

Integrating Evidence-Based Engagement Interventions Into “Real World” Child Mental Health Settings

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This article focuses on an attempt to integrate evidence-based engagement interventions into “real world” outpatient child mental health settings in order to increase access to care for urban youth and their families. More specifically, empirical support for introducing engagement interventions into child clinical settings will be reviewed. Then, specific engagement interventions that are delivered during the initial telephone contact with a child’s adult caregiver or during the first face-to-face contact with a child and family are described with attention paid to the training necessary to assist service providers in adopting this change in practice. Factors that serve to facilitate or impede adoption of evidence-based engagement interventions are also reviewed. Finally, preliminary evidence for the effectiveness of integrating such evidence-supported approaches is presented. [*Brief Treatment and Crisis Intervention* 4:177–186 (2004)]

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In the early 1980s, Knitzer (1982) severely criticized the child mental health service delivery system as failing to respond to youths in serious need of mental health care. Two decades later, rates of child mental health difficulties remain at alarming levels, with an estimated

17% to 26% of youths in need of mental health care across the United States (Brandenburg, Friedman, & Silver, 1987; McCabe et al., 1999; NIMH, 2001; Tuma, 1989). Within low-income urban communities, rates of child mental health need have been found to be even higher, with as many as 40% of youths exhibiting significant mental health issues (Tolan & Henry, 1996). Yet, despite the presence and recognition of significant need among our nation’s children, evidence continues to accumulate that children are not receiving adequate mental health care (Burns et al., 1995; DHHS, 1999; Kadzin, 1993; McKay, McCadam, & Gonzales, 1996; McKay, Stoewe, McCadam, & Gonzales, 1998).

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This situation is most unfortunate, given that over the last two decades, there have been important advances in the area of child mental health, including understanding of the etiology of child mental health difficulties, as well as recent findings linking evidence-based services with significant reductions in child mental health difficulties (DHHS, 1999). Thus, supporting the current child mental health service delivery system and introducing new knowledge while simultaneously increasing access and utilization of care has become a national priority. In fact, closing the gap between youth in need of mental health care and receipt of the most appropriate, empirically supported care has been identified by the U.S. Surgeon General as one of the most significant public health issues for the nation to address (DHHS, 1999; U.S. Public Health Service [USPHS] 2001, 2002).

This article will focus on an attempt to integrate evidence-based engagement interventions (the method providers use to assist youth and families in overcoming obstacles, thereby involving youth in needed mental health services) into “real world” outpatient child mental health settings in order to increase access to care for urban youth and their families. More specifically, empirical support for introducing engagement interventions into child clinical settings will be reviewed. Then, specific engagement interventions that are delivered during the initial telephone contact with a child’s adult caregiver or during the first face-to-face contact with a child and family are described with attention paid to the training necessary to assist service providers in adopting this change in practice. Factors that serve to facilitate or impede adoption of evidence-based engagement interventions are overviewed here. Finally, evidence for the potential effectiveness of such evidence-based approaches is presented.

Issues Related to Engaging Youth and Their Families in Mental Health Care

According to numerous recent reports and studies (U.S. Public Health Service, 2000, 2001; NIMH, 2001; Ringel & Sturm, 2001), the majority of all children with mental health problems do not receive any mental health service. For example, a report by the National Institute of Mental Health (NIMH, 2001) concluded that approximately 75% of children with mental health needs did not receive any type of mental health care, with the disparity between need and use of services highest among youth of minority groups. These rates are identical to those reported in the mid-1980s by the Office of Technology Assessment (U.S. Congress, 1986), indicative of the fact that the level of need for services remains unchanged despite decades of scientific progress in developing evidence-based assessments, treatments, and services for children.

Further, addressing the particular disparities that exist for youth of color in terms of receiving appropriate, high-quality care has been urgently emphasized (Padgett, Patrick, Burns, Schlesinger, & Cohen, 1993). Addressing the mental health needs of minority-group youth living in urban areas has emerged as a most critical issue given the substantial evidence that these youths are the most deeply affected by the stressors that exist within inner-city communities, notably poverty, community violence, inadequate child serving resources, undersupported schools, substance abuse, and multiple health epidemics (Attar, Guerra, & Tolan, 1994; Weist et al., 2001).

Barriers That Impact Parents’ Obtaining Needed Mental Health Care for Their Children

Over the last 10 years, research has identified numerous barriers to urban youth receiving the

care that they need and deserve (USPHS, 2001). Kazdin and colleagues in a series of articles (Kazdin, Holland, & Crowley, 1997; Kazdin & Wassell, 2000) have examined the impact of perceptions of barriers by families on treatment participation in outpatient care. Most notably, Nock and Kazdin (2001) found that parent expectations predicted subsequent barriers to treatment participation and premature termination from therapy. Recently, Kazdin and Wassell (2000) found that barriers to participation in treatment also were significantly associated with therapeutic change. Although studies examining the impact of perceived barriers are rare, MacNaughton (2001) examined predictors of parents' adherence to recommendations made by psychologists after the evaluation of clinic-referred children. Perceived barriers were the most salient predictor of adherence to recommendations. The implication is that continuity of care may be seriously compromised if the perception of barriers by families is high.

Family perceptions of aspects of the therapeutic relationship and the degree to which the families are involved in service planning have also emerged as important issues (Garcia & Weisz, 2002; Koren et al., 1997; McCabe et al., 1999). Garcia and Weisz (2002) examined factors that distinguished treatment completers from treatment dropouts. The factor that accounted for the largest variance and distinguished dropouts from completers was therapeutic relationship problems. In addition, parental attitudes about mental health services, parental discipline efficacy, family stress and presence, and encouragement from social support networks to seek help have been found to be significantly related to keeping a first appointment within an outpatient mental health program and to longer lengths of stay in services for urban youth and their families (McKay, Pennington, Lynn, & McCadam, 2001; Harrison, McKay, & Bannon, in press). Also, the

match between parental preference for type of service offered to children and what the child actually receives has been significantly associated with longer lengths of involvement in child mental health care (Bannon & McKay, in press). Further, types of service—with more innovations, such as multiple family groups or school-based services—have also been found to be positively related to ongoing involvement in child mental health services (Atkins et al., 1998; McKay, Harrison, Gonzales, Kim, & Quintana, 2002; McKay, Quintana, Kim, Gonzales, & Adil, 1999).

Cultural issues related to factors that predict termination also play a role in understanding these processes (McCabe et al., 1999; Snowden, 2001; Richardson, 2001). For example, McCabe et al. (1999) identified factors that predict premature termination among Mexican American children in outpatient psychotherapy. Parents who were less educated, who felt that they and their child should be able to overcome the child's mental health problems on their own, and who felt that emotional and behavioral problems should be handled by increasing discipline were more likely to terminate prematurely. In addition, parents who perceived more barriers to treatment and expected their child to recover quickly were more likely to drop out of treatment after attending just one session. McCabe et al. suggested that more culturally sensitive interventions are needed to improve retention and prevent dropout. Richardson (2001) similarly found distinct differences between African American and white parents in the types of attitudes they held toward mental health services, with African American parents reporting more negative expectations. These findings suggest that attitudes and expectations may influence not only parents' decisions to seek mental health care for their child, but also their interest in ongoing involvement with the mental health system for children. Thus, collaborating with parents to

ensure access to care for children and actively intervening to enhance rates of attendance and involvement in care are clearly needed.

Interventions to Increase Involvement in Mental Health Services

Although there is a clear need for additional research in order to understand what strategies increase service use for youth and their families, there is strong evidence that intensive engagement interventions implemented during initial contacts with youth and their families, either on the telephone or during a first interview, can boost service use substantially. For example, several studies have shown that telephone intake procedures that go beyond information gathering and focus on overcoming potential barriers to service involvement can substantially increase both attendance at initial appointments and ongoing service involvement. Shivack and Sullivan (1991) reported a 32% increase in attendance when the clients were simply reminded of their appointment.

Szapocznik and colleagues (1988) achieved significant success engaging adolescent substance abusers and their families through use of an intensive, family-focused engagement intervention delivered via the telephone. Of the families that were randomly assigned to the "business as usual" intake process, 57.7% failed to come to their first clinic appointment. In comparison, 7.1% of families in the intensive engagement condition failed to attend their intake appointment. There are also indications that the engagement method had impact beyond attendance at intake. In the comparison condition, 41% of families that were engaged eventually dropped out of treatment prematurely, whereas only 17% of families intensively engaged later dropped out of the services (Santisteban et al., 1996; Szapocznik et al., 1988). This significant success can be attributed

to the intervention that frames the initial contact with the adult caregiver of the youth as the beginning of service provision. The provider attempts to establish a working alliance with the caregiver and develop strategies that will help all family members attend an intake appointment. Further, the provider often reaches out to other family members who are defined as critical to successful involvement in services.

In another series of published articles, details of a telephone and first interview engagement intervention are presented (McKay, McCadam, et al., 1996; McKay, Nudelman, & McCadam, 1996; McKay et al., 1998). More specifically, an intensive telephone engagement strategy was tested within urban child mental health settings. This telephone engagement intervention was associated with an approximately 30% increase in attendance at initial clinic appointments (see McKay, McCadam, et al., 1996, 1998, for details). Again, this strategy utilized the first telephone contact with an adult caregiver as an opportunity to intervene beyond the typical goal of gathering information. This intervention sought to: (1) clarify for both the caregiver and the provider the need for child mental health care, (2) maximize the caregiver's investment and efficacy in relation to help seeking, (3) identify attitudes about and previous experiences with mental health care that might dissuade the adult from bringing the child for services, and (4) develop strategies to overcome concrete obstacles, such as lack of time, transportation, and child care issues.

Additional engagement strategies have also been tested to increase families' length of stay in outpatient child mental health services, as early termination is an often-cited difficulty. For example, a test of a first interview engagement intervention revealed a significant increase in the number of child mental health sessions and fewer dropouts with a sample of urban families (McKay, Nudelman, et al., 1996). This first interview engagement strategy con-

sisted of working on the following tasks during the first face-to-face contact with the youth and his or her family: (1) clarification of the roles of the worker, agency, intake process, and possible service options, (2) setting the foundation for a collaborative working relationship, (3) identification of concrete, practical issues that can be immediately addressed, and (4) development of a plan to overcome barriers to ongoing involvement with the agency. These same telephone and first interview engagement interventions are being integrated into 11 outpatient child mental health sites across a large metropolitan area and are described next.

Integrating Evidence-Based Engagement Interventions into Child Mental Health Settings

Overview

Currently, within 11 sites providing outpatient child mental health services, four to eight staff members who interact with families, including both clinical staff and reception/administrative staff, have received a 1-day training focused on engaging youth presenting with mental health needs and their families in outpatient services. In addition, at each of the sites, an “engagement team” has been organized, consisting of the site’s intake workers, representatives from the clinical and administrative staff, and supervisors. This team oversees the implementation of engagement interventions at each site. Further, monthly meetings with each site team to fine-tune interventions and collect child mental health usage outcome data are ongoing.

Training Description

The *Engaging Youth and Families* training is an 8-hour intensive workshop with the goal of enhancing understanding of child, family, community, and system barriers to child mental

health care and helping service providers develop a set of strategies for youth and their families to overcome these barriers.

The training is divided into two sections: (1) first contact engagement skills and (2) initial interview engagement skills. Both sections of the training address the barriers that make it difficult for youth and families to receive services, through an examination of factors that serve to facilitate or impede service use at the level of the family, the child/youth, the agency setting, and the environmental context. Provider participants have in-depth discussions on key barriers, such as the stigma associated with seeking mental health care, mistrust of professionals, fear of being blamed, and discouragement by other family members. In addition, trainees practice utilizing different approaches to engaging urban families through participation in training exercises specifically designed to promote development of new skills. Furthermore, continuous proactive problem solving around concrete obstacles to care and service involvement is encouraged.

Key Training Elements

The first portion of the training familiarizes provider participants with evidence-based engagement interventions and the importance of research in producing and fine-tuning engagement strategies. This is accomplished through a brief but meaningful look at existing research studies upon which the current engagement training is based. Published findings supporting evidence-based engagement interventions is provided to all participants. A key component of this segment of the training highlights the importance of evaluating any new engagement procedures that are implemented as a result of the training. Next, provider participants focus on the identification and utilization of telephone engagement skills in order to help parents/caregivers invest

initially in treatment for their child; and, perhaps most importantly, provider participants actively work on developing active problem-solving skills. These problem-solving skills are to be applied as the parent/caregiver identifies barriers during the initial telephone contact that impede the family from coming to the initial face-to-face appointment. The discussions and exercises assist trainees to rethink misconceptions of barriers to involvement in mental health services, specifically those related to lack of time, transportation, child care, perceptions of services and staff, and competing priorities. Race, ethnic/cultural issues, recognition of poverty, and issues of safety versus community violence are all crucial elements of the instructional process and are emphasized as considerations to be aware of throughout the telephone engagement process.

The second half of the training focuses on preparing for the initial face-to-face interview with a child and his/her family. More specifically, the training focuses on identification and utilization of essential skills that set the foundation for engaging a youth and family in the service process. A primary skill that the training focuses on is fostering workers' abilities to form collaborative working relationships with adult caregivers and youths. Collaboration means specifically balancing the requirement to obtain information that agencies need for funding purposes (assessment forms, insurance forms, etc.) with helping the children/parents to "tell their own story" about the presenting issues. Providers are taught that during this first face-to-face interaction, they should focus on identifying an immediate and practical concern that can be addressed rapidly to encourage ongoing involvement. Furthermore, provider participants learn techniques that are meant to foster commitment by the family and increase perceptions of potential helpfulness of mental health care. Finally, trainees learn how to emphasize the develop-

ment of a shared language and understanding in an effort to build a solid foundation for future work together.

All of the discussions and activities throughout the training underscore how critical it is for providers to develop and utilize focused and culturally sensitive engagement skills that address the range of barriers that can exist within families, urban environments, and agencies and that potentially interfere with the process of engagement. In addition, provider participants begin to see engagement as an undeniably necessary step to any service provision and worth increased time in order to ensure that a youth and her/his adult caregiver return for ongoing care.

Training Activities

The activities throughout the training help to clarify concepts, generate discussion, and enhance learning. The activities are designed to elicit innovative approaches to real situations and issues that providers encounter with youth and families. The realness and authenticity of the activities have benefited by the participation of a group of parent consumers who helped to create the activities and also produced a video entitled *I Went for an Intake and Never Came Back*. Thus, training activities include active exercises (role-plays, scenarios, and group work), the video, and visual aids. The video of "real" parents voicing their concerns about the care that they or their child received in the mental health or helping system allows provider participants the opportunity to discuss and respond to parent concerns and issues within an atmosphere that promotes self-examination and reduces defensiveness. At the conclusion of the video, provider participants offer recommendations in their own words on how to engage the parents in the film and address their prior negative experiences.

Challenges to Implementation of Evidence-Based Engagement Interventions

Several challenges arise in the training of providers within “real world” agencies on new strategies to promote engagement of youth and families. Even before training staff, agency leadership must see the benefits and the need for the training. Given the evidence that clients’ past perceptions of their interactions with helper-professionals have a significant impact on whether they seek and/or continue services, it is imperative that leadership understands that support staff, such as administrative assistants, receptionists, and security are seen by clients as part of the “helper” group and have an impact in client retention. These support staff often have “first contact” with clients long before clients see or even speak to a clinician or intake worker and therefore must be involved in client engagement training. The challenge is to get the leadership to start thinking “outside the box” long before the training ever begins.

The challenge to help clinicians and support staff think innovatively about the way they approach engaging clients is a central theme in the training. This involves staff recognizing barriers they have themselves set up (e.g., “I’ve tried everything”; blaming; using the label “resistant client”) and looking at system and/or agency barriers (e.g., crowded waiting rooms, lengthy intake processes). In addition, the training is meant to assist support staff in thinking of themselves as an integral part of the team that has an impact on client perceptions about the agency and on retention. Many of these challenges imply underlying value shifts within agencies about how they see and work innovatively with clients.

Preliminary Evaluation

Preliminary implementation data suggest positive response to the training by providers,

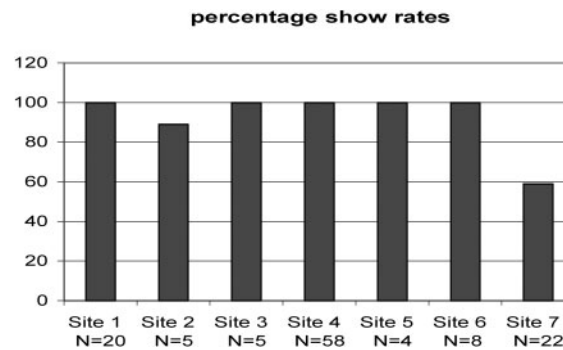


Figure 1

Rates of return after initial appointment by site.

a willingness to organize staff around issues of engagement across sites, and the creation of data tracking mechanisms at each of the sites and indicate that engagement interventions are being implemented during initial client contacts. Preliminary data from the first of seven outpatient child mental health sites are summarized in Figure 1.

As Figure 1 shows, several of the sites have been able to achieve 100% show rates from first to second contact at their agencies. The lowest rate of return is 60% at one site. These rates of return are in considerable contrast with published data suggesting that 50% no-show rates and failure to return are extremely common (Kazdin & Wassell, 2000; McKay, McCadam, et al., 1996). As the study of the rates of engagement continue in each of these outpatient sites over the next year, these rates of show can be considered as only trends until data collection on many more families has been completed.

Conclusion

In several studies, Weisz and collaborators have raised the awareness of the child mental health services research field regarding important differences between providers who deliver services within tightly controlled clinical trials

and those who provide services within real-world settings (Weisz, 2000; Weisz & Hawley, 1998; Weisz, Weiss, & Donenberg, 1992). Further, there is increasing recognition that if we want evidence-based services to be applied in such real-world settings, then providers within these settings must be capable of delivering them to their client populations within the constraints of their agencies' policies and procedures. Thus, the engagement intervention training described here represents an important step to supporting real-world providers in implementing changes in their practice that are necessary to increase access to youth and their families in need.

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References

- Atkins, M. S., McKay, M., Arvanitis, P., London, L., Madison, S., Costigan, C., et al. (1998). Ecological model for school-based mental health services for urban low income aggressive children. *Journal of Behavioral Health Services and Research, 5*, 64–75.
- Attar, B. K., Guerra, N. G., & Tolan, P. H. (1994). Neighborhood disadvantage, stressful life events, and adjustment in urban elementary-school children. *Journal of Clinical Child Psychology, 23*, 391–400.
- Bannon, W., & McKay, M. (in press). Youth need or parental preferences: Which relates to urban child mental health service use? *Families in Society*.
- Brandenburg, N. A., Friedman, R. M., & Silver, S. E. (1987). The epidemiology of childhood psychiatric disorders: Prevalence findings from recent studies. *Journal of the American Academy of Child and Adolescent Psychiatry, 29*, 76–83.
- Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangi, D., Farmer, E., et al. (1995). Children's mental health service use across service sectors. *Health Affairs, 14*, 147–159.
- DHHS [U.S. Department of Health and Human Services]. (1999). *Mental health: A report of the surgeon general*. Rockville, MD: Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
- Garcia, J. A., & Weisz, J. R. (2002). When youth mental health care stops: Therapeutic relationship problems and other reasons for ending youth outpatient treatment. *Journal of Consulting & Clinical Psychology, 70*, 439–443.
- Harrison, M., McKay, M., & Bannon, W. (in press). Inner-city child mental health service use: The real question is why youth and families do not use services. *Community Mental Health Journal*.
- Kazdin, A. E. (1993). Adolescent mental health: Prevention and treatment programs. *American Psychologist, 48*, 127–141.
- Kazdin, A. E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology, 65*, 453–463.
- Kazdin, A. E., & Wassell, G. (2000). Predictors of barriers to treatment and therapeutic change in outpatient therapy for antisocial children and their families. *Mental Health Services Research, 2*, 27–40.
- Knitzer, J. (1982). Children's rights in the family and society: Dilemmas and realities. *American Journal of Orthopsychiatry, 52*, 481–495.
- Koren, P. E., Paulson, R. I., Kinnery, R. F., Yatchmenoff, D. K., Gordon, L. J., & DeCillo, N. (1997). Service coordination in children's mental health: An empirical study from the caregiver's perspective. *Journal of Emotional & Behavioral Disorders, 7*(2), 72–82.
- MacNaughton, K. (2001). Predicting adherence to recommendations by parents of clinic-referred children. *Journal of Consulting & Clinical Psychology, 69*, 262–270.
- McCabe, K., Yeh, M., Hough, R. L., Landsverk, J., Huriburt, M. S., Culver, S. W., et al. (1999). Racial/ethnic representation across five public

- sectors of care for youth. *Journal of Emotional and Behavioral Disorders*, 7, 72–82.
- McKay, M., Harrison, M., Gonzales, J., Kim, L., & Quintana, E. (2002). Multiple family groups for urban children with conduct difficulties and their families. *Psychiatric Services*, 53, 1467–1469.
- McKay, M., McCadam, K., & Gonzales, J. (1996). Addressing the barriers to mental health services for innercity children and their caretakers. *Community Mental Health Journal*, 32, 353–361.
- McKay, M., Nudelman, R., & McCadam, K. (1996). Involving inner-city families in mental health services: First interview engagement skills. *Research on Social Work Practice*, 6, 462–472.
- McKay, M., Pennington, J., Lynn, C. J., & McCadam, K. (2001). Understanding urban child mental health service use: Two studies of child, family, and environmental correlates. *Journal of Behavioral Health Services & Research*, 28, 1–10.
- McKay, M., Quintana, E., Kim, L., Gonzales, J., & Adil, J. A. (1999). Multiple family groups: An alternative for reducing disruptive behavioral difficulties of urban children. *Research on Social Work Practice*, 9, 414–428.
- McKay, M., Stoewe, J., McCadam, K., & Gonzales, J. (1998). Increasing access to child mental health services for urban children and their care givers. *Health and Social Work*, 23, 9–15.
- NIMH [National Institute of Mental Health]. (2001). *Blueprint for change: Research on child and adolescent mental health*. National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment. Washington, DC: Author.
- Nock, M., & Kazdin, A. (2001). Parent expectancies for child therapy: Assessment and relation to participation in treatment. *Journal of Child & Family Studies*, 10, 155–180.
- Padgett, D. K., Patrick, C., Burns, B. J., Schlesinger, H. J., & Cohen, J. The effect of insurance benefit changes on use of child and adolescent outpatient mental health services. *Medical Care*, 31, 96–110.
- Richardson, L. A. (2001). Seeking and obtaining mental health services: What do parents expect? *Archives of Psychiatric Nursing*, 15, 233–241.
- Ringel, J., & Sturm, R. (2001). National estimates of mental health utilization and expenditures for children in 1998. *Journal of Behavioral Health Services & Research*, 28, 319–333.
- Santisteban, D. A., Szapocznik, J., Perez-Vidal, A., Kurtines, W., Murray, E. J., & LaPerriere, A. (1996). Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness. *Journal of Family Psychology*, 10, 35–44.
- Shivack, N., & Sullivan, T. (1991). Use of telephone prompts at an inner-city patient clinic. *Hospital and Community Psychiatry*, 40, 851–853.
- Snowden, L. R. (2001). Barriers to effective mental health services for African Americans. *Mental Health Services Research*, 3, 181–187.
- Szapocznik, J., Perez-Vidal, A., Brickman, A. L., Foote, F. H., Santisteban, D. A., Hervis, O. E., et al. (1988). Engaging adolescent drug abusers and their families into treatment: A strategic structural systems approach. *Journal of Consulting and Clinical Psychology*, 56, 552–557.
- Tolan, P. H., & Henry, D. (1996). Patterns of psychopathology among urban poor children: Comorbidity and aggression effects. *Journal of Consulting and Clinical Psychology*, 64, 1094–1099.
- Tuma, J. M. (1989). Mental health services for children: The state of the art. *American Psychologist*, 44, 188–199.
- U.S. Congress, Office of Technology Assessment (1986). *Children's mental health: Problems and services—a background paper*. OTA-BP-H-33. Washington, DC: U.S. Government Printing Office.
- U.S. Public Health Service. (2000). *Report of the surgeon general's conference on children's mental health: A national action agenda*. Washington, DC: Department of Health and Human Services.
- U.S. Public Health Service. (2001). *Youth violence: A report of the surgeon general*. Washington, DC: Department of Health and Human Services.
- Weist, M. D., Acosta, O. M., & Youngstrom, E. A. (2001). Predictors of violence exposure among inner-city youth. *Journal of Clinical Child Psychology*, 30, 187–198.

- Weisz, J. R. (2000). Agenda for child and adolescent psychotherapy research: On the need to put science into practice. *Archives of General Psychiatry, 57*, 837–838.
- Weisz, J. R., & Hawley, K. M. (1998). Finding, evaluating, refining, and applying empirically supported treatments for children and adolescents. *Journal of Clinical Child Psychology, 27*, 206–216.
- Weisz, J. R., Weiss, B., & Donenberg, G. R. (1992). The lab versus the clinic: Effects of child and adolescent psychotherapy. *American Psychologist, 47*, 1578–1585.