# Treatment engagement of individuals experiencing mental illness: review and update

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*Individuals living with serious mental illness are often difficult to engage in ongoing treatment, with high dropout rates. Poor engagement may lead to worse clinical outcomes, with symptom relapse and rehospitalization. Numerous variables may affect level of treatment engagement, including therapeutic alliance, accessibility of care, and a client's trust that the treatment will address his/her own unique goals. As such, we have found that the concept of recovery-oriented care, which prioritizes autonomy, empowerment and respect for the person receiving services, is a helpful framework in which to view tools and techniques to enhance treatment engagement. Specifically, person-centered care, including shared decision making, is a treatment approach that focuses on an individual's unique goals and life circumstances. Use of person-centered care in mental health treatment models has promising outcomes for engagement. Particular populations of people have historically been difficult to engage, such as young adults experiencing a first episode of psychosis, individuals with coexisting psychotic and substance use disorders, and those who are homeless. We review these populations and outline how various evidence-based, recovery-oriented treatment techniques have been shown to enhance engagement. Our review then turns to emerging treatment strategies that may improve engagement. We focus on use of electronics and Internet, involvement of peer providers in mental health treatment, and incorporation of the Cultural Formulation Interview to provide culturally competent, person-centered care. Treatment engagement is complex and multifaceted, but optimizing recovery-oriented skills and attitudes is essential in delivery of services to those with serious mental illness.*

**Key words:** Engagement, recovery, schizophrenia, shared decision making, person-centered care, first episode psychosis, alliance

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Individuals living with serious mental illness are often difficult to engage in ongoing treatment, and dropout from treatment is all too common. According to data from both the U.S. National Comorbidity Survey and the Epidemiologic Catchment Area survey, up to half of individuals with a serious mental illness had not received mental health treatment in the prior year[1]. Poor engagement may lead to exacerbation of symptoms, rehospitalization, and not fully realizing the potential benefits of treatment.

Because numerous factors contribute to maintaining someone's commitment to and willingness to engage in treatment or causing someone to leave, it is a challenge to outline key components to enhance engagement[2]. Disengagement may be related to issues of utility (people feel the treatment is not working), attitude (people feel mistrustful, or coerced), or practical reasons (treatment may be difficult to get to, difficult to schedule). There is not a one-size-fits-all approach, as engagement occurs in the context of an individual's unique personality, social and life circumstances, and symptom burden. In order to most effectively improve treatment engagement, approaches that target any and all of these presumed roadblocks may be used. In this review we highlight various innovations in mental health treatment, both practical and conceptual, which have been shown to improve engagement in this treatment.

We have found it helpful to view techniques and tools for increasing engagement within the framework of "recovery-oriented care". Recovery, as defined by the Substance Abuse and Mental Health and Services Administration (SAMHSA) in the U.S., is "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential"[3]. The recovery movement embodies a shift in attitude and clinical approach that has been emerging over the past few decades, with the President's New Freedom Commission report recommending that mental health care be recovery-oriented, consumer- and family-driven[4]. Four dimensions of recovery-oriented practice are promoting citizenship, organizational commitment, supporting personally defined goals, and a strong working relationship[5]. The approaches we review below are all promising ways for service providers to increase engagement in those with serious mental illness, assuming a recovery-oriented stance.

One very important feature of recovery-oriented care is its explicit prioritization of autonomy, empowerment and respect for the person receiving services[6,7]. As such, we outline factors that may enhance a client's experience of mental health treatment and hope for recovery. We discuss critical factors for the therapeutic alliance, shared decision making, and person-centered care, as related to treatment engagement. Next, we discuss how these have been applied within a few populations that are thought to be "difficult to engage", and show how various recovery-oriented practices have helped improve engagement. We then more closely focus on some specific practices, and describe how incorporating these into a treatment model may enhance engagement. We conclude by outlining the difficulties of engagement from the provider's standpoint, and ways that this can be addressed as the field of mental health services evolves.

## ATTITUDES AND INTERPERSONAL FOCUS

### The therapeutic alliance

In her qualitative analysis of young adults engaged in treatment for first episode psychosis, Stewart[8] theorizes that the quality of relationships developed in the treatment process

between providers and recipients may serve an important role in determining success of engagement.

Alliance is one component of treatment relationships that has been examined empirically, and has been described as the dynamic ability to work together in the interest of problem solving, with three elements: goals, task and bond. It has been consistently shown to be a chief predictor of successful outcomes in psychotherapy[9].

Alliance has also been found to be important in work with individuals who have serious mental illness. Frank and Gunderson[10] measured working alliance among patients receiving treatment for schizophrenia and found that individuals who were able to form a good alliance with their therapists within the first 6 months were more likely to stay in treatment and adhere to medications, and had a better outcome at 2 years. Within the first episode psychosis population, Melau et al[11] examined the association between working alliance and clinical and functional outcomes, and concluded that an initial strong working alliance may serve as a prerequisite for adherence to services specialized for first episode psychosis, laying a foundation for positive treatment outcome.

Because of the importance that working alliance seems to have for clinical outcome and engagement, it is essential to identify which modifiable components predict good therapeutic alliance with patients who may be difficult to engage. In a study of patients with schizophrenia and schizoaffective disorder, independent predictors of therapeutic alliance included clinician's recovery orientation, lower reported self-stigma, and greater levels of insight. Interestingly, severity of clinical symptoms, attachment style, age and duration of treatment were not related to quality of alliance[12]. This study shows that, at least at some levels, the alliance can be enhanced by recovery-oriented efforts made by the clinician.

Given the importance of the therapeutic alliance in influencing engagement in care and the relationship between clinicians' recovery orientation and alliance, it is critical for providers to adopt a recovery orientation to facilitate engagement in care.

## Person-centered care

The concept of person-centered care is becoming increasingly common in the changing health care landscape[13]. Person-centered care has no single, operationalized definition or standard of measurement. We find the following description of person-centered care in the setting of mental health services to be particularly compelling and a good framework for the following discussion: "a comprehensive approach to understanding and responding to each individual and their family in the context of their history, needs, strengths, recovery hopes and dreams, culture and spirituality... assessments, recovery plans, services and supports, and quality of life outcomes are all tailored to respect the unique preferences, strengths, vulnerabilities (including trauma history) and dignity of each whole person"[13]. It is the concerted effort to incorporate an individual's own culture, background and immediate goals into treatment planning.

Mental health services that integrate elements addressing an individual's immediate needs may enhance engagement[14-16]. For example, housing and finances are two potential sources of significant stress that may impinge on someone's wellbeing. Addressing these barriers as specific components of clinical care can help enhance engagement, both directly and indirectly. If someone is financially secure and housed, he/she may have fewer concrete barriers to coming to treatment appointments. A more indirect, broader outcome of addressing these components in health care may be that the treatment recipient will feel helped, enhancing faith within the system, building alliance, and serving as a foundation for future treatment work.

Shared decision making can be seen as one approach to providing person-centered care. In contrast to more authoritative models of health care delivery, shared decision making is a collaborative, dynamic, interactive process between two equally involved parties. In this model, physician and patient both take part in an exchange of information that leads to an agreed decision for treatment[17]. Over the past decade, this approach to clinical care has gained a following, though many of the studies examining its efficacy have been done in non-psychiatric populations. Though multiple studies have suggested that shared decision making is effective for those with serious mental illness, providers may be concerned that patients' decisional making capacity is impaired, and thus, may be less likely to use shared decision making with this group[18].

Given that one common theme that has emerged in analyses of successful engagement is the participant's feeling that his/her goals, desires and life situation are being considered, it stands to reason that a more shared decision making stance can improve engagement in care. In a cross-sectional study of nearly 900 outpatients with mental illness, patient self-reported shared decision making revealed significant deficits. A majority of the study participants reported that their doctors did not want to know their level of involvement desired in decision making, and that their doctors did not ask them about their preferences[17]. Those who reported higher levels of shared decision making tended to have a more positive attitude towards medications and higher self-efficacy. Though causality cannot be determined, we can hypothesize that, if a person feels involved in the decision making process, he/she may be more likely to feel positive about potential treatment options. Further, self-efficacy itself has been associated with improved clinical outcome. The most important outcome of shared decision making may not be the actual decision point, but rather, the process that takes place between the patient and provider. An open, exploratory and non-judgmental space allows for trust to build and ideally enhances treatment engagement.

Not all patients, both in psychiatric and non-psychiatric care, want high levels of involvement in decisions regarding their treatment. Understanding this can guide treatment and creation of decision making aids. In patients with schizophrenia, a clear association has been found between treatment

satisfaction and degree to which patients wanted to be involved in medical decision making. Those who felt coerced into treatment or had higher levels of treatment dissatisfaction (lower perceived fairness and worse pharmacological experiences) reported wanting more involvement in their treatment choice. In contrast, those who were convinced that they needed medications and expressed high satisfaction saw less necessity to participate in medical decision making[19].

In a study of veterans with serious mental illness, greater preferences for participation in shared decision making were found among those who were African American, working for pay, had college or higher education, had diagnoses other than schizophrenia, and had a poor therapeutic relationship with provider[20]. The study noted that decision making preferences change over time and a constant evaluation of where the patient stands is one important aspect of good clinical care.

Web-based and electronic decision making tools can be helpful for implementation of shared decision making in treatment settings. One study examined the utility of incorporating a computer-based tool for shared decision making in a waiting area of a community mental health clinic, where individuals with serious mental illness received treatment. Participants used this tool prior to doctor's appointments, which generated a written sheet outlining any decisional conflicts they had to bring up with the physician. Participants found this useful in clarifying their own dilemmas, in allowing them to bring up difficult topics, and in organizing their thoughts[21]. Other web-based and electronic decision making tools have been developed, and are generally accepted by both patients and clinicians[22].

## "DIFFICULT TO ENGAGE" POPULATIONS

We now review the literature on engagement in individuals experiencing first episode psychosis, homeless individuals, and people with co-occurring serious mental illness and substance use disorder (dual diagnosis). Various recovery-oriented strategies have been used to enhance engagement in these populations. Identification of these strategies can help inform the design of mental health services that maximize treatment engagement.

### First episode psychosis

Research suggests that approximately one third of young adults experiencing a first psychotic episode delay treatment for 1-3 years. Further, 80% drop out within the first year of care[8]. This high attrition rate highlights the inherent difficulties in engaging young people in care.

Multiple causes for early dropout from treatment or disengagement have been offered, including poor alliance, mistrust of the system, and poor insight into the need for treatment. Additionally, young adulthood is a time of separation from authority figures and self-discovery towards individuation and autonomy. Early termination of treatment in first episode psychosis programs has been linked to a more chronic course of illness, increased need for hospitalization, a slowed recovery process, and increased levels of functional disability[8].

First episode psychosis programs, with multidisciplinary teams comprised of therapists and supported education and employment specialists, have gained momentum internationally[23,24]. These programs provide early access to care and intensive psychosocial services, in efforts to decrease duration of untreated psychosis, improve symptom burden, and enhance recovery[25]. Specialized first episode psychosis programs may have greater success in engaging young people in care than routine mental health services[26], keeping people in treatment longer than standard community clinics[27].

Some research has been done to identify particular components of these unique treatment programs that either enhance or diminish engagement. Many first episode psychosis programs are purposefully placed outside of traditional adult mental health clinics, as it has been shown that these settings are identified with alienation and treatment dropout[28,29]. Strong engagement may be related to enhancing a young person's wish to be respected, supported and understood[7].

A qualitative analysis of young adults who were successfully engaged in treatment highlighted shared themes that seemed to promote engagement[8]. For example, in the acute hospitalization phase, two factors were crucial in enhancing engagement: timely introduction of the early psychosis program staff and development of positive relationships with peers on the unit. Other themes that emerged as enhancing engagement were those of collaboration, rational understanding of problems, and a commitment to finding solutions. Multiple participants also commented on the negative experience of acute adult hospitalization. If this negative, frightening experience is the entrée of a young adult into the world of mental health services, it stands to reason that improving the experience and countering it with supportive outpatient services may enhance engagement.

In an analysis of patients who had participated in the RAISE Connection early intervention program, four domains seemed to influence engagement: individualized care, program attributes, family member engagement and personal attributes[30]. For many participants, one key factor of the program was the focus on their own goals: engagement was correlated with receiving non-traditional services that supported such goals, such as supported employment and education.

These studies focused on aspects of the early intervention programs that the participants identified as enhancing engagement. Other studies have examined what participant-level attributes may either enhance or interfere with treatment engagement. Low service engagement has been linked to childhood trauma, high agreeableness, more severe symptoms and poor alliance[31]. Poorer engagement, as rated by clinicians, has also been found to be associated with greater positive and negative symptoms, greater general psychopathology and poorer premorbid social adjustment[2].

Specialized first episode psychosis programs, designed to engage young people through their design, approach and services offered, may be a strategy for enhancing engagement in care in this group that has often delayed treatment and traditionally drops out of treatment in large numbers.

## Homelessness

Homeless individuals face many barriers to engaging in mental health treatment in traditional settings, including complex social service, medical and mental health needs; high rates of substance use disorders; other priorities that may supersede mental health treatment; and, particularly among street homeless individuals, a mistrust of helping professionals[32]. Homeless individuals may also have strengths that can be harnessed in treatment, including well-developed street skills and knowledge of the service system[33].

Assertive outreach to homeless individuals involves making contact with them on their terms – where they live – rather than at an agency setting[33]. Assertive community treatment is an evidence-based practice that has been adapted for homeless individuals. It uses a multidisciplinary team-based approach to provide case management, mental health and substance use treatment, crisis intervention, employment support, and family services to individuals in the community. Homeless assertive community treatment teams have been found to decrease psychiatric hospitalization and emergency room use, increase housing stability, reduce symptom severity and, particularly relevant for engagement, increase outpatient visits[34,35].

Despite the focus of the assertive community treatment model on treatment engagement, little is known about which specific elements promote engagement, particularly among homeless individuals. A recent qualitative study with assertive community treatment staff, not focused on those who are homeless, identified the following as primary elements for engaging clients[36]: therapeutic alliance between staff and clients, persistence and consistency, the provision of practical assistance and support rather than a sole focus on medications, the team decision making process, acceptance of clients as they are, and flexibility. A British study of engagement in assertive community treatment compared to community mental health teams, again not specific to homeless individuals, found that the small caseloads and team approach of assertive community treatment facilitated treatment engagement[37].

Critical time intervention is another evidence-based practice focused on helping homeless individuals engage in treatment, with a particular focus on periods of transition, such as the transition from the hospital or shelter to housing. Critical time intervention workers provide time-limited intensive case management using a phase-based approach with decreasing intensity over time. The model includes practical assistance, linkage, advocacy, and motivational enhancement to strengthen individual's long-term ties to services and supports. Outcomes include decreased risk of homelessness following hospital discharge[38] and decreased symptom severity[39]. Like assertive community treatment, critical time intervention has an explicit focus on engagement.

A qualitative study of critical time intervention aimed to understand the role of the relationship between practitioners and clients in the model, identifying a "non-authoritative" and "humanistic" working relationship, in which workers respected client autonomy and maintained flexibility with regard to client contact and service activities. Workers followed clients' leads and used informal approaches to connecting in order to facilitate the development of client trust[40].

So, in the evidence-based treatment models that have found to be successful for individuals with serious mental illness who are homeless, it seems that an explicit focus on the development of a positive working relationship, meeting clients where they are, persistence, provision of practical assistance, and flexibility in approach are common elements which may serve to promote engagement.

## Comorbid substance use and serious mental illness

Individuals with serious mental illness are more likely than those without such illnesses to use substances, with some studies suggesting that 50-60% of people with schizophrenia have a comorbid substance use disorder[41-43]. It is well-known that those with serious mental illness and substance use are more difficult to engage than those without, and traditional treatments have failed to effectively engage this population[43-46].

In fact, comorbid substance abuse is one of the strongest factors associated with non-initiation and non-engagement in mental health treatment[1]. This difficulty in initiating and maintaining treatment engagement has multiple downstream effects, including frequent rehospitalization, high symptom severity, impaired psychosocial functioning, as well as trans-institutionalization in jails and other non-mental-health settings[47].

One reason why individuals with dual diagnosis may be less engaged in treatment is the fragmentation of the care system. Historically, substance use treatment services and psychiatric treatment programs were entirely disconnected, with different funding streams, training and philosophical approaches to treatment. Because of this, people dually diagnosed seeking out treatment were often excluded from either program. A person seeking out substance use treatment was told to first treat "psychiatric" symptoms and vice versa. In addition to introducing yet another hurdle to provision of care, this "sequential treatment" approach did not take into account the interactive and cyclical nature of these disorders[48].

Integrated dual diagnosis treatment programs (IDDT) began to develop in the 1990s[41], attempting to address the fragmented treatment that dually diagnosed individuals were receiving. These programs emphasized outreach, comprehensiveness, long-term perspective, and a consistent approach and philosophy[41,49]. Clinicians were trained in motivational techniques, collaboration, social support interventions, and

many such programs also included a community-based component. IDDT is now an evidence-based treatment for people with dual diagnosis, with studies indicating that this approach improves various clinical outcomes, including treatment participation, possible reductions in substance use, more days in stable housing, and greater reductions in psychiatric hospitalization and arrest[50]. Some studies have shown that integrated treatment programs, as well as assertive community treatment, enhance initial and ongoing engagement in the dually diagnosed[43,44,47].

Within various treatment programs that treat comorbid substance and mental health conditions, factors identified to enhance engagement include shared goals, optimistic outlook that does not focus on medications, ongoing psychoeducation, collaborative team-based care, and community outreach. One study found that treatment engagement in a dual diagnosis program was higher when individuals were referred from inpatient units rather than from the community[51]. It is not clear what component of the inpatient stay served to strengthen later engagement, but this finding is interesting and may suggest that, for certain subsets of the dually diagnosed, inpatient stabilization may be helpful.

One recent study explored the use of peer support in initial engagement in mental health services among veterans with substance use disorders and/or high recidivism. Peers specifically targeted early engagement, providing psychoeducation and bringing participants to their first appointments. This study found that peer support significantly increased treatment engagement, in both treatment-as-usual and experimental integrated treatment conditions[52]. This highlights peer support as an emerging tool to enhance engagement in those with dual diagnosis.

## RECOVERY-ORIENTED TECHNIQUES FOR ENGAGEMENT

Below we outline emerging treatment innovations that can optimize engagement in creative, novel ways. We chose them as they all attempt to improve the experience of treatment for the participant. The three strategies outlined below each aim to make treatment more accessible, more focused on the client's needs, and less stigmatizing, in various different ways. To that end, we believe that they embody the spirit of recovery-oriented care, and may help to improve treatment engagement.

### Electronics/technology

In a time when the Internet, smartphone apps, and social media serve to connect more and more people to each other, it seems appropriate to consider how to use these technologies in the treatment of those with serious mentally illness to promote engagement. There are many theoretical ways that information and communication technologies can improve engagement and enhance treatment, with multiple different tools to deliver: open messaging boards, closed therapeutic websites, mobile phones, and even smart medication bottles that may improve medication adherence[53].

One justification for incorporating these technologies into mental health treatment is that they may serve as a natural way to expand the reach of services and reduce barriers to care. This can be important in situations where there are limited providers[54]. It has been proposed that various online and smartphone platforms can serve as a "gateway" to mental health services, removing some hurdles to initial engagement and allowing people an introduction to services in a low-risk, comfortable scenario. This can also be useful for people who have dropped out of treatment and are considering re-engaging, but may have some impediments, either personal (self-stigma, limited insight) or practical (difficult to get to or coordinate).

People experiencing symptoms or questions and seeking out more information may turn to the Internet and social media for answers and support. In a recent study of young adults at an early intervention program, an overwhelming majority endorsed using social media (97.5%), with an average of $>2$ hours per day. Thirty percent of participants reported discussing their symptoms in social media settings, and searching for information about their symptoms. The majority of this population was amenable to clinicians approaching them during crisis via social media[55].

Disengagement during times of symptom resurgence may lead to particular distress, and potentially result in visits to the emergency room or inpatient unit. If providers and treatment programs use social media or Internet-based technologies to connect with clients during times of disengagement, perhaps symptom escalation or rehospitalization may be decreased. One way to think of this is as assertive outreach of the 21st century: instead of providers meeting clients in the community, they can meet them online.

Internet-based treatments have also been developed, with promising results[56,57]. One randomized controlled trial of a therapist-moderated website showed that participation led to a decrease in positive symptoms and an improvement in knowledge about schizophrenia[58]. Tablets and other information and computer technologies have been shown to help promote initial engagement in supported employment[59]. Populations who currently do not have access to cutting edge information and communication technologies, such as those who are homeless, may be even more likely to benefit. For marginalized people with few resources, use of technology may add to their sense of belonging and help build social connections. These platforms can be used for psychoeducation, initial engagement or even treatment[60].

Cloud-based electronic medical records are currently being developed. These systems are secure and compliant to the U.S. Health Insurance Portability and Accountability Act. With a patient's consent, they can allow for information exchange across various organizations and health care providers. Recently, the concept of personalized health records has emerged within these cloud-based systems. They allow for secure

messaging and integration of medical records between patient and provider. Implementation of such personalized health records can enhance patient engagement[61]. By incorporating the patient into his/her own treatment decision making process, and providing easy access and communication with providers, they may remove some practical and perceived barriers to care.

Mental health programs can consider the use of all aforementioned technology-based interventions as part of their treatment approaches to increase engagement. Future studies should focus on how to best incorporate burgeoning technologically-based treatments and connections to care into existing services, taking into consideration the risks associated with Internet and technology, such as need to maintain privacy and mitigate discrimination[62].

### Peer support

Some studies have suggested that those who have difficulties adhering to or engaging in treatment may have trouble trusting perceived authority figures[31]. Further, many individuals with serious mental illness may feel alienated, marginalized and stigmatized. For this reason, and several others, the use of peer services may enhance engagement in those with serious mental illness.

Over the past decade, peer provider networks have blossomed throughout the U.S., and peer providers now exist in multiple different treatment settings, as well as free-standing peer-run agencies. Peer support has been defined as "a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement on what is helpful"[63]. The President's New Freedom Commission on Mental Health Care called for a broader distribution of peer-based services[4]. Additionally, peer support is now a Medicaid reimbursable service[64].

A review of a peer-led Wellness Recovery Action Plan program highlighted the benefits that participants experienced, including increased sense of self-determination, self-awareness, and positive effects on engagement with traditional providers and self-advocacy[65]. In a study of adults with serious mental illness in community care, traditional case management was compared with peer-delivered case management[66]. The aim was to investigate whether participants receiving peer-delivered services at the beginning of their treatment would be more engaged in services at follow-up (6 and 12 months). This study found that patients receiving peer-delivered services were more engaged at the 6-month point than those with traditional case management services. This between-group difference disappeared at 12 months, which may point to the importance of incorporating peer supports at the initial stages of treatment, in order to rapidly build a working alliance and enhance engagement when the risk of dropout, symptom relapse and rehospitalization is particularly high. Of note, in both groups, the participants who endorsed feeling understood and well-liked at 6 months had higher self-reported motivation for treatment.

Army and combat veterans are a group that has been traditionally difficult to engage in mental health treatment. A recent qualitative study of army veterans found that the major barrier to engaging in initial treatment is self-perceived stigma, and soldiers having trouble knowing or accepting that they need help. Participants in this study were generally positive about the idea of incorporating formal peer networks into initial treatment, noting that it might decrease both internal and external stigma. Soldiers suggested that peer networks could serve as role models, for example if a soldier who is perceived as strong and respected by others discloses his own battle with mental illness[67]. Peer supports have been shown to lower recidivism rates in veterans with substance abuse problems[52]. Though the veteran population is a unique one, self-stigma and need for role modeling may be universal for people struggling with mental illness.

### Cultural Formulation Interview

Individuals with serious mental illness from racial and ethnic minority groups are less likely than non-Hispanic whites to engage in mental health treatment[68,69]. The reasons for this are varied and numerous, and include system as well as social and cultural barriers[70-74]. Providing culturally competent care may be one way to enhance engagement.

One concrete tool for providing culturally sensitive care, and assessing an individual's cultural background to help guide diagnosis and treatment, is the Cultural Formulation Interview (CFI). Introduced in DSM-5, this is a 16-item questionnaire, supplemented by 12 modules. It also includes an informant version in order to obtain material from caregivers such as family members[75]. The conceptual idea behind the CFI is that a person's culture and contextual background will shape the way he/she perceives mental illness, treatment, and engagement with the treatment team.

Cultural information includes the social structures in which the individual resides, local environmental resources (financial, time), and individual circumstances. The cultural context is seen as dynamic and unique to each individual. And thus, though there may be trends among different minority groups in regards to how they view their symptoms and treatment, this cannot be assumed and has to be assessed individually. To that end, using the CFI in treatment is a way of explicitly acknowledging the unique individual and focusing on his/her goals and needs.

Though a relatively new tool, the CFI may enhance cross-cultural communication[76], which may improve treatment engagement.

## CONCLUSIONS

Many innovative strategies are emerging to improve treatment engagement. As demonstrated in this review, engagement strategies focus on practical methods and tools, as

well as on helping to change attitudes and overall approaches to treatment of people with mental illness. In order to implement these strategies to improve engagement, mental health providers, too, must feel engaged with the work they are doing. The new approaches call for open-mindedness and flexibility about a shifting structure and delivery of mental health care.

Though, presumably, all mental health providers are in this field because they are dedicated to improving the well-being and health of those who suffer from mental illness, individual and systemic barriers may prevent providers from delivering treatment that optimally enhances participant engagement. The realities of working within the current mental health system include limited resources, limited time, and increasing oversight by managed care companies. Clinicians commonly cite these concerns as reasons why they are reluctant to change treatment services or take on a more recovery-oriented approach. In tandem, there are myriad attitudinal concerns about recovery-oriented treatment, including fear of increased risk, concern that only certain types of participants can be engaged in treatment, and an assumption that recovery-oriented services devalue professional skills[77].

It is clear that, in order to affect global change, these concerns must be addressed. Services can be streamlined to more efficiently utilize resources, relieving some of the existing pressures that psychiatrists face, and thus allowing them more time to engage in face-to-face, meaningful clinical interactions[78]. Making concerted efforts to address fears, stigma, misconceptions and practical constraints will help to transform our mental health system to improve initial and ongoing engagement.

This review is not exhaustive, and other areas to consider as ways to enhance treatment engagement include wellness and exercise, role of families – including siblings – in treatment engagement, and use of trauma-informed care to engage individuals with traumatic pasts. Future areas of research may explore issues related to training and implementation of engagement strategies in the context of a rapidly evolving mental health care landscape.

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