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Community Providers' Experiences With Evidence-Based Practices: The Role of Therapist Race/Ethnicity

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Abstract

Objectives: Examining therapists' experiences implementing evidence-based practices (EBPs) is fundamental to understanding how these interventions are perceived, adapted, and delivered in community settings. However, little is known about racial/ethnic variation in the experiences of therapists serving racial/ethnic minority youth and their families. Through an innovative QUAN → qual → QUAN mixed-methods approach, we examined differences in therapists' perceptions, adaptations performed, and client-engagement challenges in the largest county-operated department of mental health in the United States.

Method: Surveys were completed by 743 therapists (Latinx [44%], White [34%], other ethnic minority [22%]), most of whom were female (88%), master's level (85%), and unlicensed (58%). A subset of therapists (n = 60) completed semistructured interviews.

Results: Latinx therapists reported more positive experiences implementing EBPs, making more adaptations to EBPs, and encountering fewer client-engagement challenges than therapists from other racial/ethnic groups. Qualitative analyses expanded on these results, revealing that Latinx therapists commonly described adapting EBPs in terms of language and culture to improve fit and promote client engagement. Informed by these qualitative themes, a refined statistical model revealed that the ability to deliver EBPs in languages other than English might have accounted for differences in therapist-reported EBP adaptations and client-engagement challenges.

Conclusions: The findings suggest that racial/ethnic minority therapists have positive experiences in implementing EBPs in community settings. In the case of Latinx therapists,

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bilingual/bicultural competence may facilitate adapting EBPs in ways that reduce perceptions of engagement challenges with racially/ethnically diverse clients.

Keywords

therapist; evidence-based practices; community implementation; cultural adaptation; racial/ethnic minority

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There has been an increased push to implement evidence-based practices (EBPs) in community settings as an effort to provide services to the 40% of youth with mental health needs (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003). EBPs are interventions with demonstrated effectiveness that have the potential to improve quality of care (Kazdin, 2008). Nevertheless, EBPs are often developed and tested in research settings that differ significantly from routine practice in terms of the population served (Ehrenreich-May et al., 2011; Southam-Gerow, Weisz, & Kendall, 2003), therapist workload and competing demands (Weisz, Ugueto, Cheron, & Herren, 2013), as well as levels of training and supervision available to therapists (Beidas et al., 2012; Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010). Community implementation of EBPs generally yields diminished effects compared with efficacy trials (Southam-Gerow et al., 2010; Torrey, Bond, McHugo, & Swain, 2012; Weisz, Krumholz, Santucci, Thomassin, & Ng, 2015; Weisz et al., 2009). Explanations for this "voltage drop" often include attention to diversity in clients served and the background characteristics of community therapists. In particular, when community therapists' attitudes toward and perceptions of EBPs are unfavorable, EBP implementation outcomes, including adoption, fidelity, and sustained use, are poor (Nelson, Shanley, Funderburk, & Bard, 2012; Reding et al., 2018; Stahmer & Aarons, 2009).

Despite the fact that this is the most diverse mental health workforce in history (American Psychological Association, 2018), the EBP implementation experiences of racially/ethnically diverse therapists have been understudied. Examining potential racial/ethnic differences in how therapists perceive and employ EBPs is especially crucial because of concerns in the field regarding the fit of researcher-developed, manualized, and less flexible EBPs with the needs of clients served in community settings (DiMeo, Moore, & Lichtenstein, 2012). Given that EBPs have been developed with homogeneous samples, community therapists have expressed concerns about their cultural fit and appropriateness for diverse clients (Cabassa & Baumann, 2013; Southam-Gerow, Rodríguez, Chorpita, & Daleiden, 2012). Despite limited evidence that EBPs are less suited to treat racial/ethnic minorities than nonmanualized treatments (Huey, Tilley, Jones, & Smith, 2014; Pina, Polo, & Huey, 2019), therapists' preconceptions of and attitudes toward EBPs may affect the success of community implementation efforts.

Previous research on racial/ethnic differences in therapists' attitudes toward EBPs is mixed. For example, preimplementation studies—studies examining therapists' attitudes toward potentially using manualized EBPs in their future work with youth and their families—suggest that African American and Latinx therapists endorse more negative attitudes compared with White therapists (Aarons, Cafri, Lugo, & Sawitzky, 2012; Aarons, Glisson, et al., 2012; Aarons et al., 2010). However, surveys including Latinx, Asian American, and

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African American therapists who have had previous experience in implementing EBPs, such as child–parent psychotherapy (CPP), Managing and Adapting Practice (MAP), Seeking Safety (SS), trauma-focused cognitive–behavioral therapy (TF-CBT), and the Positive Parenting Program (Triple P), have revealed no racial/ethnic differences in therapists' perceptions of such practices (Reding et al., 2018). In some cases, racial/ethnic minority therapists (i.e., Latinx) reported more positive perceptions of EBPs than White therapists (Barnett et al., 2017). Thus, it may be essential to distinguish between general predispositions toward EBPs and perceptions of actual implementation experiences with EBPs because the former may or may not represent a proximal predictor of the latter. Nevertheless, most published studies on therapist perceptions of EBPs in the context of ongoing implementation have not examined associations with therapist race/ethnicity (e.g., Beidas et al., 2015; Nakamura, Higa-McMillan, Okamura, & Shimabukuro, 2011; Nelson et al., 2012).

General attitudes toward EBPs may determine whether racial/ethnic minority therapists are reluctant versus enthusiastic about utilizing these interventions. Dubiousness about EBP fit may lead therapists to feel that interventions need to be adapted to ensure their relevance and effectiveness when serving diverse families (Aisenberg, 2008; Cabassa & Baumann, 2013). For instance, community therapists appear to adapt EBPs based on perceived needs (Aarons, Green, et al., 2012), including client characteristics such as cultural background (Barnett et al., 2019), and these adaptations are likely shaped by their perceptions of the EBP being delivered (Lau et al., 2017). There is also evidence that Latinx therapists report adapting EBPs to a greater extent than White therapists (Lau et al., 2017) and, that therapists' cultural background affects the types of adaptations undertaken (Saifan, Brookman-Frazee, Barnett, Gonzalez, & Lau, 2018). However, it is still unclear what factors may underlie racial/ethnic differences in therapist-driven adaptations of EBPs, and qualitative data may shed light on the nature of these adaptations.

Another potential factor that may drive therapists' experiences in community EBP implementation with diverse families is perceived client engagement. Families served in community settings tend to be more racially/ethnically diverse, come from backgrounds of lower socioeconomic status (SES), and have more complex clinical presentations than those served in research settings (Ehrenreich-May et al., 2011; Southam-Gerow et al., 2003). Research suggests that compared with White parents, racial/ethnic minority parents show less active participation in treatment sessions by disclosing less about their perspectives on therapy activities and expressing less enthusiasm regarding making changes at home (Dickson, Zeedyk, Martinez, & Haine-Schlagel, 2017; Stadnick, Haine-Schlagel, & Martinez, 2016). Similarly, racial/ethnic minority families are more likely than White families to terminate treatment prematurely (Snell-Johns, Mendez, & Smith, 2004; Stevens, Kelleher, Ward-Estes, & Hayes, 2006; Whittaker & Cowley, 2012). Calls to diversify the mental health workforce have been driven in part by the assertion that racial/ethnic minority therapists may be in a better position to facilitate client engagement in diverse communities (e.g., U.S. Department of Health and Human Services, 2001). However, there is little evidence bearing on how therapist race/ethnicity may be associated with perceptions of challenges in engaging diverse clients in EBP delivery. Previous studies have led to mixed findings, ranging from no significant racial/ethnic differences in therapists' reports of clients

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expressing concerns/doubts about treatment or levels of engagement in sessions (Gellatly et al., 2019) to results suggesting that Latinx therapists report fewer instances of clients not participating in sessions compared with White therapists (Lau et al., 2018). Given these inconsistent results, mixed-methods analyses may be useful to understand how diverse therapists perceive and respond to client-engagement challenges within community EBP implementation.

The objective of this study was to examine the experiences of racial/ethnic minority therapists implementing EBPs in community settings serving primarily racial/ethnic minority families. We compared therapists across racial/ethnic groups in terms of their perceptions of EBPs used, reported adaptations to EBPs, and perceived client-engagement challenges in the delivery of EBPs. Expanding on traditional mixed-methods designs in implementation research (Palinkas, 2014), this study employed an innovative QUAN → qual → QUAN design. In this sequential approach, initial quantitative analyses were used to examine differences across Latinx, other racial/ethnic minority groups, and White therapists, followed by qualitative analyses of therapists' narratives, with the purpose of convergence and expansion of the quantitative results. These qualitative analyses narrowed potential interpretations of observed quantitative differences by therapist race/ethnicity (Hamilton & Finley, 2019). The qual → QUAN phase informed the final quantitative analyses to test an expanded research question informed by the qualitative analysis (Nastasi, Hitchcock, & Brown, 2010; Palinkas, 2014). Thus, this iterative mixed-methods approach allowed findings at one stage to influence decisions regarding methods at a later stage (Nastasi et al., 2010), which is consistent with best practices in sequential mixed-methods research (Teddlie & Tashakkori, 2010).

Method

Study Context

The Los Angeles County Department of Mental Health (LACDMH) is the largest publicly funded county mental health department in the United States, annually serving over 250,000 individuals (LACDMH, n.d.). Approximately 92% of youth receiving care through the LACDMH are racial/ethnic minorities (i.e., 73.3% Latinx, 15.8% Black/African American, 2.2% Asian American/Pacific Islander, 0.3% Native American/Alaska Native; Ashwood et al., 2018). The large majority of youth clients are Medicaid eligible or have Healthy Families insurance coverage, although some youth without such coverage may receive services if they are at risk of maltreatment or are involved in the welfare system (LACDMH, n.d.). In 2009, the LACDMH began the Prevention and Early Intervention (PEI) Transformation, a large-scale reform of youth mental services that provided contracted agencies reimbursement for the delivery of EBPs (i.e., CPP, MAP, SS, TF-CBT, Triple P) for children and youth. The LACDMH provided early implementation support (i.e., initial training and consultation).

Recruitment and Procedures

Data for the current study were drawn from the Knowledge Exchange on Evidence-Based Practice Sustainment (4KEEPS) project (Lau & Brookman-Frazee, 2016), which examined

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the sustainment of these initial EBPs. Nighty-eight agencies directly operated or contracted by the LACDMH were invited to participate in the 4KEEPS Therapist Survey. Of these 98 agencies, 69 (71%) provided therapist contact information or the option for therapists to complete the survey directly. Eligible therapists were those who delivered one of the six EBPs in fiscal year 2013–2014. Participants received a $20 gift incentive for survey completion.

Additionally, 14 agencies representing 28 program sites (i.e., clinics) were recruited to be part of an "in-depth" data-collection phase that included semistructured interviews with agency leaders and therapists. A total of 126 therapists completed interviews and received a $40 incentive. A random stratified sample of therapists' interviews was selected for transcription and qualitative analysis. Interviews were sorted by the EBPs discussed and sequentially selected at random until 15 interviews per EBP were included. Institutional Review Boards at LACDMH and University of California, Los Angeles approved all study procedures.

Participants

Out of 856 participants who completed the 4KEEPS Therapist Survey, 743 (87%) were eligible for analysis in the current study because they reported delivering at least one of the six EBPs and completed all relevant measures. Most therapists were female (88%), master's level (85%), and unlicensed (58%). The sample was racially/ethnically diverse, with 44% Latinx, 34% White, 12% Asian American/Pacific Islander, 7% African American/Black, and 3% who identified as multiracial or members of other racial/ethnic groups. There were insufficient numbers of therapists who identified as Asian American/Pacific Islander, African American/Black, or multiracial to examine separately. However, we elected to retain them in the sample and aggregated them into a group described as therapists from "other racial/ethnic minority groups." This decision permitted us to examine Latinx therapists as a distinct group in a system context serving predominantly Latinx clients while at the same time allowing us also to retain other racial/ethnic minority therapists who may hold views of EBP implementation shaped by racial/ethnic minority status and/or bicultural competence. The majority of therapists (57%) reported that they were able to deliver services in a language other than English. Spanish (48%) was the most commonly reported bilingual competence (93% of Latinx therapists reported being able to deliver services in Spanish), although other therapists (9%) reported being able to provide services in other languages, such as Mandarin, Cantonese, and Farsi. Therapists reported using an average of 2.31 EBPs (standard deviation [*SD*] = 1.08, range = 1–5) with their clients.

For the qualitative portion of this study, 60 out of the 126 interviews were selected for transcription, coding, and qualitative analysis. Fifty-three (88%) interviews were with female therapists; 38 (63%) identified as Latinx, 11 (18.5%) as White, and 11 (18.5%) as other ethnic minorities. Twelve (20%) therapists reported being licensed, with 52 (87%) having a master's degree and 6 (10%) having a doctoral degree. There were no significant differences between the survey sample and the interview sample on any key demographics. Therapists discussed an average of 2.23 (*SD* = .67, range = 1–3) EBPs in their interviews.

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Measures

Therapist characteristics.—Therapists completed the Therapist Background Questionnaire (Brookman-Frazee, Drahota, & Stadnick, 2012). Professional background variables included licensure status, mental health discipline (e.g., marriage and family therapy, social work, psychology), highest degree obtained (i.e., master's, doctoral degree), and therapists' years of experience. Demographic variables included age, gender, and race/ethnicity. This measure has been shown to be reliable and valid in diverse community therapist samples (Barnett et al., 2017; Saifan et al., 2018).

Questions related to therapist race/ethnicity included (a) "Are you Hispanic? (Yes/No)," and (b) "What is your race? (Select one: White, Black or African American, American Indian or Alaska Native, Asian American/Pacific Islander, Multiracial, Other)." If therapists selected "Other," they were asked to specify their response by writing their self-identified race. Therapist self-identified race responses were reviewed and recoded if they fit with previously given categories (e.g., Chicano/a/x, Latino/a/x, Mestizo/a = Hispanic; Native American = American Indian or Alaska Native). Similarly, all therapists who indicated being "Hispanic" were considered Latinx regardless of their race. After this recoding, the composition of the sample was 44% Latinx, 34% White, and 22% other racial/ethnic minority.

General attitudes toward EBPs.—Two subscales from the Evidence-Based Practice Attitudes Scale (EBPAS; Aarons, 2004) were used to assess general therapist perceptions toward adopting EBPs. Therapists completed the Openness and Divergence subscales, each of which consisted of four items and were rated on a 5-point Likert scale from 0 (*not at all*) to 4 (*a very great extent*). The Openness scale measures therapists' willingness to try or use new interventions and EBPs (e.g., "I like to use new types of therapy/interventions to help my clients"). The Divergence scale measures therapists' views of EBPs as not clinically useful and less valuable than clinical experience (e.g., "Clinical experience is more important than using manualized therapy/interventions"). Internal consistency was acceptable for both Openness (α = .79) and Divergence (α = .70). The EBPAS's validity and national norms for community therapist samples are well established (Aarons et al., 2010).

Perceptions of EBPs delivered.—The Perceived Characteristics of Intervention Scale (PCIS; Cook, Thompson, & Schnurr, 2015) was adapted to measure implementation experiences with all EBPs ever used with a client. Eight of the original 20 items were administered to therapists in the current sample. Examples of items include "[EBP] is more effective than other therapies I have used," "[EBP] is aligned with my clinical judgment," and "[EBP] can be adapted to meet the needs of my patients." Therapists rated their agreement with each item on a 5-point Likert scale from 1 (*not at all*) to 5 (*a very great extent*). The mean composite score was used (range = 1–5), with higher scores representing more favorable perceptions of an EBP. The total scale demonstrated excellent internal consistency for all practices in the current sample, with Cronbach's alphas ranging from .92 to .96. This measure has been shown to be valid for racially/ethnically diverse community therapists in previous studies (Gellatly et al., 2019; Lau et al., 2017). In the current study, we used the average PCIS score across all EBPs delivered by the therapist.

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Reported therapist adaptations to EBPs.—The Adaptations to Evidence-Based Practices Scale (AES; Lau et al., 2017) is a six-item scale assessing therapist adaptations to EBPs delivered. Therapists rate six items using a 5-point Likert scale (0 = *not at all*, 4 = *a very great extent*) to indicate the extent to which they made each type of adaptation when delivering a specified EBP, including (a) modifying the presentation of EBP strategies, (b) shortening or condensing the pacing of the EBP, (c) lengthening or extending the pacing of the EBP, (d) integrating supplemental content or strategies, (e) removing or skipping components, and (d) adjusting the order of sessions or components. Therapists completed the AES for every EBP that they endorsed using within the past 2 months. The AES generates two subscales, including augmenting adaptations (i.e., modifying the presentation, integrating supplemental content or strategies, and lengthening or extending the pacing of the practice) and reducing/reordering adaptations (i.e., removing or skipping components, adjusting the order of sessions or components, and shortening or condensing the pacing of the practice). This measure was developed with a sample of mostly racial/ethnic minority therapists (Lau et al., 2017). Reliability was excellent for both subscales in this sample (α = .95–.98). In the current study, we used the average AES score across all EBPs delivered by the therapist.

Perceived client-engagement challenges.—Within a broader questionnaire asking respondents about their delivery of one of the six EBPs of interest with a client over the past 2 months, therapists were asked to report on whether they encountered any of seven client-engagement challenges (Lau et al., 2018). The Expressed Client Concerns subscale included the following four items about the client: "Expressed concerns about the relevance/acceptability/helpfulness of an intervention strategy," "Described practical barriers to using an intervention strategy (e.g., resources, materials, time)," "Verbalized a lack of familiarity of concepts presented in therapy," and "Expressed difficulty mastering skills presented in therapy." The Limited Client Engagement in Therapy Activities subscale included the following three items about the client: "Demonstrated apathetic or disinterested behavior," "Avoided participating in therapy activities," and "Consistently veered off topic from the material presented." Construct validity and internal consistency were supported by confirmatory factor analyses (CFA)—in a sample of mostly racial/ethnic minority community therapists—showing a good-fit model for a 2-factor solution with standardized factor loadings ranging from .46 to .75 (Lau et al., 2018).

Semistructured interview.—Therapists were interviewed using a semistructured interview guide that probed their attitudes toward and perceptions of EBPs, as well as implementation experiences with these practices. Therapists were asked a series of questions related to individual EBPs that they had ever used with a client. The interview followed a funnel approach, with broader questions followed by more specific follow-up probes. The following main topics were covered using the stem questions and a standard set of follow-up probes: (a) EBP appeal: "What do you like most about [EBP]?"; (b) EBP limitations: "What did you find most challenging about using [EBP]?"; (c) EBP adaptations: "Have you had to make any adaptations to [EBP]? If so, what kinds of adaptations?"; (d) EBP implementation support: "What types of supports have made this practice easier for you to deliver?"; and (e) EBP challenges: "What did you find most challenging about using [EBP]?"

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Data Analytic Plan

Quantitative analyses.—In examining the association between therapist race/ethnicity and EBP implementation experiences, it is crucial to statistically control for other therapist factors previously shown to be associated with implementation outcomes. There is evidence of differences in therapists' attitudes toward EBPs based on such characteristics as theoretical orientation (Reding et al., 2018), licensure status (Barnett et al., 2017; Nakamura et al., 2011), educational attainment (Nakamura et al., 2011; Reding et al., 2018), and years of clinical experience (Aarons, Glisson, et al., 2012; Reding et al., 2018; Stahmer & Aarons, 2009). Although these variables represent relevant covariates to isolate, it is also possible that some of them may not be related to the implementation outcomes examined in the current study. To select the final covariates, we conducted (a) partial correlations between candidate control variables to identify covariates that contributed unique variance in predicting implementation outcomes, and (b) correlations among candidate covariates to eliminate redundant variables (i.e., highly correlated variables). Because the sample was mostly female (88%), we also statistically controlled for gender. Nevertheless, all significant results in this study did not differ when male therapists were excluded from the analyses.

Given mixed findings related to racial/ethnic differences in general attitudes toward EBPs (Aarons, Cafri, et al., 2012; Aarons, Glisson, et al., 2012; Aarons et al., 2010; Barnett et al., 2017; Reding et al., 2018; Stahmer & Aarons, 2009), as well as the importance of differentiating general predispositions from actual experiences with EBPs, general attitudes toward EBPs were also included as covariates. Statistically controlling for EBPAS scores could help identify explanations behind racial/ethnic differences in EBP implementation that go beyond attitudinal inclinations. Table 1 shows the correlations between all variables included in the final models.

We conducted a multivariate analysis of covariance (MANCOVA) to examine the effect of therapist ethnicity on (a) perceptions of EBPs delivered, (b) perceived client-engagement challenges (i.e., expressed client concerns and limited client-engagement behaviors), and (c) reported therapist adaptations to EBPs (i.e., augmenting and reducing/reordering adaptations). These analyses included therapist gender, years of clinical experience, and attitudes toward EBPs (i.e., EBPAS Openness and Divergence scores) as covariates. Statistically significant multivariate tests were followed by univariate analyses testing the effect of therapist ethnicity on the individual dependent variables via analysis of covariance (ANCOVA) while employing the same set of covariates. For significant ANCOVA results, pairwise comparisons employing a Bonferroni correction were used to identify differences across groups while minimizing Type I error.

Qualitative coding.—A codebook was generated that included 39 codes related to perceptions of, adaptations to, and engagement challenges with EBPs (see Barnett et al., 2017, 2019 for a detailed description of code generation). The coding team consisted of three coders and two master coders (i.e., cotrainers). Four transcripts served as "gold standards," which were first coded and discussed by the two master coders until consensus was reached. Then, following a training procedure, the three coders were instructed to code the gold-standard transcripts, after which the coders and master coders discussed the codes

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and refined the codebook until reaching consensus. Once codes were finalized and the coding team reached consensus on the initial gold-standard transcripts, the remaining 56 transcripts were divided among coders to be independently coded following the training phase. Fifty percent of all independently coded transcripts were randomly selected to be reviewed by the master coder, and discrepancies were resolved through discussion to achieve consensus.

Qualitative analytic plan.—Qualitative analyses followed a stepwise methodology of consensus, co-occurrence, and comparison (Willms et al., 1990), which is consistent with current qualitative methods in implementation research (Hamilton & Finley, 2019; Palinkas, 2014). This iterative methodology allows for the refinement of code definitions and the logic of the coding scheme, as well as the collaborative development of themes (Hamilton & Finley, 2019). Co-occurring codes and illustrative quotes were analyzed and discussed with the research team to identify qualitative themes that potentially mapped onto significant quantitative results previously identified. Two members of the team (Giovanni Ramos and Tamar Kodish) independently reviewed coded transcript excerpts to identify themes emerging from interviews with Latinx, White, and other racial/ethnic minority therapists and compared their generated themes as a means to achieve concordance in thematic analysis. A final thematic agreement was reached through consensus meetings with coders and the senior researchers in the team. Finally, prominent themes emerging from these qualitative analyses (i.e., frequently mentioned themes, themes with the richest information content) were used to identify potential quantitative variables that could refine a new statistical model for further analyses.

Mixed-methods integration.—The combination of quantitative and qualitative methods within the same sample occurred in a recursive manner such that subsequent research questions were refined as a reaction to the results of previous analyses, making it possible to make more informed inferences about the event under study (Nastasi et al., 2010; Teddlie & Tashakkori, 2010). As such, the functions of this sequential QUAN → qual → QUAN design were (a) convergence, using both quantitative and qualitative approaches to answer research questions (i.e., triangulation); (b) expansion, using standardized measures to assess variables and employing interviews to provide depth of understanding; and (c) development —employing qualitative results to formulate new questions that could be answered by further quantitative analyses (Palinkas, 2014).

Results

Initial Quantitative Results

Table 2 shows descriptive statistics for the overall sample as well as each therapist group. The initial MANCOVA examining the effect of race/ethnicity on perceptions of EBPs delivered (i.e., PCIS score), reported therapist adaptations to EBPs (i.e., augmenting and reducing/reordering adaptations), and perceived client-engagement challenges (i.e., expressed client concerns and client disengaged behaviors) showed a significant multivariate effect of therapist race/ethnicity while accounting for all covariates, $F(10, 1466) = 4.256$, $p < .001$, partial $\eta^2 = .028$, Pillai's trace = .056. Univariate ANCOVAs testing the main effect

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of therapist race/ethnicity on the individual outcome variables showed significant differences in perceptions of EBPs delivered, $F(2, 736) = 7.822$, $p < .001$, partial $\eta^2 = .021$; reported number of augmenting adaptations, $F(2, 736) = 3.946$, $p = .020$, partial $\eta^2 = .011$; and reported client disengaged behaviors, $F(2, 736) = 10.682$, $p < .001$, partial $\eta^2 = .028$. No significant effects of therapist race/ethnicity on reducing/reordering adaptations or expressed client concerns were found. Bonferroni pairwise comparisons across groups revealed that Latinx therapists had more positive perceptions of EBPs delivered compared with White therapists (corrected $p < .001$, 95% confidence interval [CI] [0.649, 2.684]), Latinx therapists reported making more augmenting adaptations compared with White therapists (corrected $p = .042$, 95% CI [0.013, 0.950]), and Latinx therapists also reported fewer client disengaged behaviors compared with White (corrected $p < .001$, 95% CI [−0.654, −0.194]) and other racial/ethnic minority therapists (corrected $p = .011$, 95% CI [−0.572, −0.055]).

Qualitative Results

Qualitative analyses were then used to examine the extent to which the therapist narratives converged and expanded upon the identified quantitative racial/ethnic group differences. Three key areas of convergence and expansion were identified: (a) therapists' perceptions of EBPs delivered, which converged with Latinx therapists endorsing higher scores on the PCIS; (b) Latinx therapists' described approaches to EBP adaptation, which mapped onto the quantitative finding of higher augmenting adaptations on the AES; and (c) Latinx therapists' experiences with client-engagement challenges, which aligned with quantitative results on the lower frequency of client disengaged behaviors. We organized the results by the three key areas, first describing common or universal subthemes that emerged in interviews across all racial/ethnic groups, then reporting on emergent themes specific to Latinx therapists that converged with and expanded upon quantitative results. Table 3 displays prominent themes and exemplar quotes arising in interviews with Latinx therapists.

Perceptions of EBPs

Although the quantitative model showed that Latinx therapists reported more positive views on EBPs compared with White therapists, the qualitative results showed that therapists across all racial/ethnic groups described overall positive experiences in implementing EBPs in their work in the community. More specifically, multiple therapists described perceptions that EBPs are flexible enough to allow room for tailoring to clients' needs. Therapists across racial/ethnic groups also noted positive views of the structured nature of EBPs, which in turn bolsters confidence in therapists' ability to deliver interventions.

Upon further exploration of Latinx therapists' narratives, we found two emergent themes unique to Latinx therapists. Latinx therapists frequently indicated that the EBP structure facilitates work with racially/ethnically diverse clients (Theme 1, Quote a). Besides, Latinx therapists often noted that having an EBP to guide treatment reduces stress related to preparing for sessions and providing services to many clients each day (Theme 2, Quote b). These types of comments were not as apparent among White or other racial/ethnic minority therapists.

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Experiences with Augmenting Adaptations

Although quantitative results suggested that Latinx therapists made more augmenting adaptations than their White and other racial/ethnic minority peers, therapists from all groups commonly described adding "transdiagnostic techniques" into EBPs to deal with a diverse array of presenting problems. More specifically, therapists reported using therapeutic strategies, such as positive reinforcement, psychoeducation, and relaxation techniques, regardless of the EBP protocol they were following. According to these therapists' narratives, these techniques promoted treatment engagement as well as symptom improvement with their clients.

Expanding on the quantitative results indicating that Latinx therapists made more augmenting adaptations than White therapists, qualitative interviews showed that Latinx therapists frequently expressed awareness of cultural factors that could affect their work with families in the community (Theme 3, Quote c). By being attuned to cultural factors, Latinx therapists reported making cultural adaptations to EBPs related to the language of delivery, especially in their work with Spanish-speaking clients (Theme 4, Quote d). According to Latinx therapists, common cultural adaptations also included emphasizing rapport building, simplifying the language employed to make terms more accessible, and slowing down the pace in sessions to facilitate learning (Theme 5, Quote e). Finally, Latinx therapists often discussed providing case management and additional care coordination services for their clients, reflecting a more holistic approach to improving client life conditions outside a potentially narrower focus of psychotherapy (Theme 6, Quote f).

Experiences with Engagement Challenges

Although the quantitative results suggesting that Latinx therapists reported fewer client disengaged behaviors than White therapists, qualitative interviews revealed that therapists across all racial/ethnic groups often faced client-disengagement challenges, particularly in trauma cases. Most therapists reported facing constant challenges to engage families in trauma-narrative practices due to logistics (e.g., the lack of a private/safe space to conduct trauma-narrative work) and attitudinal barriers (e.g., stigma, traditional gender roles, cultural norms around disclosure).

Expanding on quantitative findings indicating that Latinx therapists reported fewer client-disengaged behaviors compared with White and other racial/ethnic minority therapists, qualitative analyses showed that Latinx therapists described facing similar engagement challenges as other therapists. However, Latinx therapists also described employing numerous strategies to improve treatment engagement with their clients—including difficult-to-engage clients such as trauma cases (Theme 7, Quote g). Similarly, Latinx therapists described making more adaptations for racial/ethnic minority families that targeted engagement through providing culturally robust interventions (Theme 8, Quote h).

Second-Phase Quantitative Results

Informed by the qualitative findings showing that Latinx therapists made numerous cultural adaptations to EBPs, especially in terms of language—adaptations that could affect therapists' experience with EBPs and client engagement—we conducted a second

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MANCOVA that included therapist ability to deliver the EBP in another language as a new covariate. This MANCOVA also examined the effect of race/ethnicity on perceptions of EBPs delivered (i.e., PCIS score), reported therapist adaptations to EBPs (i.e., augmenting and reducing/reordering adaptations), and perceived client-engagement challenges (i.e., expressed client concerns and client disengaged behaviors). Model 2 showed significant differences across groups over and above all covariates, $F(10, 1{,}458) = 2.903$, $p = .001$, partial $\eta^2 = .020$, Pillai's trace = .039. Univariate ANCOVAs showed significant racial/ethnic differences in perceptions of EBPs delivered, $F(2, 732) = 5.629$, $p = .004$, partial $\eta^2 = .015$; reported client disengaged behaviors, $F(2, 732) = 6.420$, $p = .002$, partial $\eta^2 = .017$; and reported expressed client concerns, $F(2, 732) = 3.453$, $p = .032$, partial $\eta^2 = .009$. No significant effects of therapist race/ethnicity were identified for augmenting or reducing/reordering adaptations. Bonferroni pairwise comparisons across groups revealed that Latinx therapists had more positive perceptions of EBPs delivered compared with White therapists (corrected $p = .004$, 95% CI [0.426, 2.947]), Latinx therapists reported fewer client disengaged behaviors compared with White (corrected $p = .001$, 95% CI [−0.701, −0.134]) and other racial/ethnic minority therapists (corrected $p = .041$, 95% CI [−0.606, −0.009]), and Latinx therapists reported fewer expressed client concerns than White therapists (corrected $p = .033$, 95% CI [−0.461, −0.014]).

Discussion

The present study addresses a gap in the implementation literature by examining how therapists from different racial/ethnic groups perceive and employ EBPs in community settings. Although previous studies have examined therapists' characteristics that affect EBP use (e.g., Barnett et al., 2017; Beidas et al., 2015; Nakamura et al., 2011; Reding et al., 2018), to our knowledge, this is the first study to focus on therapists' racial/ethnic background as a source of variance in perceptions of, adaptations to, and perceived barriers associated with EBP implementation. Employing an innovative sequential QUAN → qual → QUAN approach, we identified potential explanations of racial/ethnic differences in EBP implementation experiences beyond attitudinal predispositions.

First, this study suggests that despite quantitative group differences identified in perceptions of EBPs, the overall experience of all racial/ethnic minority therapists was in the favorable range. This finding indicates that regardless of racial/ethnic background, community therapists reported positive views of EBPs they delivered, an outcome that contrasts with concerns in the field regarding the (un)willingness of diverse community therapists to implement EBPs in community settings (Cabassa & Baumann, 2013; Southam-Gerow et al., 2012). In this regard, therapists' narratives were exceptionally informative because all therapist groups reported benefiting from the manualized nature of EBPs, which facilitates their work and bolsters their confidence. These findings diverge from previous preimplementation studies indicating that community therapists are skeptical toward EBPs given their structured protocols (DiMeo et al., 2012). As a whole, the findings in this area highlight the importance of distinguishing between therapists' preconceptions about EBPs and their actual implementation experiences in the community.

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In terms of differences across groups, Latinx therapists reported more positive perceptions of EBPs than White therapists in a system serving primarily racial/ethnic minority youth and their families. However, other racial/ethnic minority therapists were no different in their perceptions from Latinx or White therapists. These findings indicate that compared with White therapists, racial/ethnic minority therapists have at least similar, and in some cases more positive, perceptions of the EBPs they use in their everyday work. This fact is encouraging given previous concerns raised by preimplementation studies showing that racial/ethnic minority therapists have negative attitudes toward EBPs (Aarons, Cafri, et al., 2012; Aarons, Glisson, et al., 2012; Aarons et al., 2010). As to the significantly more positive perceptions of EBPs among Latinx therapists compared with White therapists, qualitative analyses indicated that Latinx therapists might be able to capitalize on the structure of EBPs to plan their sessions with racial/ethnic minority families, which in turn reduces the stress related to working with numerous hard-to-reach clients. The Latinx therapists in this sample, who worked mostly with low-income Latinx families, appeared especially well-equipped to serve these families and make use of the EBPs in this work.

A second main finding focuses on adaptations made to EBP protocols. Although some differences across groups were found, therapists from all groups reported making augmenting adaptations to EBP protocols. In their narratives, therapists indicated adding content to EBP protocols (e.g., extra rapport-building activities, additional psychoeducation, relaxation techniques) to increase treatment engagement with their clients. This finding is consistent with previous studies indicating that community therapists modify EBPs more often than not (Aarons, Green, et al., 2012; Barnett et al., 2019; Lau et al., 2017). Furthermore, adaptations as those described by these therapists align with what has come to be known as *common factors in psychotherapy* (Laska, Gurman, & Wampold, 2014; Wampold, 2015), which are active ingredients of psychotherapy that are not related to any specific EBP protocol but promote significant therapeutic change (Wampold, 2015). As such, most therapist-reported adaptations described in this sample could be considered “good clinical practices” and not radical modifications to the original EBP content.

Despite these commonalities, Latinx therapists also reported making significantly more of these adaptations compared with White therapists. This finding aligns with a previous study showing that Latinx therapists made numerous augmenting adaptations to improve EBP fit for their racially/ethnically diverse clients (Lau et al., 2017). Our qualitative findings further revealed that Latinx therapists reported awareness of cultural factors, such as minority status, immigration experiences, and language preference, all of which affect treatment acceptability and engagement. As such, Latinx therapists commonly reported providing additional psychoeducation about EBPs and changing EBP terminology to increase families’ “buy-in” for treatment. Similarly, Latinx therapists indicated making frequent language-related adaptations in their work with racially/ethnically diverse families, especially Spanish-speaking families. Besides, therapists’ narratives showed that Latinx therapists were aware of the importance of addressing contextual factors that affect treatment engagement with underserved families through additional case management and care coordination. By addressing contextual sources of stress that interfere with therapy engagement, Latinx therapists may be able to deliver a more robust dose of treatment, which in turn is associated with better treatment outcomes in child psychotherapy (Chu & Kendall, 2004). As a whole,

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these findings suggest that EBP adaptations—changes that Latinx therapists mostly consider cultural in nature—are strategies consistent with overall clinical competency (Laska et al., 2014; Wampold, 2015). This interpretation is consistent with research showing that although they are somewhat distinctive, cultural competency and overall clinical competency are highly interconnected (Constantine, 2002, 2007; Fuertes & Brobst, 2002; Fuertes et al., 2006). Thus, Latinx therapists seem able to combine their bilingual/bicultural background with their clinical training to serve culturally diverse families better.

Quantitative findings in this area also showed that although Latinx therapists made numerous EBP adaptations, they did so without performing more reducing adaptations (i.e., deviations from the protocol or omission of core strategies). This finding is significant, given previous concerns about how therapist-driven adaptations could compromise EBP integrity when interventions are perceived as not culturally relevant (Lau, 2012; Morawska et al., 2012). In summary, Latinx therapists appeared to invest time engaging with EBPs to improve their relevance and fit for diverse clients in a way that augmented EBP delivery and supplemented EBPs with other services. These efforts may help explain their overall more positive EBP perceptions. Furthermore, qualitative analyses identified another factor underlying differences in EBP modifications across groups: Latinx therapists, who were overwhelmingly bilingual, made significant language-related adaptations to EBPs. However, the fact that no differences in EBP adaptations emerged after statistically controlling for the therapist's ability to deliver EBPs in another language suggests that many EBP adaptations may rest on linguistic/cultural translation.

Because Latinx therapists adapted EBPs to improve their relevance and appeal, it is not surprising that they also reported fewer client disengaged behaviors (i.e., veering off topic, avoiding participating in therapy activities, showing disinterested behavior) compared with White therapists. These results are consistent with a previous study suggesting that compared with White therapists, Latinx therapists reported fewer challenges with client disengagement in their work (Lau et al., 2018). Latinx therapists' bicultural and bilingual competence, as well as investment in EBP adaptations as previously described, may account for these differences. Indeed, qualitative analyses showed that all therapists working with racial/ethnic minority families faced similar challenges with lack of self-disclosure and limited participation in therapy exercises, which is consistent with previous studies (Dickson et al., 2017; Stadnick et al., 2016). However, Latinx therapists also described numerous strategies to overcome such client disengagement, which may have affected their perception of those engagement barriers. Somewhat surprising was the finding that Latinx therapists also reported fewer client disengaged behaviors compared with other racial/ethnic minority therapists. These differences may be due, in part, to the population that these therapists served. Most child clients seen in this system context were Latinx, and many caregivers were monolingual Spanish speakers. Thus, it is possible that other racial/ethnic minority therapists faced similar language/cultural barriers to engage these clients in treatment as those encountered by White therapists. This hypothesis is supported by therapists' narratives showing that other racial/ethnic minority and White therapists reported similar difficulty dealing with cultural norms about self-disclosure and engaging clients in therapy activities, which is also consistent with previous research (Dickson et al., 2017; Stadnick et al., 2016). Relatedly, after statistically controlling for the therapists' ability to deliver EBPs in another

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language, Latinx therapists also reported fewer expressed client concerns (i.e., verbalizations about treatment acceptability, lack of familiarity with EBP strategies, and difficulties using and mastering EBP skills) compared with White therapists. It is possible that by being able to communicate with clients in their native language, Latinx therapists can increase EBP "buy-in," which in turn reduces concerns about treatment relevance and the client's ability to learn and use EBP techniques. This hypothesis is consistent with evidence that non-English-speaking families prefer to receive care from bilingual/bicultural therapists because these services provide a greater sense of trust, cultural understanding, and accuracy of communication (Villalobos et al., 2016).

Despite the implications of these results for the successful implementation of EBPs in community settings, there are some study limitations. First, indicators of implementation experiences relied on therapist self-report. Studies using behavioral indicators of implementation experiences (e.g., session observations) are warranted. Second, the characteristics of this sample may not be representative of the mental health workforce at large. In our study, most therapists were racial/ethnic minorities who served mostly racial/ethnic minority youth, which is not the case in other public-sector systems. Third, therapist–client racial/ethnic matching needs to be further examined, given the mixed findings in this area (Cabral & Smith, 2011). Although we acknowledge potential matching effects in our results, additional studies are needed to examine how this variable affects therapists' perceptions of and experiences with EBPs. Fourth, the "other racial/ethnic minority" category included therapists from very different cultural backgrounds, which makes future disaggregated analyses necessary. Fifth, client characteristics could affect implementation experiences over and above therapist characteristics. As the qualitative data suggest, some clinical presentations (e.g., trauma) may be especially challenging, which in turn may affect therapists' EBP use and perceptions.

Over the last two decades, diversifying the mental health workforce has been promoted as a strategy to reduce mental health disparities among racial/ethnic minorities (U.S. Department of Health and Human Services, 2001). The results of this study suggest that racial/ethnic minority therapists capitalize on their cultural and language competencies to serve hard-to-reach families. More specifically, Latinx therapists not only reported positive perceptions of EBPs but also described making more modifications—including cultural adaptations—that improved treatment engagement in their work with diverse clients.

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References

Aarons GA (2004). Mental health provider attitudes toward adoption of evidence-based practice: The Evidence-Based Practice Attitude Scale (EBPAS). Mental Health Services Research, 6, 61–74. 10.1023/B:MHSR.0000024351.12294.65 [PubMed: 15224451]

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Aarons GA, Cafri G, Lugo L, & Sawitzky A (2012). Expanding the domains of attitudes towards evidence-based practice: The Evidence Based Practice Attitude Scale-50. Administration and Policy in Mental Health and Mental Health Services Research, 39, 331–340. 10.1007/s10488-010-0302-3 [PubMed: 20607597]

Aarons GA, Glisson C, Green PD, Hoagwood K, Kelleher KJ, Landsverk JA, … the Research Network on Youth Mental Health. (2012). The organizational social context of mental health services and clinician attitudes toward evidence-based practice: A United States national study. Implementation Science, 7, 56. 10.1186/1748-5908-7-56 [PubMed: 22726759]

Aarons GA, Glisson C, Hoagwood K, Kelleher K, Landsverk J, & Cafri G (2010). Psychometric properties and U.S. national norms of the Evidence-Based Practice Attitude Scale (EBPAS). Psychological Assessment, 22, 356–365. 10.1037/a0019188 [PubMed: 20528063]

Aarons GA, Green AE, Palinkas LA, Self-Brown S, Whitaker DJ, Lutzker JR, … Chaffin MJ (2012). Dynamic adaptation process to implement an evidence-based child maltreatment intervention. Implementation Science, 7, 32. 10.1186/1748-5908-7-32 [PubMed: 22512914]

Aisenberg E (2008). Evidence-based practice in mental health care to ethnic minority communities: Has its practice fallen short of its evidence? Social Work, 53, 297–306. 10.1093/sw/53.4.297 [PubMed: 18853666]

American Psychological Association. (2018). Demographics of the U.S. psychology workforce: Findings from the 2007–16 American Community Survey. Washington, DC: Author.

Ashwood JS, Kataoka SH, Eberhart NK, Bromley E, Zima BT, Baseman L, … Burnam MA (2018). Evaluation of the mental health services act in Los Angeles County: Implementation and outcomes for key programs. Rand Health Quarterly, 8, 2. 10.7249/RR2327

Barnett M, Brookman-Frazee L, Regan J, Saifan D, Stadnick N, & Lau A (2017). How intervention and implementation characteristics relate to community therapists' attitudes toward evidence-based practices: A mixed methods study. Administration and Policy in Mental Health and Mental Health Services Research, 44, 824–837. [PubMed: 28236076]

Barnett ML, Brookman-Frazee L, Gonzalez JC, Zhan C, Rodriguez A, Stadnick NA, & Lau AS (2019). Qualitative reports of how and when therapists adapt children's evidence-based practices during community implementation. Journal of Clinical Child and Adolescent Psychology, 48, 894–905. 10.1007/s10488-017-0795-0 [PubMed: 30024316]

Beidas RS, Marcus S, Aarons GA, Hoagwood KE, Schoenwald S, Evans AC, … Mandell DS (2015). Predictors of community therapists' use of therapy techniques in a large public mental health system. Journal of the American Medical Association Pediatrics, 169, 374–382. 10.1001/jamapediatrics.2014.3736 [PubMed: 25686473]

Beidas RS, Mychailyszyn MP, Edmunds JM, Khanna MS, Downey MM, & Kendall PC (2012). Training school mental health providers to deliver cognitive-behavioral therapy. School Mental Health: A Multidisciplinary Research and Practice Journal, 4, 197–206. 10.1007/s12310-012-9074-0

Brookman-Frazee LI, Drahota A, & Stadnick N (2012). Training community mental health therapists to deliver a package of evidence-based practice strategies for school-age children with autism spectrum disorders: A pilot study. Journal of Autism and Developmental Disorders, 42, 1651–1661.10.1007/s10803-011-1406-7 [PubMed: 22102293]

Cabassa LJ, & Baumann AA (2013). A two-way street: Bridging implementation science and cultural adaptations of mental health treatments. Implementation Science, 8, 90. 10.1186/1748-5908-8-90 [PubMed: 23958445]

Cabral RR, & Smith TB (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. Journal of Counseling Psychology, 58, 537–554. 10.1037/a0025266 [PubMed: 21875181]

Chu BC, & Kendall PC (2004). Positive association of child involvement and treatment outcome within a manual-based cognitive-behavioral treatment for children with anxiety. Journal of Consulting and Clinical Psychology, 72, 821–829. 10.1037/0022-006X.72.5.821 [PubMed: 15482040]

Constantine MG (2002). Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes toward counseling and ratings of their counselors' general and multicultural counseling competence. Journal of Counseling Psychology, 49, 255–263. 10.1037/0022-0167.49.2.255

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Constantine MG (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. Journal of Counseling Psychology, 54, 1–16. 10.1037/0022-0167.54.1.1

Cook JM, Thompson R, & Schnurr PP (2015). Perceived Characteristics of Intervention Scale: Development and psychometric properties. Assessment, 22, 704–714. 10.1177/1073191114561254 [PubMed: 25520213]

Costello EJ, Mustillo S, Erkanli A, Keeler G, & Angold A (2003). Prevalence and development of psychiatric disorders in childhood and adolescence. Archives of General Psychiatry, 60, 837–844. 10.1001/archpsyc.60.8.837 [PubMed: 12912767]

Dickson KS, Zeedyk SM, Martinez J, & Haine-Schlagel R (2017). Examining ethnic disparities in provider and parent in-session participation engagement. Journal of Children’s Services, 12, 47–58. 10.1108/JCS-12-2016-0022

DiMeo MA, Moore GK, & Lichtenstein C (2012). Relationship of evidence-based practice and treatments: A survey of community mental health providers. Journal of Community Psychology, 40, 341–357. 10.1002/jcop.20516

Ehrenreich-May J, Southam-Gerow MA, Hourigan SE, Wright LR, Pincus DB, & Weisz JR (2011). Characteristics of anxious and depressed youth seen in two different clinical contexts. Administration and Policy in Mental Health and Mental Health Services Research, 38, 398–411. 10.1007/s10488-010-0328-6 [PubMed: 21197564]

Fuertes JN, & Brobst K (2002). Clients’ ratings of counselor multicultural competency. Cultural Diversity and Ethnic Minority Psychology, 8, 214–223. 10.1037/1099-9809.8.3.214 [PubMed: 12143099]

Fuertes JN, Stracuzzi TI, Bennett J, Scheinholtz J, Mislowack A, Hersh M, & Cheng D (2006). Therapist multicultural competency: A study of therapy dyads. Psychotherapy: Theory, Research, Practice, Training, 43, 480–490. 10.1037/0033-3204.43.4.480

Gellatly R, Brookman-Frazee L, Barnett M, Gonzalez JC, Kim JJ, & Lau AS (2019). Therapist reports of EBP client engagement challenges in sessions with diverse youth and families in community mental health settings. Child & Youth Care Forum, 48, 55–75. 10.1007/s10566-018-9472-z [PubMed: 32132809]

Hamilton AB, & Finley EP (2019). Qualitative methods in implementation research: An introduction. Psychiatry Research, 280, 112516. 10.1016/j.psychres.2019.112516 [PubMed: 31437661]

Huey SJ Jr., Tilley JL, Jones EO, & Smith CA (2014). The contribution of cultural competence to evidence-based care for ethnically diverse populations. Annual Review of Clinical Psychology, 10, 305–338. 10.1146/annurev-clinpsy-032813-153729

Kazdin AE (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. American Psychologist, 63, 146–159. 10.1037/0003-066X.63.3.146

Langley AK, Nadeem E, Kataoka SH, Stein BD, & Jaycox LH (2010). Evidence-based mental health programs in schools: Barriers and facilitators of successful implementation. School Mental Health: A Multidisciplinary Research and Practice Journal, 2, 105–113. 10.1007/s12310-010-9038-1

Laska KM, Gurman AS, & Wampold BE (2014). Expanding the lens of evidence-based practice in psychotherapy: A common factors perspective. Psychotherapy, 51, 467–481. 10.1037/a0034332 [PubMed: 24377408]

Lau A, Barnett M, Stadnick N, Saifan D, Regan J, Wiltsey Stirman S, … Brookman-Frazee L (2017). Therapist report of adaptations to delivery of evidence-based practices within a system-driven reform of publicly funded children’s mental health services. Journal of Consulting and Clinical Psychology, 85, 664–675. 10.1037/ccp0000215 [PubMed: 28471210]

Lau AS (2012). Reflections on adapting parent training for Chinese immigrants: Blind alleys, thoroughfares, and test drives. In Bernal G & Rodríguez M. M. Domenech (Eds.), Cultural adaptations: Tools for evidence-based practice with diverse populations (pp. 133–156). Washington, DC: American Psychological Association. 10.1037/13752-007

Lau AS, & Brookman-Frazee L (2016). The 4KEEPS study: Identifying predictors of sustainment of multiple practices fiscally mandated in children’s mental health services. Implementation Science, 11, 31. [PubMed: 26956621]

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Lau AS, Gonzalez JC, Barnett ML, Kim JJ, Saifan D, & Brookman-Frazee L (2018). Community therapist reports of client engagement challenges during the implementation of multiple EBPs in children's mental health. Evidence-Based Practice in Child and Adolescent Mental Health, 3, 197–212. 10.1080/23794925.2018.1455545 [PubMed: 31263771]

Los Angeles County Department of Mental Health. (n.d.). About DMH. Retrieved from https://dmh.lacounty.gov/about/

Morawska A, Sanders MR, O'Brien JO, McAuliffe C, Pope S, & Anderson E (2012). Practitioner perceptions of the use of the Triple P–Positive Parenting Program with families from culturally diverse backgrounds. Australian Journal of Primary Health, 18, 313–320. 10.1071/PY11106 [PubMed: 22950888]

Nakamura BJ, Higa-McMillan CK, Okamura KH, & Shimabukuro S (2011). Knowledge of and attitudes towards evidence-based practices in community child mental health practitioners. Administration and Policy in Mental Health and Mental Health Services Research, 38, 287–300. 10.1007/s10488-011-0351-2 [PubMed: 21499945]

Nastasi B, Hitchcock J, & Brown L (2010). An inclusive framework for conceptualizing mixed methods design typologies: Moving toward fully integrated synergistic research models. In Tashakkori A & Teddlie C (Eds.), Sage handbook of mixed methods in social & behavioral research (pp. 305–338). Thousand Oaks, CA: Sage. 10.4135/9781506335193.n13

Nelson MM, Shanley JR, Funderburk BW, & Bard E (2012). Therapists' attitudes toward evidence-based practices and implementation of parent-child interaction therapy. Child Maltreatment, 17, 47–55. 10.1177/1077559512436674 [PubMed: 22353671]

Palinkas LA (2014). Qualitative and mixed methods in mental health services and implementation research. Journal of Clinical Child and Adolescent Psychology, 43, 851–861. 10.1080/15374416.2014.910791 [PubMed: 25350675]

Pina AA, Polo AJ, & Huey SJ (2019). Evidence-based psychosocial interventions for ethnic minority youth: The 10-year update. Journal of Clinical Child and Adolescent Psychology, 48, 179–202. 10.1080/15374416.2019.1567350 [PubMed: 30746965]

Reding MEJ, Guan K, Regan J, Palinkas LA, Lau AS, & Chorpita BF (2018). Implementation in a changing landscape: Provider experiences during rapid scaling of use of evidence-based treatments. Cognitive and Behavioral Practice, 25, 185–198. 10.1016/j.cbpra.2017.05.005

Saifan D, Brookman-Frazee L, Barnett M, Gonzalez JC, & Lau AS (2018). Ethnic minority community therapists' acculturation and reported adaptations to children's evidence-based practices. Cultural Diversity and Ethnic Minority Psychology, 24, 530–540. 10.1037/cdp0000203 [PubMed: 29963881]

Snell-Johns J, Mendez JL, & Smith BH (2004). Evidence-based solutions for overcoming access barriers, decreasing attrition, and promoting change with underserved families. Journal of Family Psychology, 18, 19–35. 10.1037/0893-3200.18.1.19 [PubMed: 14992607]

Southam-Gerow MA, Rodríguez A, Chorpita BF, & Daleiden EL (2012). Dissemination and implementation of evidence-based treatments for youth: Challenges and recommendations. Professional Psychology: Research and Practice, 43, 527–534. 10.1037/a0029101

Southam-Gerow MA, Weisz JR, Chu BC, McLeod BD, Gordis EB, & Connor-Smith JK (2010). Does cognitive behavioral therapy for youth anxiety outperform usual care in community clinics? An initial effectiveness test. Journal of the American Academy of Child & Adolescent Psychiatry, 49, 1043–1052. 10.1016/j.jaac.2010.06.009 [PubMed: 20855049]

Southam-Gerow MA, Weisz JR, & Kendall PC (2003). Youth with anxiety disorders in research and service clinics: Examining client differences and similarities. Journal of Clinical Child and Adolescent Psychology, 32, 375–385. 10.1207/S15374424JCCP3203_06 [PubMed: 12881026]

Stadnick NA, Haine-Schlagel R, & Martinez JI (2016). Using observational assessment to help identify factors associated with parent participation engagement in community-based child mental health services. Child & Youth Care Forum, 45, 745–758. 10.1007/s10566-016-9356-z [PubMed: 27587943]

Stahmer AC, & Aarons G (2009). Attitudes toward adoption of evidence-based practices: A comparison of autism early intervention providers and children's mental health providers. Psychological Services, 6, 223–234. 10.1037/a0010738 [PubMed: 21796262]

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Stevens J, Kelleher KJ, Ward-Estes J, & Hayes J (2006). Perceived barriers to treatment and psychotherapy attendance in child community mental health centers. Community Mental Health Journal, 42, 449–458. 10.1007/s10597-006-9048-5 [PubMed: 16964565]

Teddlie C, & Tashakkori A (2010). Overview of contemporary issues in mixed methods research. In Tashakkori A & Teddlie C (Eds.), Sage handbook of mixed methods in social & behavioral research (pp. 1–42). Thousand Oaks, CA: Sage. 10.4135/9781506335193.n1

Torrey WC, Bond GR, McHugo GJ, & Swain K (2012). Evidence-based practice implementation in community mental health settings: The relative importance of key domains of implementation activity. Administration and Policy in Mental Health and Mental Health Services Research, 39, 353–364. 10.1007/s10488-011-0357-9 [PubMed: 21574016]

U.S. Department of Health and Human Services. (2001). Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General. Rockville, MD: Center for Mental Health Services.

Villalobos BT, Bridges AJ, Anastasia EA, Ojeda CA, Hernandez Rodriguez J, & Gomez D (2016). Effects of language concordance and interpreter use on therapeutic alliance in Spanish-speaking integrated behavioral health care patients. Psychological Services, 13, 49–59. 10.1037/ser0000051 [PubMed: 26349073]

Wampold BE (2015). How important are the common factors in psychotherapy? An update. World Psychiatry, 14, 270–277. 10.1002/wps.20238 [PubMed: 26407772]

Weisz JR, Krumholz LS, Santucci L, Thomassin K, & Ng MY (2015). Shrinking the gap between research and practice: Tailoring and testing youth psychotherapies in clinical care contexts. Annual Review of Clinical Psychology, 11, 139–163. 10.1146/annurev-clinpsy-032814-112820

Weisz JR, Southam-Gerow MA, Gordis EB, Connor-Smith JK, Chu BC, Langer DA, … Weiss B (2009). Cognitive-behavioral therapy versus usual clinical care for youth depression: An initial test of transportability to community clinics and clinicians. Journal of Consulting and Clinical Psychology, 77, 383–396. 10.1037/a0013877 [PubMed: 19485581]

Weisz JR, Ugueto AM, Cheron DM, & Herren J (2013). Evidence-based youth psychotherapy in the mental health ecosystem. Journal of Clinical Child and Adolescent Psychology, 42, 274–286. 10.1080/15374416.2013.764824 [PubMed: 23402704]

Whittaker KA, & Cowley S (2012). An effective programme is not enough: A review of factors associated with poor attendance and engagement with parenting support programmes. Children & Society, 26, 138–149. 10.1111/j.1099-0860.2010.00333.x

Willms DG, Best JA, Taylor DW, Gilbert JR, Wilson DM, Lindsay EA, & Singer J (1990). A systematic approach for using qualitative methods in primary prevention research. Medical Anthropology Quarterly, 4, 391–409. 10.1525/maq.1990.4.4.02a00020

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Public Significance Statement

Considering concerns in the field regarding provider–client cultural mismatch and potential lack of data supporting the efficacy of evidence-based practices (EBPs) for racial/ethnic minority groups, investigators have increasingly called for attention to diversifying the mental health workforce. This study shows that racial/ethnic minority therapists, especially Latinx therapists, capitalize on their language and cultural competencies to serve hard-to-reach racial/ethnic minority youth and their families.

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Table 1

Correlations Between Variables Included in Statistical Models

Variable	1	2	3	4	5	6	7	8	9	10
1. PCIS	—	.041	−.122 **	−.042	−.140 **	.402 **	−.116 **	−.017	−.025	.091 **
2. AES Augmenting	.041	—	.633 **	.099 **	.058	.051	.171 **	−.092 *	.041	1
3. AES Reducing	−.122 **	.633 **	—	.074 *	.102 **	−.042	.287 **	−.093 *	−.122 **	.633 **
4. Expressed client concerns	−.042	.099 **	.074 *	—	.250 **	.066	.075 *	−.008	−.042	.099 **
5. Client disengaged behaviors	−.140 **	.058	.102 **	.250 **	—	−.028	.026	.029	.037	−.117 **
6. EBPAS Openness	.402 **	.051	−.042	.066	−.028	—	−.142 **	−.090 **	.402 **	.051
7. EBPAS Divergence	−.116 **	.171 **	.287 **	.075 *	.026	−.142 **	—	−.021	.164 **	−.116 **
8. Years of clinical practice	−.017	−.092 *	−.093 *	−.008	.029	−.090 **	−.021	—	.018	−.017
9. Gender	−.025	.001	.091 *	.058	.037	−.035	.164 **	.018	—	−.025
10. Bilingual capacity	.091 **	.109 **	.037	.034	−.117 **	.054	.002	−.114 **	.003	—

Note. PCIS = Perceived Characteristics of Intervention Scale; AES = Adaptations to Evidence-Based Practices Scale; EBPAS = Evidence-Based Practice Attitudes Scale.

* $p < .05$.

** $p < .01$.

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Table 2

Means and Standard Deviations of Outcome Variables and Covariates

	Overall (n = 743)		**Latinx (n = 331)**		**White (n = 247)**		**O-REM (n = 165)**	
Variable	***M***	***SD***	***M***	***SD***	***M***	***SD***	***M***	***SD***
PCIS	27.469	5.547	28.229	5.655	26.656	5.417	27.177	5.346
AES Augmenting	4.004	2.339	4.306	2.553	3.697	2.122	3.843	2.129
AES Reducing	2.018	1.599	2.105	1.783	1.864	1.362	2.074	1.530
Expressed client concerns	0.750	0.895	0.710	0.859	0.790	0.944	0.771	0.892
Client disengaged behaviors	1.090	1.133	0.870	0.989	1.300	1.219	1.198	1.197
EBPAS Openness	2.876	0.662	2.946	0.675	2.848	0.622	2.779	0.683
EBPAS Divergence	1.349	0.754	1.338	0.772	1.284	0.733	1.469	0.737
Years of clinical practice	6.588	5.966	5.692	5.241	8.147	7.194	6.000	4.680

Note. O-REM = other racial/ethnic minority; M = mean; PCIS = Perceived Characteristics of Intervention Scale; AES = Adaptations to Evidence-Based Practices Scale; EBPAS = Evidence-Based Practice Attitudes Scale.

Table 3

Qualitative Themes Among Latinx Therapists

Quantitative finding	Qualitative theme and exemplar quotes
Latinx therapists reported more positive perceptions of EBPs delivered (compared with White therapists)	**Theme 1:** EBP structure facilitates work with diverse clients
	Quote a: "I really like [EBP]. Like I said, I think it has such a great variety of, you know, for age range, for culture. I really like it. I really enjoy being able to use it with pretty much any population. Even younger kids, you know. So I like, I really like it."
	Theme 2: EBPs reduce stress associated with preparing and providing services
	Quote b: "I feel when I started using [EBP], it made me feel more confident and made me feel less stressed and overwhelmed, because it gave me a structure and additional resources that I could use."
Latinx therapists reported making more augmenting adaptations (compared with White therapists)	**Theme 3:** Awareness of cultural factors
	Quote c: "You do have to be culturally sensitive to the families and kind of getting to know what their beliefs are. Some of the things that they may not necessarily be so open to, but kind of like giving them psychoeducation onto what the importance is of it, I think allows the parents to be a little bit more open to it."
	Theme 4: Language-related adaptations
	Quote d: "Yes, just because the elements come in English and I primarily deal with Spanish-speaking clients, so that has been one of the challenges. I review it before going out with the family, but as I'm there, kind of like keeping myself on track, I have to pause, read it in English and then think about it, translate it into Spanish, and then try to fit it to each family, because if I say it in one way to one family, they may not understand me, so I have to break it down and explain it to them, both the child and the parent."
	Theme 5: Cultural adaptations are also "good clinical practices"
	Quote e: "Yeah, because a lot of the parents that I work with are monolingual, Spanish-speaking. So, I know that a lot of these elements are very new, so I have to make sure that I'm not just delivering this material that's very dry and that doesn't mean anything to them. I have to make it culturally relevant in a way where I can explain it in terms of these are some of the things that are important because your child needs to learn such-and-such. And then maybe asking them, well, what are some of the things that were important to you as a child? And making the connections. Sometimes it's a far stretch, but I have to do it in order to be able to make sure that the parent understands what it is that I'm trying to deliver."
	Theme 6: Provide "case management" services/coordinate care
	Quote f: "I make a lot of referrals, especially for the parents, whether it be, some of it might be parenting classes, it might be therapy services, it might be sometimes the need for school resources, for tutoring services, trying to target other areas that maybe my clients might specifically need."
Latinx therapists reported facing fewer client disengaged behaviors (compared with White and other racial/ethnic minority therapists)	**Theme 7:** Describe numerous strategies to improve treatment engagement
	Quote g: "Sometimes the parents … are not very available because they're working. So, I guess, having to adapt to finding a way to get the client to share that trauma narrative with someone. So, what I usually do is we'll do just practice, like the empty chair for them to pretend that mom or dad is there. But, always still trying to see how we can get the parents in."
	Theme 8: Make more adaptations for racial/ethnic minority families
	Quote h: "Well, I just really try to engage the parents. Engagement is probably something that is very important for being culturally sensitive. Because if they're not engaged, then we're not really going to get anywhere. I guess I'll just work with the parent and see where they're at. Let's see, we have a high Hispanic [sic] right here. And so sometimes the males are very … hesitant or resistant to talk about trauma especially if it's a young boy. There's like this stereotype: "Oh, boys don't cry." So, kind of seeing where they're at and working with that. Maybe just like explore or talk about why it's important that they verbalize it."

Note. EBP = evidence-based practice.

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