate time to terminate (Westmacott et al., 2010). As discussed earlier, parents play a vital role in treatment adherence and the therapeutic alliance should involve more than just aligning with the child. Therapists need to make an effort to promote a team mentality with parents to encourage a trusting, collaborative relationship. A

strong therapeutic relationship can promote more follow through between sessions and increase therapeutic change by fostering improvements in parenting skills and parent-child interactions at home (Gearing et al., 2012; Kazdin, et al., 2006). Oruche et al., (2014) indicated that parents who experienced negative interactions with staff (e.g. impersonal, strict, or mean treatment) led to losing confidence in the treatment their child was receiving, thus decreasing their treatment adherence. When a strong therapeutic alliance is not developed with parents, clinicians may view parents as resistant to participate during or between sessions. This can lead to therapists viewing parents less favorably and being less inclined to spend adequate time teaching appropriate skills (Nock & Ferriter, 2005). High staff turnover is also considered a negative interaction, as it may be frustrating for youth to tell their stories repeatedly and attempt to build rapport with a new therapist (Oruche et al., 2014).

There are many potential barriers to treatment participation, such as parental characteristics, logistical barriers, age and diagnosis of the child, and factors that are specific to the therapist, all of which may contribute to the efficacy of and adherence to mental health treatment. It may be important to note that parent and therapist views of barriers to treatment participation and premature termination do not always align (Nanniga et al., 2015; Westmacott et al., 2010), as there tends to be more agreement between clients and clinicians when the therapeutic experience was collaborative and efficacious. In contrast, there is little agreement when therapy was not a positive experience. Westmacott et al. (2010) demonstrated that clinicians' were often not accurate at predicting client perspectives for treatment failure, as therapists tend to underestimate the amount of barriers clients face. Furthermore, discrepancies have been found that indicate clinicians are more likely to attribute premature termination to the client, while clients indicated that the clinicians' role was most relevant (Gearing et al., 2012).

Regardless of what the barriers are, it can be important for clinicians to explore with clients the experience of, or the potential to experience, barriers. When barriers are identified, clinicians are better able to apply appropriate and effective strategies to address them and enhance engagement within the treatment process (Gearing et al., 2012; Nock & Ferriter).

Engagement

Engagement in the therapeutic setting is founded on the belief that treatment will be advantageous and valuable, resulting in commitment and emotional buy-in to treatment (Gopalan et al., 2010); it is the view that treatment will be cost effective and worth committing to (Haine-Schlagel & Walsh, 2015). However, there is little agreement in the literature regarding what constitutes engagement in mental health treatment. Engagement has largely been viewed as two distinct actions: attending an initial evaluation/appointment and ongoing attendance (Gopalan et al., 2010; Kim, et al., 2012). Additionally, research has been more focused on the observable or concrete aspects of engagement (i.e. attendance) over those that enhance retention and adherence (Lindsey et al., 2014). In that context, lack of engagement in mental health services may be defined as not returning after an intake or initial appointment, irregular attendance (including missing appointments without calling to cancel) or, terminating services before meeting agreed upon treatment goals (Westmacott et al., 2010). A more complex description of engagement involves two different components, behavioral and attitudinal (Lindsey et al., 2014). Behavioral components include simply attending appointments, regardless of the level of commitment or interaction with the therapist. Attitudinal engagement speaks to the level of commitment the clients have to the process, beliefs about treatment (Kim et al., 2012), and the amount of effort or follow through exhibited within, and between, sessions (Lindsey et al., 2014). Therapists can

approach lack of engagement in several ways to increase both behavioral and attitudinal engagement with their clients.

Engagement Strategies

Engagement strategies are the actions taken by clinicians to promote collaboration, trust, and commitment (i.e. therapeutic alliance) with their clients. As discussed previously, it would behoove therapists working in child and adolescent mental health settings to utilize strategies that aim to increase engagement with the client, as well as the family. Two categories of engagement strategies have been noted, those that include active efforts towards circumstantial barriers and others that are more person centered and emphasize the concerns and lived experiences of clients and families (Manfred-Gilham, 2002). If treatment was not planned, or initiated of one's own volition, there may be a need to increase engagement strategies (Nock & Ferriter, 2005). Likewise the more barriers a client faces, the intensity or number of strategies needed may also increase (Manfred-Gilham et al., 2002). If possible, clinicians should be mindful of signs that clients are becoming disengaged before appointments are missed or drop out occurs. Such indicators may include difficulty with scheduling appointments, lack of collaboration with treatment goals, failure to follow through on homework assignments, and poor progress (Gopalan et al., 2010). Strategies with some predictability for success include effective crisis management, rapport building (both for parents and clients), cultural acknowledgement, referrals to case coordinators, active problem solving, and support networking, (Lindsey et al., 2014). Verbal praise and positive reinforcement may also increase engagement in therapy (Kim et al., 2012). Engagement strategies can also be broken down further to specifically target the child, the parents, or the non-adherent behavior (Gearing et al., 2012).

Strategies Aimed at the Child

Counselors may attempt to enhance engagement with the identified client through empowering the child or adolescent and highlighting the client's power of choice and key role in treatment. The clinician might also consider following the client's pace, which may be slower than those of adult clients, and allowing them to have more control over choosing therapeutic activities (Gearing et al., 2012). Other strategies targeting the attitudinal aspects of engagement for the child or adolescent client include eliciting change talk, increasing cognitions regarding the relevance of treatment, and setting positive expectations for therapy, as well as life when treatment is complete (Lindsey et al., 2014). Providing a therapeutic setting where the therapist accepts and promotes the child's autonomy provides the child with a place to explore and increase their self-efficacy, ideally leading to more meaningful treatment participation and growth (Kim et al., 2012). Other notable tactics include peer pairing such as referrals to support groups or establishing therapeutic groups for clients of the same age group and diagnosis, and solution-focused problem solving with the client, particularly around attendance issues (Lindsey et al., 2014). While engaging the identified client is vital, at times strategies must also target parents and caregivers.

Strategies Aimed at the Parent

Educating and supporting parents while their child is in treatment may prove efficacious in enhancing treatment participation and engagement. Successful psychoeducation, which includes preparation for therapy (Stevens et al., 2008), teaching parent coping skills, and modeling communication and behavior management techniques (Lindsey et al., 2012), has been shown to reduce rates of relapse, improve interpersonal functioning, enhance the well-being of the family, and augment a client's recovery (Gearing et al., 2012; Kim & Salyers, 2008). It may

also be advantageous to address parents' expectations at the onset of therapy to reduce dropout (Nanniga et al., 2015) and, when applicable, attempt to provide treatment modalities that are desired by the parent (Block & Greeno, 2011). Based on the findings that parents tend to terminate treatment when they face or expect to face barriers, addressing them early is beneficial (Nock & Ferriter, 2005). Clinicians may improve the therapeutic alliance (and engagement) by providing time and space for parents to discuss their own difficulties and attitudes about parenting (Stevens et al., 2006), as well as exploring concomitant issues that serve as stressors and barriers to treatment (Block & Greeno, 2011). In addition to, or instead of, addressing parents' issues during the child's treatment time, offering support groups or providing referrals to outside support groups may alleviate some emotional strain for families. Family members or caregivers who are given the opportunity to learn more about their child and their illness while also being supported by those experiencing similar struggles may be more willing, or motivated, to keep up with the demands of treatment (Lindsey et al., 2014; Oruche et al., 2014). Perhaps providing a corresponding level of support for parents, when they are expected to participate equally in treatment and follow-through, would increase engagement.

Organizational or Facilitative Strategies in Response to Non-Adherence

In situations where clients and their families display attitudinal engagement, but behavioral (e.g. inconsistent attendance) engagement becomes problematic, therapists may aim interventions at those issues directly. It is important for clinicians to keep in mind that barriers are to be expected and specific obstacles should be explored when non-adherence becomes an issue (Gearing et al., 2012). Behavioral non-engagement may often be due to circumstantial barriers and can be ameliorated by strategies employed by agencies and organizations to facilitate attendance and behavioral engagement. There has been some success in this arena,

particularly in the beginning stages of treatment, when agencies utilize strategies such as sending reminder letters or automated telephone reminder systems (Kim et al., 2012). Oruche et al. (2014) found that parents believed such organizational methods would prove helpful in increasing attendance due to difficulty keeping track of appointments or losing appointment reminder cards. These strategies, however, can have logistical obstacles. For instance, clients may change phone numbers frequently and fail to keep the agency or clinicians apprised of this information (H. Feldman-Mack, personal communication, September 13, 2016). Organizations can also focus on improving behavioral engagement by offering extended hours, making treatment locations easily accessible, and allowing clients to see intake providers for follow-up appointments. Some parents have also specified that incentives such as help with transportation and child-care would eliminate some barriers that keep them from attending treatment regularly (Gearing et al., 2012).

Community child and adolescent mental health settings present unique challenges for clinicians in terms of barriers to treatment participation and engagement. Therapists are rarely concerned with the client alone, and often need to engage and work with parents and families in addition to their identified client. As there is more than one person in the family who may experience an obstacle to regular attendance or attitude toward therapy, the number of barriers may increase as well as the need to employ a variety of strategies to address them. Although a child or adolescent is the identified client in these situations, it is often parents who experience the majority of barriers including circumstantial hindrances (e.g. transportation, scheduling, financial), personal struggles (e.g. mental illness), poor expectations of therapy, or negative interactions with the therapist. Child clients also have their own risk factors such as being older (adolescent) or having an externalizing behavioral problem. Barriers that can be attributed to the

therapist include failure to provide conditions that strengthen the therapeutic alliance, and poor interactions with parents. Whatever the barriers that arise, addressing them and utilizing strategies that attempt to overcome obstacles and enhance engagement are an important part of working with children and their families in community mental health settings.

Method

Setting and Participants

This study took place in the child and youth department of a community mental health agency in a small city in western New York State. The clinic is part of the behavioral health network of a larger area hospital and health system and offers outpatient mental health treatment to children, aged 5 through 21, in the form of individual and family therapy. Initial intake appointments occur during designated walk-in hours three times a week, and patients are accepted for treatment regardless of health insurance status or type of plan. The clinic employs various mental health disciplines: Licensed Mental Health Counselors (LMHC/LMHC-P), Licensed Marriage and Family Therapists (LMFT), Licensed Master Social Workers (LMSW), Licensed Clinical Social Workers (LCSW/LCSW-R), Psychiatrists, a School Psychologist (Ph.D.), Nurse Practitioner – Psychiatric (NPP), and Psychiatric Mental Health Nurse Practitioners (PMHNP). Convenience sampling was used to recruit participants based on their employment at the clinic. Surveys were distributed to all clinicians (a total of 26) working within the child and youth department (with the exception of one clinician who was out on medical leave). Twenty-six clinicians were recruited for this study; 16 completed survey packets were returned, which yielded a 60% response rate.

Demographics. A brief survey was used to collect demographic information from participants. Demographic information included age, gender, discipline, number of years in one's

profession, and number of years at the clinic. One participant chose not to complete the demographic information. All clinicians who completed demographic information (n = 15) identified as Caucasian. A majority of clinicians (46.7%) were within the 26-34 years of age range, followed by 45-54 years of age (20%), 55-64 years of age (13.3%), and 18-24, 35-44, and 65 or older, each accounting for 6.7%. Female clinicians (66.7%) outnumbered male clinicians (33.3%) 2 to 1. LMHC/LMHC-P accounted for 26.7% of participants, LMSW comprised 20%, LCSW and LCSW- R each accounted for 13.3%. LMFT, NPPs, MD and Other (PhD.) each made up 6.7% of participants. Forty percent of participants have been in clinical practice for one to five years. Six to 10 years in practice, 11-15 years, 26 – 30 years, and 30 or more years in practice each accounted for 13.3% of participants. One participant (6.7%) has been in practice between six and 10 years. 33.3% have practiced in this clinic for one year or less. 20% had been at the clinic for three years. Those in practice at the clinic for two years, five years, and 10 or more years accounted for 13.3% each, and 6.7% had been there for 6 years.

Measures/Instruments

Two measures were utilized to explore barriers to treatment participation: the Barriers to Treatment Participation Scale – Therapist (BTPS – T), and an original survey, Clinician Attitudes of Client Treatment Barriers and Use of Engagement Strategies, which was adapted by the researcher from a similar survey created by Kim and Salyers (2008).

Barriers to treatment participation scale – therapist. The BTPS-T, created by Kazdin et al. (1997), was used originally in a community outpatient treatment facility serving children and families. There are two versions of the scale, a parent version and a therapist version. The BTPS-T is comprised of two sections; the first is a 44-item measure using a 5-point Likert scale (1 equals never a problem and 5 equals very often a problem). Four subscales assess potential

barriers to treatment participation and include 1) life stressors and obstacles/activities that compete with treatment, 2) treatment demands and issues (i.e. logistics), 3) perceived relevance of treatment, and 4) relationship with the therapist (Kazdin et al., 1997). The second section contains 14 yes/no questions inquiring about specific "critical" events that may effect treatment participation. Previous studies have indicated this scale provides adequate levels of internal consistency, convergent validity, and incremental validity (Kazdin et al., 1997).

Clinician attitudes of client treatment barriers and use of engagement strategies. The Clinician Attitudes of Client Treatment Barriers and Use of Engagement Strategies is a 33-item questionnaire adapted for this study from a similar survey created by Kim & Salyers (2008). The original survey was used to examine mental health professionals' attitudes about working with families of persons with severe mental illness. The adapted survey contains three domains; one examines clinicians' attitudes about working with families, the second investigates the use of specific approaches to enhance client engagement and participation, and the third inquires about clinicians' opinions about the agency. Answer choices include always, often, sometimes, rarely, and never.

Procedure

The researcher assembled survey packets that included a statement of informed consent, the BTPS-T, the Clinician Attitudes of Client Treatment Barriers and Use of Engagement Strategies survey, and the demographics information sheet. Each item was placed in a manila envelope and distributed to the clinicians in their employee mailboxes. The researcher also sent an email to all potential participants explaining the materials and how to return the materials to the researcher. Those who chose to participate were instructed to complete the surveys and return them in a sealed envelope to the researcher either in person or in the researcher's employee

mailbox. Participants were also instructed to return the demographic information sheet in a separate sealed envelope (envelopes were provided). The informed consent indicated that return of the survey materials would serve as proof of consent. Participants were not asked to sign a statement of informed consent to ensure that names were not used, which could connect survey answers with participants. The demographic information sheet was turned in separately as an additional safeguard for providing anonymity. After one week, an email was sent out to remind all potential participants that one-week remained to remit the survey packets. A second reminder email was sent 2 days prior to the collection deadline.

Data Analysis

Data analyses focused on descriptive statistics (frequency/percentages) for responses to all survey questions except the yes/no critical event questions (questions 45 through 58) on the BTPS-T. The critical event questions are specific to a particular client (i.e. whether or not an identified client has experienced the specified critical event); as the survey asked clinicians to think about their caseloads in general, a yes or no answer to these questions would not provide accurate, useful information. In addition to calculating the frequencies, variables were analyzed using a Pearson product-moment correlation coefficient to determine if any linear relationships were significant among variables.

Results

Barriers to Treatment Participation Scale - Therapist

The most prominent barriers on the BTPS-T were reported within the domains of life stressors and obstacles/activities that compete with treatment ("life stressors") and treatment demands and issues ("treatment issues"). Within the life stressors domain (see Table 1), transportation, scheduling, bad weather, parking at the clinic, conflicting parental activities,

stress, and the parent's job were among the most reported barriers to treatment. 81.3% of participants reported transportation to the clinic was sometimes (25%), often (50%), or very often (6.3%) a problem. 81.4% of participants reported scheduling difficulties as sometimes (56.3%), often (6.3%), or very often (18.8%) a problem. Bad weather was thought to be sometimes (62.5%) or often (12.5%) a problem. Clinicians reported that finding a place to park at the clinic was often (56.3%) or very often (12.5%) a problem. Finding childcare so the parent could come to sessions was reported as sometimes (43.8%), often (6.3%), or very often (6.3%) a problem. Participants indicated conflicting parental activities (e.g. classes, job, friends) were sometimes (56.3%), often (18.8%) or very often (6.3%) a problem. More specifically, clinicians' reported a parent's job presenting an obstacle to attending sessions sometimes (43.8%), often (37.5%), or very often (6.3%). All participants reported some degree of parents experiencing stress in their lives as a barrier to treatment as 6.3% reported a little bit of stress, 6.3% reported some stress, 62.5% reported moderate stress and 25% reported a lot of stress during treatment. Furthermore, clinicians perceived that parents believed treatment itself added a little bit of stress (56.3%), a moderate amount of stress (31.3%), or a good deal of stress (6.3%) to their lives.

In the treatment issues domain (see Table 2), almost all clinicians (93.8%) reported a perception that parents felt treatment was a little more work (56.3%) or more work (37.5%) than expected. 65.8% of clinicians indicated that information and handouts given in sessions seemed a little (62.5%) or somewhat (6.3%) confusing for the parent. Participants (87.6%) also viewed child clients as having some difficulty understanding treatment. It was perceived that parents felt a little uncomfortable (62.5%), uncomfortable (6.3%) or quite a bit uncomfortable (12.5%) with the atmosphere at the clinic.

Table 1: Life Stressors and Obstacles/Activities that Compete with Treatment

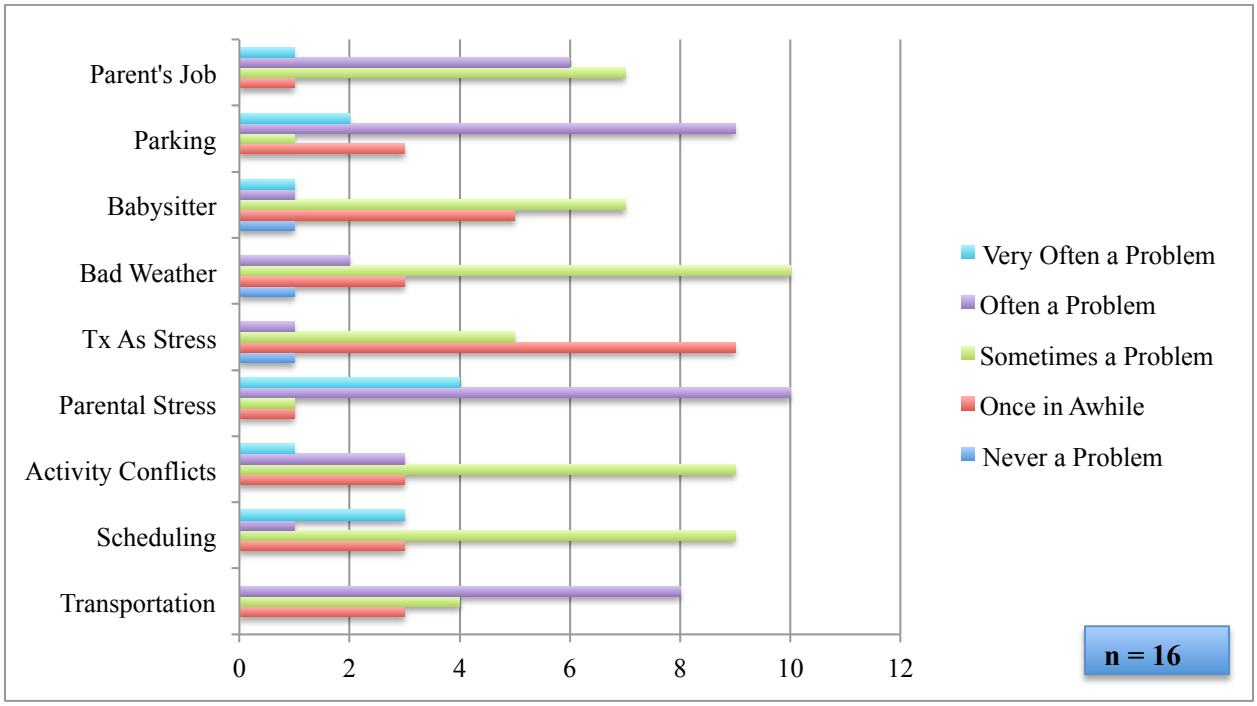
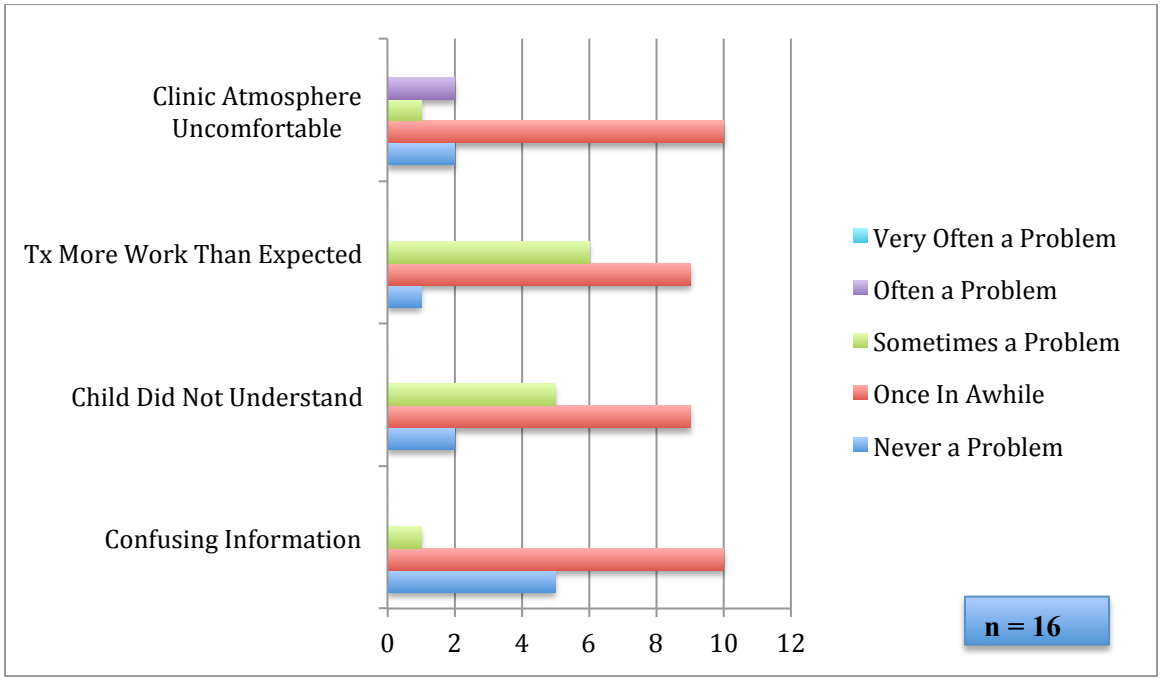


Table 2: Treatment Issues and Demands



Some notable results were also indicated in the relevance of treatment (see Table 3) and the relationship with the therapist (see Table 4) domains. Parents reportedly lost a little interest (50%) or a moderate amount of interest (25%) in coming to sessions and viewed treatment as a little less important (75%) or no longer as important (18.8%) as treatment continued. Despite views that the importance and relevance of treatment waned as time went on, clinicians did report that parents thought treatment was mostly what they expected (62.5%) and that treatment no longer seemed necessary because children showed improvement (56.3%). 75% of participants also reported that parents believed treatment helped most of the time. 93.8% of clinicians reported the perception that they were liked by the parent and were perceived as very supportive (12.5%), supportive most of the time (62.5%), or supportive (25%).

Table 3: Relevance of Treatment

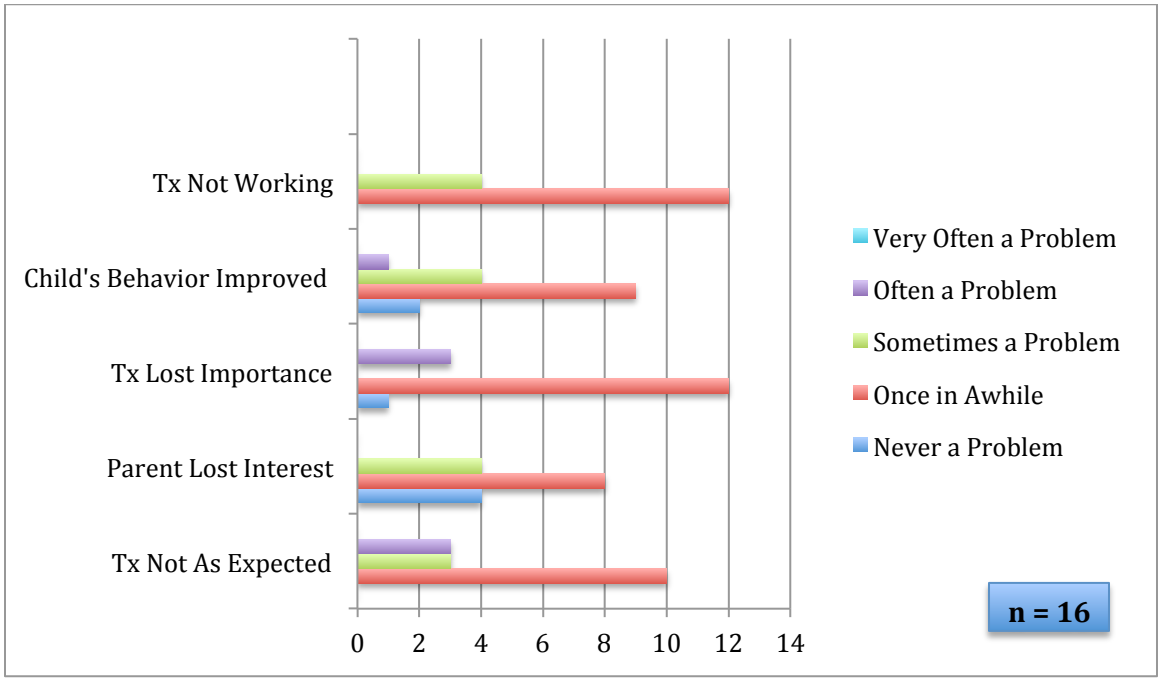
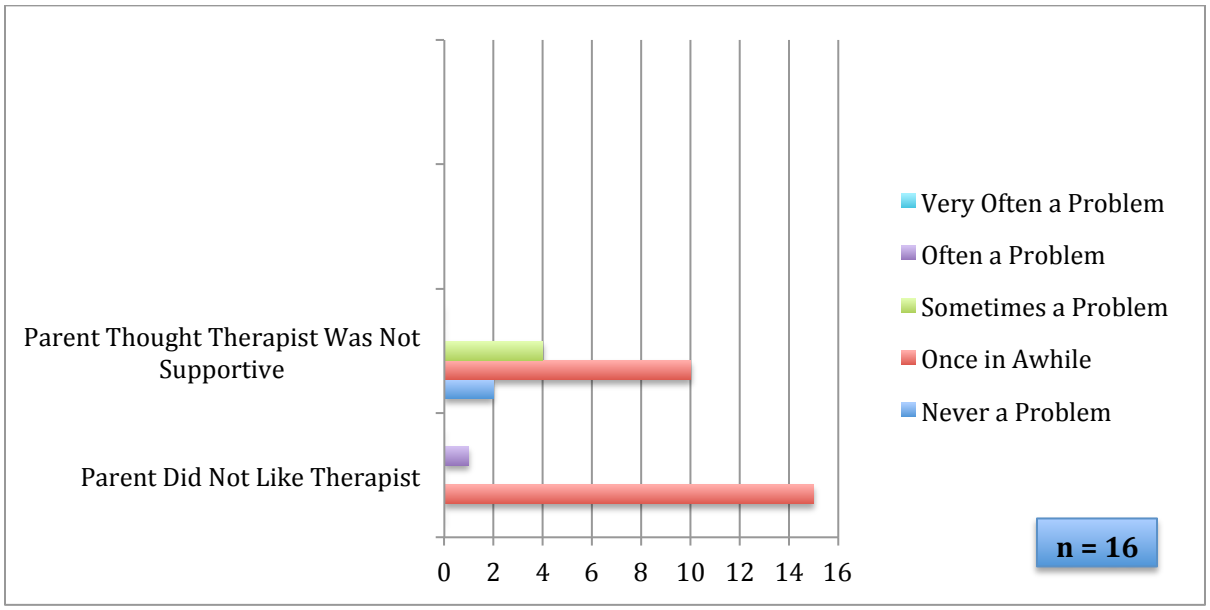


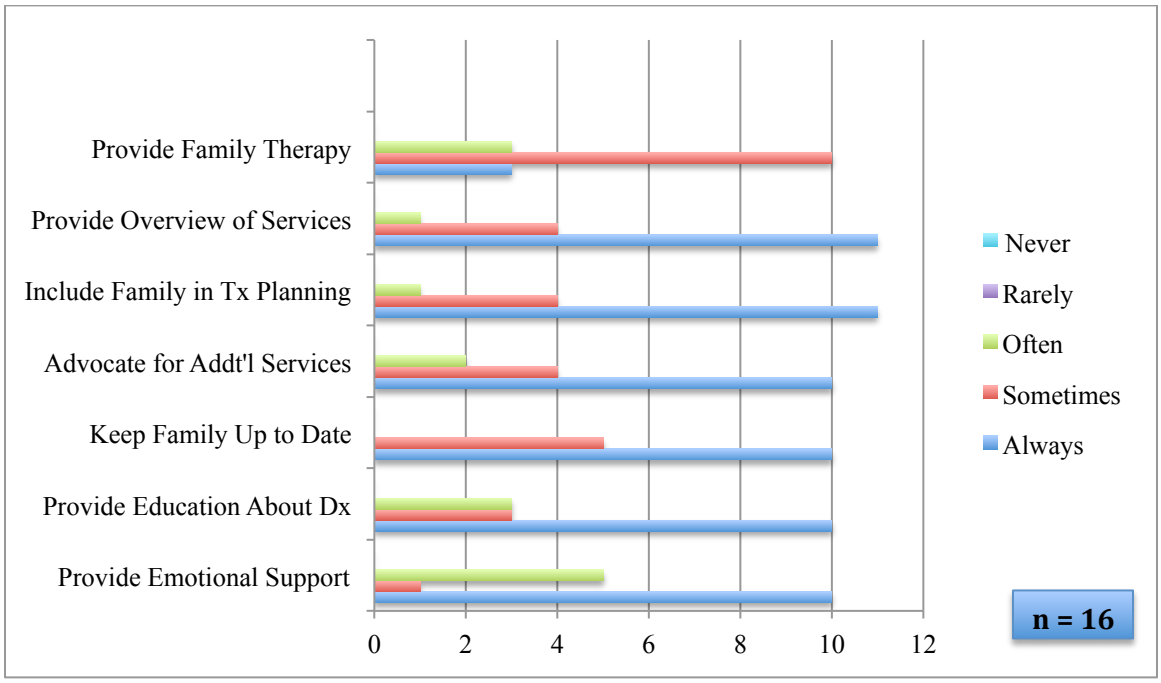
Table 4: Relationship with the Therapist



Clinician Attitudes of Client Treatment Barriers and Use of Engagement Strategies

As mentioned previously, the Clinician Attitudes of Client Treatment Barriers and Use of Engagement Strategies survey contains three sections: engagement strategies (see Table 5), attitudes about working with families (see Table 6), and opinions related to the agency (see Table 7). A majority of the participants reported "always" utilizing many strategies. 62.5% of participants indicated they "always" provide emotional support, education about patients' diagnosis and treatment, keep family up to date about patients' progress, advocate for additional services when needed, and provide family therapy "often". 87.5% reported providing crisis intervention when necessary, and 68.8% reported "always" including family in patients' treatment planning and providing an overview of services.

Table 5: Strategies



Regarding attitudes about working with families, participants indicated that other family members "always" (12.5%) or "often "(56.3%) have their own mental health issues and that working with families is "always" (43.8%), "often" (31.3%), or "sometimes" (25%) complex in nature. 75% of clinicians perceived families as "sometimes" having a lack of interest or involvement. Families were also perceived as "sometimes" (81.3%) having difficulty communicating with staff and being resistant to clinician's suggestions (62.5%). It was also believed that families "often" learn to manage patients' illnesses (62.5%) and that family involvement is "rarely" harmful to the patient (68.8%). In the agency related section, providing services for families on evenings and weekends was "always" (25%), "often" (37.5%), or "sometimes" (31.3%) difficult.

Table 6: Attitudes About Working With Families

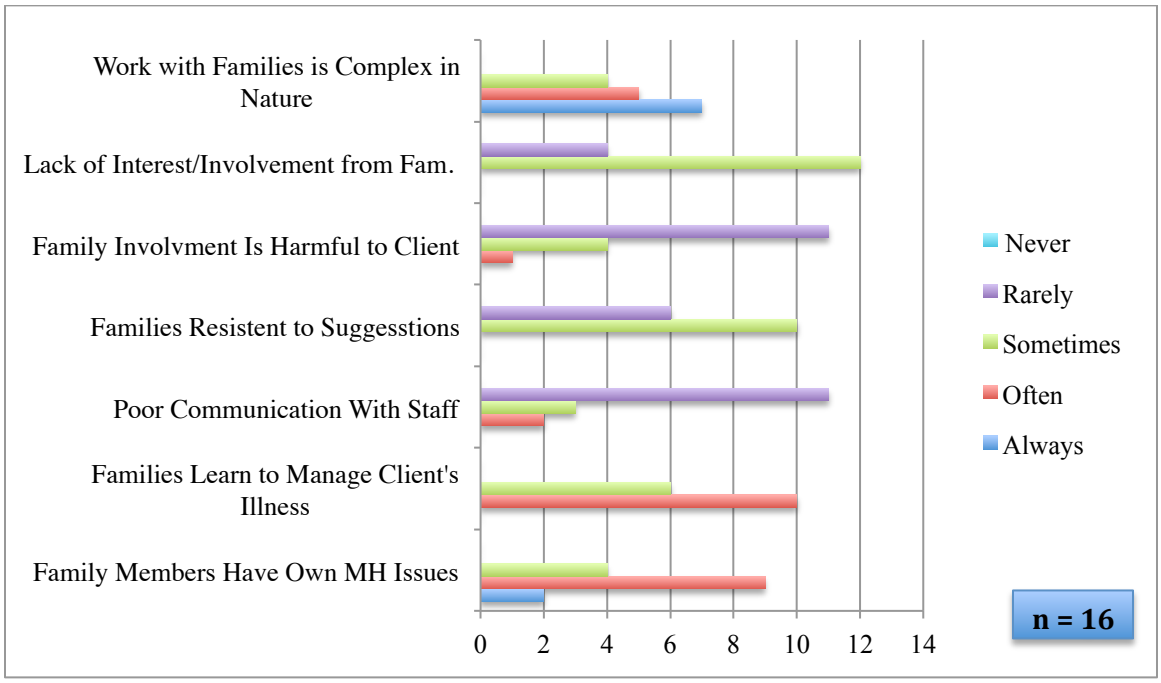


Table 7: Opinions Related to the Agency

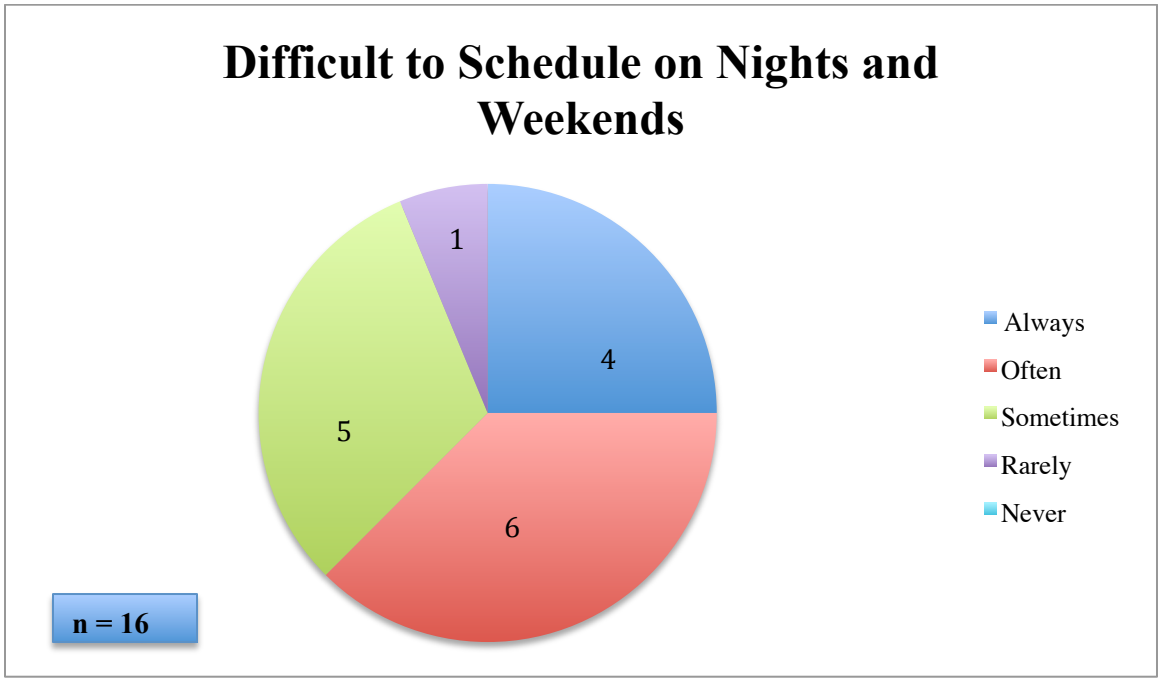


Table 8: Pearson Product-Moment Correlations

	Family Time	Liked Therapist	Staff Demand	Parent Activity	Provide Advice	Family Engage	Scheduling	Baby sitter	Tx Importance	Mediate	Tired	Complex
Ther. Confidence	**r = .920**											
Tx Length		**r = .889**							**r = .711**			
Agency			**r = .837**									
Parent Problems				**r = .817**				**r = .716**				
Include Family					**r = .792**							
Mediate						**r = .774**						
Tx As Stress											**r = .698**	
Education										**r = .698**		
Tx Work							**r = .747**					
MH Issues												**r = .685**
Babysitter				**r = .708**								
Parental Stress											**r = .698**	

(All relationships reported here were found to be significant at the .01 level)

Key:

Ther. Confidence = The parent seemed to believe that the therapist did not seem confident in their ability to carry out programs
Tx Length = The parent seemed to believe that treatment lasted too long
Family Time = It seemed that treatment took the parent away from spending time with their children
Liked Therapist = I did not believe the parent liked the therapist
Agency = There is a lack of guidance and leadership from the agency
Demands = There are too many demands on staff
Parent Problems = The parent felt that treatment did not focus on their life and problems
Parent Activity = Treatment was in conflict with another of the parents' activities (classes, friends, work)
Include Family = I include family in patient's treatment planning
Provide Advice = I provide practical advice/coping skills for specific situations
Mediate = I mediate conflicts among client and family members
Family Engage = I believe it is generally easy to engage with families
Tx Work = The parent may have felt treatment was more work than expected
Scheduling = Scheduling of appointment times for treatment seemed to be an issue
Babysitter = Getting a babysitter so the parent could come to sessions
Tx Importance = Treatment did not seem as important to the parent as sessions continued
Parental Stress – During the course of treatment the parent experienced a lot of stress in their life
Tired – The parent was too tired after work to come to a session
Education = I provide education about patient's diagnosis and treatment
Tx As Stress = The parent may have felt that treatment added another stressor to their life
MH Issues = Other family members have their own mental health issues
Complex = Working with families in complex in nature

Correlations

Statistical analyses using the Pearson product-moment correlation coefficient were performed among all scale variables (i.e. Likert rated questions) on both surveys (n = 77) to investigate potential linear relationships among variables (see Table 8). Significance was calculated at the .01 level, indicating strong relationships would be due to chance one in 100 times. For the purposes of the study, the researcher focused on linear relationships that were strong (r = .60 - .79) or very strong (r = .80 – 1.00). The strongest correlation (r = .920) occurred between the variables "the parent seemed to believe that the therapist did not seem confident in their ability to carry out programs" and "it seemed that treatment took the parent away from spending time with their children." There was also a very strong correlation (r = .889) between "the parent seemed to believe that treatment lasted too long" and "I did not believe the parent liked the therapist." A "lack of guidance and leadership from the agency" and "there are too many demands on staff" had a very strong positive correlation (r = .837). "The parent felt that treatment did not focus on their life and problems" was very strongly correlated (r = .817) with "treatment was in conflict with another of the parents' activities." A strong positive correlation (r = .792) was found among two engagement strategies: "I include family in patient's treatment planning" and "I provide practical advice/coping skills for specific situations." Other strong correlations include "I mediate conflicts among client and family members" and "I believe it is generally easy to engage with families" (r = .774); "the parent may have felt treatment was more work than expected" and "scheduling of appointment times for treatment seemed to be an issue" (r = .747); "the parent felt that treatment did not focus on their life and problems" and "getting a babysitter so the parent could come to sessions" (r = .716); "the parent seemed to believe that treatment lasted too long" and "treatment did not seem as important to the parent as sessions

continued" (r = .711); "getting a babysitter so the parent could come to sessions" and "treatment was in conflict with another of the parents' activities" (r = .708). Three sets of variables had a strong positive correlation (r = .698): "during the course of treatment the parent experienced a lot of stress in their life" and "the parent was too tired after work to come to a session," "I provide education about patients' diagnoses and treatment" and "I mediate conflict among client and family members," and "the parent was too tired after work to come to a session" and "the parent may have felt that treatment added another stressor to their life." Finally, a strong positive correlation (r= .685) was found between "other family members have their own mental health issues" and "working with families is complex in nature."

The results shown here indicate that participants perceived factors involving logistical barriers (e.g. scheduling, transportation) and parental stress as the most significant barriers to treatment participation. Participants also reported a belief that working with families is complex in nature and described parents seeming uncomfortable, confused by treatment information, and viewed treatment as more work than expected. The clinicians surveyed in this study reported utilizing several strategies that attempt to build a therapeutic alliance with families on treatment planning and offer a thorough overview of services and education about a client's diagnosis. Participants also denoted an overall perception that parents believe treatment is helpful and have favorable views of their therapists.

Discussion

This study aimed to investigate the perceptions held by clinicians in a child and adolescent community mental health clinic regarding the barriers clients face and the strategies used to enhance engagement and treatment adherence. The results mirrored several notions found previously in the literature. Parents appear to have the most significant impact on whether

or not treatment is continued or consistent. Logistical barriers like scheduling conflicts, childcare, and transportation occur quite often, and involving family in the treatment process enhance the therapeutic alliance. Known parental factors that impede attendance and engagement included parents experiencing their own mental health issues (Kazdin & Wassell, 1999), and high levels of stress (Gearing et al., 2012; Oruche et al., 2013) were supported here as a majority of participants perceived both in their experiences working with families. Logistical obstacles such as a parent's job interfering with their ability to attend treatment, difficulty scheduling due to inflexible appointment slots, inconsistent or unreliable transportation, and lack of child care options (Gearing et al., 2012; Westmacott et al., 2010) were also indicated on the results of the BTPS-T. Previous studies (Gearing et al., 2012; Kazdin, 2000; Nanniga et al., 2016; Nock, 2007; Nock & Ferriter, 2005) have shown that parental expectations of treatment, such as viewing it as too time consuming and demanding, may lead to a lower likelihood of completing or engaging fully in treatment. The results of this study echo those obstacles as most clinicians indicated parents believed treatment to be more work than expected. Additionally, information given in sessions often seemed confusing to the child as well as the parent. It may come as no surprise that as logistical barriers and life stressors accumulate, parents are less likely to accommodate treatment as an additional stressor. Clients may be unaware of the potential barriers they could face or the actual implications of certain obstacles when they attend treatment initially, but as time goes on it becomes more difficult to manage.

Providing a thorough overview of mental health services, such as treatment modalities, estimated length of treatment, and accurate indications of effort expected by clients have been illustrated as an advantageous engagement strategy (Stevens et al., 2006; Westmacott et al., 2010), one which appears to be used effectively at this clinic. A majority of participants reported

always or often providing an overview of services. They also reported that many parents viewed treatment as mostly what they expected. A positive correlation was found between the perception that treatment lasted too long and no longer seemed as important as time went on. Perhaps this implies the importance of providing an accurate overview of treatment from its onset; parents who expected a shorter course of therapy might have became less invested when treatment lasted longer than anticipated. Other effective engagement strategies that participants reported utilizing include involving family in treatment planning (Westmacott et al., 2010), providing crisis intervention and active problem solving, and advocating for additional services (Lindsay et al., 2014). Joining with parents to enhance the therapeutic alliance has proven beneficial elsewhere (Kazdin, Whitley, & Marciano, 2006; Kim et al., 2012; Manfred-Gilham et al., 2002), and can be enhanced by positive and nurturing interactions with and the emotional availability of the therapist (Block & Greeno, 2011; Oruche et al., 2014). Some studies have suggested that parents benefit from time and space to discuss their emotional hardships or life stressors (Block & Greeno; 2011; Stevens et al., 2006). Participants in this study believed they provided such support, as many reported that parents believed treatment was at least somewhat related to their life and problems. The results of this study indicate that despite many reported logistical barriers and treatment demands, participants believed that parents held a generally positive view of the clinicians and the efficacy of treatment. Although the findings here correspond with existing literature and offer a glimpse into one department of one agency's experience with clients, there are limitations, which are discussed below.

Limitations

There are several limitations to this study, which include the use of both instruments as well as the sample size. The BTPS-T was created with a companion measure, the BTPS-Parent

to be used for comparison. Ideally, the BTPS-T would be given to a clinician asking them to complete the survey for one particular client and family; the same family would also complete the BTPS-Parent and the results would be compared. The logistics of gathering data from clients as well as clinicians was beyond the scope of this study, which compromises the accuracy of the perceived barriers. While clinicians' perspectives are valid and valuable, without comparing them with the actual experiences of clients, the accuracy of those perceptions remains unknown. Furthermore, as stated above, the BTPS-T is also best used to explore barriers experienced by one specific client/family. This study asked participants to consider their caseloads in general, and, as each client faces their own obstacles and experiences, this likely limited the quality of the information that was gathered. The Clinician Attitudes of Client Treatment Barriers and Use of Engagement Strategies survey poses another limitation as it was adapted by the researcher and has not been tested for reliability and validity. Furthermore, as the sample size was less than 100, significant correlations may be spurious and results cannot be generalized to larger populations. Future research on this topic might consider a qualitative or mixed methods approach, which could provide data that is richer and more specific.

Implications for Counseling Practice

It is vital for mental health practitioners not only to be aware of barriers to treatment in general, but also as they relate specifically to clients. Awareness of typical patterns or occurrences of barriers may help inform and enact policy and procedure change in agencies that could better serve the needs of their clients. Moreover, knowledge of what barriers arise may make it easier to address them with clients as they occur. As a helping professional, one holds the responsibility of meeting a client where they are and addressing whatever need is standing in the way of their mental health and wellness. It is important to consider the costs, both monetary

and otherwise, that affect clients, particularly those in marginalized populations. For those who work several jobs, are without transportation, lack medical insurance, or any other number of circumstantial obstacles, coming to treatment may be more costly than attending treatment regularly. Counselors should keep in mind that treatment is not always feasible and do their best to provide clients with the appropriate supports and resources.

While there is a consistent and growing need for mental health services targeting children and adolescents, existing services are often underutilized, or initiated but terminated prematurely. Mental health treatment for children and adolescents is complex in nature due to the necessity of including parents as part of the therapeutic alliance. Providing quality treatment is complicated further when considering the many obstacles that may stand in the way of delivering consistent treatment. Although clinicians may make their best effort to build rapport with clients and parents by offering a thorough overview of services as well as family therapy and crisis interventions, every day stressors such as scheduling conflicts and lack of childcare or reliable transportation often interfere with families' abilities to fully benefit from mental health services. Treatment for this population can be enhanced by open discussions regarding barriers and obstacles to treatment as they arise, as well as ensuring parents and families are included as a vital part of the therapeutic alliance.

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