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ORIGINAL ARTICLE

Community Mental Health Professionals' Perceptions About Engaging Underserved Populations

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Abstract

This study explored mental health professionals' perceptions about barriers and facilitators to engaging underserved populations. Responses were coded using an iterative thematic analysis based on grounded theory. Results revealed that many professionals endorsed barriers to engaging ethnic minorities and families receiving social services. Client-provider racial and linguistic matching, therapy processes and procedures (e.g., nonjudgmental stance), and implementation supports (e.g., supervision) were commonly nominated as engagement facilitators. Many professionals felt that an organizational culture focused on productivity is detrimental to client engagement. Findings shed light on professionals' perceived barriers to delivering high-quality care to underserved communities and illuminate potential engagement strategies.

Keywords Community mental health · Engagement · Underserved populations · Mental health disparities

Nearly half of individuals in the United States meet criteria for at least one psychiatric disorder at some point during their childhood or adolescence (Merikangas et al. 2010). Despite the efficacy of current mental health interventions (Chorpita et al. 2011; Weisz et al. 2013), many youth with mental health needs do not receive professional services. Only approximately one-third of youth with mental health needs seek treatment (Merikangas et al. 2011), and even fewer youth receive evidence-based interventions for their mental health concerns (Bruns et al. 2015). Furthermore, most youth who enroll in mental health services attend fewer than six visits with a mental health or medical professional (Merikangas et al. 2011), and more than half of youth receiving services prematurely drop out of treatment (Pellerin et al. 2010). Given that unmet mental health needs among youth are associated with a variety of negative outcomes, including emotional and behavior problems, juvenile delinquency, and school dropout (Brauner and Stephens 2006), poor engagement in mental health services is a significant public health concern.

Mental health treatment engagement among traditionally underserved populations, or groups with economic, cultural, or linguistic barriers to health care (U.S. Department of Health and Human Services 2016), is even more disconcerting. For example, although there are few racial or ethnic differences in lifetime prevalence rates of psychiatric disorders, youth from ethnic minority groups are significantly less likely to receive mental health services than their non-Hispanic White peers (Garland et al. 2005; Merikangas et al. 2011). African American youth are less likely to have access to a mental health provider, seek services for mental health concerns, and receive treatments supported by research than non-Hispanic White youth (U.S. Department of Health and Human Services 2001). Relatedly, studies suggest that Latinx youth underuse mental health services (Alegria et al. 2010), such that Latinx children are significantly underrepresented across public sectors of care, including mental health, child welfare, juvenile justice, alcohol and drug treatment, and public school services for children with serious emotional disturbance (McCabe et al. 1999). Asian Americans have also been

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found to have low rates of mental health service use (U.S. Department of Health and Human Services 2001)—with one study estimating that 72% of Asian American youth have unmet mental health needs (Yeh et al. 2003). These disparities in access to mental health services are also evidenced among other traditionally underserved groups, such as youth without public or private health insurance (Kataoka et al. 2002) and youth from low-income families (Cunningham and Freiman 1996).

Youth from traditionally underserved groups are not only less likely to receive mental health services than their non-Hispanic White peers but may also see diminished benefits when they do receive evidence-based treatments (EBTs). A meta-analysis examining the efficacy of EBTs for youth with mental health needs found that the effect sizes of EBTs for ethnic minority samples tended to be smaller than for majority samples (Weisz et al. 2013). Recently, there have been efforts to develop culturally-adapted interventions to enhance the efficacy of mental health treatments for ethnic minority youth; however, research on effective cultural adaptations is limited, and questions have been raised about the relative efficacy of culturally-adapted versus unadapted interventions (Huey and Polo 2008; Pina et al. 2019). Such findings underscore the importance of understanding barriers to engaging and effectively treating youth from traditionally underserved groups, as well as of identifying solutions for reducing disparities in quality of care (e.g., Alegria et al. 2010; Huey and Polo 2008).

To date, numerous barriers to seeking and accessing high-quality mental health care for traditionally underserved populations have been identified. For instance, a client factor that tends to interfere with individuals' engagement in mental health care is stigma (Abdullah and Brown 2011), such that a client may decide not to seek or fully participate in mental health treatment in order to avoid the label of mental illness or self-critical thoughts about seeking treatment (Corrigan 2004). Provider factors may also influence clients' decision to pursue mental health services (e.g., Southam-Gerow et al. 2012). As an example, differences in ethnic and linguistic backgrounds between providers and clients may present obstacles to establishing trusting relationships (Bauer et al. 2010; Takeuchi et al. 1995). Additionally, the environment, policies, and expectations of a mental health agency or service system may influence client engagement. For example, more negative organizational climates, characterized by high stress environments, lack of support, and low pay, tend to increase staff turnover and burnout (Aarons and Sawitzky 2006), which in turn leads to poorer quality services for clients (Albizu-García et al. 2004; Glisson 2002). Furthermore, sociopolitical factors may impact clients' access to high-quality mental health services, as state and federal initiatives and funding often dictate the types of services that are available (e.g., Aarons et al. 2011).

Disparities in access to and quality of mental health care were recognized nationally two decades ago (U.S. Department of Health and Human Services 1999). As a result, identifying strategies for reducing mental health disparities for ethnic minority groups and other traditionally underserved populations has become a public health priority (U.S. Department of Health and Human Services 2001). Several recommendations have since been proposed, and their efficacy is being tested. For instance, emerging evidence indicates that employing community health workers (i.e., interventionists without formal mental health training who are members of the community they serve) to deliver mental health interventions can facilitate improved well-being and functioning among traditionally underserved populations (Barnett et al. 2018) and may minimize stigma related to having a mental health problem (Abas et al. 2016). As another example, a number of EBTs have now been adapted to be more responsive to specific groups' norms, values, and beliefs (e.g., Benish et al. 2011; Huey et al. 2014). In addition, Federal policies and programs—such as the State Children's Health Insurance Program, Medicaid Expansion State Children's Health Insurance Program, Early Periodic Screening Detection and Treatment mandate, and Affordable Care Act of 2010—have included legislation for helping to reduce disparities in mental health care (e.g., by expanding health insurance coverage; Alegria et al. 2010).

Although remarkable progress has been made toward understanding barriers and facilitators to engaging traditionally underserved communities in mental health services, relatively little is known about mental health professionals' perceptions of working with such populations. However, it is important to understand whether mental health professionals' perceived barriers to client engagement are consistent with those identified in the literature, as this would not only provide useful information about professionals' ability to recognize engagement challenges but could also point to additional considerations for delivering effective and responsive mental health care to traditionally underserved populations. For instance, if professionals endorse challenges that largely reflect engagement problems prevalent among the general population (e.g., limited parent participation; Haine-Schlagel and Walsh 2015), then it is possible that traditionally underserved communities may benefit from use of existing engagement strategies (e.g., Becker et al. 2018). However, if professionals endorse engagement challenges that are seemingly unique to traditionally underserved populations, then discovery of culturally-responsive engagement strategies may be indicated. Accordingly, in addition to determining whether professionals tend to nominate common engagement facilitators, exploring professionals' suggestions for engaging traditionally underserved youth and families could offer new ideas for reducing mental health disparities.

The present study thus sought to explore community mental health professionals' perceptions of working with youth and families from traditionally underserved populations. Specifically, this study aimed to understand what professionals perceived to be barriers or facilitators to engaging traditionally underserved youth and families. Given the limited existing research on mental health professionals' perspectives regarding this aspect of care delivery, we did not formulate any a priori hypotheses. Direct feedback from professionals was used to identify barriers to high quality care for individuals from traditionally underserved communities and to discover potentially effective and sustainable ways for improving engagement.

Method

All study procedures were approved by the Institutional Review Board of the University of California, Los Angeles.

Participants

Mental health professionals employed by one of the largest mental health and welfare agencies for children, youth, young adults, and families in southern California were invited to participate in this study during monthly staff meetings in June 2017 and July 2017. All staff meeting attendees were presented with a brief overview of the study by the Principal Investigator and asked to indicate on a paper form if they were: (a) interested in participating in the study and would like to schedule a time to be interviewed; (b) potentially interested in participating in the study and would like more information; or (c) not interested in participating in the study. After each staff meeting, the Principal Investigator followed up with any meeting attendees who expressed interest or potential interest in participating in the study. Of the 157 professionals who were present at these staff meetings, 116 professionals expressed interest or potential interest in participating in the study. Fifty-five professionals responded to scheduling inquiries made by the Principal Investigator and were ultimately interviewed about their experiences working with underserved populations. There were no significant differences between professionals who elected and did not elect to participate in the study across roles (e.g., clinician, supervisor), or clinic location. Participating professionals were given a $10 gift card upon completing the interview.

Participating professionals consisted of 21 clinicians, 9 supervisors, 6 case managers, 5 directors or assistant directors, 5 community wellness specialists (i.e., bachelor's level professionals who help clients develop coping and problem solving skills), 4 referral managers (i.e., bachelor's or master's level professionals who assist with managing and processing referrals), 3 parent partners (i.e., caregivers who have successfully navigated youth mental health or related services and who provide peer support to other caregivers on a similar journey), 1 assistant vice president, and 1 EBT trainer. Community mental health professionals in various roles were included in this study to gain shared and unique perspectives from the different individuals who interact with youth and family consumers. Of the participating professionals, 44% were Latinx or Hispanic, 29% were Caucasian, 13% were Asian, 9% were Black or African American, and 4% were of mixed ethnicity; 51% of professionals reported being bilingual in English and Spanish. The majority of professionals were female (89%), and professionals ranged in age from 25 to 64 years ($M = 38.41$, $SD = 9.54$). Professionals were predominantly Master's level (73%) and had an average of 5.48 ($SD = 7.54$; $n = 48$) years of clinical experience. They identified with a variety of primary theoretical orientations ($n = 29$): 33% cognitive-behavioral, 25% eclectic, 15% family systems, 7% psychodynamic, and 5% humanistic. They also reported having received training in an average of 2.18 ($SD = 1.65$) EBTs and having attended an average of 1.80 ($SD = 1.11$) trainings on diversity or cultural responsiveness.

Participating professionals offered services in eight mental health clinics, which serve youth and families across more than 3500 square miles. In 2017, the mental health and welfare agency featured in this study delivered services to more than 15,000 youth and families. The agency's youth and family consumers identified as Hispanic (68%), African American (17%), Caucasian (7%), "other" ethnicity (6%), and Asian (2%). Services were provided within the context of the Los Angeles County Prevention and Early Intervention (PEI) transformation, a county-wide EBT reform initiative that was approved in 2009. Specifically, the PEI transformation is focused on promoting health and well-being through high-quality prevention and early intervention services, workforce training and education, outreach, and routine outcome monitoring. To reimburse for services under the PEI Plan, which is the primary source of funding for many professionals in Los Angeles County, professionals must: be trained in an EBT approved by the PEI Plan; deliver an approved EBT with the PEI target population (e.g., underserved cultural populations, adults and youth experiencing onset of serious psychiatric illness, youth in stressed families, trauma-exposed adults and youth, youth at risk for school failure, or youth at risk of experiencing juvenile justice involvement); provide short-term and time-limited (initially only for 1 year) services; administer outcome measures; and enter and report outcome data to DMH (Los Angeles County Department of Mental Health 2016). The PEI transformation represents a significant shift in procedures and responsibilities for mental health professionals and agencies in Los Angeles County and has put the

Los Angeles County DMH at the forefront of the movement toward evidence-based practice (Lau and Brookman-Frazee 2015).

Semi-Structured Interview

Information about professionals' experiences working with underserved populations was gathered through in-person, semi-structured interviews conducted between July 2017 and September 2017. The semi-structured interview included broad, open-ended questions (e.g., "How would you describe your current work with diverse populations?" "What have been your experiences working with diverse and underserved children and families in the community?") and follow-up probes about engaging youth and families in mental health services (e.g., "What have been the barriers to engaging consumers and families from diverse cultural backgrounds?" "What has worked well for you in addressing these barriers?" "What do you think would be helpful for improving engagement with consumers and families of diverse cultural backgrounds?"). Each semi-structured interview lasted approximately 45 min. Semi-structured interviews were audio-recorded and later transcribed by members of the research team.

Semi-structured interviews were conducted by four doctoral students and one post-doctoral scholar. All interviewers received a 90-min training on conducting the semi-structured interview, which included didactics about interviewing techniques (e.g., establishing rapport, avoiding bias) and study procedures, modeling of the semi-structured interview, and role-play opportunities. Interviewers were also required to role play the semi-structured interview with the Principal Investigator before conducting any interviews with participants. Additionally, all interviewers attended biweekly meetings to review the interviewing procedures and problem solve any issues that arose in conducting the interviews.

Coding Strategy

An iterative thematic analysis based on grounded theory methods (Glaser and Strauss 1967; Strauss and Corbin 1998) was used to identify themes in participants' responses to questions about working with traditionally underserved populations. This analytic approach is commonly used in mental health services qualitative research studies (Palinkas 2014). First, three graduate students reviewed a random sample of 10 interview transcripts and engaged in open coding to identify preliminary codes derived from participants' raw responses. This open coding resulted in a pool of 255 preliminary codes, which were then discussed and refined by the investigators. Codes representing similar content were combined, and codes that were identified in two or fewer interview transcripts were subsumed under a code that was more frequently assigned. Consequently, the pool of preliminary codes was reduced to 36 codes.

Next, all interview transcripts were segmented into excerpts by a graduate student and a postdoctoral scholar through consensus. Excerpts ranged from a phrase to several sentences, depending on the length of a participant's response to a specific question from the semi-structured interview or the length of a participant's comment about a specific topic. For example, a participant's response that mentioned experiences working with ethnic minority families and experiences working with families who are homeless would be segmented into two excerpts: (1) an excerpt containing the participant's comments about working with ethnic minority families, and (2) an excerpt containing the participant's comments about working with families who are homeless.

A graduate student and a postdoctoral scholar then engaged in axial coding. Each week, coders reviewed an interview transcript and independently assigned codes to each excerpt. Twenty percent of interview transcripts (11 transcripts, 237 excerpts) were double-coded. For the double-coded transcripts, coders met weekly to review and resolve discrepancies, discuss emergent codes and codes with poor inter-rater reliability, refine code definitions, and construct/revise a codebook. Codes that demonstrated poor inter-rater reliability were redefined and oftentimes combined with similar codes. Codes that were assigned with low frequency (i.e., assigned to fewer than 10 interview transcripts) were subsumed under a code with a broader definition. For instance, the initial codes of client participation, client trust, and client-provider working alliance were subsumed under a broader code of client engagement. When codes were redefined, excerpts featuring revised codes were re-coded. Final codes for all excerpts from double-coded transcripts were determined through consensus between the two coders. The remaining transcripts were randomly assigned to be independently coded by one of the two axial coders. The final codebook listed 16 codes, which were organized into two dimensions: (1) content of professionals' responses, and (2) valence. The dimension of content of professionals' responses contained six themes: (1) client characteristics and engagement, (2) client-provider match, (3) professional characteristics and service delivery, (4) implementation supports, (5) agency climate and culture, and (6) service system and sociopolitical context. Each theme contained between one and five codes. For example, the theme of implementation supports contained codes of consultation, resources, supervision, training, and treatment team. The valence dimension contained codes of positive and negative. Each excerpt was assigned at least one code reflecting the content of the participant's response and at least one code reflecting the valence. Multiple codes could be assigned to the same excerpt—for example, an excerpt

where the participant states that it would be helpful for the agency hire more Spanish-speaking providers would be assigned codes of Agency Climate and Culture, Professional Characteristics, and Positive [valence]. See Table 1 for code titles and definitions.

Data Analyses

Inter-rater reliability between the two axial coders was assessed using Cohen's (1960) kappa, which is appropriate for measuring level of agreement for categorical variables between two coders. Based on guidelines from Landis and Koch (1977), kappa statistics with values from .00 to .20 indicate slight agreement, .21 to .40 indicate fair agreement, .41 to .60 indicate moderate agreement, .61 to .80 indicate substantial agreement, and .81 to 1.00 indicate almost perfect to perfect agreement.

Frequency distributions were used to determine the percentage of participating professionals who made positive and/or negative comments about the influence of client characteristics, client-provider match, professional characteristics and service delivery, implementation supports, agency climate and culture, and system and sociopolitical context on treatment engagement for youth and families from traditionally underserved populations.

Results

Inter-rater Reliability

Results showed that inter-rater reliability ranged from moderate agreement to perfect agreement. See Table 1 for the Cohen's kappa statistic associated with each code.

Table 1 Code definitions and reliability statistics

Codes	Definition	κ
Content of provider responses		
Client characteristics and engagement		
Client characteristics	Comments about characteristics or backgrounds of youth and families referred for mental health services	.85
Client engagement	Comments about clients' therapeutic alliance, therapy expectations, participation, attendance, or understanding of therapy procedures and process	.72
Client-provider match	Comments about match or mismatch between client and provider characteristics or backgrounds	.89
Professionals' characteristics and service delivery		
Provider Characteristics	Comments about professionals' characteristics or backgrounds	.77
Provider Experience	Comments about professionals' clinical experience	.80
Provider Procedures	Comments about what professionals do with clients	.70
Provider style	Comments about how professionals behave with clients	.75
Implementation supports		
Consultation	Comments about the frequency, structure, or topic of consultation with another mental health professional	.84
Resources	Comments about the distribution, types, or topics of resources or information	.84
Supervision	Comments about the frequency, structure, or topic of supervision, or comments about providers' working alliance with supervisors	1.00
Training	Comments about the frequency, structure, or topic of trainings for providers	.97
Treatment team	Comments about the frequency, structure, or topic of treatment team meetings, or comments about members of the treatment team (e.g., psychiatrists, behavioral specialists, parent partners)	.97
Agency climate and culture	Comments about the environment, policies, or expectations of the agency	.82
Service system and sociopolitical context	Comments about the environment, policies, or expectations of the county or state mental health system, or comments about social or political forces	.92
Valence		
Positive	Comments with positive valence, such as comments about treatment facilitators or favorable perceptions	.71
Negative	Comments with negative valence, such as comments about treatment barriers or unfavorable perceptions	.85

Client Characteristics and Engagement

Barriers to working with specific client populations were endorsed by 67% of participating mental health professionals (Fig. 1). Many professionals spoke about challenges that they have encountered in working with ethnic minority youth and families. As stated by a clinician, "A lot of Chinese families have a lot of stigma and biases towards mental health, and things like that I see as a major barrier. A lot of Chinese families believe that you only get in treatment if you are sick, so by trying to let them stay in treatment, you're indicating to them that their kids are sick." A program manager noted, "I've worked with a family who was East Indian… They had very different cultural views and practices and actually that was a barrier because I didn't know that much about that culture." Many professionals shared that challenges are sometimes presented when working with youth and families receiving social services. A member of the agency's leadership team mentioned, "Their perception of anyone coming into their home providing services is intimidating, for a lot of the population based on their experience with the system in LA county, DCFS system… It's hard for many of them to see us in a helping role. They see us in a role of taking something away many times. And so many of the populations, when we go into their home, they initially start off extremely paranoid and resistant." Several professionals also mentioned feeling uncertain about how to work effectively with the diverse individuals referred for mental health services. For instance, a case manager shared, "I work with diverse… different families and sometimes it does get challenging working in the mental health field because everybody has their own personal beliefs. You know, culturally, and so it's hard when you have to come in and know rules and what not."

Positive comments about working with specific client populations were made by 31% of participating mental health professionals. A community wellness specialist commented, "I worked with a family for 2 years that was from Libya. They were so nice, so sweet, always wanted to feed me, so I tried lots of their food because in my background, it's rude not to take the food and you can't say no so you just eat it. Every time, I would never leave hungry cause she would always feed me. But she would tell me a lot about how she grew up and how she didn't understand why his behaviors were occurring. She didn't understand how to help him because he was born here. So that was, that was really interesting."

Three-fourths of participating mental health professionals discussed specific client engagement problems (e.g., difficulties building rapport with clients, challenges with client participation and attendance). A case manager stated, "I think they're so used to being judged by, you know, the powers that be, the people who took away their kids, or whoever's in the system. They're so used to being judged, and they tend to be judgmental as well, and so they're always on the defense." A referral manager noted, "It's really the families being consistent. I think when there's chaos going on, so we're talking to the families, we can hear the chaos in the background, the

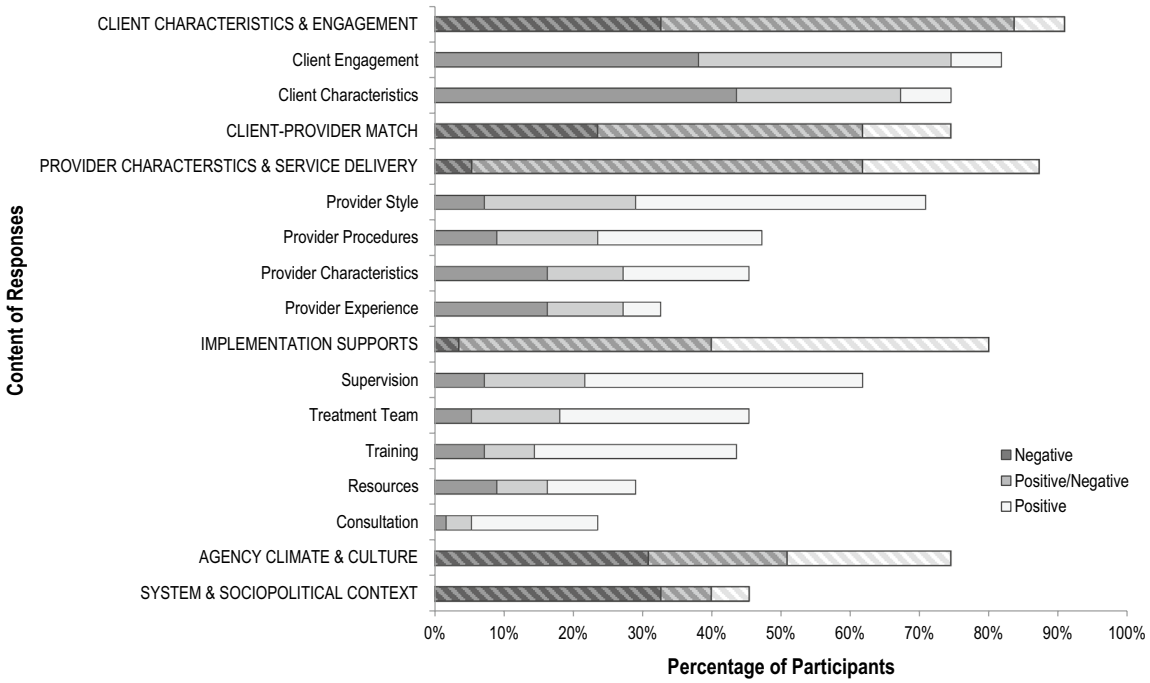

Fig. 1 Content and valence of provider responses by subtheme and code

family's overwhelmed, the parent's overwhelmed. And then so following up with an appointment and actually attending it is difficult."

Positive comments about client engagement were made by 44% of professionals. For instance, a community wellness specialist shared, "I think people from different cultures can relate very easily to me… Most of the time it feels like a welcome addition to have someone with a different culture in their home." Additionally, an assistant director stated, "I like to talk to clinicians and supervisors about phases of treatment and how you should still be building ongoing rapport. It shouldn't just be in the initial beginning. You need to do that ongoing so that you really strengthen the relationship."

Client-Provider Match

Negative statements about client-provider matching were made by 62% of participating mental health professionals: 100% of referral managers, 78% of supervisors, 60% of directors or assistant directors, 60% of other professionals, 57% of clinicians, 50% of case managers, and 40% of community wellness specialists (Fig. 2). For instance, as described by a clinician, "I had an Asian client and that was exciting for me because she was my first Asian client… She was Cambodian. I'm Filipino. And then her family was kind of traditional when it came to mental health where they really felt like, 'What are you doing? That's not real treatment. You're just going to mess when her brain, kind of make her crazier.' I thought that being Asian and walking into that room, it would help them with the buy in, but it didn't. [Her grandfather] looked at me like, 'You're a traitor to our culture.'" A supervisor shared a more mixed view about matching clients and providers with similar characteristics or backgrounds: "Back when I was still in school, I went to my first site where I was going to do work as a clinician. I remember when they hired me, they were really happy to get me because, being Black and male, and it was a very, very White area. And, they saved a caseload for me, and they couldn't wait until I got there, and I noticed, 'Wow, everyone on my caseload is Black in a very White area. Huh? I wonder what that's about.' They saved them for me, right? I didn't know what to think, whether to feel honored, like 'Wow,' or to feel offended, like 'Really?'" Additionally, some professionals mentioned client-provider matching inconsequentially impacting client engagement. A clinician noted, "As far as connecting with the culture, I mean I don't pretend to be an expert like I'm clearly a white practitioner and I'm not fooling anybody. Like I speak some Spanish, but they know it's like white girl Spanish, so, you know, I just… I don't pretend to be an expert, I'm just open to what they have to say and it tends to work out pretty well."

Positive perceptions about client-provider racial and linguistic matching were endorsed by 51% of participating mental health professionals: 80% of other professionals, 67% of clinicians, 67% of supervisors, 40% of community wellness specialists, 25% of referral managers, and 17% of case managers (Fig. 3). Many professionals suggested that clients should work with a provider who speaks their native language. As shared by a clinician, "We don't have enough Spanish speaking therapists. And we have an interpretation

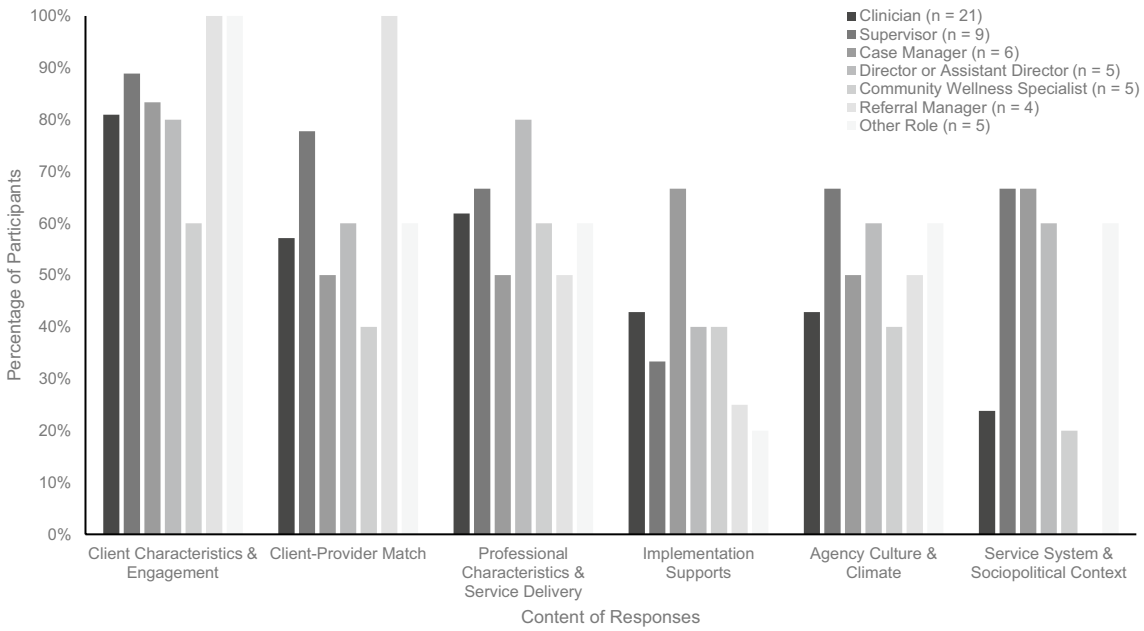

Fig. 2 Responses with negative valence by professional role

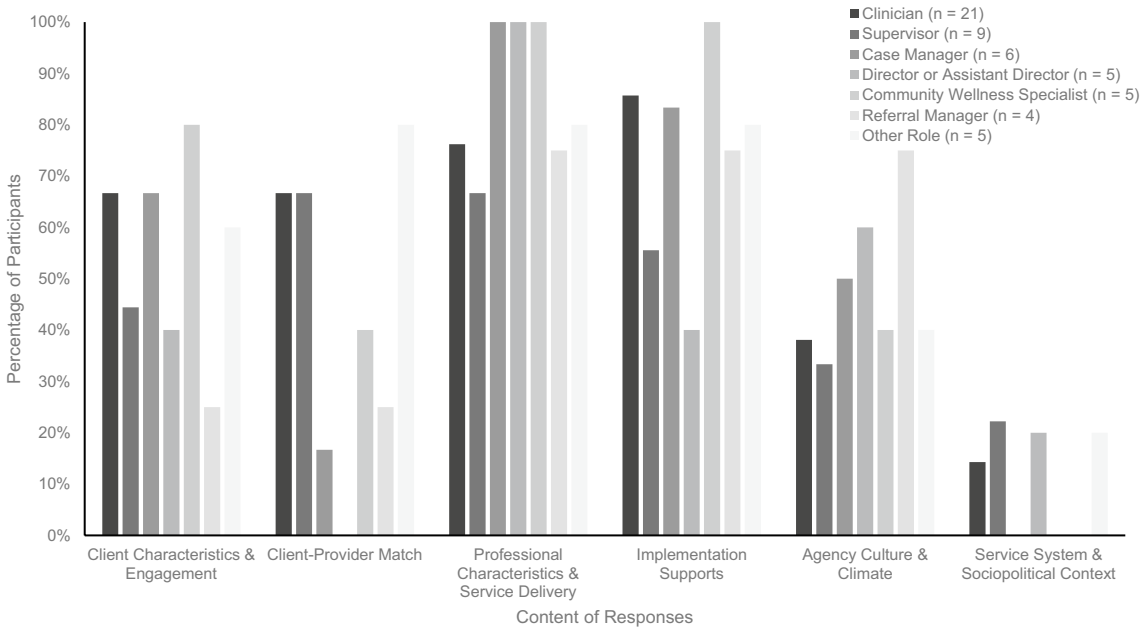

Fig. 3 Responses with positive valence by professional role

department… They're phenomenal. They do the best as they can. I think we all do the best that we can, but that's such an obvious barrier that comes up so much. It's been interesting, even with the birth to 5 [years old] work, like sometimes the 2- and the 3-year-olds, they are only speaking Spanish. It's one thing to do interpretation with the caregiver, I think it's another thing to like have to utilize it with a little kid in play therapy. It's just I don't know that it's effective." Several professionals reported that matching clients with providers of the same race or ethnicity is helpful for treatment engagement. For example, as noted by a member of the leadership team, "I think what has been helpful is that I have a very diverse staff. And with that diverse staff, I think the paranoia sometimes when we go into the home is not there because they're able to look into someone's eyes that look like theirs… the perception is that they feel you understand their journey, and that has been extremely helpful for our clients."

Professional Characteristics and Service Delivery

Engagement barriers related to professionals' characteristics (e.g., race, ethnicity, religion, years of experience) and service delivery were identified by 62% of participating mental health professionals. As shared by a community wellness specialist, "I'm a white male, so sometimes I work with certain families, they just see me in a negative light from the get go. I had one mother that wanted me to yell at her kid, and I think in her culture, that's what a man does to the kid. You know? I mean, that was her complaint that I never yelled at him." A clinician stated, "We are providing education to families, and I haven't always felt really equipped to do that… but if I had resources available and I was like, 'Your child is like dealing with this. I suggest that you go to this educational group or this parenting group like because then you'll find out so much more that way and… I'm limited in like the support that I can provide you but go here.'"

Engagement facilitators related to professionals' characteristics and service delivery were discussed by 82% of professionals. Several professionals mentioned that their clinical role facilitates client engagement. As described by a parent partner, "It's really important that they have a parent partner on the case because the other team members are more like clinical and they feel like too much like professionals to the families. So, I feel that by experiencing it and knowing what they're going through, it helps us to be able to communicate with them on a different level." Many professionals also reported that being respectful, nonjudgmental, and personable is helpful for engaging individuals in mental health services. For instance, a clinician stated, "I like to go in and point out that they are the experts in their life in their home. Empower the parents so they feel like I'm there to support and not to judge and mostly keep an open mind to learn from them. Because if we don't share the same culture, if we don't share the same experiences or anything else, I can definitely learn from them and that helps to establish the rapport and the trust that we need." Another clinician noted, "Just being genuine because I think sometimes we think that as a therapist, like we think we have to look a certain way, act a certain way, talk a certain way. And yes you do remain

professional but at the same time you're a person and to be genuine I think is really important." Professionals also shared that they have found assessment and psychoeducation procedures to facilitate client engagement. A referral manager noted, "I think maybe finding a way to ask them, ask the families up front without being insensitive… if they can share with us if they have any cultural concerns or if there's anything that we need to know, you know, off the bat so that we can better help them out." As expressed by an assistant director, "Once we kinda provide that psychoeducation and they see that we are a partner with them, for the most part I would think that it works."

Some therapy procedures were nominated as both an engagement challenge and facilitator. For example, when discussing strategies for making services more convenient and accessible for traditionally underserved youth and families, a community wellness specialist shared, "With the public transportation, we say we have the tokens here, so, we help them with the process. For the gas piece, I think we just try to see if it's an option for us to go to the home." However, that same professional mentioned, "I've encountered situations where families are given the whole token thing, and I know we don't make the offering [of] transportation to our consumers on a consistent basis. Just because if we were to offer it to one, we would probably need to offer it to the rest of the other families and that's sometimes not do-able."

Implementation Supports

Forty percent of participating mental health professionals made at least one negative comment about an implementation support. These comments pertained to supervision (22% of participants), treatment teams (18%), resources (16%), training (14%), and consultation (6%). For instance, in regards to supervision, a clinician shared, "I think it would be nice if, you know, if it was a regular thing for the supervisors to meet more with the clients because I'm finding that, there's some things that I just can't explain or like relay super well to my supervisor and it's kind of hard to take her feedback on some things sometimes because she's never met the client." In reference to working as part of a treatment team, a case manager noted, "I've had coworkers that think they're being sensitive to certain cultural backgrounds, but they'd say things that are not sensitive. So that's a conversation with that person like, 'You were trying to be funny, but it isn't funny. Don't say that in front of certain people because that's offensive.' And, learning to communicate with that coworker about how they're being perceived by the family."

The majority of participating mental health professionals (76%) viewed implementation supports as an engagement facilitator. Positive comments were made about supervision (55% of participants), treatment teams (40%), training (36%), consultation (22%), and resources (20%). For instance, in reference to supervision, a case manager shared, "I think all the supervisors that I have had have been extremely supportive because they have been in the field themselves so they have that experience of working with different cultural backgrounds. Also if there's a particular family that I don't have the experience… either their ethnicity or cultural background, whatever, they might have it, so I think that my communication with supervisors that I've had in the past, including here, have been open to feedback from me or vice versa to learn something different so that I can get the families engaged." When discussing treatment teams, a supervisor stated, "I think that everyone comes in with a unique perspective, especially when you have like the role of a parent partner, it's more of the life experience, like going to school or getting books or anything like that… when I was younger, I came in as a clinician… You know all the parents like look at me, 'You're young. You don't have any kids. What do you know?' And I would come in with a parent partner, and they would respect her. And she would let them know, 'She really knows what she's talking about.' So it's just, you know, having that team approach and valuing everyone's perspective and appreciating the people that you work with." Additionally, a clinician commented, "I think trainings are always helpful. If not to give you actual like steps to engage or anything like that, but to at least open your mindset of the different populations that you might encounter."

Agency Climate and Culture

Many professionals (51%) felt that certain aspects of the agency's climate and culture may be engagement barriers, including system influences that are embedded within agency policies and procedures. For example, an assistant director commented, "[A] barrier has been just clinicians not really fully understanding the importance of building that rapport and hearing from [clients] because they're feeling like really rushed with having to do the 30 day paperwork and so maybe not taking as much time as they should with just really slowing down and just really just listening to that family and building that rapport."

Conversely, 44% of participating mental health professionals mentioned that the agency's climate and culture has facilitated client engagement in mental health services. As noted by an assistant director, "I think we have a strong leadership team… Our leaders are all very involved in different change initiatives in Los Angeles or statewide or nationwide… I am sent to many different venues to gather information from other professionals that might have more successes in some areas, not only learn it but come back, share it, and teach it, so we get a lot of support to do those kind of things. Then, you know, that kind of trickles down to

your supervisors and to your core staff that are on the team and any time that we can, we try to send team members to different conferences and different venues to learn. So, you know, a lot of times they're going and they're getting their own education on how to do this, and so I think that's really helpful."

Service System and Sociopolitical Context

Barriers related to the mental health service system or sociopolitical context were identified by 40% of participating mental health professionals: 75% of supervisors, 60% of directors or assistant directors, 58% of other professionals, 24% of clinicians, and 20% of community wellness specialists. As stated by a case manager, "Sometimes it has nothing to do with the agency but a lot to do with politics because they want you to open the cases really quickly, so maybe they're pressuring us to open it quick, faster than what the family's needs might be." A care manager shared, "I think that one of the pressures is billing. The people who do direct services are so focused on billing… so I think the pressures that some of the staff have is kind of an obstacle to how they engage with families." Some professionals also voiced concerns about the impact of the current sociopolitical climate on client engagement. For instance, an EBT trainer commented, "Working with the Latino population right now, we have clients that are fearful to give us information we need sometimes when we're completing our necessary paperwork. They're fearful to give you certain kinds of information for fear of issues of deportation and things like that." A community wellness specialist also noted, "I think that's just a very real phenomenon that our families are experiencing. The fear of immigration, the fear of the what-ifs and that's not something we're able to control."

Engagement facilitators related to the mental health service system or sociopolitical context were identified by 12% of participating mental health professionals: 25% of supervisors, 20% of directors or assistant directors, 14% of clinicians, and 8% of other professionals. For instance, a clinician shared, "I really enjoy it… that's why I've stayed in DMH for so long because it can be hard work, but I think that's what kept me in agencies like this is because of that is the population that we serve."

Discussion

This study aimed to explore community mental health professionals' perceptions about engaging youth and families from traditionally underserved populations in mental health services. By better understanding perceived barriers and facilitators to treatment engagement for traditionally underserved youth and families, we hope to inform efforts that can be taken by professionals, agencies, and service systems to reduce disparities in access to and quality of mental health care.

Results suggest that most professionals perceived challenges to engaging certain populations (e.g., ethnic minority youth, families receiving social services). These perceptions are consistent with the extant literature, which indicates that many youth, particularly those from ethnic minority or low-income families, are often sub-optimally engaged in treatment (Merikangas et al. 2011). Notably, professionals were not often able to identify solutions to these barriers; rather, their positively-valenced comments about working with specific populations or about client engagement tended to reflect a lack of barriers rather than the identification of solutions to reduce mental health disparities. These findings emphasize the continued need to develop and disseminate solutions for engaging and providing effective mental health care to traditionally underserved populations. For instance, although numerous culturally-adapted treatments have been developed and tested over recent years (e.g., Huey and Jones 2013)—representing remarkable contributions to the evidence base on effective treatments for traditionally underserved groups—such treatments have yet to be widely adopted within community mental health settings (e.g., Bruns et al. 2015; Garland et al. 2010). That is, many EBTs have only recently started to gain traction within the community (Southam-Gerow et al. 2014), to say nothing of the culturally-adapted variants of these treatments.

Given the extensive time and efforts required to develop, test, and disseminate culturally-adapted treatments and the mixed evidence for cultural tailoring (Huey et al. 2014), some have recommended that professionals employ existing EBTs with traditionally underserved populations and consider cultural adaptations only if treatment barriers or opportunities arise (Huey et al. 2014; Huey and Polo 2008; Lau 2006). This approach of selectively incorporating culture into treatment has several potential benefits including: (a) capitalizing on existing knowledge about effective mental health services (e.g., defaulting to existing EBTs as first-line interventions rather than developing, disseminating, and implementing culturally-specific interventions) (e.g., Huey et al. 2014); (b) allowing treatment to be tailored to meet the dynamic and unique needs of the diverse individuals who seek mental health treatment (e.g., adapting treatment based on client response to the intervention rather than a priori implementing a culturally-adapted or unadapted EBT) (e.g., Chorpita and Daleiden 2014); and (c) reducing the number of contingencies that require solutions (e.g., focusing on identifying and resolving implementation challenges rather than trying to understand, test, and train professionals in a variety of potential adaptations or cultural worldviews).

For example, to address some of the engagement concerns raised (e.g., client mistrust of mental health professionals),

it could be helpful to train professionals in discrete engagement strategies that could be employed only if or when an engagement problem arises (e.g., Becker et al. in press). This approach would leverage knowledge from efficacious interventions to address engagement barriers that may be particularly prevalent among traditionally underserved populations. Training professionals in common engagement strategies would also build upon professionals' existing skillsets, without necessarily requiring professionals to learn multiple culturally-specific protocols or attend a series of specific cultural competency trainings (e.g., Huey et al. 2014).

One solution that was commonly offered by professionals for facilitating treatment engagement was to match clients with professionals with similar characteristics or backgrounds. Indeed, some studies indicate that linguistic and/or racial matching of clients and professionals can improve clients' psychotherapy outcomes (e.g., Griner and Smith 2006). However, as noted by some professionals from this study and supported by at least one meta-analysis (Cabral and Smith 2011), client-provider matching is not universally effective. Additionally, it might not always be possible for agencies to match clients with providers with similar characteristics or backgrounds, given the composition of available staff and the sociodemographics of the treatment-seeking population.

Many professionals also identified parent partners (i.e., caregivers who provide peer support and who are employed members of the treatment team) as valuable resources for facilitating treatment engagement. Mental health professionals' positive perceptions of parent partners are supported by the literature on paraprofessionals (i.e., members of the community who promote access to health information and resources), which suggests that paraprofessionals might be particularly effective at engaging individuals from traditionally underserved populations given their contextual knowledge and shared experiences (Rusch et al. 2018). Accordingly, mental health agencies might consider assigning a parent partner to cases that are at risk for poor treatment engagement. Given the limited funding and resources available to community mental health agencies and service systems, decisions about how many parent partners or other paraprofessionals to recruit into the workforce as well as how to capitalize on the strengths of their paraprofessional versus professionally trained providers might also be worthy of consideration.

Other nominated solutions for addressing engagement challenges among traditionally underserved populations focused on therapy processes (e.g., being respectful and nonjudgmental) and procedures (e.g., psychoeducation, assessment). These therapy processes and procedures were consistent with the existing literature on efficacious interventions for improving treatment engagement (e.g., Becker et al. 2018), suggesting that traditionally underserved youth and families may benefit from unadapted, evidence-based engagement strategies. These findings also indicate that professionals may be knowledgeable of and open to implementing at least select evidence-based practices for improving client engagement.

To help implement these solutions for engaging traditionally underserved populations, many professionals perceived supervision, training, resources, and consultation to be beneficial. These perspectives have been echoed by mental health services researchers, who have increasingly explored the promise of these implementation supports for promoting the delivery of high quality services. For instance, supervision has been progressively regarded as a valuable natural resource for encouraging professionals' evidence-informed practice (Becker et al. in press; Dorsey et al. 2013). As such, supervisors might help professionals make decisions about when and how to culturally adapt treatment if indicated (e.g., Lau 2006) or might facilitate multicultural supervision or professionals' active learning of evidence-informed approaches to cultural competence (Constantine 2001). More research is needed to understand how these implementation supports can be optimized for reducing mental health disparities. However, findings regarding the perceived helpfulness of these implementation supports indicate that professionals would be receptive to receiving supervision, training, resources, and consultation that could improve their cultural responsiveness to traditionally underserved populations.

Many professionals also described how organizational policies, procedures, and environments can influence their work with traditionally underserved populations. For instance, professionals commented that it has felt rewarding to contribute to a shared mission and to be part of an organization that values the provision of high quality services to clients from underserved groups. Such positive comments about an agency and service system promoting the routine use of EBTs are encouraging as an increasing number of mental health organizations prioritize the delivery of evidence-based practices. Additionally, these views are consistent with the literature on the impact of organizational culture and climate on work attitudes (Aarons and Sawitzky 2006; Glisson and James 2002), which indicates that work environments with achievement (e.g., taking on challenging tasks), individualistic (e.g., developing staff's full potential), and supportive norms (e.g., encouraging others) tend to have relatively high staff job performance and job satisfaction and relatively low rates of staff emotional exhaustion and turnover. As such, organizations may benefit from fostering a positive work environment—for example, by supporting management to adopt transformational leadership principles (Green et al. 2013), whereby leaders construct a workplace that promotes respect, a common vision, creative thinking, and opportunities for professional development.

Furthermore, it is worthwhile for agencies and service systems to consider how to support professionals' delivery of high quality mental health services in the current sociopolitical context. As an example, in response to their clients' growing immigration questions and concerns, the mental health agency featured in this study supplied their professionals with Red Cards—or index cards that describe the constitutional rights of U.S. citizens and noncitizens in multiple languages (e.g., "You have constitutional rights: Do not sign anything without first speaking to a lawyer. You have the right to speak with a lawyer"; Immigrant Legal Resource Center 2016). Such actions have the potential to not only elicit more favorable perceptions about an agency or service system's climate and culture but also reduce mental health disparities among traditionally underserved populations.

Although this study has several strengths, including its comprehensive examination of professionals' perceptions of barriers and facilitators to engaging traditionally underserved populations, some caveats are in order. For instance, one limitation is that all participating professionals were recruited from a single mental health agency in Los Angeles, CA. Professionals were assigned to service areas spanning more than 3500 square miles and reflect diverse clinical roles, ages, races/ethnicities, and years of clinical experience; however, it is possible that these findings may not be representative of perceptions held by mental health professionals working in other agencies, service systems, or sociopolitical contexts. Another limitation is that the mental health professionals typically discussed engagement barriers and facilitators in general terms. Accordingly, more research is needed to understand what mental health professionals perceive to be the specific steps for better engaging traditionally underserved populations (e.g., how can providers assume a respectful and nonjudgmental stance in therapy?) and which facilitators or solutions might map onto which barriers (e.g., when would covering psychoeducation be most helpful?). Relatedly, the efficacy of participating professionals' suggestions for engaging traditionally underserved populations was untested in this study. Although many nominated facilitators were consistent with the literature, it is unknown whether the suggested strategies would be effective in engaging traditionally underserved populations in mental health services. As such, fruitful avenues for future research include testing the effectiveness of the nominated solutions and exploring engagement strategies supported by practice-based evidence (e.g., Ammerman et al. 2014). An additional limitation of this study is that participants were asked about the nature rather than the presence of engagement barriers and facilitators. This decision was made based off of the well-documented mental health disparities among traditionally underserved populations (Alegria et al. 2010) and research recommending the use of open-ended questions for gathering more detail about a phenomenon (Patton 1987); however, future research should consider examining community mental health professionals' sensitivity to engagement barriers and facilitators. Another limitation is that mental health professionals' responses may be positively skewed, as it is possible that participants may have felt pressured to emphasize positive aspects of their work and to minimize any challenges in their work. Several measures were taken to reduce the risk of social desirability bias, including semi-structured interviews being conducted by researchers who were not associated with the mental health and welfare agency and the use of open-ended, follow-up questions to gather detailed information about perceived barriers and facilitators to engaging youth and their families. Lastly, since many professionals' responses focused on barriers and facilitators to engaging ethnic minority youth and families, further research should investigate professionals' perceptions about working with other traditionally underserved groups (e.g., low-income families, individuals without public or private health insurance).

Conclusions

Findings from this study highlight the multitude of perceived barriers to engaging traditionally underserved youth and families in community mental health services. Although the current literature on youth mental health (e.g., Chorpita et al. 2011) and engagement (e.g., Becker et al. 2018) interventions may offer some solutions, mental health professionals' suggestions indicate that there are likely opportunities to intervene at the level of the provider (e.g., paraprofessionals could be assigned to the case), supervisor (e.g., supervisors could attend cultural competency trainings to foster multicultural supervision), agency (e.g., agencies could distribute resources related to common client concerns), and service system (e.g., service systems could encourage transformational leadership). Further research is needed to explore feasible, effective, and sustainable strategies for mitigating disparities in access to and quality of mental health care, and the current findings on mental health professionals' perceived engagement barriers and facilitators may serve as a useful guide for informing promising intervention directions.

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Compliance with Ethical Standards

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

Ethical Approval Approval by the institutional review board of the University of California, Los Angeles was obtained before the study was conducted. 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.

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