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Therapist Reports of EBP Client Engagement Challenges in Sessions with Diverse Youth and Families in Community Mental Health Settings

R. Gellatly¹, L. Brookman-Frazee^{2,3}, M. Barnett⁴, J. C. Gonzalez⁴, J. J. Kim¹, A. S. Lau¹

¹University of California, Los Angeles, Los Angeles, CA, USA

²University of California, San Diego, La Jolla, CA, USA

³Child and Adolescent Services Research Center, San Diego, CA, USA

⁴University of California, Santa Barbara, Santa Barbara, CA, USA

Abstract

Background—The implementation of evidence-based practices (EBPs) in community settings appears to result in reduced benefit relative to controlled trials. This difference in outcomes may be attributable in part to engagement challenges therapists encounter when delivering EBPs to low-income ethnic minority youth and families.

Objective—The current study sought to identify therapist, client, and session characteristics associated with therapist-reported engagement challenges in therapy sessions, as well the associations between two types of client engagement challenges and therapists' self-reported ability to deliver the EBP in sessions within a system-driven implementation in public children's mental health services.

Method—One hundred and three therapists reported on two types of engagement challenges—Limited Client Engagement and Expressed Client Concerns—in 702 sessions with 274 clients.

Results—Results indicated that therapists reported a higher frequency of Limited Client Engagement in sessions with male clients and in sessions where the youth was present, and by therapists with smaller caseloads. No variables significantly predicted Expressed Client Concerns. Both types of engagement challenges were negatively associated with therapists' report of their ability to carry out intended activities in the same session.

R. Gellatly, reshram@ucla.edu.

Conflict of interest All authors declare that they have no conflict of interest.

Access to Data Resham Gellatly, M.A., Anna Lau, Ph.D., and Lauren Brookman-Frazee, Ph.D. take responsibility for the integrity of the data and the accuracy of the data analysis.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

Conclusions—Findings suggest that therapists may benefit from learning strategies to address these two distinct types of engagement challenges encountered in implementation of EBPs with diverse families in community settings.

Keywords

Community mental health; Dissemination and implementation; Barriers; EBP implementation; Engagement

Introduction

In an effort to reach the estimated 20–40% of children who have a psychiatric disorder, there has been a push to implement evidence-based practices (EBPs) in children's community mental health settings (Costello et al. 2011). EBPs refer to treatment practices with demonstrated effectiveness supported by research (Kazdin 2008). However, the implementation of EBPs in community settings has not consistently resulted in improved clinical outcomes (Weisz and Kazdin 2010). While some studies find that EBPs are more effective than usual care in community service settings (Chorpita and Southam-Gerow 2006), other studies have found that EBPs delivered by community therapists do not outperform usual care (Southam-Gerow et al. 2010).

Multiple factors likely contribute to reduced impact of community implementation of EBPs on client outcomes. Outer context factors, such as service system policy and funding environments, as well as inner context factors, including organizational, provider, and consumer characteristics, have been hypothesized to influence implementation efforts in children's mental health services (Aarons et al. 2011). Inner context factors related to staffing and EBP compatibility with clinician perceptions and consumer concerns have been of particular interest (Aarons et al. 2009; Damschroder et al. 2009). Among these factors influencing the implementation process in real-world settings, providers' real-time experience with client recipients of EBPs has not received as much study. However, client characteristics and engagement needs in community settings may help to account for the observed dilution of EBP effects in usual care settings, sometimes referred to as the "implementation cliff."

Engagement has been defined as a dynamic, multifaceted process that represents an individual's commitment to treatment (Becker et al. 2017). Models of engagement consistently include multiple dimensions (e.g., Haine-Schlagel and Walsh 2015; King et al. 2014; Lindsey et al. 2013), and generally include behavioral dimensions including attendance, homework completion, and other markers of participation; relational dimensions including therapeutic alliance and other aspects of relationship quality; and cognitive dimensions that encompass attitudes, motivation, and expectations of therapy (Becker and Chorpita 2016). Engagement challenges across these domains have been conceptualized as potential barriers to the robust delivery of EBPs (Becker et al. 2017), and poor management of such challenges may help account for the voltage drop when EBPs are transported to community settings.

Furthermore, engagement in child treatment is complex as it is generally initiated by caregivers, and youth may not understand or agree with the targets of treatment (Hawley and Weisz 2003). In such instances, children's readiness and motivation for treatment may be low, negatively impacting engagement and in-session behavior (Panichelli-Mindel et al. 1995). Youth client characteristics such as gender, age, and presenting problem have also been found to impact level of engagement (McKay and Bannon 2004). Additionally, caregivers who perceive themselves as lacking the ability to contribute to their child's treatment may be less engaged (Frankel and Simmons 1992; Morrissey-Kane and Prinz 1999). Therapists are tasked with navigating the myriad factors influencing youth and caregiver engagement over the course of treatment, a responsibility that becomes more challenging in community implementation of EBPs where therapists have less training, supervision, and ongoing support, and larger caseloads, compared to therapists in RCTs (e.g., Beidas and Kendall 2010; Drake et al. 2001; Langley et al. 2010; Rapp et al. 2005).

The context of community practice may be related to increased probability of engagement challenges relative to effectiveness trials. Studies have shown that participants in controlled trials testing EBPs differ systematically from clients seen in community mental health settings. Ethnic minority families are typically underrepresented in RCTs examining EBPs, leading to a gap in the evidence base on the efficacy of EBPs for diverse communities (Aisenberg 2008; Mak et al. 2007). In contrast, youth seen in publicly funded mental health services are highly diverse in terms of race and ethnicity and face increased socioeconomic disadvantage and life stressors relative to research clinic samples (Southam-Gerow et al. 2008). Children and adolescents treated in community mental health settings also have higher rates of comorbidity (Southam-Gerow et al. 2012) and are more likely to be involved in multiple sectors, such as the child welfare system and special education, pointing to a high level of need (Burns et al. 1995). The contextual factors of clinical complexity, socioeconomic disadvantage, and ethnic diversity among youth seeking treatment in community clinics may partially explain the attenuated treatment effects when EBPs are transported to usual care. Some of this attenuation is likely be driven by limited client engagement that is closely tied to poor treatment outcomes (Danko et al. 2016; Haine-Schlagel and Walsh 2015; Kazdin and Wassell 1999).

Client engagement challenges may include families expressing concerns about the relevance of skills being taught or hesitations about trying these skills on their own, as well as limited engagement in session. Research findings suggest that ethnic minority families, compared to Non-Hispanic Whites, show lower levels of active participation in treatment (Dickson et al. 2017; Orrell-Valente et al. 1999; Stadnick et al. 2016), and more likely to drop out of treatment prematurely (Kazdin and Whitley 2003). Because ethnic minorities are underrepresented in trials populating the evidence base, therapists have expressed reservations that EBPs may not be responsive to the needs of ethnic minority clients and could require adaptation to address poor engagement (Addis et al. 1999; Lau et al. 2011). In a community survey of therapists, the most commonly reported disadvantage of EBPs was the lack of tailoring to accommodate client preferences and culture (DiMeo et al. 2012). Therapists report the need to modify EBPs in response to perceived problems such as low acceptability of treatment activities and limited previous experience with skills prescribed in EBPs (e.g., Lau et al. 2011). Despite therapists' efforts to adapt EBPs to make them more

appropriate for disadvantaged, diverse clients served in community settings, families may express concerns about the relevance or feasibility of strategies taught, or they may demonstrate limited participation compared to those served in clinical research settings (Dickson et al. 2017).

While there is as yet limited data on the extent to which community therapists report encountering specific types of in-session engagement challenges to implementing EBPs with their diverse clients, studies have investigated the impact of different types of engagement challenges. In their early work, Patterson and Chamberlain (1994) used observational coding to characterize client engagement challenges in evidence-based parent training. They noted challenges related to clients expressing difficulty learning and using the skills being taught (*I can't* behaviors) as well as challenges related to client refusal to use skills being taught (*I won't* behaviors). Sequential analyses suggested that "*I won't*" behaviors denoting disengagement were more likely to lead to negative therapist response, such as confrontation and expressing dislike for the caregivers, than "*I can't*" behaviors in which clients expressed concerns about their ability to produce the targeted skills. Over the course of treatment, "*I won't*" engagement challenges predicted a lower dose of parent training being delivered. Research has also shed light on client engagement challenges and therapist responses in youth-directed interventions. In the Coping Power group intervention for children with disruptive behavior, children's negative behavior in session predicted poorer treatment outcomes (Lochman et al. 2017). In cognitive behavioral therapy for adolescent depression, observed youth resistance to therapy in an initial session was associated with more therapist praise and more unstructured exploration of motivation for treatment in subsequent sessions (Jungbluth and Shirk 2009). Taken together, these findings suggest that different types of client-related engagement challenges in treatment may negatively affect therapist EBP implementation outcomes.

Evidence also suggests that therapist factors may explain variance in EBP implementation outcomes. For example, community therapists' attitudes toward EBPs are related to implementation outcomes including adoption (Reding et al. 2014) and engagement in training activities (Nelson et al. 2012; Pemberton et al. 2015). Therapists' own attitudes toward EBPs may shape the challenges they perceive throughout EBP delivery. Conversely, it is plausible that challenging in-session interactions with clients during implementation shape therapist perceptions of EBPs. Ringle et al. (2015) examined barriers to implementing CBT for anxious youth and found that community therapists reported that client factors including stressors, comorbidity, and low motivation presented the greatest challenges to implementation. Yet it remains unclear whether therapists' perceptions of challenges in the delivery of EBPs are driven by their experiences with clients' negative reactions to EBP delivery or by their general perception of EBPs as helpful or unhelpful.

A recent study examined therapist perceptions of engagement challenges in the context of mandated EBP implementation (Lau et al. 2018). Therapists reported on two types of engagement challenges encountered during the implementation of an EBP with a child client in the previous 2 months: Expressed Client Concerns and Limited Client Engagement in Therapy Activities. The content for the scale was developed based on the literature on client engagement challenges in children's mental health (Becker et al. 2015; Haine-Schlagel and

Walsh 2015; Patterson and Chamberlain 1994; Stadnick et al. 2016). The original scale elicited retrospective report of seven engagement challenges that arose in the delivery of an EBP to a child in the previous 2 months of care. Items in the Expressed Client Concerns subscale included clients (i.e., caregiver or child) voicing a concern about therapy related to (a) low relevance/acceptability/helpfulness of the intervention, (b) practical barriers related to the intervention, (c) difficulties mastering skills, and (d) lack of familiarity of concepts. The Limited Client Engagement in Therapy Activities subscale included three items related to poor engagement: (e) apathetic or disinterested behavior, (f) avoiding participation in therapy activities, and (g) consistently veering off topic. Support for the subscales was derived through a conceptually driven, confirmatory factor analysis (CFA) revealing that the two-factor solution had good model fit, with standardized factor loadings ranging from .46 to .75 (Lau et al. 2018).

Furthermore, substantive findings from this previous study indicated that therapists who reported positive perceptions of the EBP being delivered were less likely to report instances of limited client engagement. Additionally, Hispanic/Latino therapists participating in the study reported fewer engagement challenges compared to Non-Hispanic White therapists. Given that the majority (69.6%) of the clients participating in the study were Hispanic/Latino, this finding may suggest that therapist ethnicity might have a bearing on client engagement and implementation outcomes, such that clients are more engaged in treatment when it is delivered by a therapist who they feel understands their culture (Berger et al. 2014). In addition, therapist reports of Limited Client Engagement in Therapy Activities, but not Expressed Client Concerns, were related to a lower self-assessed ability to deliver the EBP (Lau et al. 2018). These findings suggest that whereas limited client participation might portend barriers to EBP implementation, clients being comfortable or even invited to share their concerns about an intervention may not be associated with a therapist's compromised ability to deliver care as intended. However, the retrospective nature of the reports over a 2-month period of treatment may have impacted therapist recollection of challenges encountered. The present investigation extends the previous study with a focus on real-time reports of engagement challenges within sessions, providing a more immediate assessment of implementation process.

The current study was conducted within a large-scale system-driven implementation in children's mental health services (Lau and Brookman-Frazee 2016) and investigated community therapists' encounters with in-session engagement challenges when delivering EBPs. The study addressed three aims, with the first two exploratory aims investigating frequency and predictors of different types of client engagement challenges. First, we sought to characterize how often community therapists report two distinct types of engagement challenges in the delivery of EBPs with low-income ethnic minority youth and families. Second, we examined predictors of therapist-reported EBP engagement challenges, including session-level characteristics (e.g., presenting problem focus, EBP being delivered, youth and caregiver attendance at session), client socio-demographic characteristics (e.g., gender, race/ethnicity) and therapist factors (e.g., race/ethnicity, licensure status, caseload characteristics, and perceptions of the specific EBPs being delivered). Third, we examined associations between therapist report of client engagement challenges and their assessment of the extent to which an EBP was delivered as planned in that session. Based on previous

findings (Lau et al. 2018), we hypothesized that limited client engagement would be associated with reduced therapist ability to deliver the EBP as planned, while expressed client concerns would not necessarily be associated with therapists' perceived success with EBP implementation in the session.

Method

Recruitment and Procedure

The study was conducted in the context of the Los Angeles County Department of Mental Health's (LACDMH) Prevention Early Intervention (PEI) initiative within children's mental health services. Beginning in 2010, LACDMH provided implementation support for six EBPs addressing a range of child and adolescent mental health problems: Cognitive Behavioral Interventions for Trauma in Schools (CBITS), Child-Parent Psychotherapy (CPP), Managing and Adapting Practice (MAP), Seeking Safety (SS), Trauma Focused Cognitive Behavior Therapy (TF-CBT), and Triple P Positive Parenting Program (Triple P).

Ninety-eight agencies directly operated or contracted by LACDMH to deliver at least one of these six EBPs were eligible for inclusion in the 4KEEPS study (for more details on the larger study and implementation context see Lau and Brookman-Frazee 2016). Of these 98 agencies, 69 agencies (70.4%) participated in a larger online survey study. Program leaders from participating agencies were invited to participate in the more intensive In-Depth portion of the 4KEEPS Study, which included face-to-face interviews with program leaders and therapists, along with session data from therapists delivering one of the six EBPs under investigation. Fourteen agencies with 24 program sites that represented urban, suburban, and semi-rural areas served by LACDMH participated in the in-depth study.

Therapists were recruited for participation in the 4KEEPS in-depth study at staff meetings. They were asked to participate in an interview with study staff, record up to three sessions for up to three clients receiving one of the six EBPs, and report on their delivery of EBP strategies at each session and again at the end of a 2-month period. Therapists obtained written consent from caregivers to audio-record sessions. Identifying information was not collected about clients or caregivers. When reporting on their delivery of EBPs at the session level, therapists were asked about the occurrence of engagement challenges encountered. Therapists were instructed to submit online surveys reporting on their sessions within 1 week of the session. Sessions for which data were submitted more than 1 week after the session (9.7%) were excluded from analyses.

Procedure

All procedures were approved by the Institutional Review Board at the University of California, Los Angeles and the Human Subject Review Committee at the Los Angeles County Department of Mental Health. Informed consent was obtained through an in-person recruitment process. Therapists received a \$20 incentive for completing a baseline survey and a \$10 incentive for each session on which they provided data.

Participants

Participants included 103 community therapists from 14 agencies who delivered one of the six evidence-based practices of interest to 274 children or adolescents (see Table 1). Participants were primarily female ($N = 91$, 88.3%), unlicensed ($N = 83$, 80.6%), and most had a master's degree ($N = 88$, 85.4%). Therapists self-identified as Hispanic/ Latino ($N = 57$, 55.3%), Non-Hispanic White ($N = 22$, 21.4%), Asian-Pacific Islander ($N = 15$, 14.6%), and African-American ($N = 9$, 8.7%). Therapists reported an average of 4.44 years of practice ($SD = 4.39$), 2.40 years at their current agency ($SD = 2.38$), and a caseload of 17.15 clients ($SD = 6.91$). More than half of therapists reported being able to provide services in more than one language ($N = 63$, 61.1%), and the majority reported a primarily cognitive behavioral orientation ($N = 62$, 60.2%).

Therapists provided session data for 274 clients. The average number of clients per therapist was 2.66 and the average number of sessions with data per therapist was 6.82. Therapists submitted three sessions for 66.4% of clients, two sessions for 21.17% of clients, and one session for 12.4% of clients.

Clients were slightly more than half female ($N = 138$, 50.4%), 9.78 years ($SD = 3.85$) on average, and predominantly Hispanic/Latino ($N = 193$, 70.4%) (see Table 1). Across all sessions, the presenting problem being focused upon included externalizing behavioral problems (attention/hyperactivity problems, disruptive behaviors/conduct problems; $N = 229$, 32.6%), internalizing problems (mood, anxiety; $N = 265$, 37.7%), trauma ($N = 195$, 27.8%), and other problems (substance use, autism; $N = 13$, 1.9%). Therapists reported different presenting problems being addressed across sessions for 31 clients (11.3%). Session participants were as follows: 57.8% youth only, 32.1% youth and caregiver, and 10% caregiver only (see Table 1). As therapists did not indicate whether the engagement challenge was demonstrated by the youth or the caregiver in joint youth-caregiver sessions, any reference to "client engagement challenges" describes engagement challenges with any family member participating in session.

Measures

Therapist Characteristics

Therapists reported their personal and professional history on the Therapist Background Questionnaire (Brookman-Frazee et al. 2012). Personal characteristics included age, gender, and race/ethnicity. Professional information included licensure status and caseload characteristics.

Practice-Specific Perceptions

The Perceived Characteristics of Intervention Scale (PCIS; Cook et al. 2015) was developed to allow for the comparison of therapist attitudes towards different EBPs. In the original PCIS, 20 items were developed to measure the theory-based model of perceived characteristics of innovation (Rogers 1962, 2003; Greenhalgh et al. 2005), which may impact therapists' attitudes toward and uptake of different EBPs. Psychometric analysis of the original PCIS indicated a unidimensional scale that tapped global perceptions of

therapist perceptions of interventions. Eight items were included in the current survey that assessed perceptions of relative advantage (e.g., “[The practice] is more effective than other therapies I have used”), compatibility (e.g., “[The practice] is aligned with my clinical judgment”), complexity (e.g., “[The practice] is easy to use”), and potential for reinvention (e.g., “[The practice] can be adapted to meet the needs of my patients”). Therapists rated each item on a 5-point Likert scale (1 = not at all, 5 = a very great extent) based on the extent to which they agreed with each statement for every practice for which they had ever received training or ever delivered. The total scale demonstrated excellent internal consistency for all practices in the current sample with Cronbach’s alphas ranging from .91 to .99.

Session-Level Client Engagement Challenges

Therapists completed the measure following each session with a client. Therapists reported on the client’s gender, ethnicity, age, type of EBP delivered, and completed a checklist to indicate whether client-related engagement challenges arose. Items assessing client engagement challenges were adapted from the 2-month retrospective report measure of client engagement challenges for an index case described in a previous study (Lau et al. 2018). Therapists were asked to report on four of the original seven items, indicating whether each engagement challenge had occurred. The Expressed Client Concerns subscale included two items: “Expressed about the relevance/acceptability/helpfulness of an intervention strategy” and “Expressed difficulty mastering skills presented in therapy.” The Limited Engagement in Therapy Activities subscale included two items: “Demonstrated apathetic or disinterested behavior” and “Avoided participating in therapy activities.” The reliability of the engagement challenges items and subscales at the therapist-level were supported by analyses of the prospective correlations between mean occurrence of therapist-reported engagement challenges across the sessions with a given client over the study period and their subsequent retrospective reports of challenges encountered over previous 2 months with that client (range $r = .28-.43$, $p < .001$). Construct validity and factorial validity of the current session-based version of the engagement challenges measure was supported by a confirmatory factor analysis (CFA). Using Mplus statistical software (version 7.4, Muthén and Muthén 2012), a multi-level CFA was conducted to confirm that the two-factor model fit the data with a reduced number of items in each subscale. Based on the literature, we examined multidimensional structure only at Level 1 (sessions) and modeled data at the higher levels of nesting (Level 2 [client] and Level 3 [therapist]) as a single dimension (Muthén 1994; Muthén and Muthén 2012). We found strong loadings (above .40; Hinkin 1995, 1998) at the session level on the two factors, and we found support for a unidimensional structure at levels 2 and 3 (see Table 2). At the session level, the correlation between the two subscales was $r = .34$, $p = .04$.

Reported Ability to Carry Out Planned Session Activities

In the post-session survey, therapists were also asked to rate a single item indicating the “extent to which they were able to carry out their intended activities for the session” using a 6-point Likert scale (0 = not at all, 5 = fully). Reliability of this item was supported by analysis of the prospective correlation between mean therapist report of their ability to carry out intended activities across sessions with a given client over the study period and their

subsequent retrospective report of ability to carry out intended activities in sessions over the previous 2 months with that client ($r = .66, p < .001$).

Data Analytic Plan

Predictors of Session-Level Client Engagement Challenges

Multilevel logistic regression models examined predictors of occurrence of Expressed Client Concerns and Limited Engagement in Therapy Activities in a given session. Four-level models were specified with sessions (level 1) nested within clients (level 2) nested within therapists (level 3) nested within agencies (level 4). Therapists in this sample came from 14 agencies, with some therapists working within the same agency; thus, agency level clustering was accounted for. Therapist-level predictors included race/ethnicity, licensure, caseload, and perceptions of the practice delivered (i.e., PCIS score). Client-level variables included race/ethnicity, gender, and age. For the purpose of analyses, race/ethnicity was recoded into categories for Hispanic/Latino, Non-Hispanic White, and Other Ethnic Minority. Presenting problem, EBP delivered, and youth presence in session were included as session-level variables.

Predictors of Therapist-Reported Ability to Carry Out Planned Session Activities

A four-level mixed-effects multilevel regression model was used to examine predictors of therapist-reported ability to carry out planned session activities. Predictors included at the therapist, client, and session levels were consistent with predictors in the previous analyses. Additionally, we included each type of client engagement challenge (Expressed Client Concerns and Limited Engagement) as predictors in this model.

Results

Descriptive Analysis of In-Session Client Engagement Challenges

Descriptive analyses were conducted in SPSS v. 23 using 702 sessions delivered to 274 clients by 103 therapists. In Table 3, reported occurrence of client engagement challenges are summarized across session-, client-, and therapist-levels. At least one of the challenges was reported in 27.7% of sessions. Specifically, Expressed Client Concerns were reported in 16.6% of sessions and Limited Client Engagement challenges were reported in 15.4% of sessions. Therapists reported Limited Client Engagement challenges in 33.6% of sessions when the youth was present, but in only 7.1% of caregiver-only sessions. Expressed Client Concerns were reported in 36.0% of sessions when the youth was present and 25.7% of caregiver-only sessions.

At the client level, individual client engagement challenge items were reported in 17.2–19.7% of sessions. At least one challenge of any type was reported for 48.9% of clients across their sessions. Specifically, Expressed Client Concerns were reported for 31.0% of clients, and Limited Client Engagement challenges were reported for 29.9% of clients.

Predictors of Therapist-Reported Client Engagement Challenges

Two multilevel logistic regressions were conducted in Stata v.14.2 to identify predictors of any reported Expressed Client Concern and any Limited Client Engagement using a four-level nested structure with sessions (level 1) nested within clients (level 2) nested within therapists (level 3) nested within agency (level 4). There were no significant predictors of the occurrence of Expressed Client Concerns (see Table 4). In the Limited Client Engagement model, several variables emerged as significant predictors (see Table 4). Therapists with larger caseloads were less likely to report Limited Client Engagement ($B = -.099, p < .001$). Furthermore, Limited Engagement was more likely to be reported in sessions with male child clients ($B = .722, p = .026$). At the session level, therapists were more likely to report limited engagement in sessions when the youth was present compared to caregiver-only sessions ($B = 1.347, p = .014$). Therapists' licensure status, ethnicity, and perceptions of the practice being delivered were not significantly related to reported challenges, nor were clients' ethnicity, age, or presenting problem type.

Predictors of Therapist Reported Ability to Carry Out Planned Session Activities

We examined the association between therapist-, client-, and session-level predictors, including each type of reported client engagement challenge and therapist ratings of the extent to which they were able to carry out their intended activities or focus for the session. Session predictors included presenting problem, practice delivered, youth presence in session, and therapist report of client engagement challenges. Client predictors included age, gender, and race/ethnicity. Therapist predictors included race/ethnicity, PCIS score for the practice delivered in session, caseload, and licensure status. A multilevel logistic regression with a four-level nested structure with sessions (level 1) nested within clients (level 2) nested within therapists (level 3) nested with agencies (level 4) was used. Because the base rates of each category of challenges were low (endorsed in fewer than 1 in 5 sessions), a dichotomous outcome was used rather than the count of engagement challenges reported.

Expressed Client Concerns and Limited Client Engagement were both found to significantly predict therapists' reported ability to carry out the intended activities of the session (see Table 5). Therapists who reported encountering at least one Expressed Client Concern reported they were less able to carry out the intended session activities than therapists who did not encounter any Expressed Client Concerns ($B = -.241, p = .040$). Similarly, therapists who reported at least one encounter with Limited Client Engagement reported more difficulty carrying out the intended session activities compared to therapists who did not face challenges associated with limited engagement in activities ($B = -.412, p < .001$). Compared to Externalizing problems. Other presenting problem was also associated with decreased ability to carry out intended activities ($B = -.987, p = .003$). An association was found between therapists' more positive perceptions of the practice and their reported ability to carry out intended session activities ($B = .210, p = .003$).

Discussion

As EBPs continue to be implemented with increasing frequency in community mental health systems across the country (Hoagwood et al. 2014; McHugh and Barlow 2010), questions

have arisen regarding the robustness and sustainability of these efforts. Previous research suggests that a number of factors may impact EBP implementation, including therapist training and attitudes toward EBPs (Aarons 2004; Edmunds et al. 2014; Lim et al. 2012; Nakamura et al. 2011; Reding et al. 2014). However, relatively little is known about real-time client engagement challenges that arise during implementation of EBPs in community settings. In order to address this gap in the literature, the current study examined therapist-, client-, and session-level predictors of therapist reports of client-related engagement challenges encountered when delivering EBPs to low-income ethnic minority youth and families receiving care in the context of a system-driven implementation of multiple EBPs.

Results from our first objective revealed that therapists reported at least one engagement challenge in over 27% sessions. Expressed Client Concerns and Limited Client Engagement occurred with similar frequency (16–17% of sessions). In terms of occurrence of engagement challenges, it was significantly more likely that a challenge related to Expressed Client Concerns was reported in caregiver-only sessions compared to youth-only sessions, whereas the opposite pattern was true of Limited Client Engagement. Compared to youth, it is plausible that caregivers may be better equipped to voice, or feel more comfortable in voicing, their concerns about interventions to therapists. In fact, in parent training EBPs there is often an emphasis on collaborative process wherein therapists encourage parents to discuss how strategies fit for families and how strategies may need to be tailored to be feasible (Lau et al. 2018; Ollendick et al. 2016; Reid et al. 2001). Previous research suggests that caregivers commonly express concerns about their ability to carry out parenting interventions, with concerns about feasibility and self-efficacy (i.e., “I can’t” reactions) being more common than active resistance (i.e., “I won’t” reactions) (Patterson and Chamberlain 1994). In contrast, youth may be more likely to be reluctant participants in therapy and may express this through limited in-session engagement, particularly when they did not initiate therapy.

Multilevel analyses focused on our second research objective revealed significant predictors of therapist reports of challenges related to Limited Client Engagement. At the therapist level, therapists with larger caseloads were significantly less likely to report limited engagement challenges than therapists with fewer clients. Although not expected, this finding may suggest that therapists managing a large caseload may be less likely to notice or attend to client behaviors indicative of problems with engagement. In youth sessions, the most commonly reported challenge was apathetic or disinterested behavior, a non-verbal behavior that might occur but may not be remarked upon when therapists are burned out and less attentive to engagement issues. If this is the case, it may be helpful for therapists to build time into sessions to actively elicit concerns from clients in order to pick up on and address potential engagement challenges. On the other hand, it is possible that therapists who carry smaller caseloads provide more intensive services to clients with higher needs and more complex presentations, which could be associated with more challenges (Henggeler and Schaeffer 2016). Additionally, therapists providing services to challenging clients may be experiencing burnout. Burnout is common among therapists in community mental health settings, where clients are often clinically complex (Morse et al. 2012). In a recent study (Lau et al. 2018), therapists who reported being less burned out reported encountering fewer limited client engagement challenges. Providing ongoing implementation supports, such as

EBP-specific supervision and consultation, to therapists who have smaller caseloads because they serve high-need clients could potentially buffer burnout (Kim et al. 2018) and reduce perceived challenges related to limited client engagement.

At the client level, therapists reported limited engagement challenges significantly more often in sessions with male clients than session with female clients. Boys may be more difficult to engage in traditional counseling and might benefit from specific therapeutic strategies encouraging participation in treatment (Haen 2011; Kiselica and Englar-Carlson 2008). However, an association between gender and treatment engagement has not been well established (Godley et al. 2011; Lee et al. 2012; Lau et al. 2018). Future investigations might further examine the role of client gender in youth engagement processes, particularly engagement defined as limited participation in therapy, at the session level.

Finally, at the session level, therapists were more likely to report challenges related to limited engagement when the youth was present in session compared to when the youth was not present. This finding may point to caregivers being more willing participants than youth in therapy, including a subset of youth who may not feel a need to be in treatment (Webster and Harrison 2008). This may be the case because adult gatekeepers are often the ones who initiate treatment for youth, particularly for conduct problems (Ballon et al. 2004; Lynn Mensinger et al. 2006; Sussman et al. 2008). Additionally, sessions without youth may differ qualitatively in their purpose and structure, leading to a difference in therapist encounters with limited engagement.

Reports of client engagement were unrelated to client and therapist demographics, presenting problem, and therapists' perceptions of the EBP. These results did not converge with previous findings that externalizing problem focus and unfavorable therapist perceptions of the EBP were associated with Limited Client Engagement in therapists' 2-month retrospective reports of engagement challenges (Lau et al. 2018). Retrospective reporting may generate a more impressionistic view of the treatment process colored by one's general attitudes toward the EBP protocol. Although therapists' attitudes toward the EBP delivered in each session was not related to reports of disengaged behavior in the current study, in a previous study (Lau et al. 2018) therapists were less likely to note difficulties with engagement over the 2-month reporting window when they had positive perceptions of the EBP being delivered.

We did not identify systematic predictors of Expressed Client Concerns in EBP sessions. There were similar base rates of Expressed Client Concerns and Limited Client Engagement, so limited statistical power is not a likely explanation of null findings. Rather Expressed Client Concerns may reflect a variety of different challenges that are not uniformly associated with client, therapist, or session characteristics. On one hand, expressing concerns may reflect a high level of engagement and investment in therapy such as when a caregiver is very invested in treatment but not confident about their ability to make changes. A recent study used observational coding of in-session barriers in a caregiver-mediated intervention and found that client-expressed concerns were positively associated with parent participation and therapist adherence to the intervention (Guan et al. 2018). These results align with earlier findings from a parent-mediated intervention, in which observed caregiver "I can't"

concerns resulted in a higher dose of parent training being delivered (Patterson and Chamberlain 1994). Such findings suggest that clients' expression of concerns offers therapists an opportunity to clarify relevance of treatment strategies and spend more time teaching skills, resulting in more robust EBP delivery. In contrast, this challenge may also arise when a client is very displeased with an intervention, such as when a caregiver finds a proposed strategy unacceptable. Future research may do well to differentiate among various types of Expressed Client Concerns (e.g., about feasibility, self-efficacy or acceptability) to understand differential associations with engagement and EBP implementation outcomes.

The third objective of the study was to examine the association between therapist-reported client engagement challenges and their self-assessed ability to carry out the intended activities of the session. The question posed here is whether therapists experienced these challenges as barriers to the delivery of the EBP in a given session. Both types of challenges were negatively associated with therapists' reported ability to deliver session activities as planned. This is in contrast to retrospective reports where Limited Client Engagement in activities was associated with derailed implementation whereas Expressed Client Concerns were not (Lau et al. 2018). At the session level, both Expressed Client Concerns and Limited Client Engagement may take space that interferes with the planned activities of the day, but only Limited Client Engagement interferes with implementation success over a longer course. Therapists working with clients who are minimally engaged in therapy may experience burnout and negatively perceive their delivery of EBPs beyond the session in which the client was difficult to engage (Lau et al. 2018). In contrast, Expressed Client Concerns may provide an opportunity for therapists to hear clients' concerns about an EBP and work through questions about treatment, a process that might derail treatment in the short term, but potentially reap benefits in the long term. It is important to note that the association between engagement challenges and reported implementation success held controlling for therapists' perceptions toward the practice being delivered. Positive perceptions of the practice were independently associated with self-assessed implementation. Therapists who feel positive about the EBP are more likely to report being able to stay on task in EBP sessions.

Taken together, these findings suggest that there are at least two distinct types of client engagement challenges that are commonly reported by therapists delivering EBPs to diverse children and families in community settings. Both may impinge on therapists' ability to implement a plan for a given session, but Limited Client Engagement may represent a more pernicious barrier to EBP implementation over the course of treatment (Lau et al. 2018). Given that therapists more commonly reported limited engagement in activities in session where the youth was present, therapists may benefit from learning strategies to promote and support youth engagement in therapy (Becker et al. 2017). Therapists may also benefit from further investigations of the types of engagement challenges that arise in session. The present study sheds light on in-session engagement challenges and their impact on the course of therapy, yet there may be others in addition to the two examined here.

While the current investigation provides a look at therapist perceptions of EBP delivery on a session-by-session basis, the study had several limitations that should be considered. First, this study was carried out within a large public mental health system where EBPs were

fiscally mandated. Findings may not generalize to other service settings and EBP implementation contexts. Further, our sample was comprised of a high proportion of unlicensed therapists, a proportion near double that found in a nationally representative sample of community mental health therapists (Schoenwald et al. 2008). Unlicensed therapists may have limited experience delivering EBPs and thus may be more likely to report challenges with client engagement. However, licensure status was not associated with therapist report of engagement challenges. Additionally, therapists were asked to select clients they believed would remain in treatment for the next 2 months at a minimum to allow time for data collection. Because of this, the clients chosen were likely in an active phase of treatment after the initial intake and planning phase and were unlikely to be in the end stage of treatment. It is also possible that therapists picked clients who were more engaged in treatment and seemed less likely to drop out of care. This aspect of the study design could have implications for our findings, as therapists selected clients who were engaged enough in treatment to have progressed beyond the initial phase. Therefore, it is possible that fewer overall engagement challenges may have been reported in the client sample compared to a sample in which clients were randomly selected. Another limitation of the study is that we relied on therapists' reports of client engagement challenges and EBP implementation. Future studies should include observational and independent informant reports of challenges to understand their impact on implementation outcomes. It may be helpful to gather clients' perspectives on engagement challenges to understand how clients think therapists can better address their needs in session. Also, therapist report was included as both a predictor and outcome in our final research question. The observed association between therapist report of engagement challenges and their perceived ability to carry out planned session activities may be due to shared method variance (Podsakoff et al. 2003). It will be important to examine whether therapist-reported engagement challenges at the session level predict therapist report of ability to implement an EBP over a full course of treatment, as assessed by multiple methods. Finally, therapists did not rate challenges exhibited by youth and caregivers separately. It may be possible that challenges reported in combined youth and caregiver sessions may have stemmed from youth behaviors rather than caregivers. Future investigations should separate engagement challenges associated with youth versus caregivers in these commonly held joint sessions.

Notwithstanding these limitations, the current study provides insight into therapist perceptions of client engagement challenges that arise when implementing EBPs with diverse youth and families in community mental health settings. As the end users of EBPs in the public mental health sector, attention to community therapists' lived experiences with implementation is important to improving clinical outcomes. It may be helpful for therapists to learn about types of engagement challenges and their impact on the course of treatment. Therapists who encounter client-expressed concerns might benefit from conceptualizing concerns as opportunities for engagement and teaching rather than barriers to EBP delivery. Encouraging expression of concerns could also help clients who disengage from treatment or demonstrate limited participation re-engage in the process. In addition to therapists encouraging clients to express concerns, a number of evidence-based strategies for increasing engagement in multiple domains have been identified (Becker et al. 2017). Disseminating this knowledge and providing therapists with supports enabling them to use

strategies to optimally respond to client engagement challenges in their real-time delivery of EBPs may increase the fit and acceptability of EBPs to community settings.

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Table 1

Therapist, client, and session characteristics

	Frequency (%)	Mean (SD)
<i>Therapist characteristics (N = 103)</i>		
Race/ethnicity		
Hispanic/Latino	57 (55.3%)	
Other ethnic minority	23 (23.3%)	
Non-Hispanic White	22 (21.4%)	
Licensure status		
Licensed	20 (19.4%)	
Unlicensed	83 (80.6%)	
Clients in caseload		17.15 (6.91)
<i>Client characteristics (N = 274)</i>		
Race/ethnicity		
Hispanic/Latino	193 (70.4%)	
Other Ethnic Minority	66 (24.1%)	
Non-Hispanic White	15 (4.7%)	
Gender		
Female	138 (50.4%)	
Male	136 (49.6%)	
Mean age		9.78 (3.85)
<i>Session characteristics (N = 702)</i>		
Presenting problem		
Externalizing	229 (32.6%)	
Internalizing	265 (37.7%)	
Trauma	195 (27.8%)	
Other	13 (1.9%)	
Youth present	631 (90%)	
Practice		
CBITS	50 (7.1%)	
SS	366 (52.3%)	
TFCBT	27 (3.9%)	
TP	219 (31.3%)	
MAP	38 (5.4%)	

Table 2

Factor loadings at the session level from a two-factor model

Engagement challenge	Factor loading
Expressed concerns about relevance/acceptability/helpfulness of an intervention strategy	.54 *
Expressed difficulty mastering skills presented in therapy	.56
Demonstrated apathetic or disinterested behavior	.77 *
Avoided participating in therapy activities	.89 *

Standardized factor loadings depicted.

*
 $p < .05$

Table 3

Frequency of client engagement challenges across levels

Engagement challenge	Session level (N = 702) % Occurrence	Client level (N = 274) % Occurrence	Therapist level (N = 103) % Occurrence
Expressed concerns about relevance/acceptability/helpfulness of an intervention strategy	8.3	17.2	36.9
Expressed difficulty mastering skills presented in therapy	9.9	19.3	41.7
<i>Any expressed client concern</i>	16.6	31.0	60.2
Demonstrated apathetic or disinterested behavior	10.2	19.7	39.8
Avoided participating in therapy activities	8.8	18.2	37.9
<i>Any limited client engagement</i>	15.4	29.9	57.3
<i>Any client engagement challenge</i>	27.7	48.9	76.7

Table 4

Logistic regression models predicting therapist-reported client engagement challenges

	Expressed client concerns			Limited engagement in therapy activities		
	Estimate	SE	Odds ratio	Estimate	SE	Odds ratio
<i>Client characteristics</i>						
Age	– .007	.049	.993	– .011	.050	.989
Male	.332	.311	1.39	.722 *	.323	2.06
Race/ethnicity (Non-Hispanic White)						
Hispanic/Latino	– .153	.648	.858	.162	.710	1.18
Other Ethnic Minority	– .326	.702	.722	.546	.747	1.73
<i>Therapist characteristics</i>						
Race/ethnicity (Non-Hispanic White)						
Hispanic/Latino	– .498	.449	.608	– .524	.421	.592
Other ethnic minority	– .601	.545	.548	– .737	.483	.478
PCIS mean	.399	.224	1.49	.305	.192	1.36
Caseload	– .031	.030	.970	– .099 ***	.027	.906
Licensed	– .020	.439	.980	– .403	.410	.668
<i>Session characteristics</i>						
Presenting problem (externalizing ^a)						
Internalizing ^b	.183	.387	1.20	.258	.388	1.29
Trauma	– .232	.515	.793	– .326	.513	.722
Other ^c	.183	1.10	1.15	– 1.39	1.38	.250
Youth present	– .833	.485	.435	1.347 *	.650	3.85
Practice						
CBITS	– .556	.673	.574	.166	.626	1.18
SS	.099	.346	1.10	.156	.341	1.67
TFCBT	1.07	.685	2.91	.182	.799	1.20
TP	– .133	.395	.876	– .099	.402	.907
MAP	– .479	.667	.620	– .407	.740	.666

*
p .05;**
p .01;***
p .001, reference group in parentheses^aIncludes: attention/hyperactivity problems; disruptive behavior or conduct problems^bIncludes: anxiety; mood^cIncludes: autism spectrum disorders; substance use; other

Table 5

Predictors of therapist-reported ability to implement the EBP

	Estimate	SE
<i>Client characteristics</i>		
Age	.022	.015
Male	– .061	.106
Race/ethnicity (Non-Hispanic White)		
Hispanic/Latino	.214	.235
Other ethnic minority	– .097	.247
<i>Therapist characteristics</i>		
Race/ethnicity (Non-Hispanic White)		
Hispanic/Latino	– .042	.185
Other ethnic minority	.008	.216
PCIS	.210 **	.071
Caseload	.013	.011
Licensed	.166	.180
<i>Session characteristics</i>		
Presenting problem (externalizing ^a)		
Internalizing ^b	.067	.133
Trauma	.194	.172
Other ^c	– .987 **	.373
Youth present	– .050	.168
Practice		
CBITS	– .329	.225
SS	– .046	.128
TFCBT	.391	.264
TP	– .039	.144
MAP	.024	.249
<i>Client engagement challenges</i>		
Expressed client concerns	– .241 *	.114
Limited engagement in activities	– .412 ***	.118

*
p .05;**
p .01;***
p .001,

reference group in parentheses

^aIncludes: attention/hyperactivity problems; disruptive behavior or conduct problems^bIncludes: anxiety; mood^cIncludes: autism spectrum disorders; substance use; other