

Exploring Service Engagement among Youth in Concurrent Disorder Services: A Qualitative Study

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Abstract

Background

Despite an increasing prevalence of co-occurring mental health and substance use (MH&SU) problems, or concurrent disorders among youth (14–24 years), evidence-based and developmentally appropriate services for youth with concurrent disorders remain limited. Compounded by high rates of discontinuing services early among this population, little research has focused on understanding youth's service engagement in Concurrent Disorder services. As such, this qualitative study explored youth's experience and perspectives of service engagement in a Concurrent Disorders service.

Methods

Semi-structured interviews were conducted with N = 20 youth (14–24 years) attending a Concurrent Disorder outpatient program at an addiction and mental health centre in Toronto, Canada. Youth who attended an initial session in the program between 2016 and 2018 were approached. Interviews explored how youth perceived their own engagement in Concurrent Disorder services and factors that influenced engagement within these services. Thematic analysis was employed.

Results

Engagement was shown to be a multidimensional and dynamic process that spans youth's participation in sessions, their progress toward goals, and disengagement in services. It was also shaped by their perspectives of clinicians and the therapeutic approach, alongside their motivation and readiness to change. Youth emphasized the importance of relational approaches and clarity around re-engagement. These insights highlight the need for flexible, youth-centred approaches to strengthen engagement.

Conclusions

The findings contribute to the limited qualitative evidence on youth engagement in Concurrent Disorder services. Findings highlight a need for flexible, relational, and youth-centred approaches that recognize engagement as a dynamic, non-linear process.

INTRODUCTION

Evidence shows an increased prevalence of youth concurrent disorders, or co-occurring mental health concerns and problematic substance use.¹ In Ontario, Canada a longitudinal, cross-sectional cohort study in 2021² showed that 28.7% of students (16–19 years) met criteria for a concurrent disorder. Estimates from a cross-sectional descriptive study in Vancouver, British Columbia showed that among N = 100 youth (14–25 years) seeking services, 87% endorsed symptoms of both mental health and substance use (MH&SU) concerns³. Also referred to as comorbidity or dual disorders, concurrent conditions represent a broad spectrum of problematic substance use and mental health challenges (e.g., mood and anxiety disorders with substance use disorders)⁴.

Prevention, early identification, and timely intervention are essential to reduce the burden of concurrent disorders across the life course. Yet, treatment for youth concurrent disorders is challenging and complex due to the interaction between co-occurring MH&SU conditions⁵. These challenges create a strain on youth, families, communities, and the broader healthcare system⁵. For example, youth with concurrent disorders access a greater number of services, and experience longer hospitalizations, greater MH&SU complexity (i.e., symptoms that are enduring, impactful, and severe), higher rates of relapse, and poorer prognoses compared to youth with one disorder^{3,6,7}. Furthermore, these youth also face inadequate and delayed treatment, which is associated with an increased risk of poor health outcomes⁸. At the same time, these youth have high rates of disengagement with approximately 32%-60% discontinuing MH&SU services within the first month of treatment⁹⁻¹¹. This service disengagement has been attributed to inadequate access to appropriate, specialized, and integrated services that address both MH&SU concerns¹²⁻¹⁴.

Promoting youth engagement, or active involvement in intake, assessment, and treatment, in programs is one way to increase youth's use of Concurrent Disorder services^{3,15}. Youth engagement in services is associated with more relevant, developmentally appropriate, and accessible services, as well as continued service use and positive health outcomes¹⁶. Yet, there is limited research on youth engagement in Concurrent Disorder services, including factors that facilitate or hinder their engagement within these services. Of the limited research available, findings on service engagement have been mixed. Some studies of youth engaging in mental health treatment with problematic substance use have been associated with reduced service engagement^{17,18}. Other studies showed that youth engaging in substance use services with comorbid diagnoses of conduct disorder¹¹, mood or anxiety disorders¹⁹, have been associated with greater service engagement. Further, there is limited evidence on engagement within integrated (i.e. simultaneous) MH&SU treatment²⁰⁻²².

The Transtheoretical Model (TTM)²³ offers a useful lens for understanding youth engagement in concurrent disorder services. The TTM conceptualizes intentional behaviour change as a dynamic, cyclical process in which individuals move through stages of precontemplation, contemplation, preparation/action, and maintenance within mental health services²⁴. Relapse is a common part of the change trajectory, wherein an individual may return to an earlier stage²³. According to TTM, youth may enter and engage with services at different stages of readiness, underscoring the importance of service approaches that are flexible, non-judgmental, and responsive to youth where they are at in their change process²⁴.

Published research on concurrent disorders has predominantly focused on the use of quantitative methods^{2,3}, with limited qualitative evidence exploring youths' perspectives of these services. Qualitative research within health services is beneficial as it provides rich information on youth's experience, attitudes, needs, and behaviours^{25,26}. As such, our exploratory research questions for this study were: How do youth perceive their own engagement in services for concurrent disorders? What are youth's

perspectives regarding factors that influence engagement in services for concurrent disorders? The objective of the current study was to explore youth's experiences and perspectives of service engagement in Concurrent Disorder services, identifying barriers and facilitators to engaging in these services. Ultimately, the aim of the study is for the findings to inform Concurrent Disorder services and engagement-focused interventions.

METHODS

Study design and setting

This qualitative study consisted of semi-structured interviews with youth (14–24 years) attending a Concurrent Disorder outpatient program at an addiction and mental health centre in Toronto, Canada. This centre is one of the few specialized settings in Canada that offers a range of service options for youth with concurrent disorders. Youth either self-refer to the program or are referred by a physician, hospital, community agency, or school. Ethics approval was obtained by University of Toronto (REB: 35667) and the Centre for Addiction and Mental Health (REB: 158/2007-06). The Standards for Reporting Qualitative Research (SRQR) were followed (Additional file 1).

Participants and Recruitment

Youth who attended an initial session in the Concurrent Disorders program between 2016 and 2018 were approached to participate in the study. Youth were eligible to participate if they were currently attending, or had previously attended, outpatient services for concurrent disorders at the mental health centre and had accessible electronic health records. Youth were excluded if they were referred for outpatient treatment from another facility, were admitted to inpatient treatment or the emergency department, or had an inaccessible electronic health record. A total of N = 20 youth were interviewed.

Procedure

Informed consent

was obtained from all participants. Youth participated in a 45–60-minute semi-structured interview at the addiction and mental health centre. Semi-structured interviews explored how youth perceived their own engagement in Concurrent Disorder services and factors that influenced engagement in these services. Specifically, questions were asked about youth's involvement and engagement in services, the extent to which they followed the clinician's recommendations and suggestions, reasons to continue or discontinue services, client and service-related factors that facilitated engagement, and client and service-related factors that compromised engagement (Additional File 2). A doctoral student (AB) in Clinical Psychology and trained in qualitative interviewing conducted and recorded the interviews. Youth received \$20 honoraria for their time.

Statistical Analysis

Interviews were audio recorded and transcribed by a study team member using Microsoft Word. Transcriptions were anonymized, organized, and analyzed using NVivo 12²⁷. Thematic analysis was employed, using an iterative inductive and deductive process^{28,29}. This approach was used as it aligned with the goals and design of the study. Each transcript was read through twice by the primary coder (AB). Initial coding focused on deductively analyzing the data and developing a preliminary framework to organize the codes. Informed by previous literature^{30,31}, these deductive categories aligned with the interview questions and how factors (e.g., MH&SU concerns, social support, service delivery) facilitated or compromised service engagement. This approach was followed by inductive coding and capturing youth's perspectives of engagement. To establish inter-coder agreement³², a second coder independently coded a subset of the data (five transcripts). The coding team reviewed the codes, after which the percent agreement between coders was calculated. Results indicated a high level of inter-coder consistency, with 91.1% agreement overall. Any discrepancies in codes were discussed by the coders and changes to the codes were made accordingly.

RESULTS

Participants ranged in age from 16–24 years, with a mean age of 19.9 years (SD = 2.4). Ten participants identified as White and ten participants identified as Indigenous, Black, or racialized. The majority of youth (n = 12, 60%) lived with caregivers/family.

Participants discussed their perspectives and experiences of service engagement. Themes generated from the analysis focused on youth's multidimensional behaviours of engagement and re-engagement, as well as factors that supported or hindered their engagement in services. Five thematic clusters were generated: service engagement as multi-dimensional; non-engagement as a choice; social and experiential factors as influencing service engagement; service-level, relational factors that influence engagement; and motivation and readiness to change.

Theme 1. Engagement as multi-dimensional

Almost all participants described service engagement as encompassing multiple, interconnected behaviours. These behaviours included attendance, in-session participation, and work completed between sessions.

Most participants described attending scheduled clinical sessions as necessary for service engagement. A few youth, who attended services at the time of the interview, reported that they missed an occasional session and would reschedule or return for the following session. Other youth, who were not attending services at the time of the interview, described diminishing attendance. These youth reported that this would happen when they missed a few scheduled sessions, did not reschedule or follow up on the service's attempts to reschedule, with no further contact made.

It's not going to make a big difference I guess if I miss one, and then it just ends up being like five in a row, which turned into an 'ah screw it' kind of situation (Y17; age 19).

Participation in sessions, described as talking, listening, and contributing to discussions, was identified as a component of service engagement. Many youth described setting goals and putting notes or reminders in their phone as important aspects of participation in services. These youth reported that participation was easier during individual therapy compared to group therapy, as they perceived individual therapy as a more comfortable space to speak openly. A few youth perceived that they should participate in guided group discussions or activities because they felt an expectation to do so. These youth also talked about how they wanted to make the time worthwhile, yet were hesitant to share their ideas or experiences.

I definitely do try to put my two cents in and be a part of the group (Y03; age 23)

Most participants believed that meeting goals or following the clinician's recommendations between sessions was an important component of service engagement. These youth described practicing mindfulness exercises and socializing more, while reducing their use of substances, as examples of how they enacted engagement outside of sessions.

Theme 2. Non-engagement as a choice, with the option to re-engage at a later time

The majority of participants indicated that they had not considered disengaging from services, as they perceived these sessions essential to improving their functioning. These youth believed that they could not improve and sustain the progress they had made on their own.

Of the participants who had disengaged, their perspectives on discontinuing services revealed why some youth decided to disengage and were subsequently lost to follow-up. A few of the participants, not attending services at the time of the interview, did not perceive themselves as having "dropped out" but rather as having "stopped services". These youth perceived that disengagement did not reflect a failure on their part; rather, it was perceived as a choice that they made based on their own needs and desires at that time.

I guess just the idea that there's people out there who need more help than I need, and their problems are greater, so I feel like mine aren't as valid (Y09; age 18).

All of the participants who had disengaged from services reported wanting to re-engage, particularly as they had experienced subsequent MH&SU concerns. However, they described the re-engagement process as challenging. For these youth, disengagement evoked feelings of shame as time passed. Meanwhile, others reported that they did not know what steps they needed to take to re-engage or believed they would have to start over. They were uncertain if they would re-engage in the last stage of services or if they would have to start at intake again.

Now that I haven't been for a couple of months, I would have to talk to a psychiatrist again once a week for a couple more weeks, and go and fill out another twenty forms, and talk to a hundred people (Y16; age 21).

These participants described confusion about how to re-engage and questioned whether re-engagement was an option. This uncertainty was expressed as a barrier to service re-engagement for participants. At the same time, these youth expressed a desire to have ongoing contact with services so they could reconnect if and when they felt ready to re-engage.

Theme 3. Social and experiential factors that influence service engagement

All participants described social and experiential factors that facilitated or hindered their service engagement and re-engagement. Social factors focused on support from friends, partners, and families, while experiential factors focused on how MH&SU concerns influenced engagement.

Relationships with friends, family members, and romantic partners were perceived as having a positive influence on service engagement. Most participants identified support and family member involvement as facilitating engagement. These youth reported that their parents motivated and encouraged them, as opposed to forcing them, to attend sessions. Some youth indicated that they were encouraged by their friends or partners to continue attending services. This encouragement and support were described as friends and partners voicing their concerns about the extent to which substances affected the youth or their relationship, while providing reminders of how services could help. Support from friends was noted as particularly beneficial when youth experienced doubt or frustration about attending services.

When I was in my fit of rage and I was like, 'I'm not going back to [facility]'...I was calling one of my friends and she was like, 'You just need to think about the long run...I know it's important for you to stay. (Y05; age 17)

Several participants described how their friends would support them by accompanying them to the services. Some participants also spoke about forming close relationships with peers in the services, and the positive impact that these relationships had on their attendance in group sessions.

We've met through services so...building friendship on something that you both have in common is a pretty strong relationship...it's helpful because you can talk about things from what you learned inside and then normal stuff (Y07; age 17).

A few participants reported that they experienced pressure from their partner to attend services, describing it as an ultimatum. Participants who were no longer attending services, described feeling pressure from their caregivers to re-engage in services. Meanwhile, one youth in treatment indicated they did not experience pressure from family, but instead placed pressure on themselves to attend services to repair trust and improve relationships with friends and family.

I get this sense that if I don't go then she's going to take me less seriously because she's going to think that I'm not trying hard enough to get better and maybe she will give up on me if I give up (Y08; age 21).

Several youth reported that they perceived mental health benefits from attending sessions, which motivated them to continue to engage in services. Other youth noted that symptoms related to anxiety or mood disorders adversely influenced their treatment engagement. These youth expressed feeling overwhelmed by their symptoms and as such, avoided services. One youth, who had disengaged from services at the time of the interview, described how their MH&SU challenges made it difficult for them to re-engage. This youth identified fear, dread, and uncertainty about revisiting these challenges and repeating their story, which made them unsure about service re-engagement.

Theme 4. Service-level, relational factors influencing engagement

All participants described service-level, relational factors that facilitated or undermined their engagement. These factors focused on the therapeutic relationship and service environment. Facilitators to engagement included positive relational approaches with the clinician, as well as the development of skills. Factors that hindered youth engagement and reduced their willingness to return focused on perceived judgement from clinicians and peers in the program, which created shame and discomfort.

Subtheme 1. Facilitators

Service-level, relational facilitators of engagement centered on the therapeutic relationship, specifically the clinician's approach and their warmth, acceptance, and respectful, non-critical stance. This approach helped youth feel understood, comfortable, and safe in sessions. Some participants shared how they preferred a relational approach over structured service sessions.

All participants identified their interactions with clinicians as important to their comfort and openness to participating sessions. It also shaped how they perceived they were benefiting from the treatment. It was important to participants that clinicians be warm, friendly, and attentive. They also described how they were more open and comfortable during sessions when they perceived that the clinician accepted rather than judged them, especially in conversations about their substance use. Nearly all participants described how they felt at ease when the clinician understood and accepted their substance use.

[My therapist] never really told me to stop doing what I'm doing...smoking weed wise. She never told me it's not a good idea (Y06; age 17).

Most youth identified other aspects of services that facilitated their participation. These participants described engaging in multiple types of treatments at the same time (i.e., group Dialectical Behaviour Therapy (DBT) and individual therapy). These youth also perceived the benefit of person-centred approaches, including feeling supported which enhanced their willingness to share their ideas and

experiences. They described how it helped them feel that they were improving and getting what they wanted out of the sessions.

Some youth indicated that learning and practicing skills in treatment (i.e., opposition action in DBT) facilitated their participation in sessions. A few youth described structured, therapeutic approaches as impersonal, emphasizing the importance of a relational approach alongside skills-based work.

Some counsellors like to focus more on skills, like DBT and CBT, by the book. I'm not really into that too much. I mean I do like coping skills, but I like it also when I feel like it's a person that I'm talking to and not a textbook. (Y02; age 18)

Subtheme 2. Barriers

Most participants spoke about treatment-level, relational barriers to engagement. These barriers focused on the therapeutic relationship with the clinician, feeling comfortable and safe within therapy, and participants' perceptions of how they would be viewed and evaluated by the clinician and their peers in group therapy.

Some participants described feeling afraid of how clinicians would perceive their behaviour in services. For example, several youth described experiencing shame and embarrassment, worrying that they would be perceived negatively by the clinician, due to poor engagement and difficulty adhering to treatment. One youth shared how they had relapsed and disengaged from services because they perceived they would be judged by their clinician. A few youth expressed feeling worried and uncomfortable when raising specific topics, which adversely impacted their engagement.

I purposely try to avoid talking about the upsetting or troubling topics, which are the ones I really should be talking about, because I don't want to leave feeling more overwhelmed with stress (Y09; age 18).

Practical aspects of service delivery were identified as barriers to engagement. Appointment times were identified as a barrier to service attendance, with participants who had already disengaged describing conflicts related to school or work, as well as travel time to the clinic. Getting to the clinic from home, school, or their job was challenging because they had to arrange a ride from a family member or take public transportation. In addition, almost all youth expressed frustration at the lack of timely appointments and straightforward scheduling.

...if I could just schedule an appointment for next week, then I'd probably be more willing to [come back]...if it was just handed to me (Y16; age 21).

Several youth expressed a fear of being judged by the clinician for their substance use challenges, particularly when they raised concerns about their efforts to change. In group therapy, these youth were afraid of being the centre of attention and judged if they brought up difficult topics, such as trauma, mental health challenges, and substance use. Other youth described feeling afraid of being embarrassed or judged in group therapy if they stayed silent, as they worried others may think negatively of them.

Theme 5. Motivation and readiness to change

Most participants described experiencing some degree of internal motivation to address their MH&SU challenges. This motivation took different forms, including a desire to reduce substance use, seek withdrawal support, or address underlying issues. Some youth shared feeling motivated to make changes. A few youth described feeling discouraged by the difficulty of implementing and sustaining changes, as well as by the emotional reactions they experienced when they perceived themselves as having failed.

Many youth described taking action between sessions, such as cutting down on substance use or attending school on a regular basis. A few participants expressed distress about the impact of substance use on their functioning, which further reinforced their desire to change.

“I feel like my life is on hold because of the alcohol...I want to go back to school. I want to get a more satisfying job” (Y01; age 21).

Implementing these behavioural changes brought up mixed feelings for most participants. These youth described working on themselves as positive and motivating, while others reported feeling overwhelmed by adding these tasks to their routine.

[Waking up, going to school, getting a job] sounds impossible to me because I can’t even do normal things that people do every day (Y09; age 18).

Several participants reported experiencing improvements and positive changes in their mental health, which further enhanced their motivation to engage and work towards their goals. Other youth recognized the benefits of treatment, yet felt that actively working on their mental health and reducing substance use was daunting and challenging to sustain.

Almost all participants acknowledged how difficult it was to translate their motivation into action and sustaining changes over time. Following clinical recommendations and goals, such as reducing the frequency of substance use was the most common and difficult challenge to address. Participants detailed the ongoing effort these changes required, particularly when attempting to change long-standing behaviours:

I’ve been trying to apply it to life. It’s hard when you’re stuck in your ways. It’s been so long. It’s hard and it takes time, so you just gotta try and push at it every day (Y03; age 23).

A number of youth described how they wanted to reduce their substance use and commit to change in order to meet the clinician’s expectations, even when they did not feel ready. One participant shared how they were not ready or wanting to change their substance use:

I guess a lot of it is knowing when you’re actually ready to make a change and not just saying you want to and not being ready to do anything. Which is hard for me because I don’t know if like really determined to

change my lifestyle right now, even though I know I should. (Y17; age 19).

Several youth reported attempting to reduce their substance use with limited success, which was often accompanied by feelings of shame and guilt. They highlighted the difficulty of replacing substance use with adaptive coping strategies, such as physical activity or relaxation.

I kept telling [clinician] that like I would keep trying to do good things like meditating and studying, exercising, but then the urge to smoke marijuana would just throw that all away, and I felt like I had no control over it. (Y08; age 21)

DISCUSSION

This study explored youth's perspectives and experiences within Concurrent Disorder services, offering important insights on treatment engagement. Service engagement was shown to be multi-dimensional, encompassing participation in treatment sessions and progress towards goals. Youth also identified a number of individual, relational and service-level factors that influenced their engagement, including their perceived improvement and motivation to change, experiences of breaks in service use, and interactions with service providers. The findings contribute to the limited qualitative research on how youth experience and understand engagement in Concurrent Disorders services.

The study highlights that service engagement is a complex, multifaceted construct, influenced by youth's attitudes and beliefs about their MH&SU needs and concerns; service characteristics; and support from family, friends, and romantic relationships. This finding challenges narrow attendance-based definitions of engagement³³. The concept of engagement has lacked a clear and consistently applied definition²⁶, as well as how to measure engagement^{26,34}. Some prior research has operationalized engagement as the initiation and subsequent attendance of treatment services, defined as attending two sessions within 30 days of entering care³³, or four sessions within a pre-determined timeframe¹⁰. Other conceptualizations have emphasized clients' in- and between-session efforts towards change³⁵ and the extent of their active participation in treatment³⁶. More broadly, engagement has been conceptualized as dynamic, encompassing an interaction of behavioural (i.e., treatment adherence or efforts to engage in treatment); cognitive (i.e., perceived helpfulness of program to achieve goals); and affective (i.e., experience, interest, and interaction with treatment program) dimensions^{26,34}. The limited research available suggests a mixed methods approach to measuring these dimensions of engagement over time to understand the dynamic nature and how it changes over the course of the program²⁶.

Youth described service engagement as a flexible process that allows for periods of disengagement followed by re-engagement at a later time. Although youth articulated engagement in these terms, they also described re-engagement as inaccessible, due to a lack of clarity on treatment re-entry and ambiguity around whether they would receive the support they needed. The re-engagement process was also described as confusing and overwhelming. As indicated in the study, there are numerous factors that can lead youth to disengage from services, including symptom recurrence, increased distress, and

fears of clinician or peer judgment when attempting to re-engage. These findings highlight the need for services to adopt and implement person-centered approaches^{37–39} that build trust, support youth decision-making, and strengthen and sustain engagement. Such approaches ensure that youth direct their care journey in ways that reflect their needs, preferences, and readiness³⁷. At the same time, services should provide flexibility with care, including the availability of virtual consultations³⁸ so that the youth can re-engage in services when they are ready.

Motivation, or readiness to change, to address MH&SU challenges positively influenced youth engagement in services and is aligned with prior research^{39–42}. Consistent with previous research^{43–45}, youth described how their motivation, and at times their ambivalence, toward service engagement became apparent after attending a few sessions. Some youth described how once they were engaged individually, they felt compelled to articulate readiness to reflect and reinforce clinicians' expectations. Other youth reported that if they perceived their initial encounter with services as a poor fit, their motivation to engage diminished. Clients' initial readiness to change, before starting treatment, has been shown to be associated with greater service engagement^{39,40,46}. One possible explanation as to why some youth have difficulty enacting the changes they commit to during treatment could be low self-efficacy⁴⁷. Previous research has showed that confidence in one's ability to take action has been linked to the development and application of adaptive coping skills⁴⁸. Meanwhile, other research has showed that higher levels of anxiety and depression have been associated with reduced confidence in one's capability to reduce substance use⁴⁹.

Feelings of shame, embarrassment, and fear of judgement were shown to adversely influence youth service engagement. This finding aligns with previous research, showing that experiences of shame are associated with an individuals' fear of feeling shame again (or the anticipation of shame), which functions as an internal threat⁵⁰. Youth also described experiencing shame, guilt, and embarrassment about substance use, which has been shown to compromise engagement in previous studies^{31,51}. Clinicians' attitudes can also contribute to shame and fear of judgement^{52,53} adversely influencing service engagement, a finding of this study. These attitudes can undermine youths' sense of empowerment and shape their perceptions of clinicians and services^{52,53}. In contrast, prior research has shown that shame and fear of stigma can foster a sense of understanding and relatability with peers in treatment programs, thereby facilitating engagement⁵⁴. As such, treatment programs may not be doing enough to support youth in processing shame related to their MH&SU challenges. At the same time, clinicians may not be employing techniques to prepare youth for, or reduce the likelihood of, experiencing uncomfortable emotions related to their MH&SU concerns and/or engaging in services to address these challenges.

Implications for Services

Findings from this study are consistent with the need for service delivery models that systematically identify and reduce barriers to engagement, while strengthening factors that promote sustained

involvement in Concurrent Disorder services. A standardized and comprehensive definition of youth engagement in treatment programs is warranted. Using participatory mixed methods, this definition should be co-designed with youth in Concurrent Disorder services and may include behavioural, affective, and cognitive dimensions of engagement²⁶.

Motivation or readiness to change was an important finding as it highlighted factors that contribute to or hinder youth's progress in services. Clinicians can assess youth's readiness to change using the Stages of Change model based on the TTM²⁴. The model includes four stages: (i) precontemplation, wherein a need to change behaviour has not yet been recognized or actively considered; (ii) contemplation, or the recognition of the problem and considerations for change; (iii) preparation/action, or the initiation of change; and (iv) maintenance, wherein new skills and behaviours are practiced to sustain change²⁴. The model acknowledges that relapse may occur during change process and may involve a return to an earlier stage of change²⁴. Clinicians can propose interventions specific to the youth's stage of change to increase motivation and promote positive change²⁴. For example, motivational interviewing techniques such as exploring discrepancies and resistance^{55,56}, in addition to a client-centered approach to treatment⁵⁷, may be particularly useful for promoting engagement and motivation to change.

Ensuring that youth understand that services are available and appropriate regardless of their readiness to change is essential. Integrated services should utilize a 'meet youth where they are' approach that empowers and supports them to achieve their goals. Empowerment has been described as a positive, self-transformative process through which youth develop intrinsic motivation and gain greater control over the actions that shape their identities and facilitate positive change⁵⁸. These findings support continued movement toward youth-centred approaches that promote autonomy and agency in the change process, rather than relying solely on clinician-as-expert models and. Engagement is further supported when clinicians encourage youth to develop and generate their own solutions⁵⁹.

Findings highlight important implications for services seeking to support youth who have disengaged from care. Regular check-ins following a youth's decision to stop attending services may facilitate re-engagement. These check-ins could provide opportunities to discuss alternative service options and clarify the steps involved in returning to care. As youth in this study expressed concerns about being judged for disengagement, it is essential that clinicians convey acceptance and reinforce youths' autonomy in decisions about re-engagement. Re-engagement may also be more likely when service options align with youths' preferences. For example, service preferences in terms of access to specific therapeutic approaches, preferred clinicians, shorter wait times, drop-in or booster sessions, flexible scheduling, or virtual modalities⁶⁰. Additionally, offering multiple options for communication, such as text or email, to accommodate youth preferences and differing levels of access to technology may support engagement with services.

There are some limitations to the study. The study was conducted in one Concurrent Disorder service in Toronto, Canada which may limit generalizability to other services. Future research could explore

engagement experiences of youth in various Concurrent Disorder services to determine good practices and lessons learned. Youth in the study were 16–24 years of age and milestones prominent in adolescence are different from young adulthood and may pose unique challenges to engaging in services. Future research should use a developmental lens to examine factors related to engagement in services. In addition, interviews were retrospective, particularly for youth no longer attending services. This could have introduced recall bias. Future research should capture youth experiences while in services or soon after they occur, as well as at consistent timepoints.

CONCLUSIONS

This study underscores the need for Concurrent Disorder services to adopt flexible, relational, and youth-centered approaches that recognize engagement as a dynamic and multifaceted process. Youth emphasized the importance of supportive and non-judgemental therapeutic relationships, as well as pathways for re-engagement. By incorporating youth-defined understandings of engagement, attending to motivational and emotional barriers, and offering services that prioritize responsiveness and continuity, services can more effectively meet the needs of youth navigating the complexities of concurrent disorders.

Abbreviations

DBT
Dialectical Behaviour Therapy
MH&SU
Mental health and substance use
SRQR
Standards for Reporting Qualitative Research
TTM
Transtheoretical Model

Declarations

Ethics approval and consent to participate.

The study is in accordance with the Declaration of Helsinki. Ethics approval was obtained by University of Toronto (REB: 35667) and the Centre for Addiction and Mental Health (REB: 158/2007-06). Informed consent was obtained from all participants.

Consent for publication.

Consent was obtained directly from participants.

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Author Contribution

AB contributed to designing the research question and conducted the analysis. MQD contributed to interpretation of the data and drafted the manuscript. All co-authors (AB, MPB, JJ, JH) reviewed the manuscript. JH contributed to designing the research, oversaw the conduct of the study, interpreted the data, reviewed the manuscript and provided study leadership; JH is the overall guarantor of the work.

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Data Availability

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

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