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Engaging Families in Adolescent Substance Use Services: Applying Lessons Learned from Youth Behavioral Health Services

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Abstract

Although family involvement is widely recognized as a critical component of effective care for adolescent substance use (ASU), caregivers and family members are not systematically involved in services. This article integrates three complementary frameworks describing family involvement and family engagement into a single account of family engagement in ASU services using a family systems lens. In doing so, we draw from family systems theories, engagement literature, and evidence from family-based interventions for ASU. We then discuss the implications for family engagement measurement, interventions, and treatment coordination in ASU services focused on scientific Foundations and Frontiers to advance research and clinical practice. We conclude with an innovative prototype training, audit, and feedback system illustrating how integrating family engagement conceptualization, measurement, intervention, and coordination can bolster provider use of evidence-based family engagement techniques through training, self-reflection, feedback, and decision-making support.

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Introduction

National and international agencies recommend family involvement in services and partnerships between healthcare providers, patients, and families to address youth substance use (e.g., Waller & American Society of Addiction Medicine, 2023), yet families are not systematically engaged in services (Partnership to End Addiction, 2025). *Family engagement* refers to the size and strength of the collaborative partnership between families and providers within service activities (Bobek et al., 2024). *Family involvement* refers to the structure of the partnership, that is, in what role or capacity family members participate in activities (e.g., provide assessment data, consult on treatment goals, join treatment sessions) (Bobek et al., 2025; Pielech et al., 2024).

Efforts to increase family involvement in substance use services will be unsuccessful unless the youth treatment system of care starts with improving its capacity to meaningfully engage family members (Tambling et al., 2022). Several complementary frameworks [REDACTED] address different aspects of family engagement, but have not yet been integrated into a single approach. Bobek and colleagues (2024) described a continuum of family involvement segmented into three branches (i.e., family collaboration, family skills training, and systemic family therapy) emerging from empirical research and clinical theory. Hogue and colleagues (2021) mapped opportunities to deepen family involvement and engagement across four phases of services (i.e., Treatment Preparation, Initiation, Stabilization, and Recovery). The REACH framework (Becker et al., 2018) elaborates the multidimensional conceptualization of treatment engagement in youth behavioral health services, and aligns this conceptualization with corresponding measurement approaches, clinical procedures, and service coordination principles that guide treatment delivery. Each framework addresses a different facet of the same issue: what

family involvement looks like, when it occurs, and how engaged families are at any given point. In this article, we use a family systems lens to integrate these three frameworks into a single account of family engagement in ASU services. We use REACH as the organizing structure because it contributes something distinct from Bobek's and Hogue's frameworks: a way to assess the quality and dimensionality of engagement at any given level of family involvement or phase of treatment. We then describe how this infusion enhances REACH with regard to family engagement measurement, clinical interventions, and services coordination for ASU.

Adolescent Substance Use Prevalence Rates

Substance use among adolescents (aged 13-17) is a persistent national public health problem. Data from the 2025 Monitoring the Future National Survey indicate among 8th grade students, 18.5% reported ever using alcohol (more than just a few sips), 10.6% marijuana, 15.6% nicotine via vaping, and 21.8% using any illicit drug including inhalants (Miech et al., 2025). These lifetime prevalence rates are more than tripled among 12th graders: 48.7% reported using alcohol, 34.4% marijuana, 31.3% nicotine via vaping, and 39% using any illicit drug including inhalants. Overall, in 2024, 7.8% of persons aged 12-17 met criteria for a substance use disorder in the past year (SAMHSA, 2025). ASU is associated with physical and mental health problems as well as other health problems like physical injuries, sexual risk behaviors, social and relationship problems, academic difficulties, and driving under the influence or riding with an impaired driver (Nath et al., 2022; Osilla et al., 2019). When insufficiently addressed, ASU often continues into adulthood, precipitating long-term substance use and mental health disorders, a cascade of other health consequences, and enormous economic costs to society (Recovery Centers of America, 2020).

Family Involvement in Adolescent Substance Use Services

National and international agencies recommend family involvement in services to address ASU. NIDA's comprehensive care model for effective treatment identifies family involvement and family-based services as important quality indicators of substance use disorder treatment (NIDA, 2020). SAMHSA has been prioritizing funding for research implementing family therapy and family-based treatments. The American Academy of Pediatrics (AAP) patient and family-centered care model advocates for collaborative partnerships between patients, families, and providers during substance use prevention and early intervention (AAP, 2025) and the most recent treatment standards for adolescents and young adults published by the American Society of Addiction Medicine (ASAM) stipulate family-centered care to be an essential driver of service quality (Waller & ASAM, 2023).

Family members can participate in ASU services in many ways. Bobek and colleagues (2024) describe a continuum of family involvement with three conceptual anchors. At one end of the continuum is Family Collaboration, wherein caregivers are engaged as adjunctive supports and consultants to adolescent-directed services to facilitate adolescent-focused treatment goals. The middle of the continuum is Family Skills Training, wherein family members participate in parent training and family behavior change interventions focused on family communication and problem-solving. Caregivers are engaged as session participants and receive family- or caregiver-directed components to improve family functioning via new family skills. The other end of the continuum is Systemic Family Therapy, wherein the family is centralized as the primary client, and family therapy interventions are used to address treatment needs and resolve conflict by repairing family relationships.

Along this continuum of family involvement there are ample opportunities for increasing family participation and engagement in ASU services. Hogue and colleagues (2021) developed a

conceptual framework presenting such opportunities across four phases of treatment services: Treatment Preparation, Treatment Initiation, Treatment Stabilization, and Recovery. According to this framework, during Treatment Preparation, family outreach strategies can be used to prepare families for services including promoting services accessibility and addressing common services barriers. During Treatment Initiation, family engagement strategies target motivation and participation, and family members can be invited to collaborate on treatment goals. Treatment Stabilization can feature use of family-based interventions like family education, family skills training, and systemic family therapy. Finally, families can be included in Recovery through family-based relapse prevention planning and general wellness promotion.

Despite widespread recommendations for utilizing family-based interventions to treat ASU, and the availability of robust frameworks to guide family involvement in services (e.g., Bobek et al., 2025; Hogue et al., 2021), family members are not routinely included in ASU services. Chou and colleagues (2024) are among the first to describe the prevalence of evidence-based family-based services in substance use disorder clinics, analyzing data from the National Treatment Center Study (Edmond et al., 2015). They report that whereas about 75% of treatment centers offer opportunities for family involvement, less than half of eligible families actually participate in treatment in some form. Similarly, data from the 2023 National Substance Use and Mental Health Services Survey show that while 72% of facilities surveyed offer "family counseling," none of the 14 clinical/therapeutic approaches included under this umbrella term were evidence-based family-focused engagement practices or interventions (SAMHSA, 2023). Aside from these basic utilization rates, we know very little about the extent to which families are routinely engaged and integrated in ASU services because it is neither routinely nor rigorously studied.

To date much of the research investigating family engagement in ASU services has relied primarily on behavioral indicators of involvement like session attendance and participation. This is true for youth behavioral health services writ large (Acri et al., 2017) as well as the few studies assessing engagement in ASU treatment (e.g., Szapocznik et al., 2013). This narrow, unidimensional operationalization of engagement is problematic and ultimately hampers efforts to understand and improve family engagement. Reducing engagement to attendance and participation misses key contextual barriers implicated in engagement and in doing so frames engagement as an attribute inherent in clients and family members, which can further stigmatize highly vulnerable groups like people who use alcohol and other drugs (Avery, 2019). For instance, it is not uncommon in clinical practice and research to find judgmental and blaming language like "resistant" and "uninterested" to describe low engagement among family members (Becker et al., 2021). Moreover, singular focus on behavioral indicators of engagement limits the pool of potential engagement strategies to those targeting behavior change (e.g., appointment reminders to improve session attendance), rather than a multidimensional set of strategies that can engage families in multiple domains and ways like psychoeducation about substance use and services (Becker et al., 2015). Moreover, by the time low engagement is made manifest behaviorally as poor attendance, participation, or drop out, it may be too late to improve engagement in other ways.

Family-Based Youth Engagement in Behavioral Health Services: Comprehensive Framework for Research and Practice

Transforming family engagement research and practice for ASU services requires a framework for conceptualizing engagement. Frameworks provide an organizing structure to the various concepts and ideas that represent a phenomenon, in this case, family engagement

(Nilsen, 2015). Contemporary conceptualizations of treatment engagement are described in detail by Becker and Chorpita (2023). Briefly, this perspective characterizes engagement as a multidimensional, dynamic, and contextual construct. Engagement is understood as a latent construct reflected in behavioral (e.g., attendance, participation), cognitive (e.g., beliefs, readiness, expectations), and social (e.g., therapeutic alliance) domains (e.g., Becker et al., 2018; Haine-Schlagel & Walsh, 2015; King et al., 2014; Piotrowska et al., 2017; Pullmann et al., 2013; Staudt, 2007), which may vary within and across individuals. Engagement is inherently dynamic, shifting within a single treatment session (e.g., Zlotnick et al., 2020) and over the course of care (e.g., Becker et al., 2023; Halfon et al., 2019). Engagement is also contextual, emerging from ongoing interactions between clients and their broader ecology, including providers, families, service systems, and the structure of treatment itself (e.g., Eubanks et al., 2018; Fjermestad et al., 2021; O'Keeffe et al., 2020; Ovenstad et al., 2020).

One approach to operationalizing this perspective is the REACH framework (Becker et al., 2018), which specifies five-dimensions of engagement: *Relationship* (therapeutic alliance; Shirk & Karver, 2003), *Expectancy* (beliefs about a successful outcome; Nock & Kazdin, 2005), *Attendance* (session presence; Nock & Ferriter, 2005), *Clarity* (understanding of treatment approach and roles; Shuman & Shapiro, 2002), and Homework (participation through in-session involvement and between-session practice; Nock & Ferriter, 2005). These dimensions were rationally derived from iterative literature reviews within youth mental health services (e.g., Becker et al., 2015; 2018) and then empirically validated in a large study using instruments designed to test the multidimensional nature of engagement (Chorpita & Becker, 2022). From the perspective of Becker and Chorpita (2023), engagement is best understood not as an individual attribute, but as a process co-constructed within therapeutic relationships and

contexts—rather than a unidimensional, static, and trait-like characteristic of the individual.

To date, REACH has represented engagement among the individuals involved in youth-facing services, including caregivers and other family members (Becker et al., 2018; Chorpita & Becker, 2022), but it has not articulated how engagement is co-constructed between family members or shaped by relational dynamics within the family system. Thus, for ASU services specifically, the REACH framework can be gainfully enhanced by incorporating systemic family engagement principles and techniques. Systemic family engagement conceptualizes client engagement as a family process. Nonattendance and dropout are understood as reflections of existing patterns of family interactions rather than the problem of any one individual. The Structural Strategic Systems Engagement (SSSE) model (Szapocznik & Kurtines, 1989) was developed to facilitate treatment engagement among treatment-reluctant youth and and their families. SSSE focuses on forming strategic alliances with family members viewed as holding significant power in the family system, often caregivers, and leveraging that alliance to motivate other family members to participate in treatment. Providers are trained to demonstrate respect, understanding, and acceptance of family members without challenging the family structure, thereby earning trust with a goal of helping family members attend the first treatment appointment. Results from two randomized studies demonstrated that SSSE was superior at engaging and retaining families compared to usual care engagement practices (Santisteban et al., 1996; Szapocznik et al., 1988). Another study testing integrated Brief Strategic Family Therapy (BSFT) and SSSE again found higher rates of treatment engagement among families assigned to the integrated BSFT and SSSE treatment compared to usual care in the community (Coatsworth et al., 2001). Similarly, Robbins and colleagues (2011) showed BSFT was significantly more effective than treatment as usual in engaging and retaining family members in treatment

Developing a family engagement conceptual framework infused with systemic family engagement principles is an ideal starting point for advancing family engagement science and practice in ASU treatment settings. Table 1 presents a prototype framework that applies the REACH framework to ASU services using a family systems lens to reflect decades of clinical wisdom from family-based treatment research including the SSSE model. This REACH application emphasizes relationally-oriented services engagement constructs within REACH domains, which are described in the following paragraphs. This application reflects our belief that service providers are responsible for fostering engagement and must flexibly adapt engagement strategies to overcome family-specific barriers (Szapocznik & Kurtines, 1989). We include references to provider cognitions and behaviors to underscore engagement as a dynamic and transactional process rather than reducing it to an attribute of individual family members.

Relationship. Unlike in individually oriented services, in family-oriented services providers must build alliances with multiple family members (Friedlander et al., 2011). Providers are also tasked with building alliance with family systems as a whole and fostering goal agreement across family members who may hold different perspectives on presenting problems and relationship challenges. Adolescents often perceive substance use as a normative aspect of adolescence, whereas parents and caregivers are more likely to view substance use as risky and problematic (Mrug & McCay, 2014). Moreover, it is not uncommon for adolescents and families to present to services under duress and high in family conflict, making treatment entry and alliance building more challenging (Shirk & Karver, 2003, Waldron et al., 2017) especially when youth are mandated to substance use services through the criminal legal system (Yeterian et al., 2013). We extend the Relationship domain to address these dynamics by including therapeutic alliance across the family system, relationships among family members participating in services,

and goal alignment among session participants.

Cognitive. This expansion addresses known barriers to family involvement in ASU services related to beliefs and expectations about family involvement in services. Youth providers often report feeling ill-equipped to collaborate with families in meaningful ways even when they believe in the clinical value of doing so (Pielech et al., 2024). Also, stigmatized beliefs held by providers about family members (e.g., biases against family members as having caused substance use and concerns about family involvement perpetuating enabling dynamics) and the efficacy of family involvement in services may curb the extent to which providers pursue opportunities to collaborate with family members (e.g. Buchholz et al., 2024; Pielech et al., 2024). As a result, even when family members facilitate treatment entry and are motivated to participate in services for their loved ones, family members are not systematically involved in services (Porter et al., 2024, 2025). The Cognitive domain is inclusive of the expectations family members and providers have about family participation in services, such as each person's role in services. It includes attitudes held by family members and service providers about family involvement in services, mutual understanding of the rationale for family participation, shared motivation and buy-in for family-focused treatment goals, and also provider knowledge and confidence working with families.

Behavioral. The focal extension to the Behavioral domain attends to provider behaviors aimed at fostering family collaboration and engagement (e.g., Bobek et al., 2025). It includes providers' critical reflection of their own beliefs, behaviors, and practices working with families (Aponte, 2022) as well as monitoring engagement over time (Friedlander et al., 2018).

In the following sections, we present engagement measurement, interventions, and coordination principles emerging from this REACH extension for ASU. We start by defining

concepts and related ideas and then describe Foundational advances in youth and family mental health services that can guide advancements in family engagement for ASU services research. We focus on the following Frontiers for family engagement in ASU services: (1) metrics and methods for measuring family engagement, (2) effective family engagement interventions and opportunities for involving family members, and (3) coordination principles to effectively identify, monitor, and address engagement challenges. We propose that advancing family engagement in ASU services requires integrating these domains. We illustrate this integration via a coordination system prototype called Train, Assess, Check, and Target (TACT) to bolster provider use of evidence-based family engagement techniques through training, self-reflection, feedback, and decision-making support.

Measurement: Multidimensional Multi-informant Methods

Measurement refers to the systematic and empirical assessment of a phenomenon to translate abstract constructs into quantifiable data. Effective measurement requires a clear definition of the construct in question (see above) and aligned metrics that are reliable and valid. The conceptualization of engagement as multidimensional, dynamic, and contextual opens new opportunities for how engagement is assessed. However, much of the empirical literature in child behavioral health services continues to reflect assumptions that engagement is unidimensional, relatively static, and observable. In a review of 52 randomized controlled trials (RCTs) testing engagement interventions in youth behavioral health services, attendance was assessed in 94% of studies, with 60% relying on attendance alone; 62% of studies measured only a single engagement dimension (Lakind et al., 2022). Across studies, 112 unique engagement indicators were used, nearly two-thirds of which indexed attendance, with far fewer capturing cognitive or relational processes. Youth (19%) and caregiver (27%) perspectives were infrequently assessed,

and 55% of measures were administered only once—often after treatment had concluded—limiting sensitivity to change over time.

Although pragmatic constraints, such as measure availability, feasibility, and assessment burden, shape measurement choices, narrow measurement approaches ultimately limit what can be learned about engagement during care. They restrict the ability to examine how engagement evolves over time, how its dimensions interact, and how it is experienced by youths and families. In turn, these limitations reduce the potential for measurement to inform timely, targeted engagement intervention (Becker & Chorpita, 2023).

The same patterns are evident in research on family engagement in ASU services. The most recent review on family engagement measures for adolescent and young adult substance use services was published in 2015 and found only 8 measures were tailored to this group (Hock et al., 2015). Only 4 measures were validated for adolescents over the age of 13 and only 2 assessed engagement in multiple domains. Advances in family engagement measurement have been stagnant in the last decade, with most research relying on measures of therapeutic alliance with youth and basic behavioral metrics of family involvement such as caregiver attendance (Haine-Schlagel & Walsh, 2015). The clinical significance of this gap is that agencies and providers adopting family-centered ASU services are ill-equipped to properly monitor family engagement. Assessing engagement across multiple dimensions in practice would require combining separate instruments, as few measures capture more than one domain (Chorpita & Becker, 2022). This fragmentation, coupled with limited longitudinal assessment and underrepresentation of consumer perspectives, constrains the ability to understand how engagement unfolds in practice and how contextual factors like family characteristics and the severity and consequences of substance use impact engagement. These limitations are

particularly consequential given evidence that providers frequently miss engagement concerns or misattribute them, especially by overlooking process-related indicators (e.g., alliance, expectations) in favor of more visible participation metrics (e.g., attendance, homework; Becker et al., 2021; Wu et al., 2026).

Foundations. Recent efforts in youth behavioral health services have sought to develop more integrative, consumer-informed approaches to assessing engagement across multiple dimensions (for a review, see Hock et al., 2015). One such effort is the development of multidimensional measures aligned with the REACH framework: the My Thoughts about Therapy instruments for youths (MTT-Y) and caregivers (MTT-CG; Chorpita & Becker, 2022). These measures assess the five REACH dimensions using parallel items and have demonstrated a five-factor structure consistent with the framework, as well as invariance across reporters and demographic groups (n = 1,807; Chorpita & Becker, 2022). These measures can be administered repeatedly to assess changes in specific engagement dimensions over time. Ongoing work aims to refine these tools and develop briefer, more scalable versions. By improving the ability to identify and differentiate engagement challenges, multidimensional measurement approaches provide a foundation for more precise and responsive intervention strategies; thus, existing instruments such as the MTT-Y and -CG are natural launching points for more effective measurement of engagement in ASU services.

Frontiers. Aligning the measurement of family engagement in ASU services with the conceptualization of engagement as a multidimensional, dynamic, and transactional process is fundamental to advancing the science. This starts with developing pragmatic and accessible multidimensional measures like *My Thoughts about Therapy* described above, that not only allow each family member to independently report on their own engagement but also provides an

opportunity for understanding interactional features of engagement. For example, how conflicting goals or poor relationships between family members shape the family system's engagement in services. Table 2 presents existing measures designed to assess family engagement in services and related constructs (i.e., therapeutic alliance) organized by engagement dimension assessed. Several gaps emerge from this review that underscore priorities for future research. Few measures assess the multiple domains of family engagement in ASU services that are described above, incorporate perspectives from multiple reporters (i.e., adolescents, caregivers, providers), reflect the developmental needs of adolescents, or are adapted for substance use services where unique engagement challenges like stigma arise. Moreover, the accessibility of existing measures is limited. Many lack publicly available items, administration and scoring directions, and interpretation guidelines.

A second opportunity for advancing family engagement measurement lies in expanding assessment to capture the contextual and dynamic nature of engagement processes (Becker et al., 2018). Conceptualizing engagement as a transactional process that unfolds between providers and families and is influenced by the family's experience with past services, current providers and agencies, and other factors in their social ecology (Ingoldsby et al., 2010), demands measuring associated constructs. Fidelity research assessing family-involved ASU services should expand fidelity measurement to include the use of clinical practices designed to establish and maintain engagement with all family members (e.g., collaborative goal planning). Moreover, in order to be clinically useful metrics must be proven sensitive to change over the course of treatment in order to provide providers with the opportunity to respond to shifts in engagement. hese advances in measurement create new opportunities to inform intervention. By identifying specific patterns and shifts in engagement, multidimensional assessment can guide the selection

and timing of targeted, evidence-based engagement strategies.

Intervention: Evidence-based Core Practices

Clinical practices designed to engage families in ASU services are often described in broader protocols and proprietary treatment manuals (e.g., manualized family therapy) that can be difficult to access (see Hogue et al., 2013). As a result, engagement practices are inconsistently defined, operationalized, and tested in clinical research, making broader dissemination more challenging. Advancing family engagement research and practice requires improving the accessibility of engagement practices.

Foundations. Research on treatment engagement interventions in children's mental health has been reviewed in detail elsewhere (Becker et al., 2018; Becker & Chorpita, 2023; 2026). Briefly, this work indicates that a range of effective engagement strategies have been identified, including appointment reminders, psychoeducation, motivational enhancement, and culturally responsive practices (Lindsey et al., 2014; Becker et al., 2018; Becker & Chorpita, 2026). These strategies often target a single engagement dimension (e.g., attendance or therapeutic alliance); thus, no single procedure functions as a "magic bullet" to achieve all engagement goals. Interventions also vary in timing, with some delivered at treatment onset and others implemented continuously to support engagement over time. Although these studies have been designed to address specific research questions, the resulting literature has often been interpreted in ways that imply engagement can be established early and maintained with relatively uniform strategies. In practice, this has contributed to procedures that are frequently front-loaded at the outset of treatment, as if engagement, once achieved, remains stable. This perspective gives limited attention to the multidimensional nature of engagement or to the ways in which engagement concerns may emerge, shift, or recur over the course of care (Becker &

Chorpita, 2023).

Efforts to organize this literature have applied multidimensional frameworks to synthesize findings across studies. A systematic review of 50 RCTs mapped diverse operationalizations of engagement onto the REACH framework and used a distillation approach to identify common "practice elements" (Becker et al., 2018). This review indicated that some practices may have broad relevance across engagement dimensions (e.g., psychoeducation is associated with outcomes across REACH dimensions), whereas others show more specific associations (e.g., appointment reminders promote attendance).

Complementary work applying distillation and matching methods across 66 RCTs described how practice patterns in the empirical literature vary according to timing, clinical problem, and target population (e.g., youth or caregiver; Becker & Chorpita, 2026). These descriptive findings suggest that engagement strategies are not applied uniformly across contexts, and that their use varies by the specific engagement dimension targeted, the clinical context, and when and with whom the practice is applied (Becker & Chorpita, 2026). Notably, substance use interventions showed distinct patterns of practice selection, with differentiation by target population. Specifically, youth-focused approaches more often emphasized strategies such as accessibility promotion, case management, reminders, performance feedback, and reinforcement-based supports, whereas caregiver-focused approaches more frequently incorporated behavioral contracting, negotiation skills, and motivational techniques (e.g., eliciting change talk; Becker & Chorpita, 2026). Collectively, distillation research highlights the importance of selecting and tailoring engagement strategies to fit the needs of individual clients, rather than relying on uniform approaches.

Frontiers. Advancing family engagement in ASU services research and practice requires

synthesizing the theoretical and empirical literature to develop a conceptual taxonomy of engagement techniques specific to ASU services and improving the accessibility of these techniques for researchers and providers. Although the field has made progress in identifying clinical practices that foster family engagement in ASU services, these techniques are only beginning to be classified in a manner amenable to researchers developing family-based protocols (e.g., Bobek et al., 2025). Family therapy distillation research by Hogue, Porter, and colleagues synthesized four family engagement techniques from manualized family therapy models for ASU (Adolescent Goal Collaboration, Parent Collaboration, Love and Commitment, Parent Ecosystem) intended to foster adolescent and caregiver engagement and therapeutic alliance (Porter et al., 2023). Techniques that maintain family engagement by centering improved family relations as a solution to presenting problems (e.g., Relational Reframe, Family-Focused Rationale) also emerged as common practice elements across models (see Hogue et al., 2017).

Table 3 presents a theoretically derived taxonomy describing opportunities to involve caregivers and other family members in ASU services, along with clinical techniques to do so in meaningful ways. The taxonomy is organized by degree of Family Involvement (i.e., Family Consultation, Family Skills Training, Systemic Family Therapy) and Treatment Phase (i.e., Outreach, Onboarding, Intervention, Recovery). Engagement techniques are gleaned from ecological family therapy models (i.e., Multidimensional Family Therapy, Brief Strategic Family Therapy, Functional Family Therapy, Multisystemic Therapy), Structural Strategic Systems Engagement (Szapocznik & Kurtines, 1989), other family-based treatments (e.g., Culturally Informed & Flexible Family Treatment for Adolescents, Santisteban & Mena, 2009; Strengths Oriented Family Therapy, Hall et al., 2008; Community Reinforcement and Family Training

[CRAFT], Meyers et al., 1998; CRAFT adaptations for parents of adolescents, Kirby et al., 2015; Waldron et al., 2007) and multicomponent interventions involving caregivers (e.g., Integrated Outpatient Cognitive-Behavioral Intervention, Esposito-Smythers et al., 2011). Taken together, these techniques centralize core family engagement principles described by Hogue and colleagues for building empathy and connecting with caregivers at treatment onset and throughout care, including: building hope, collaborating on family-oriented goals, rekindling emotional connections, understanding life circumstances, and honoring caregiver role in the family. The spectrum of protocols underscore how families can be invited to participate in ASU services in a multitude of ways including outreach phone calls, intake assessment and orientation, visitation days and family events, multi-family educational and skills groups, check-in meetings for clinical updates, treatment sessions to serve as consultants on individually oriented treatment plans (e.g., supporting homework completion outside of session), treatment sessions for family skills building, and family therapy sessions.

Coordination: Resource Systems to Guide Care

Coordination principles guide how providers use resources to accomplish a goal (Becker & Chorpita, 2023). As the field expands its repertoire of evidence-based engagement practices, a key opportunity lies in how these strategies are organized and used over time. Coordination approaches can support providers in selecting, sequencing, and adapting practices to sustain family engagement throughout care. While there have been notable advances in delineating effective family engagement interventions, the organization and use of these interventions in practice remain limited. Many evidence-based treatments integrate a few engagement procedures (Wu et al., 2022), typically front-loading them at the outset of care with the aim of establishing a relatively narrow form of “sufficient” engagement (Becker et al., 2018). Unfortunately, this

approach does not foreground engagement as something to be monitored alongside clinical progress, nor does it provide structured support for detecting, diagnosing, and addressing engagement deficits or disruptions as they emerge over time. Moreover, although many engagement practices are agnostic to the delivery context (e.g., provider education level, setting, format, audience) (Becker et al., 2018), they are often distributed across individual treatment protocols (Wu et al., 2022) rather than consolidated into a coherent system. As a result, providers are likely to draw on only a small subset of available strategies, without access to the broader intervention set in a coordinated or responsive way. Together, these limitations constrain the ability to adapt engagement efforts over time and reduce the extent to which existing knowledge can inform real-time clinical decision-making.

Foundations: These observations have informed the development of coordinated resource systems to support more responsive engagement decisions and actions, such as the Reaching Families Engagement System (RFES; Becker & Chorpita, 2023; Becker et al., 2018; Chorpita et al., 2025). Grounded in youth mental health services, the RFES integrates youth and caregiver engagement data (MTT-Y, MTT-CG), provider decision-support tools, and brief implementation guides within a recursive Plan–Do–Study–Act process. Findings from a multisite RCT (Chorpita et al., 2025) suggest that such approaches can improve the identification of engagement problems and the selection of well-matched strategies, illustrating how a multidimensional framework can be translated into structured, scalable clinical support, particularly in contexts where engagement must be actively monitored and adapted over time.

Frontiers. Researchers must develop new implementation strategies to improve use of evidence-based family engagement interventions in routine ASU care. ASU providers need to be better equipped with family engagement techniques and decision supports to improve family

involvement and engagement in services. Recent research suggests provider knowledge about evidence-based practices and how to deliver them in services can be improved through low-barriers online training systems (Hogue et al., 2022, 2023) that are both pragmatic and scalable—necessities for uptake in real world treatment settings. In the following section we propose a prototype coordination and monitoring system designed to bolster ASU provider use of evidence-based family engagement practices that draws from recent advances in developing measurement, training, and feedback systems (e.g., Becker & Chorpita, 2023; Becker et al., 2018; Chorpita et al., 2025; Hogue et al., 2019; Hogue et al., 2022; Hogue et al., 2023).

Illustrative Example. We propose **T**rain, **A**ssess, **C**heck, **T**arget (TACT), TACT integrates proposed advances in family engagement conceptualization, measurement, and intervention delivery to (1) **Train** providers in evidence-based family engagement techniques and then coach them to (2) **Assess** their own goals for family involvement and current use of evidence-based engagement practices, (3) **Check** for emerging engagement concerns across multiple dimensions, and (4) **Target** emergent concerns using evidence-based techniques.

Train. An efficient and resource-light option for training providers to deliver evidence-based practices is online training that teaches providers to better recognize and judge the extensiveness of technique delivery through coding activities (Hogue et al., 2019). Coder training increases provider knowledge about techniques and models how to deliver those techniques in practice. To build on knowledge gained via coding activities, a second strategy is clinical application training where providers practice skills via guided exercises using role-plays, rehearsal, and feedback with simulated families (Frank et al., 2020). TACT will utilize both training strategies to enhance provider self-efficacy, skill, and knowledge. Providers will learn to recognize and assess family engagement technique use via coder training wherein providers

review brief videos of staged therapy segments, rate the extent to which engagement techniques were delivered, and receive immediate feedback on their rating accuracy (Hogue et al., 2023). Then providers will engage in interactive roleplays in a virtual practice environment to practice family engagement techniques featured in coder training activities and receive immediate feedback.

Assess. The Family Engagement Taxonomy presented in Table 3 explicates three levels of family involvement (Family Consultation, Family Skills Training, Systemic Family Therapy), the corresponding goals of family involvement at various treatment phases (Outreach, Onboarding, Intervention, Recovery), and suggested clinical techniques to engage families at each intersection. During Assess, providers will be guided through a reflective exercise to locate their treatment plan along these axes and articulate what they believe to be the clinical goal of involving family members in the planned treatment. Next, providers will be prompted to self-report on their current use of engagement practices to assess the degree to which they are using engagement practices that might facilitate their targeted family involvement goal.

Check. During Check, TACT will guide providers through assessing family engagement in multiple dimensions (Cognitive, Behavioral, Relational) as detailed in the REACH for families framework (Table 1) using measures listed in Table 2 for a multidimensional view of family engagement from providers' perspectives. During this step, providers will also be prompted to self-report their beliefs and assumptions about families, and their attitudes toward family involvement in services. Providers will receive regular personalized feedback reports summarizing their stated intentions for family involvement, use of engagement techniques, and family engagement assessment data to highlight discrepancies between provider goals and behaviors. Moreover, as indicated feedback reports will provide disconfirming evidence to

challenge negative stereotypes held by providers about caregivers and families of adolescents.

Target. In the final step, providers will be coached to choose evidence-based family engagement techniques to address emergent engagement concerns identified during the previous step. Providers will be presented with a menu of techniques drawn from the Family Engagement Taxonomy (Table 3). Techniques will be suggested based on provider reported goals for family involvement in services and family engagement assessment data collected in the previous step.

Provider training, audit, and feedback systems are most effective in producing behavior change with repeated measurement, feedback, and goal setting over time (Brown et al., 2019). Providers will engage with TACT on a biweekly basis, cycling through TACT steps for iterative and timely feedback focused on actionable behaviors.

Conclusion

This article reviews systematic advances in family engagement conceptualization, measurement, interventions, and treatment coordination in youth behavioral health services that can be leveraged to advance the science and clinical practice of family engagement in ASU services. In order to improve uptake of family-based services for ASU, professionals working with adolescents must be better equipped to meaningfully engage families. The first step is advancing research to better organize family engagement principles and ideas, develop user-friendly and pragmatic family engagement measurement tools, improve accessibility to evidence-based family engagement interventions, and articulate treatment coordination principles specific to treatment engagement to guide providers in utilizing available resources. One promising direction to integrate conceptualization, measurement, intervention, and coordination in a pragmatic way is designing, testing, and refining systems like TACT that center existing evidence-based practices and require minimal resources. Moreover, systems of this kind

can yield valuable clinical data to understand family engagement patterns and problems and enrich clinical decision-making to empirically link engagement techniques to engagement outcomes.

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Table 1. A Multidimensional Conceptual Framework of Family Engagement in ASU Services

	RELATIONAL	COGNITIVE		BEHAVIORAL	
REACH description	**Relationship**	**Expectancy**	**Clarity**	**Attendance**	**Homework**
	• Therapeutic alliance	• Expectations about eventual outcomes of treatment and one's own readiness and motivation to participate	• Understanding treatment approach and its rationale, structure and goals, or the roles of each person involved in treatment	• Presence and timeliness of expected participants at a session and their active participation	• Between session therapy assignment/ predetermined activity completion rate
Family Systems extension	• Relationships among family members involved in services • Goal alignment between family members involved in services • Therapeutic alliance across the family system	• Beliefs about family involvement in services and expectations for family participation • Understanding of the rationale and process for family involvement • Motivation and buy-in for family-focused goals • Provider knowledge and confidence working with family members		• Provider self-monitoring of beliefs and assumptions about families	

Table 2. Family Engagement Measures Inventory

	Relational	Cognitive	Behavioral	Reporters
Alliance				
System for Observing Family Therapy Alliances (SOFTA; Friedlander et al., 2006)[b]	X	X	X	Observer
The Family Therapy Alliance Scale (FTAS: Pinsof & Catherall, 1986)	X	X		Youth
Therapeutic Alliance Scale for Caregivers and Parents (Accurso et al., 2013)[a]	X			Youth, caregiver, observer
Vanderbilt Therapeutic Alliance Scale-Revised (Shelef et al. 2005)[a, b, c]	X	X		Observer
Engagement				
Credibility Expectancy Questionnaire (Nock et al., 2007)[a]		X		Caregiver
Family Engagement Questionnaire (Kroll & Green, 1997)[a, b]		X		Provider
Multisystemic Therapy-Caregiver Engagement (Foster et al. 2009)[a, b, c]		X		Observer
My Thoughts about Therapy (MTT; Chorpita & Becker, 2022)[b]	X	X	X	Youth, caregiver
Parent Motivation Inventory (PMI; Nock & Photos, 2006)[a]		X		Caregiver
Parent Participation Engagement Measure (PPEM; Haine-Schlagel et al. 2015)[b]			X	Youth, caregiver
Parent Rating of Parent Involvement (Noser and Bickman 2000)[a, b]			X	Caregiver
The Child and Adolescent Level of Care System (Fallon et al. 2006)[a, b]			X	Provider

Note. The Relational dimension is meant to reflect relationships between session participants inclusive of client alliances with providers; Cognitive to reflect treatment expectancies and clarity; and Behavioral to reflect attendance, participation, and between-session assignment completion.

[a]Hock et al. 2015 review

[b]Validated for adolescents (age 12-19)

[c]Validated for substance use services

Table 3. Taxonomy of Family Engagement in Adolescent Substance Use Services

	Phase 1 Outreach	Phase 2 Onboarding	Phase 3 Intervention	Phase 4 Recovery
Family Consultation: *Caregivers are resources to help define and support treatment goals of adolescent-focused treatment*[a]				
Goal	Reduce barriers to caregiver participating in treatment onboarding	Adolescent, caregiver, and provider have mutual understanding of treatment process and objective of caregiver participation	Caregiver learns how to support adolescent achieve identified individual treatment goals	Caregiver understands their role in supporting adolescent's recovery goals
Example family involvement	• Outreach phone call	• Intake assessment • Intake session(s)	• Multi-family support and educational groups • Caregiver check-in(s) • Periodic session attendance • Direct-to-family supports	• Multi-family support and educational groups • Periodic session attendance • Direct-to-family supports
Engagement techniques	• Ally with and activate caregivers to participate in treatment onboarding • Assess and address logistical and psychosocial barriers to participating in treatment onboarding	• Provide treatment orientation • Develop plan for caregiver participation in treatment sessions • Provide rationale for caregiver involvement	• Provide psychoeducation • Collaborate on ways caregiver can reinforce the treatment agenda and emerging skills in home environment • Recruit caregiver to help monitor treatment progress	• Provide psychoeducation • Collaborate on ways caregiver can reinforce recovery plan • Recruit caregiver to help monitor recovery progress
Family Skills Training: *Caregivers are participants to improve targeted parenting strategies and family communication skills*[b]				
Goal	Reduce barriers to caregiver participating in treatment onboarding	Adolescent, caregiver, and provider have mutual understanding of treatment process and endorse family-oriented goals	Family learns skills to improve family dynamics and promote healthy adolescent development	Caregiver builds knowledge and skills to support recovery process and relapse prevention
Additional family			• Multi-family skills groups • Family skills sessions	• Family recovery planning sessions

involvement examples			• Home visits	
Additional engagement techniques		• Collaborate on family focused goals • Provide family focused rationale for skill building	• Revisit family goals and rationale	• Provide family-focused psychoeducation • Collaborate on ways caregiver can support recovery goals and reinforce recovery plan
Systemic Family Therapy: *Family is the client with goal of improving relationships among family members and between family members and systems*[c]				
Goal	Reduce barriers to caregiver participating in treatment onboarding	Adolescent, caregiver, and provider have mutual understanding of treatment process and endorse family-oriented treatment goals	Repair family relationships and reduce risk factors across systems	Family builds knowledge in recovery process and relapse prevention and develops family-based relapse prevention plan
Additional family involvement examples			• Family therapy sessions • Home visits and therapy	
Additional engagement techniques		• Enhance caregiver feelings of love and commitment • Explore ecosystems • Instilling hope for family therapy as a new opportunity for change	• Relational reframing • Provide rationale for relationship repair	• Collaborate on family-based recovery and relapse prevention plan

[a]Examples: Integrated Outpatient Cognitive-Behavioral Intervention, Esposito-Smythers et al. 2011), Motivational Enhancement Therapy with Family Check-Up (Spirito et al., 2018)

[b]Examples: Adolescent Community Reinforcement Approach (Godley et al., 2001); Family Behavior Therapy (Azrin et al., 2001); Family Support Network (Dennis et al., 2004); Youth Opioid Recovery Support (Fishman & Wenzel)

[c]Examples: Multisystemic Therapy (Henggeler et al., 2009); Functional Family Therapy (Sexton & Alexander, 2004); Multidimensional Family Therapy (Liddle et al., 2005); Brief Strategic Family Therapy (Szapocznik et al., 2003)