2011

Enrolling and Engaging High-Risk Youths and Families in Community-Based, Brief Intervention Services

Richard Dembo
University of South Florida, rdembo@usf.edu

Laura M. Gulledge
University of Southern Mississippi, Laura.Gulledge@usm.edu

Rhissa Briones-Robinson
University of South Florida

Ken C. Winters
University of Minnesota, winte001@umn.edu

Published in final edited form as:
J Child Adolesc Subst Abuse. 2011 September ; 20(4): 330–335. doi:10.1080/1067828X.2011.598837.

ENROLLING AND ENGAGING HIGH-RISK YOUTH AND FAMILIES IN COMMUNITY-BASED, BRIEF INTERVENTION SERVICES

Richard Dembo, Ph.D.
University of South Florida Department of Criminology 4202 E. Fowler Avenue Tampa, FL 33620

Laura Gulledge, M.A.
University of Southern Mississippi School of Criminal Justice 118 College Drive Hattiesburg, MS 39406

Rhissa Briones Robinson, M.A.
University of South Florida Department of Criminology 4202 E. Fowler Avenue Tampa, FL 33620

Ken C. Winters, Ph.D.
Department of Psychiatry University of Minnesota F282/2A West 2450 Riverside Avenue Minneapolis, MN 55454

Abstract

Increasing interest has been shown in Brief Interventions for troubled persons, including those with substance abuse problems. Most of the published literature on this topic has focused on adults, and on the efficacy of these interventions. Few of these studies have examined the critical issues of enrollment and engagement in Brief Intervention services. The present paper seeks to address the shortcomings in the current literature by reporting on our experiences implementing NIDA funded, Brief Intervention projects involving truant and diversion program youth.

Introduction

Involving high risk youths and their families in community based intervention services continues to constitute a major challenge facing the delivery of substance abuse services. Most studies of program attrition have focused on adult populations (Wierzbicki & Pekarik, 1993). Relatively few studies have looked at adolescents, and fewer still have examined program attrition among substance involved adolescents (see: Mensinger, Diamond et al., 2006). Further, previous research has focused on client characteristics, such as demographic factors, which are immutable to change.

The unfortunate lack of research attention on program attrition among substance involved adolescents has limited our insight into ways to reduce their high rates of program dropout, averaging 60 percent, among child and adolescent patients seeking mental health services (Pelkonen, Marttunen et al., 2000). Research indicates that adolescents who drop out of treatment are more troubled, less likely to show improvement while in treatment, and more likely to experience future psychosocial difficulties, than adolescents who complete treatment (Pelkonen, Marttunen et al., 2000; Santisteban, Szapacznik et al., 1996). Accordingly, a serious need exists to increase our understanding of the factors leading to failure to enroll and engage (sustain the involvement of) youths with substance use issues in intervention services. In this effort, it is important to consider process as well as client factors. In particular, consideration of client perceptions of treatment relevance, as well as treatment and practical obstacles to becoming involved in treatment, need to be examined (Mensinger, Diamond et al., 2006). In recent years, increased interest has been shown on the delivery of brief intervention for substance involved youths and their families. These

interventions include Brief Strategic Family Therapy (Coatsworth, Santisteban et al., 2001), other family focused interventions (Spoth, Redmond et al. (2004), motivational enhancement therapy (Dennis, Godley et al., 2004), cognitive behavioral therapy (Dennis, Godley et al., 2004), motivational interviewing (Dunn, Deroo et al., 2001), and solution focused brief therapy (Gingerich & Eisengart, 2000). These interventions have involved a number of different target groups and settings: (1) schools (Spoth, Redmond et al., 2004), (2) homeless youth (Peterson, Baer et al., 2006), (3) community-based services (Breslin, Sdao-Jarvie et al., 2002), (4) primary care settings (Stern, Meredith et al., 2007), (5) emergency clinics (Burke, O'Sullivan et al., 2005), and a few have involved (6) young offenders (Sinha, Easton et al., 2003), and (7) Hispanic youths (Santiseban, Coatsworth et al., 2003). The published literature on brief interventions has focused on efficacy (Dunn, Deroo et al., 2001; Grenard, Ames et al., 2006). Although the results of many of these studies point to the promise of these interventions, several studies suggest they are not very effective with youths who regularly use MDMA or cocaine (Marsden, Stillwell et al., 2006), and may not endure (McCambridge, Slym et al., 2008). At the same time, the literature does suggest these interventions can serve as stand alone services for youths in need of short-term help, or as a beginning step in the change process for individuals needing more specialized or longer-term care (Breslin, Sdao-Jarvie et al., 2002).

Few brief intervention studies have examined enrollment and engagement experiences encountered in the delivery of these services (but see: e.g., Mensinger, Diamond et al., 2006). Perhaps, due to their relatively short duration, these issues are not felt to be of as much concern as in the provision of longer-term therapy/intervention services. Yet, as we argue in this paper, engaging and maintaining adolescent involvement in community-based, brief intervention services: (1) is critically important in being able to provide these services, and (2) often present unique challenges that need to be overcome if brief interventions are to have an opportunity to produce positive outcomes.

The present paper discusses the enrollment and engagement experiences we encountered in implementing two community-based, brief intervention services for substance involved youths in two separate sites: (1) Juvenile Drug Court in Hillsborough County, Florida and (2) a Truancy Intake Center, located on the campus of the Hillsborough County Juvenile Assessment Center in Tampa. Following a description of these programs, we summarize the enrollment and engagement issues we encountered, and compare our experiences with those reported in studies of longer term interventions. We conclude with suggestions for future research, and improving brief intervention service delivery.

Description of the Brief Intervention Programs

Juvenile Drug Court

Youth arrested on misdemeanor charges, who do not have a significant arrest history or previous arrests on felony charges are eligible, with State Attorney Office approval, for placement in a diversion program. Arrested youths in Hillsborough County, Florida, are processed at the Juvenile Assessment Center (JAC) where, among other things, they are asked to provide a urine specimen for drug testing as part of the JAC assessment process. Youths who are arrested on drug related charges, or who are found to be drug positive at the time of their JAC processing are often recommended to Juvenile Drug Court. Youths arrested on non-drug related charges, but who report use to a JAC assessor, are often placed, again with State Attorney approval, in other diversion services.

Juvenile Drug Court is a six to twelve month program. Youths entering the program, and their parents, are asked to sign a contract in which the youths admit guilt and agree to follow program rules and regulations. Contract signing occurs at a Juvenile Drug Court Orientation,

usually held bi-weekly, and is followed by an initial arraignment, and reporting that day to a drug treatment program for a urine drug test. At that time, a psychosocial assessment is scheduled for a later date. The assessment information is used to place the youth in one or more community-based treatment programs, reflecting differing intensity and length of program services. Less intensive programs last six months; the most intensive programs last up to twelve months. Progress in the program is based in compliance with the requirements of the treatment program, including random urine drug tests, as well as making required court appearances, satisfactory progress at school, and behaving responsibly at home. Youths who successfully complete the program will have their charges sealed in their records.

Recruitment into the Brief Intervention Project occurred during the Juvenile Drug Court Orientation meetings. During these meetings, community service agencies were given an opportunity to give a brief overview of their services. BI project staff were also able to make a brief presentation about the BI-Court project to parents and youths at the orientation meeting. At the end of the orientation meeting, we were able to approach eligible youths and their parents to begin our enrollment process. Youths charged with a non-felony offense associated with illicit drug use or charged with a non-felony offense for illicit drug possession or possession of drug paraphernalia or who tested positive during processing at the JAC following arrest, were 12 to 17 years of age and lived within a 25 mile radius of the court house were eligible for this project. BI services were free.

Enrollment at Juvenile Drug Court Orientation involved project staff answering any questions parents and youths had about the project, and staff requesting an in-home meeting to discuss the project further. Of the 239 youth who were eligible for enrollment, approximately 63% of families agreed to an initial in-home meeting. Of families who agreed to an initial in-home meeting, approximately 67% completed the baseline assessment. In contrast to the treatment program placement, which was required by the juvenile drug court, participation in the Brief Intervention project was voluntary.

Following the project consent and assent processes, the staff member proceeded to complete a baseline interview. Following completion of this interview, and a quality control review of the interview material by another staff member, the family was randomly assigned to one of three service groups: (1) the usual program services, (2) two BI sessions with the youth, or (3) two BI sessions with the youth, one BI session with the parent, and one BI session with both the youth and parent. The BI incorporates elements of Rational-Emotive Therapy (RET) and Problem-Solving Therapy (PST) to help develop these adaptive beliefs and coping skills. Drug involvement is viewed as learned behavior that develops within a context of personal, environmental, and social factors (Catalano, Hawkins, Wells, & Miller, 1991; Clark & Winters, 2002) that shape and define drug use attitudes and behaviors. Developed over the course of an adolescent's learning history and prior experience with drugs, maladaptive beliefs and coping skill deficits are viewed as primary determinants of drug use. The goal of the BI therapist sessions is to diminish factors contributing to drug use (e.g., maladaptive beliefs) and promote factors that protect against relapse (e.g., problem solving skills). Following is a brief description of these sessions:

SESSION 1 (Youth)—Focuses on discussing information about the youth's substance use and related consequences, the level of willingness to change, examining the causes and benefits of change, and discussing what goals for change the youth would like to select and pursue. Youth are allowed to pursue goals of drug abstinence or reduction in drug use.

SESSION 2 (Youth)—Reviews the youth's progress with the agreed upon goals, identifies risk situations associated with difficulty in achieving goals, discusses strategies to overcome

barriers toward goal achievement, reviews where the youth is in the state of change process, and negotiates either continuation or advancement of goals.

SESSION 3 (Parent)—Informed by an integrated behavioral and family therapy approach, the parent session addresses: the youth's substance use issues, parent attitudes and behaviors regarding this use, parent monitoring and supervision to promote progress towards their child's intervention goals, and parent communication skills to enhance youth-parent connectedness.

SESSION 4 (Parent and Youth)—The focus of this session is to establish a dialogue between the youth and his/her parent. During this session, youth and parent rate one another on a number of relationship areas: family relations, school, social relationships, and youth substance use, and assess the convergence and divergence of their views of one another. Efforts made by the youth and parent in improving communication, quality of time spent with one another, and their overall relationship are reviewed. Next, the interventionist reinforces the positive changes that both the youth and parent have accomplished, and explores ideas for possible change. Concrete suggestions are given for ways to improve communication in stressful situations, and in improving coping and problem solving skills.

Each session last for 1-1/4 hours, and the sessions occur about a week apart. With youth and parent/guardian permission, the BI sessions are tape recorded for fidelity/adherence assessment.

The Hillsborough County Truancy Intake Center

Established in 1993, the Hillsborough County, Truancy Intake Center (TIC) is a crime prevention tool designed to get students back into the mainstream of school by reducing student dropout (Hillsborough County Sheriff's Office, 1997). Students who are not in school can be taken into custody by various law enforcement agencies located throughout Hillsborough County and transported to the TIC. At the center, the youth is transferred to an officer of the Tampa Police Department (TPD) or a deputy from the Hillsborough County Sheriff's Office (HCSO). The receiving officer calls the youth's parents/ guardians, informs them the youth has been picked up for truancy, and requests that the parents/guardians pick up the youth at the TIC by 4 p.m. that day.

Following a brief intake meeting with the HCSO deputy or TPD officer assigned to the TIC, the truant youth is placed in a large “classroom” (the TIC has been declared a school site), where processing activities continue. Under the supervision of a TIC counselor, the youth completes a Juvenile Self-Report Screening Package, probing psychosocial functioning including alcohol and other drug use. The Hillsborough County School District (HCSD) has assigned a full-time social worker to the truancy center who meets with truant youths to obtain a more complete picture of the psychosocial issues relating to their truant behavior.

The TIC counselor completes a cover sheet on the youth which requires access to information on the youth from various computer databases to which the Tampa JAC is linked: (1) the Florida Department of Juvenile Justice (DJJ), (2) the TPD, (3) the HCSO, and (4) the HCSD. A copy of the school system's emergency card information is provided to JAC truancy program law enforcement officers as needed. The HCSD social worker assigned to the TIC completes a “truancy alert” form which is sent to the youth's school (including the school guidance counselor) for appropriate follow-up. When necessary, the JAC school social worker will also communicate directly with appropriate school-based personnel.

When the youth's parents or guardians arrive at the TIC during normal working hours, they are initially directed to meet with a truancy center law enforcement officer. During this meeting, the officer or deputy discusses the specifics of the youth's infraction. A “School Referral” form is also given to the parents/guardians, which they must present to their child's school administrator the next day for re-admittance to the school. The school social worker then meets with the parents/guardians to share with them the information that was gathered during the youth's processing at the TIC. The parents/guardians are encouraged to assist the school social worker in developing an action plan to support the truant youth. In many cases, recommendations going beyond the educational domain are indicated to make an appropriate impact on the family's situation. After the family leaves the TIC, they meet with a school administrator to discuss the consequences of the student's action. The school administrator will indicate the results of the conference on the “School Referral” form, and mail it to the TIC. (If parents/guardians are not able to pick up their child before the TIC closes, the truant youth is temporarily placed in another building on the JAC campus until his/her parents/guardians arrived.)

Brief Intervention Services—Under funding by the National Institute on Drug Abuse, a Brief Intervention service (Winters & Leitten, 2007) has been included as a follow-up for truant youths who meet the following criteria: (1) aged 11 to 15, (2) have no official record of delinquency or up to two misdemeanor arrests, (3) have some indication of alcohol or other drug use – as determined by a screening instrument (the Personal Experience Screening Questionnaire [Winters, 1992]) or the HCSD social worker located at the TIC, and (4) live within a 25 mile radius of the TIC. Additionally, any HCSD social worker or guidance counselor can make referrals to the Brief Intervention service as well. The Brief Intervention services for truant youths include Sessions 1 and 2, or Sessions 1, 2, and 3 provided to youths attending Juvenile Drug Court. The goal of the BI therapist sessions is to promote abstinence and prevent relapse among drug using adolescents through the development of adaptive beliefs and problem-solving skills.

Enrollment into the BI project, which is voluntary, involves two major steps: (a) a brief meeting with the youth and his/her parent/guardian when the youth is picked up at the TIC and (b) a follow-up, in-home meeting at which time youth and parent/guardian questions about the project are answered, the consent/assent process completed, and separate youth and parent baseline interviews accomplished. Following baseline assessment, and interview form quality control, participants are randomly assigned to one of three service conditions: (1) three, in-home meetings with a staff member to provide referral assistance, (2) two, in-home BI sessions for the youth by the brief interventionist, and (3) two, in-home BI sessions for the youth, and one, in-home BI session for the parent/guardian. All in-home sessions/services are free. Information collected is kept strictly confidential. Each BI session lasts for approximately 1-1/4 hours, and they occur about a week apart. With youth and parent/guardian permission, the BI sessions are tape recorded for fidelity/adherence assessment.

Enrollment and Engagement Issues

We have found that the challenges relating to enrollment into, and engaging in, these projects are decidedly different. Given the short term nature of these brief interventions, it is very important that these challenges be addressed as early as possible. It is also important to note that, since our Brief Intervention Programs were not designed to identify and study enrollment and engagement issues, we did not systematically collect information on their frequency or interrelationships. However, our experience indicates that denial, logistical support/practical obstacles, parent enabling, and staff—client relationships tend to be among the most common issues we encountered. Following are a listing and short description of the

most frequently encountered challenges to family involvement in these two brief intervention projects.

Enrollment: Youth and Parent/Guardian Agreement to Participate in Brief Intervention Services

Denial—In our experience, this enrollment issue has emerged in both of the brief intervention settings. First, at Juvenile Drug Court enrollment, the parent/guardian and/or youth will claim that the youth has no drug use issues. Second, following parent/guardian and youth agreement to meet with a Truancy Project staff member at their home to discuss the project further, the parent/guardian will deny the youth has any drug use issues.

Vignette #1: While at the Juvenile Drug Court orientation, “Bobby” and his mother, “Mrs. Brown” agreed to participate in both the diversion program and Brief Intervention service. Similar to many of the youth entering the diversion program, Bobby was arrested on a drug possession charge (i.e., possession of less than 20 grams of marijuana.) During the first in-home meeting for the brief intervention, Bobby insisted that he did not use drugs. He asserted that he was given the drug to hold for a friend and was caught with it in his possession. Although Bobby and Mrs. Brown had the option to contest the charges in court, they did not decide to do so as to avoid the risk of Bobby being adjudicated delinquent and the arrest charge remaining on his record. (The arrest charges of youth who successfully complete the drug court program are sealed.)

Vignette #2: While at the Truancy Intake Center, “Shantel” self-reported substance use on the Personal Experience Screening Questionnaire (PESQ). Additionally, she also openly discussed her substance use with the HCSD social worker. However, while being questioned in their home about this substance use, Shantel retracted the statements she made about drug use during the TIC assessment process. Her mother, “Mrs. Jones,” who does not live in the same household as Shantel, called project staff the day following her daughter's initial assessment. Mrs. Jones was extremely upset that we would imply that her daughter used drugs. She fervently denied that Shantel had ever used alcohol or marijuana and indicated that she did not want her to participate in the brief intervention.

The Perceived Value of the Brief Intervention—In a number of cases, parents/guardians have felt the Brief Interventions were not of sufficient duration and intensity to remediate their child's drug use issues.

Vignette #3: At Juvenile Drug Court orientation, “Maria” and her father, “Mr. Perez,” were approached by brief intervention staff to discuss potential enrollment. After a brief explanation of the program's intent and services, Mr. Perez felt that his daughter needed a program that offered longer term, more intensive services. He further indicated that his daughter was a frequent marijuana user who often ran away from home. Mr. Perez felt that since Maria was going to be mandated into a longer treatment program as part of the diversion program anyway, a separate program with so few sessions would not be sufficient to exact change in Maria's behavior and drug use frequency.

Logistical Support/Practical Obstacles—Since project services were provided in the youths' homes during the weekdays and weekends, we did not encounter problems often experienced by office-based service programs, such as transportation difficulties, or service program accessibility. Instead, our enrollment activities were challenged by the established Juvenile Drug Court Orientation and TIC processing procedures we could not change. Following are some of the challenges we faced.

Vignette #4: Youths and parents/guardians attending Juvenile Drug Court Orientation were presented with considerable information about: (1) events and decisions leading to the youth being assigned to the program by the State Attorney's Office, (2) the Juvenile Drug Court program and its requirements, and (3) the program contract. Families often found this to be a stressful event. While many families wanted to reach out for help for their child, some families were concerned that the time commitment needed to participate in the Juvenile Drug Court program might preclude involvement in any other program or service activities. Brief Intervention staff quickly became sensitized to this situation, and with the developed support of drug court treatment providers, presented BI services as being complementary to those provided by the longer-term drug court treatment programs.

Vignette #5: A different, major challenge was presented to BI enrollment activities at the TIC. At the beginning of the BI Truancy Project, a major instrument used to identify youth drug use, a key criterion for project eligibility, was the Personal Experience Screening Questionnaire [PESQ] (Winters, 1992). The TIC processing circumstances (i.e., law enforcement contact on the street and at the TIC) reduced the likelihood youths would self-disclose problem behavior while at the center. Brief Intervention staff modified, with IRB approval, the study enrollment protocol to involve accepting referrals from the TIC-based, HCSD social worker, and taking referrals from social worker and guidance counselors assigned to community-based schools. These actions have increased eligible enrollees for the Truancy Project. However, we continue to experience enrollment challenges at the TIC.

Parent enabling—This situation is most often encountered when BI project eligible youths are picked up by their parent/guardian at the TIC.

Vignette #6: During their initial enrollment meeting, “Dontavious” and his mother, “Ms. Smith,” did not disagree that he might have a drug use issue. However, Mrs. Smith expressed that Dontavious' drug use had not reached a threshold to warrant any intervention services. As such, she declined to participate in brief intervention services. In this case, as in many others, this form of parent enabling resulted in more serious consequences. Several months later, Dontavious and Mrs. Smith were seen at Juvenile Drug Court Diversion by a BI-Court project staff member; Dontavious had been arrested for possession of marijuana and possession of narcotics equipment.

Morphing a substance use problem into another problem—Problem morphing was encountered in several cases during BI Truancy Project enrollment at the TIC.

Vignette #7: During Juvenile Drug court orientation, “Mrs. White” and her son “Sam,” were approached by brief intervention staff to inquire about their interest in participation. Sam had been charged with marijuana possession, yet claimed that he had only found the drugs under a bush at school when caught. Mrs. White believed that our services may be beneficial to Sam, but felt as though a mentorship program would be more beneficial. Mrs. White did not think the main issue was one of substance use, but rather, one that had resulted from a lack of positive mentors in Sam's life. Mrs. White asked if the BI staff member could provide mentorship services before all other services. However, the goal of the BI is to foster abstinence and/or decreased use of substances. As such, Mrs. White decided to decline our services.

Mistrust of Research Establishment—Mistrust is often encountered when initially meeting families at the Truancy Intake Center or drug court orientation. Issues of mistrust may also carry over into the first in-home meeting before a full explanation of project services is provided to the family. Due to the environment in which BI staff initially meets

potential families, youth and/or parents often associate BI staff with punitive authority figures such as law enforcement officers or Department of Child & Family staff.

Vignette #8: The brief interventionist, during her first session with “Charles,” felt rapport was developing well during introductions and initial dialogue. As the session progressed, the youth gained confidence in sharing his experiences although he was speaking reluctantly and quietly. However, law enforcement officers appeared at the door with a pick-up order for Charles during this initial session. Charles believed the interventionist was responsible for law enforcement officers coming to detain him. (Charles' mother obtained a court order for Charles to be placed in a detox unit; law enforcement officers were executing that order.) These circumstances resulted in a significant amount of mistrust between Charles and his interventionist. Unfortunately, Charles has since refused any participation in the BI program.

Engagement: Maintaining Participation in Brief Intervention Services

Staff—Client Relationships—Many of the Brief Intervention services were delivered by two, trained, and supervised staff members. However, even though both female staff members received good or better client Satisfaction Ratings, one of the two brief interventionists was better able to successfully connect and work with assigned families.

Vignette 9: Therapist 1 was more apt to successfully connect and work with assigned families than Therapist 2. This was due, in part, to Therapist 1's outgoing personality and flexibility in working with at-risk families. For instance, the “Miller” family arrived late to their first session with Therapist 2. On the evening of the second session, Mrs. Miller called Therapist 2 to let her know they would be arriving a few minutes late. Therapist 2 told Mrs. Miller that she would wait for them. However, when Mrs. Miller arrived, Therapist 2 had already left the home. Understandably, Mrs. Miller was upset and wanted to cancel participation in the program. In another instance, the “Ng” family was referred to our program by a diversion case manager. Although the Ng family lived a few miles outside of the project mile radius, BI staff enrolled them in the program as they are often flexible with taking families that lived a few miles out of the service area. Without supervisor approval, Therapist 2 informed the Ng family that in order to receive services, they would have to meet her half the distance from their home to our office location. As the program was initially presented to them as an in-home service, this demand was justifiably considered unreasonable by the Ng family and they no longer wanted to participate. Thankfully, in these cases, staff was able to identify these problems and successfully re-engage the youths and parents/guardians in Brief Intervention services with the assistance of Therapist 1. Ongoing oversight of Brief Intervention delivery is of critical importance.

Transience—A sizable number of families we work with, in both the BI-Court and BI-Truancy projects, move to other addresses without informing intervention or other project staff. This is a common experience in working with at-risk youths and their families, and presents obvious service delivery challenges.

Vignette #10: “Mr. Rodriguez” sent his daughter, “Selena” to live with another relative out-of-state in an effort to cut her ties with delinquent peers, and/or because it was felt that Selena's new residential location would provide her with a more positive, less troubled environment. Brief intervention staff was unaware that Selena had moved out-of-state until we contacted her father for their first follow-up appointment. BI staff arranged to call Selena on a relative's cell phone to conduct her follow-up interview.

Vignette #11: The first in-home appointment we had with “Edward” and his mother, “Mrs. Burns,” took place in Mrs. Burns' apartment. Shortly thereafter, Mrs. Burns was evicted and

moved in with her other son and daughter-in-law. Soon after the move, the daughter-in-law accused Edward of stealing her drugs. Edward then went to live with his other brother in a mobile home across town. After this brother was arrested and jailed for domestic battery on his girlfriend, Mrs. Burns picked Edward up and the two of them began to live out of Mrs. Burns' car. Frequent moves and home displacement made it very difficult for BI staff to remain in contact with this family.

Parent Dysfunction—A sizable number of families served by the Brief Intervention projects at Juvenile Drug Court and the Truancy Intake Center are experiencing multiple problems. In addition to the mental health and substance use problems client youths may have, the youths' parents/guardians or other relatives often have to cope with personal problems they are experiencing in these areas. Further, many families we work with involve a single biological parent, most often the mother, living alone or with a significant other such as a stepfather, boyfriend, relative or friend; relatively few families involve both biological parents. Many of our families live economically stressed lives.

Vignette #12: "Taneshia" shares a home with her mother, "Ms. Gordon," and four siblings in addition to another single-parent family of three. Ms. Gordon was the only household member bringing in a steady income; no one else in the home was employed. The home environment was always extremely disorderly and chaotic. Ms. Gordon worked long hours, leaving little time to tend to ordinary household upkeep. Older youth living in the home did very little to assist Ms. Gordon in caring for younger siblings and/or helping with household chores. The stress of Mrs. Gordon's overwhelming amount of responsibilities only added to the strain of the home environment. Moreover, although Ms. Gordon had long since quit her own drug use, she was aware that both of her older daughters were regularly using substances together in the home while she was away at work. The large number of people residing in the home also made it challenging to complete assessment and intervention sessions.

Failed Parent Attempts to Obtain Nurturance from the Interventionist—An interesting challenge we have faced was client (usually parent/guardian) seeking of nurturance from the interventionist–beyond that provided by the intervention protocol. This usually involved parent seeking help with personal problems. Brief Interventionists were trained to provide referrals to community service programs to address these problems. At the same time, some parents/guardians insisted the Brief Interventionist personally provide this help and support. A skillful response to this situation maintained the engagement of at least one project family.

Vignette #13: "Victor's" dad, "Mr. Rubio," returned to Florida to live in a home he and his wife owned. Mr. Rubio was in the process of divorcing his wife. The household consisted of Victor, Mr. Rubio, Mr. Rubio's wife, and his wife's boyfriend. During one of the intervention session sessions, Mr. Rubio broke down crying, and asked the interventionist to help him. The interventionist felt Mr. Rubio has significant psychological problems that required mental health counseling, and she, in line with study protocol, provided Mr. Rubio with referral information. Mr. Rubio was not very happy with this response, reiterating his request that the interventionist help him. After a long discussion as to why the interventionist could not provide the mental health counseling that he apparently needed, Mr. Rubio reluctantly withdrew his insistence.

Comparison of Brief versus Longer-Term Intervention Themes

We completed several literature searches to learn the enrollment/recruitment and engagement/retention experiences of longer-term interventions. Since the experiences of

prevention and treatment studies can be different, we separated them for comparison purposes. Tables 1 and 2 present these exploratory results.

Several interesting patterns are suggested in the data. First, as can be seen, there are few similarities in enrollment experiences across the brief intervention and longer-term prevention and treatment interventions. Admittedly, although the current review of previous interventions was not completely exhaustive, only one main theme, intervention value/relevance, was found across both brief and longer-term treatment studies. Themes including denial and payment for enrollment emerged across the current brief intervention services and longer-term prevention studies.

In contrast to the few similarities in enrollment themes between brief intervention and longer term prevention, and intervention/treatment services, many similar themes emerged across brief intervention and longer-term intervention studies in regard to engagement/retention issues. For instance, issues which can have an adverse effect on client engagement and retention, such as the importance of staff-client match, treatment readiness, and logistical support/practical obstacles, occur across brief and longer-term intervention studies. Not surprisingly, brief intervention studies and the Juvenile Drug Court and the TIC brief intervention projects share the most similarities with longer-term prevention studies. These themes include: (1) staff/client matching, (2) client/family transience, (3) client/family dysfunction/problems, (4) logistical support/practical obstacles, (5) payment for retention, and (6) maintaining contact.

The above comparisons have been made with exploratory and heuristic purposes. It is important to note that, a number of the enrollment and engagement experiences reported in the various studies reviewed reflect the different target groups who were involved in these efforts, as well as the number of intervention sessions provided to youth and/or their families. For example, the brief interventions Mensinger et al. (2006) report on range from 5 to 22 sessions over a 12 week period; whereas, the Brief Intervention Truancy project and Brief Intervention Court project involved three and four sessions, respectively, within a 4–6 week period. Moreover, while extensive, the current review is not an exhaustive review of the literature.

Previous Efforts to Improve Treatment/Intervention Involvement

A number of attempts have been to identify and address the factors that reduce or prevent participant involvement in treatment/intervention services. A completed literature review identified a number of these studies. Most of the studies focus on treatment engagement in treatment/intervention services, such as Multisystemic Therapy (MST) (Henggeler et al., 1998), Brief Strategic Family Therapy (BSFT) (Szapocznik et al., 1988), and Multidimensional Family Therapy (MDFT) (Liddle, 1992), which often involve providing services for three months or more. We were not able to locate any studies addressing enrollment and engagement strategies focusing on brief intervention efforts.

The literature on engagement in longer term treatment, particularly that involving family therapy, highlights a number of family dynamics affecting treatment engagement. For example, Dakof, Tejeda et al. (2001) report that engagement in MDFT treatment was related to more positive parental expectations for their child's educational achievement and more reports of their child's externalizing symptoms. Szapocznik, Perez-Vidal et al., (1988) found that engagement in BSFT could be improved by identifying types of therapeutic resistances and resisting families, viewing the symptom (e.g., drug abuse or resistance to treatment) as a mechanism of family self-regulation, and having the therapist use theoretically based interventions to reduce these resistances. In another area, Englebrecht, Peterson et al. (2008) noted that the literature on treatment engagement in juvenile residential settings is very

limited. They found that youths who made attributions of responsibility or blame for their behavior that led to their being placed in the residential setting were more likely to become involved in treatment.

Conclusion

In light of the various intervention and treatment studies discussed above, a number of challenges involving enrollment and engagement of participants warrant attention. It is critical to identify strategies that enhance the success of these research endeavors. Some strategies that have proven successful are described below.

Successful enrollment and engagement of participants relies heavily on the manner in which the interventionist communicates with families. Encouragement, patience, support, non-judgmental acceptance, as facets of pro-social communication, each contributes to the success of program implementation. Further, attention should be paid to each family's concerns, and a subsequent responsiveness to these worries should reflect a willingness to assist. Families involved in Brief Intervention and longer-term service programs should value their interactions with the interventionist, while also feeling supported in the challenges they endure.

The challenges that some of these families face (e.g., limited transportation, few opportunities during the work week for appointments, financial limitations) are met by our current BI programs. Brief Interventionists are flexible in meeting with families in their homes during the evenings and on weekends. Consequently, families do not have to worry about transportation/traffic issues, and getting their child to an appointment on time. Additionally, as mentioned above, families in need of supportive services often lead busy and chaotic lives. Flexibility with time and patient understanding are important in order to retain participants. It may take a number of reschedules in order to complete a session, but an interventionist who is persistent and patient while dealing with these logistical and practical obstacles, often succeeds.

When appropriate, interventionists and supportive staff should maintain friendly contact with their participants. Sending cards or postcards to youth and their families during birthdays and holidays indicates that they are remembered, while also reminding them of their program involvement. For families that are hard to reach, calling at different times of the day and leaving phone messages, and making visits to the home when family members are likely to be present (e.g., weekend morning hours), may be needed to encourage program participation. It is also important that attempts to make contact with families should be logged and documented by the interventionist and/or support staff.

We have also found that paying each family member a modest sum of $5 for attending each of our Brief Intervention sessions has been successful in encouraging their participation (see: Heinrichs, 2006; Capaldi et al., 1997). This modest sum is not at level to make families feel under undo pressure to participate. Rather, as we inform the families, we value the time they share with us, and the payment reflects our appreciation of this.

Our experiences and review of the literature suggest a significant gap in our current understanding of enrollment and engagement issues experienced by various types of interventions targeting diverse groups. It may be important for future brief intervention and longer-term intervention studies to systematically collect, record, and report their enrollment and engagement experiences. Such information would have great value in informing implementers of future interventions about issues they need to consider in being able to successfully carry out their work.

Acknowledgments

Preparation of this manuscript was supported by NIDA Grant # R01-DA-021561, Richard Dembo PI, and NIDA Grant # R21 DA020542, Ken C. Winters PI. The authors are grateful for NIDA's support. However, the research results reported and the views expressed in this paper do not necessarily imply any policy or research endorsement by our funding agency.

References

Al-Halabi Diaz S, Secades-Villa R, Perez JM, Fernanadez-Hermida JR, Garcia-Rodriguez O, Crespo JL. Family Predictors of Parent Participation in an Adolescent Drug Abuse Prevention Program. Drug and Alcohol Review. 2006; 25(4):327–331. [PubMed: 16854658]

Boyd-Franklin N, Smith-Morris T, Bry BH. Parent and Family Support Groups with African American Families: The Process of Family and Community Empowerment. Cultural Diversity and Mental Health. 1997; 3(2):83–92. [PubMed: 9231536]

Breslin C, Li S, Sdao-Jarvie K, Tupker E, Ittig-Deland V. Brief Treatment for Young Substance Abusers: A Pilot Study in an Addiction Treatment Setting. Psychology of Addictive Behaviors. Journal of the Society of Psychologists in Addictive Behaviors. 2002; 16(1):10–16.

Brody GH, Murry VM, Gerrard M, Gibbons FX, Molgaard V, McNair L, Brown AC, et al. The Strong African American Families Program: Translating Research into Prevention Programming. Child Development. 2004; 75(3):900–917. [PubMed: 15144493]

Brown R, Killian E, Evans WP. Familial Functioning as a Support System for Adolescents' Postdetention Success. International Journal of Offender Therapy and Comparative Criminology. 2003; 47(5):529–541. [PubMed: 14526594]

Burke PJ, O'Sullivan J, Vaughan BL. Adolescent Substance Use: Brief Interventions by Emergency Care Providers. Pediatric Emergency Care. 2005; 21(11):770–776. [PubMed: 16280955]

Capaldi DM, Chamberlin P, Fetrow RA, Wilson JE. Conducting Ecologically Valid Prevention Research: Recruiting and Retaining a “Whole Village” in Multimethod, Multiagent Studies. American Journal of Community Psychology. 1997; 25(4):471–492. [PubMed: 9338955]

Catalano RF, Hawkins JD, Wells EA, Miller J, Brewer D. Evaluation of the Effectiveness of Adolescent Drug Abuse Treatment, Assessment of Risks for Relapse, and Promising Approaches for Relapse Prevention. The International Journal of Addictions. 1990–1991; 25(9A/10A):1085–1140.

Clark DB, Winters KC. Measuring Risks and Outcomes in Substance Use Disorders Prevention Research. Journal of Consulting and Clinical Psychology. 2002; 70(6):1207–1223. [PubMed: 12472298]

Coatsworth JD, Santisteban DA, McBride CK, Szapocznik J. Brief Strategic Family Therapy versus Community Control: Engagement, Retention and an Exploration of the Moderating Role of Adolescent Symptom Severity. Family Process. 2001; 40(3):313–332. [PubMed: 11676271]

Coatsworth JD, Duncan LG, Pantin H, Szapocznik J. Retaining Ethnic Minority Parents in a Preventive Intervention: The Quality of Group Process. The Journal of Primary Prevention. 2006; 27(4):367–389. [PubMed: 16802072]

Cohen DA, Linton KLP. Parent participation in an adolescent drug abuse prevention program. Journal of Drug Education. 1995; 25(2):159–169. [PubMed: 7658296]

Dakof GA, Tejeda M, Liddle HA. Predictors of Engagement in Adolescent Drug Abuse Treatment. Journal of the American Academy of Child and Adolescent Psychiatry. 2001; 40:274–281. [PubMed: 11288768]

Dennis M, Godley SH, Diamond G, Tims FM, Babor T, Donaldson J, Liddle H, Titus J, Kaminer Y, Webb C, Hamilton N, Funk R. The Cannabis Youth Treatment (CYT) Study: Main Findings from Two Randomized Trials. Journal of Substance Abuse Treatment. 2004; 27(3):197–213. [PubMed: 15501373]

Dunn C, Deroo L, Rivara FP. The Use of Brief Interventions Adapted from Motivational Interviewing Across Behavioral Domains: A Systematic Review. Addiction (Abingdon, England). 2001; 96(12):1725–1742.

Englebrecht C, Peterson D, Scherer A, Naccarato T. “It's not my fault”:Acceptance of responsibility as a component of engagement in juvenile residential treatment. Children and Youth Services Review. 2008; 30:466–484.

Gingerich WJ, Eisengart S. Solution-focused Brief Therapy: A Review of the Outcome Research. Family Process. 2000; 39(4):477–498. [PubMed: 11143600]

Gottfredson D, Kumpfer K, Polizzi-Fox D, Wilson D, Puryear V, Beatty P, Vilmenay M. The Strengthening Washington D.C. Families Project: A Randomized Effectiveness Trial of Family-Based Prevention. Prevention Science. 2006; 7(1):57–74. [PubMed: 16555144]

Grenard JL, Ames SL, Pentz MA, Sussman S. Motivational Interviewing with Adolescents and Young Adults for Drug-Related Problems. International Journal of Adolescent Medicine and Health. 2006; 18(1):53–67. [PubMed: 16639859]

Haggerty K, MacKenzie E, Skinner M, Harachi T, Catalano R. Participation in “Parents Who Care”: Predicting Program Initiation and Exposure in Two Different Program Formats. The Journal of Primary Prevention. 2006; 27(1):47–65. [PubMed: 16421658]

Henggeler, SW.; Mihalic, SF.; Rone, L.; Thomas, C.; Timmons-Mitchell, J. Blueprints for Violence Prevention, Book Six: Multisystemic Therapy. Center for the Study and Prevention of Violence; Boulder, CO: 1998.

Heinrichs N, Bertram H, Kuschel A, Hahlweg K. Parent Recruitment and Retention in a Universal Prevention Program for Child Behavior and Emotional Problems: Barriers to Research and Program Participation. Prevention Science. 2005; 6:275–286. [PubMed: 16075192]

Heinrichs N. The Effects of Two Different Incentives on Recruitment Rates of Families into a Prevention Program. The Journal of Primary Prevention. 2006; 27(4):345–365. [PubMed: 16802074]

Hillsborough County Sheriff's Office. Standard operating procedure. Author; Tampa, FL: 1997. (ENF 705.02)

Jackson-Gilfort A, Liddle H, Tejeda M, Dakof G. Facilitating Engagement of African-American Adolescents in Family Therapy: A Cultural Theme Process Study. Journal of Black Psychology. 2001; 27:321–340.

Lee S, August G, Bloomquist M, Mathy R, Realmuto G. Implementing an Evidence-Based Preventive Intervention in Neighborhood Family Centers: Examination of Perceived Barriers to Program Participation. The Journal of Primary Prevention. 2006; 27:573–597. [PubMed: 17039398]

Liddle, HA. Family Therapy Techniques for Adolescents with Drug and Alcohol Problems. In: Synder, W.; Ooms, T., editors. Empowering Families (ADAMHA Monograph from the first National Conference on the Treatment of Adolescent Drug, Alcohol and Mental Health Problems.). U.S. Public Health Service, U.S. Government Printing Office; Washington, D.C.: 1992.

Liddle H, Jackson-Gilfort A, Marvel F. An Empirically Supported and Culturally Specific Engagement and Intervention Strategy for African American Adolescent Males. American Journal of Orthopsychiatry. 2006; 75:215–225. [PubMed: 16719641]

Marsden J, Stillwell G, Barlow H, Boys A, Taylor C, Hunt N, Farrell M. An Evaluation of a Brief Motivational intervention Among Young Ecstasy and Cocaine Users: No Effect on Substance and Alcohol Use Outcomes. Addiction (Abingdon, England). 2006; 101(7):1014–1026.

McCambridge J, Slym RL, Strang J. Randomized Controlled Trial of Motivational Interviewing Compared with Drug Information and Advice for Early Intervention Among Young Cannabis Users. Addiction (Abingdon, England). 2008; 103(11):1809–1818.

Mensinger JL, Diamond GS, Kaminer Y, Wintersteen MB. Adolescent and Therapist Perception of Barriers to Outpatient Substance Abuse Treatment. The American Journal on Addictions. 2006; 15(Supplemental 1):16–25. [PubMed: 17182416]

Mitrani V, Prado G, Feaster D, Robinson-Batista C, Szapocznik J. Relational Factors and Family Treatment Engagement among Low-Income, HIV-Positive African American Mothers. Family Process. 2003; 42:31–45. [PubMed: 12698597]

Orrel-Valente JK, Pinderhughes EE, Valente E Jr. Laird RD. If it's offered, will they come? Influences on Parents' Participation in a Community-Based Conduct Problems Prevention Program. American Journal of Community Psychology. 1999; 27(6):753–783. [PubMed: 10723534]

Pelkonen M, Martunnen M, Paippala P, Lonnquist J. Factors Associated with Early Dropout from Adolescent Psychiatric Outpatient. Journal of the American Academy of Child and Adolescent Psychiatry. 2000; 39(3):329–336. [PubMed: 10714053]

Peterson PL, Baer JS, Wells EA, Ginzler JA, Garrett SB. Short-term Effects of a Brief Motivation Intervention to Reduce Alcohol and Drug Risk Among Homeless Adolescents. Psychology of Addictive Behaviors. Journal of the Society of Psychologies in Addictive Behaviors. 2006; 20(3): 254–264.

Prinz R, Smith E, Dumas J, Laughlin J, White D, Barron R. Recruitment and Retention of Participants in Prevention Trials Involving Family-Based Interventions. American Journal of Preventative Medicine. 2001; 20:31–37.

Santisteban DA, Coatsworth JD, Perez-Vidal A, Kurtines WM, Schwartz SJ, LaPerriere A, Szapocznik J. The Efficacy of Brief Stratiegic/Structural Family Therapy in Modifying Behavior Problems and an Exploration of the Mediating Role that Family Functioning Plays in Behavior Change. Journal of Family Psychology. 2003; 17(1):121–133. [PubMed: 12666468]

Santisteban DA, Szapocznik J, Perez-Vidal A, Kurtines W, Murray EJ, LaPerriere A. Efficacy of Brief Strategic Family Therapy in Modifying Hispanic Adolescent Behavior Problems and Substance Use. Journal of Family Psychology: JFP. Journal of the Division of Family Psychology of the American Psychological Association (Division 43). 1996; 17(1):121–133.

Sinha R, Easton C, Renee-Aubin L, Carroll KM. Engaging Youth Probation Referred Marijuana-Abusing Individuals in Treatment: A Pilot Trial. The American Journal on Addictions/American Academy of Psychiatrists in Alcoholism an Addictions. 2003; 12(4):314–323.

Spoth R, Redmon C, Shin C, Azevedo K. Brief Family Intervention Effects on Adolescent Substance Initiation: School-level Growth Curve Analyses 6 years Following Baseline. Journal of Consulting and Clinical Psychology. 2004; 72(3):535–542. [PubMed: 15279537]

Stern SA, Meredith LS, Gholson J, Gore P, D'Amico EJ. Project CHAT: A Brief Motivational Substance Abuse Intervention for Teens in Primary Care. Journal of Substance Abuse Treatment. 2007; 32(2):153–165. [PubMed: 17306724]

Szapocznik J, Perez-Vidal A, Brickman AL, Foote FH, Santisteban d. Hervis O. Engaging Adolescent Drug Abusers and Their Families in Treatment: Structual Systems Approach. Journal of Consulting and Clinical Psychology. 1988; 56:552–557. [PubMed: 3198813]

Wierzbicki M, Pekarik G. A Meta-Analysis of Psychotherapy Drop-out. Professional Psychology Research and Practice. 1993; 24(2):190–195.

Winters KC. Development of an Adolescent Alcohol and Other Drug Abuse Screening Scale: Personal Experience Screening Questionnaire. Addictive Behaviors. 1992; 17(5):479–490. [PubMed: 1332434]

Winters KC, Leitten W. Brief Intervention for Drug-Abusing Adolescents in a School Setting. Psychology of Addictive Behaviors. 2007; 21(2):249–254. [PubMed: 17563146]

Table 1

Enrollment Issues in Intervention

Experience Themes	Brief Prevention/Intervention	Long Term Intervention	
		Prevention	Treatment
Enrollment			
Denial	Δ	Cohen & Linton, 1995	
Intervention Value/Relevance	Δ Mensinger et al., 2006;Al-Halabi Diaz et al., 2006		Mensinger et al., 2006
Logistical Support/Practical Obstacles	Δ		
Enabling	Δ		
Morphing Problems	Δ		
Initial Rapport		Capaldi et al., 1997; Prinz et al., 2001	
Stigmatization		Prinz et al., 2001; Cohen & Linton, 1995	Haggerty et al., 2006
Mistrust of Research	Δ		
Concern Invasion of Privacy		Heinrichs et al., 2005	
Payment for Enrollment	Δ	Heinrichs, 2006; Capaldi et al., 1997	

Δ Indicates issues encountered in the Brief Intervention Truancy project and Brief Intervention Court project

Table 2

Engagement / Retention Issues in Intervention

Experience Themes	Brief Prevention/Intervention	Long Term Intervention	
		Prevention	Treatment
Engagement / Retention			
Staff/Client Match	Δ Mensinger et al.,2006	Orrell-Valente et al., 1999 Prinz et al., 2001; Boyd-Franklin et al.,1997	Mensinger et al., 2006 Coatsworth et al., 2006
Client/Family Transience	Δ	Capaldi et al., 1997	
Parent/Family Dysfunction Problems	Δ Al-Halabi Diaz et al., 2006	Orrell-Valente et al., 1999 Gottfredson et al., 2006	
Parent Attempt to Obtain Nurturance	Δ		
Need for Cultural Themes		Brody et al.,2004	Boyd-Franklin et al., 1997 Jackson-Gilfort et al.,2001 Liddle et al., 2006
Treatment Readiness	Mensinger et al., 2006		Mensinger et al., 2006
Logistical Support/Practical Obstacles	Δ Mesninger et al., 2006	Capaldi et al., 1997; Heinrichs et al., 2005 Lee et al., 2006	Brown et al., 2003 Mitrani et al., 2003 Mensinger et al., 2006
Payment for Retention	Δ	Heinrichs, 2006; Capaldi et al., 1997	
Family Support			Mitrani et al., 2003; Brown et al., 2003
Maintaining Contact	Δ	Capaldi et al., 1997	
Duality of Participant		Coatsworth et al., 2006	

Δ Indicates issues encountered in the Brief Intervention Truancy project and Brief Intervention Court project.