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Toward Application of Evidence in Diverse Contexts:

Building a Model for Strategic Action and Selective Real-Time Adaptation

A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Psychology

by

Alayna Lee Park

2020

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ABSTRACT OF THE DISSERTATION

Toward Application of Evidence in Diverse Contexts:

Building a Model for Strategic Action and Selective Real-Time Adaptation

by

Alayna Lee Park

Doctor of Philosophy in Psychology

University of California, Los Angeles, 2020

Professor Bruce F. Chorpita, Chair

The past 25 years have been characterized by remarkable advances in the development and testing of evidence-based treatments (EBTs) for a variety of youth mental health problems. However, the public health impact of these EBTs has been less than desired or expected. The majority of youth with mental health concerns do not receive EBTs, and when EBTs are delivered in public sectors of care, they have been shown to produce effect sizes well below those seen in randomized clinical trials. A common view among providers serving diverse youth in the community is that EBTs often do not fit their clients' characteristics, values, and needs. Accordingly, numerous questions have been raised about how to provide mental health services that are both effective and responsive to youth in the community.

This dissertation sought to elucidate strategies for improving the utility of EBTs for the diverse youth referred for community mental health services. The first study examined the applicability and implementation of EBTs for youth accessing community mental health services

following a county-wide EBT reform initiative. Results showed that a set of more than 30 EBTs had limited applicability to the service sample and that most youth did not receive EBTs delivered with fidelity. In light of these findings suggesting that EBTs may need to be adapted to better fit the needs of the diverse youth in the community, the second study explored providers' perceptions of barriers and facilitators to engaging traditionally underserved youth in community mental health services. Providers identified barriers to effectively engaging ethnic minority youth as well as families receiving social services. Assigning clients to providers with similar backgrounds, striving for a respectful and nonjudgmental therapeutic style, and making use of implementation supports such as supervision were commonly nominated as strategies for improving client engagement in community mental health services. To identify commonly researched strategies for incorporating culture into psychotherapy, the third study reviewed the literature on psychosocial interventions for ethnic minority youth. This review identified various strategies for incorporating culture into psychotherapy, such as matching clients with providers with similar backgrounds, using handouts that depict ethnic minority youth and families, and allocating time in sessions to discuss issues of prejudice and discrimination. These strategies for culturally tailoring treatment were featured in one-third of effective psychosocial interventions, although most of these interventions targeted disruptive behavior problems among Black and Latinx youth. Findings from these three dissertation studies indicate that the diverse youth seen in community mental health settings may benefit from the selective adaptation of EBTs and highlight opportunities for enhancing the effectiveness and responsiveness of mental health care for traditionally underserved youth and families.

The dissertation of Alayna Lee Park is approved.

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2020

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Park, A. L., Tsai, K. H., Guan, K., & Chorpita, B. F. (2018). Unintended consequences of evidence-based treatment policy reform: Is implementation the goal or the strategy for higher quality care? *Administration and Policy in Mental Health and Mental Health Services Research*, *45*, 649-660.

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CHAPTER 1:

Unintended Consequences of Evidence-Based Treatment Policy Reform:

Is Implementation the Goal or the Strategy for Higher Quality Care?

Abstract

This study examined patterns of evidence-based treatment (EBT) delivery following a county-wide EBT reform initiative. Data were gathered from 60 youth and their 21 providers, who were instructed to deliver therapy as they normally would under the EBT initiative. Results showed limited applicability of county-supported EBTs to this service sample, and that most youth did not receive traditional delivery of EBTs. Findings suggest that it may be unrealistic to expect providers to deliver EBTs with fidelity with all clients, and that EBT implementation may be best thought of as a strategy for improving mental health services rather than a goal.

Introduction

In response to increasing calls to improve the quality of community mental health services for children and their families (National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001; Rotheram-Borus, Swendeman, & Chorpita, 2012), more than 650 EBTs have now been developed and tested to treat a variety of child psychopathologies (Chorpita, Bernstein et al., 2016). Despite the current wealth of EBTs and associated literature, however, EBTs are not typically delivered in community mental health settings (Garland et al., 2010; Gyani, Shafran, Myles, & Rose, 2014; Zima et al., 2005).

To better promote the widespread adoption of EBTs in community mental health settings, an increasingly common strategy has been the development of policy initiatives that support the routine use of EBTs within these contexts (McHugh & Barlow, 2010). As of 2009, 94% of regions (from the 50 United States, the District of Columbia, and two United States territories) reported that their legislature had implemented policies that promoted the use of EBTs in the community (Cooper & Aratani, 2009). These policy initiatives have included strategies such as the offering of fiscal incentives for delivering EBTs, provision of EBT training and consultation, fostering of partnerships between EBT developers and county-based agencies to assist in the uptake of EBTs, and mandated use of EBTs.

One of these early statewide EBT reform initiatives stemmed from California's Mental Health Services Act (MHSA). In November 2004, California voters passed the MHSA, which promised a dedicated funding source for the delivery of specific types of mental health services by imposing a 1% income tax on personal income in excess of $1 million. The funding generated from this tax has since served as the primary funding source for mental health services provided

by several county mental health departments and is expected to exceed $2 billion for the 2016-2017 fiscal year (California Department of Mental Health, 2016).

As the nation's largest county mental health department, the Los Angeles County Department of Mental Health (LACDMH) receives hundreds of millions in MHSA funding every year. Since their Prevention and Early Intervention (PEI) Plan was approved by the state in 2009, the LACDMH has used their allocated MHSA funding to promote the use of EBTs by offering mental health agencies the opportunity to receive reimbursement for the delivery of EBTs, promising practices (i.e., practices that seem to produce good outcomes but lack research supporting their generalizability), and community-defined-evidence practices (i.e., practices that have yielded good outcomes and have high acceptability within the community). Additionally, to support providers' delivery of these specific mental health services to children and families in need, the LACDMH has sponsored trainings in six EBTs: Child-Parent Psychotherapy (CPP; e.g., Lieberman, Van Horn, & Ippen, 2005), Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Stein et al., 2003), Group Cognitive Behavioral Therapy of Major Depression (GCBT-MD; e.g., Lewinsohn, Clarke, Hops, & Andrews, 1990), Positive Parenting Program (Triple P; e.g., Sanders, Markie-Dadds, Turner, & Ralph, 2004), Seeking Safety (SS; e.g., Najavits, Gallop, & Weiss, 2006), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; e.g., Cohen & Mannarino, 1996)[1].

Although the LACDMH PEI Plan represents an impressive accomplishment in terms of promoting the widespread adoption of EBTs, it remains unclear whether such efforts are fully

[1] The LACDMH PEI Plan is intended to promote effective mental health services for underserved cultural populations, individuals experiencing onset of serious psychiatric illness, children and youth in stressed families, trauma-exposed individuals, children and youth at risk of school failure, and children and youth at risk of or experiencing juvenile justice involvement. Given the aims of this study, we have focused on aspects of the PEI Plan related to early intervention for children and youth.

successful at producing the intended public health impact for children and families in need. For instance, concerns have been voiced regarding the reality that many of the children treated in community mental health settings do not resemble those treated in the context of randomized clinical trials and that this discrepancy may mitigate the potency of EBTs for these individuals (Hawley & Weisz, 2002). Indeed, children treated in community-based service clinics are more likely to come from low-income, single-parent, and ethnic-minority families relative to those treated in research clinics (Ehrenreich-May et al., 2011; Southam-Gerow, Chorpita, Miller, & Gleacher, 2008). Additionally, Chorpita, Bernstein, & Daleiden (2011) found that a set of 832 treatments matched the presenting problem, age, and gender of only 71% of youth in a statewide mental health system—in other words, this extensive set of treatments had not been tested with samples that matched the characteristics of 29% of youth in this service system. This gap in the treatment literature has, accordingly, prompted the question of how to provide effective psychotherapy to the youth for whom no EBTs currently exist (e.g., Hawley & Weisz, 2002).

In the absence of structured guidance on how to manage exceptions within mental health treatments or within systems (e.g., selecting a treatment for a youth who does not resemble youth in the EBT literature), Chorpita and Daleiden (2014) have articulated that providers or system administrators may (a) ignore the exception, or (b) improvise a solution. For instance, a provider who "ignores" the lack of resemblance between her client and the youth for whom an EBT has been tested may engage in "off-label" use of an available EBT. Within the medical field, off-label use of pharmaceutical drugs refers to a prescription that is not FDA-approved for the patient's specific condition or age group (Wittich, Burkle, & Lanier, 2012). Off-label drug use is common practice in the treatment of a variety of health (e.g., Radley, Finkelstein, & Stafford, 2006) and mental health concerns (e.g., Chen et al., 2006). As an example, morphine is often

prescribed to treat moderate to severe pain experienced by children, despite having never received FDA-approval for pediatric patients (Shah, Hall, & Goodman, 2007). Relatedly, mental health service providers may engage in off-label use of EBTs by delivering an EBT that was designed to treat a different presenting problem (e.g., using an EBT for traumatic stress with a youth presenting with Major Depressive Disorder) or a different age group (e.g., using an EBT for adolescent mental health concerns with an 11-year-old child).

Alternatively, mental health service providers may "improvise" when assigned to treat a client for whom no EBTs currently exist. One such strategy is to modify the content and/or sequencing of an EBT. For example, rather than following an EBT manual from cover to cover, a provider may decide to modify the content of an EBT by implementing select practices from multiple EBTs that might collectively address her client's mental health concerns or to modify the sequencing of an EBT by skipping practices from the EBT that might not be relevant to her client. Modified delivery of EBTs has been shown to be commonplace within community mental health settings (Palinkas et al., 2013), and building evidence suggests that individualized application of procedures from EBTs, guided by decision-support resources (e.g., flowcharts that outline default sequences for applying EBT procedures) and real-time practice and progress monitoring (e.g., Chorpita, Bernstein, & Daleiden, 2008), are effective in improving client functioning and symptomatology (e.g., Chorpita et al., 2017; Daleiden et al., 2006; Weisz et al., 2012).

Providers may also improvise by delivering therapy that is not informed by the EBT literature. Given the low dosage of EBT practices found in previous studies on community mental health services (e.g., Garland et al., 2010; Zima et al., 2005), such improvisations are seemingly common and may suggest a need for providers to supplement EBTs with therapy

practices that can meet the complex and often unpredictable needs of their clients. For instance, recent studies indicate that when emergent client stressors arise during the therapy process, providers frequently improvise for much of the session (e.g., giving advice to a client) in lieu of delivering planned EBT practices (Guan et al., 2017).

Despite remarkable efforts to promote EBT implementation in the community, it seems inevitable that providers in service systems that encourage (if not mandate) the routine use of EBTs will encounter a mismatch between the characteristics of their clients and those that EBTs were designed to treat. Considering that even providers in service systems with a high penetration of EBTs are trained in three or fewer EBTs (Reding, Chorpita, Lau, & Innes-Gomberg, 2014), well-intentioned implementation strategies, such as the provision of EBT training and consultation and offering of fiscal incentives for delivering EBTs, could fall short of expectations in ways that were not anticipated at the time practice policies were developed.

The Current Study

The current study thus sought to examine patterns of EBT delivery following a county-wide EBT reform initiative. The study aims were to: (1) determine the applicability of the EBTs offered by the LACDMH PEI Plan to youth accessing LACDMH services; (2) identify the frequency with which providers used traditional delivery of EBTs, engaged in off-label use of EBTs, modified delivery of EBTs, or delivered therapy that was not informed by the EBT literature; and (3) examine whether training in EBTs promoted use of procedures from EBTs. Given the well-documented discrepancy between youth featured in clinical trials and youth receiving community mental health services (e.g., Chorpita et al., 2011), it was hypothesized that the set of EBTs supported by the LACDMH PEI Plan would not perfectly match the presenting problems and ages of youth accessing LACDMH services. Should this be the case, it was

expected that mental health providers would need to at least occasionally engage in off-label use of EBTs, modify their delivery of EBTs, or deliver therapy that is not informed by the children's mental health intervention literature. Previous studies of EBT use in usual care contexts (e.g., Garland et al., 2010; Zima et al., 2005) also suggest that traditional delivery of EBTs may be lower than desired or expected within a mental health service system that supports and incentivizes the use of EBTs. Lastly, it was hypothesized that training in EBTs would be associated with increased use of EBT procedures, when such EBT procedures are relevant to the case – that is, providers who are trained in an EBT that matches their client's presenting problem and age group may be more likely to deliver that EBT than providers who are not trained in a matching EBT. By investigating the applicability and implementation of EBTs within a county-wide EBT reform initiative, we hoped to examine whether EBT implementation efforts translate into use of EBTs and, if not, to identify opportunities for promoting high quality mental health services.

Method

This study used data from a randomized effectiveness trial comparing a modular EBT with multiple community-implemented EBTs (CIT) for youth, aged 5-15 years, in Los Angeles County (Chorpita et al., 2017). The treatment phase of the randomized effectiveness trial took place from 2010 to 2014. All study procedures were approved by the institutional review board of the University of California, Los Angeles as well as by those institutional review boards of participating service agencies that requested independent reviews.

Participants

Provider sample. This study included providers ($N = 21$) who were randomized to deliver CIT as part of the effectiveness trial. Of these providers, 52% were Latino/a or Hispanic,

29% were Caucasian, 10% were Asian American, and 10% were of mixed ethnicity. Providers were predominantly female (95%), and averaged 35.57 (*SD* = 9.63) years of age and 3.86 (*SD* = 4.18) years of clinical experience since obtaining their most advanced degree. Most providers were Master's level (90%); 38% listed their primary theoretical orientation as cognitive-behavioral, 19% as eclectic, 19% as psychodynamic, 14% as humanistic, and 10% as family systems.

Providers in the CIT condition of the randomized effectiveness trial agreed to use the treatment procedures that they normally would within the context of a county-wide EBT reform initiative (i.e., the LACDMH PEI Plan). Providers were employed by three different community mental health agencies in Southern California, and delivered predominantly weekly outpatient mental health care to children, transition-aged youth, and families. Providers reported receiving workshop-based training and consultation in an average of 2.55 (*SD* = 1.61) county-supported EBTs (see Table 1).

Youth sample. Sixty youth received at least one session of CIT as part of the randomized effectiveness trial. Youth ranged in age from 5 to 14 years (*Mean* = 8.30, *SD* = 2.70) and were predominantly Latino/a or Hispanic (73%). Fifty-five percent of the sample were boys. Annual family income was less than $40,000 for 92% of youth.

Youth from this sample were referred for the randomized effectiveness trial for concerns related to anxiety, depression, traumatic stress, or conduct problems. Prior to each youth beginning therapy, youth and their caregivers completed a semi-structured interview (i.e., Top Problems Assessment; Weisz et al., 2011) and a battery of standardized assessment measures [i.e., Strength and Difficulties Questionnaire (Goodman, 2001); Revised Child Anxiety and Depression Scales (Chorpita, Moffitt, & Gray, 2005; Ebesutani et al., 2010; 2011; Ebesutani,

Tottenham & Chorpita, 2015); UCLA PTSD Reaction Index; (Steinberg, Brymer, Decker, & Pynoos, 2004)], which assessed for clinically elevated symptomatology. A team of doctoral-level study staff, including the Principal Investigator of the randomized effectiveness trial, then reviewed the youth and caregiver's scores on these measures and identified the youth's principal problem area (i.e., anxiety, depression, traumatic stress, or conduct) as well as any other clinically elevated problem areas. Youth in this sample had clinical elevations in an average of 3.03 (SD = .99) problem areas (see Table 2).

Youth participants did not differ from the LACDMH service-seeking population in terms of gender [$\chi^2(1, N = 60) = .01, p > .05$] or ethnicity [$\chi^2(3, N = 60) = 5.73, p > .05$]. Similar to youth in this sample, the top three problem areas among youth accessing LACDMH services were conduct, depression, and anxiety, respectively (Los Angeles County Department of Mental Health, 2016b).

Measures

Consultation Record. The Consultation Record is a measure designed to document information about a youth's most recent treatment session, including session attendance (e.g., youth and biological mother attended session), level of caregiver participation (e.g., caregiver participated in approximately 25% of session), problem focus (e.g., provider focused on the youth's conduct problems), and implemented intervention (e.g., provider delivered Triple P). Checkboxes for nine EBTs [i.e., TF-CBT, Parent-Child Interaction Therapy (PCIT; e.g., Eyberg, Boggs, & Algina, 1995), Functional Family Therapy (FFT; e.g., Alexander & Robbins, 2011), CBITS, Incredible Years (IY; Webster-Stratton, 2006), Triple P, SS, CPP, and Depression Treatment Quality Improvement (DTQI; e.g., Asarnow et al., 2005)] are included in the intervention section of the Consultation Record as well as an "Other" checkbox, where study

staff can write in other interventions (e.g., Cognitive Behavioral Therapy, communication skills). The Consultation Record was completed for every treatment session by doctoral-level study staff during weekly consultation meetings with providers. In these meetings, study staff conducted semi-structured interviews to gather information about the most recent treatment session and recorded the provider's responses on the Consultation Record. In situations where the provider's report was unclear, study staff were trained to ask open-ended, validating questions for clarification. Previous studies have found that provider reports of session content gathered through these semi-structured interviews have been consistent with coder observation of audio- and video-taped session recordings (*Mean ICC* = .71; Ward et al., 2013; κ = .62; Park, Moskowitz, & Chorpita, 2016).

"Other" interventions (*N* = 964) documented on the Consultation Record were independently coded by a doctoral-level researcher and a graduate student researcher into one of three broad categories: EBT [i.e., the intervention listed a specific EBT (e.g., Cognitive Behavioral Therapy) or a distinct component of an EBT (e.g., PRIDE skills, which is a component of PCIT)], EBT practice, or neither. Interventions that were coded as EBTs were then further coded into type of EBT (e.g., CBT, PCIT). Interventions that were coded as EBT practices were also further coded into type of EBT practice (e.g., cognitive restructuring, relaxation exercises, rewards) (Appendix A). EBT practices were identified using the PracticeWise Evidence-Based Youth Mental Health Services Literature Database, an online searchable database that contains treatment summaries (i.e., client characteristics, practices from tested treatments) from currently 903 empirical articles of randomized clinical trials of youth psychotherapies. Inter-rater reliability for codes (i.e., EBT, EBT practice, or neither; *mean*

Cohen's κ = .95) and sub-codes (i.e., type of EBT, *mean Cohen's* κ = .91; type of EBT practice, *mean Cohen's* κ = .86) was good.

Evidence-Based Practice Training Survey. The Evidence-Based Practice Training Survey is a 14-item checklist that prompts providers to indicate the EBTs in which they have received formal training and the dates of their training(s). The measure lists 10 frequently-implemented EBTs in Los Angeles County [CBITS, CPP, DTQI, FFT, IY, Managing and Adapting Practice (MAP), PCIT, SS, Triple P, and TF-CBT] as well as four write-in fields where providers can list other EBTs in which they have been trained. The Evidence-Based Practice Training Survey was administered to providers upon study entry and study completion as well as once per year during their study participation.

Procedure

Determining EBT Coverage. The ages and problem areas that each of the 32 EBTs supported by the LACDMH PEI Plan[2] was designated to treat were determined using information from LACDMH PEI Plan documents (Los Angeles County Department of Mental Health, 2011; Los Angeles County Department of Mental Health, 2013; Los Angeles County Department of Mental Health, 2014, Los Angeles County Department of Mental Health, 2016a). The proposed age and problem area coverage for each EBT was then reviewed and approved by experts in children's mental health and a Director of Research and Clinical Training at a

[2] The EBTs supported by the LACDMH PEI Plan were selected through a feedback loop between community stakeholders (e.g., caregivers, community forum participants) and decision-making bodies (e.g., LACDMH staff, advisory groups). Although MAP—an evidence-informed services support system that offers a collection of "how to" guides for delivering common EBT practices to address a variety of mental health concerns and a searchable database that can identify the EBT practices that may be appropriate for specific clients—has been supported by the LACDMH PEI Plan since July 2010, MAP was not included in analyses because: (a) the randomized effectiveness trial from which data were gathered was designed to exclude providers who were trained in MAP; and (b) this decision enhances the generalizability of our findings to mental health service systems promoting the use of EBTs—as MAP is not an EBT per se.

LACDMH funded community mental health agency. A list of these EBTs and their coverable ages and problem areas can be seen in Table 1.

Determining Patterns of EBT Delivery. Youth were considered to have received *traditional delivery of EBT* if procedures from that EBT were implemented in more than half of their treatment sessions, according to their Consultation Records. Youth were considered to have received an *off-label EBT* if the youth's age and top three clinically elevated problem areas did not match the ages and problem areas coverable by the EBT that was most frequently implemented with the youth. Youth were considered to have received *modified delivery of EBT* if practices from unspecified EBTs (e.g., communication skills, problem solving) or multiple EBTs (e.g., procedures from TF-CBT and SS) were implemented in more than half of their treatment sessions. Lastly, youth were considered to have received *minimal EBT* if they received EBTs or EBT practices in less than half of their treatment sessions. See Table 3 for descriptions and examples of these patterns of EBT implementation.

Data Analysis

To determine the applicability of the LACDMH PEI Plan to youth accessing LACDMH services, we compared the ages and problem areas of youth in our sample with those coverable by three sets of EBTs: (1) the 32 EBTs supported by the LACDMH PEI Plan; (2) the 6 EBTs in which LACDMH offered free trainings; and (3) the EBTs in which the youth's provider was actually trained. The proportion of youth whose age and principal problem area matched the coverable ages and problem areas of at least one EBT in the set were calculated. Given individual differences in youths' developmental level, we also examined the proportion of youth from our sample who could have been covered by at least one EBT in each set if they were one year older or younger. Additionally, we examined the proportion of youth from our sample

whose principal or comorbid problem area could have been addressed by at least one EBT in each set of EBTs. Frequency distributions were used to assess the proportion of youth who received traditional EBT, off-label use of EBT, modified EBT, and minimal EBT. Lastly, to determine the association between providers' training in EBTs and client receipt of procedures from EBTs, we estimated a multi-level model, with youth nested within providers. This model assessed whether the number of EBTs in which the provider was trained, provider training in an EBT that was designed to treat the youth's age and presenting problem, and their interaction term predicted client receipt of procedures from a specific EBT (i.e., traditional EBT or off-label EBT). Multilevel logistic regression analyses were performed in SAS 9.4 using PROC GLIMMIX.

Results

How applicable are county-supported EBTs to service-seeking youth?

Sixty-three percent of youth in our sample (n = 38) could be covered by at least one matching EBT from the LACDMH PEI Plan. Seventy-two percent of youth (n = 43) could be covered if they were one year older or younger. Eighty-five percent of youth (n = 51) could be covered if the treatment focus consisted of any of the youth's presenting problems (as opposed to only the youth's principal problem). Eighty-nine percent of youth (n = 53) could be covered if they were one year older or younger *and* the treatment focus consisted of any presenting problem.

Fifty-four percent of youth (n = 32) could be covered by at least one EBT in which the LACDMH PEI Plan offered free training. Eighty-three percent of youth (n = 50) could be covered if the treatment focus consisted of any of the youth's presenting problems. The

proportion of youth who could be covered by at least one EBT in which the LACDMH PEI Plan offered free training did not change when using a more flexible age criterion.

Lastly, forty percent of youth (n = 24) could be covered by at least one EBT in which their provider was trained. Forty-two percent of youth (n = 25) could be covered if they were one year older or younger. Fifty-five percent of youth (n = 33) could be covered if the treatment focus consisted of any presenting problem, and fifty-seven percent of youth (n = 34) could be covered if they were one year older or younger *and* the treatment focus consisted of any presenting problem.

Are youth receiving evidence-informed mental health care?

Of the 60 youth in our sample, 17 (28%) received EBTs: 9 received PCIT, 5 received TF-CBT, 1 received IPT, 1 received Promoting Alternative Thinking Strategies (PATHS; e.g., Greenberg, Mihalic, Kusché, 1998), and 1 received Triple P. Eight of these youth received an EBT used off-label. Specifically, seven youth received an EBT that was designed to treat a problem area other than one of the youth's top three clinically elevated problem areas (i.e., four youth received TF-CBT for problems other than traumatic stress, such as depression, anxiety, conduct, or attention concerns; and three youth received PCIT for problems other than conduct, such as depression, anxiety, or attention concerns), and one youth received an EBT that matched that youth's presenting problem but was designed to treat older youth (i.e., IPT was used in the treatment of an 11-year-old youth). Twenty-nine youth from our sample (48%) received modified EBT as their primary intervention. Nineteen of these youth received an EBT in less than half of their sessions that was supplemented by additional EBT practices. Among youth who received modified EBT as their primary intervention, the five most commonly implemented EBT practices were: Communication Skills (n = 21), Insight Building (n = 19), Play Therapy (n

= 16), Psychoeducation for Youth (n = 16), and Relationship/Rapport Building (n = 16). Fourteen youth from our sample (23%) received minimal EBT as their primary intervention.

Does training in EBTs predict delivery of procedures from EBTs?

A multilevel, logistic regression model was used to examine whether providers' training in EBTs predicted client receipt of an EBT. Results revealed a significant interaction between the number of EBTs in which providers were trained and providers' training in an EBT that matched their clients' characteristics on client receipt of procedures from a specific EBT [$b = -4.12$, $t(12.87) = -2.66$, $p < .05$]. Subsequent simple slopes analysis showed that the number of EBTs in which providers were trained significantly predicted client receipt of procedures from a specific EBT when the provider was trained in an EBT that matched their client's characteristics [$b = 4.61$, $t(9.36) = 3.12$, $p < .05$]. The number of EBTs in which providers were trained did not significantly predict client receipt of an EBT when the provider was not trained in a matching EBT. Figure 1 displays the patterns of EBT delivery for cases seen by providers who were and were not trained in an EBT that matched their client's characteristics.

Discussion

The present study investigated the applicability and implementation of EBTs for youth and families accessing community mental health services following a county-wide EBT reform initiative. By examining patterns of EBT delivery within a mental health system promoting the routine use of EBTs, we hoped to better understand how EBT implementation efforts may encourage evidence-informed psychotherapy, but also may lead to unintended consequences such as the use of off-label, modified, or minimal EBT.

Consistent with previous research on the applicability of EBTs to youth within community mental health settings (e.g., Chorpita et al., 2011), results revealed that less than two-

thirds of the youth in our sample matched the presenting problems and ages that the 32 EBTs supported by the LACDMH PEI Plan were designed to treat. Although this number increases to nearly nine out of ten youth when considering EBT addressability for mental health concerns related to youth's presenting problems (e.g., comorbid mental health problems) and for a slightly broader age group, using EBTs with populations that are dissimilar from the samples with which those treatments were tested may not be indicated or universally beneficial and, accordingly, such decisions should perhaps be made on a case by case basis with consideration of supporting evidence. Notably, in an effort to meet the needs of a broader proportion of their service-seeking population, LACDMH has expanded the practices supported under their PEI Plan (e.g., Southam-Gerow et al., 2014); however, the current findings about the applicability of EBTs still raise several considerations. For instance, the relatively limited applicability of a set of 32 EBTs to the youth and families accessing LACDMH services underscores the complexity involved in selecting an array of EBTs for a mental health service system. That is, in a climate that is increasingly promoting the routine use of EBTs, administrators of mental health service systems are faced with the difficult, if not impossible, task of determining a select set of effective and cost-efficient EBTs to serve sometimes up to hundreds of thousands of individuals in their service system.

Further complicating this task is the current, but changing, reality that many EBTs are designed to treat a specific presenting problem (e.g., anxiety) for a specific age group (e.g., children between the ages of 7-13), which means that numerous distinct EBTs may need to be selected for a service array in order to address at least the majority of a service-seeking population's mental health concerns (e.g., Chorpita et al., 2011). In addition, there are limits on providers' time to participate in multiple EBT trainings, as well as on providers' ability to learn

and successfully implement a variety of EBT protocols with fidelity (e.g., Reding et al., 2017). The rich diversity of youth and families referred for community mental health services also raises complications in the selection of EBTs for a mental health service system, including (a) the multitude of mental health disorders that need to be treated (e.g., Weisz & Chorpita, 2011), (b) the equivocal generalizability of EBTs for traditionally underrepresented communities (e.g., ethnic minorities; Huey & Polo, 2008), and (c) the issue of how to address comorbid mental health concerns (e.g., Park et al., 2016). As more and more mental health service systems begin their own EBT reform initiatives, it is therefore important for decision-makers involved in a formal, structured process to consider the characteristics of their consumers (e.g., presenting problem, age, ethnicity), provider workforce (e.g., previous training in and/or use of EBTs), interventions under consideration (e.g., target problem, demonstrated efficacy), and service system (e.g., organizational culture, implementation climate) to optimize the set of supported interventions chosen for their service-seeking population (e.g., Damschroder et al., 2009; Powell et al., 2016; Raghavan, Bright, & Shadoin, 2008).

Results from this study also showed that only a little more than half of the youth in our sample could be covered by an EBT in which the LACDMH sponsored free training—a key strategy for promoting use of an EBT in a mental health service system (Beidas, Koerner, Weingardt, & Kendall, 2011)—and less than half of our youth participants could be covered by an EBT in which their mental health service provider was trained. These results again point to the complexity involved in assembling an array of EBTs that can meet the needs of at least the majority of consumers in a service-seeking population. Assuming that mental health service system administrators are able to select an optimal array of EBTs, it is not practically feasible for that workforce to receive immediate, concurrent training and achieve competence in all

supported EBTs. Accordingly, decisions must be made as to which EBTs should be fiscally incentivized (e.g., by offering free trainings), which can be afforded, and which providers should receive training in which EBTs. Such decisions are undeniably complicated, and raise questions about what is best for the mental health service system, its provider workforce, and its consumers. For example, is it better for a mental health agency to send all of their providers to participate in training for the same EBT, or to encourage their providers to obtain training in a diverse set of EBTs (e.g., Provider A could be trained in TF-CBT and Provider B could be trained in PCIT)? Additional barriers to EBT implementation include, but are not limited to, provider turnover (e.g., even if an agency's provider workforce is trained to meet the needs of their consumers, a quarter of those providers may leave within 2 years; Glisson et al., 2008), match between provider and supervisor EBT training (e.g., providers may encounter difficulties delivering an EBT with fidelity if their supervisor is not trained in that EBT; Reding et al., 2017), and EBT training requirements (e.g., it may take several months for a provider to be certified to deliver an EBT, which raises issues for new providers entering the workforce who may not have received any previous EBT training, but who are encouraged or mandated to use EBTs with their clients).

Indeed, even with the extensive EBT implementation efforts enacted by LACDMH through their PEI Plan, our results showed that the majority of youth in our sample did not receive traditional EBT. These findings are consistent with previous research suggesting that providers often deliver improvised psychotherapy in the absence of structured guidance for what to do with clients for whom no EBTs currently exist (e.g., Chorpita & Daleiden, 2014). These results may also relate to providers' tendency to adapt their delivery of EBTs in response to their client's needs and characteristics (e.g., delivering select practices from a specific EBT; Palinkas

et al., 2013). Relatedly, the expectation for a provider to deliver an EBT with fidelity for a given client may be appropriate if that provider is trained in an EBT that is designed to address the client's needs and characteristics; however, as alluded to above, there are likely many cases where a provider will not be trained in an EBT that is designed to treat their client's presenting problem and age group. In those instances, it may be unrealistic to expect that provider nevertheless to use an EBT with their client without making some adaptations.

Accordingly, mental health services agencies, systems, and policies may need to rethink how to best encourage delivery of evidence-informed psychotherapy, if not solely promoting use of EBTs with fidelity. For instance, Raghavan and colleagues (2008) proposed that sustainable implementation of evidence-informed psychotherapy requires support across levels of the policy ecology (i.e., consumer, provider, agency, system, policy, and social context). As such, proponents for increasing the use of evidence in community mental health services may realistically need to consider strategies, such as: (a) offering flexible options for training providers in EBTs (agency; e.g., the LACDMH PEI Plan sponsors trainings in six EBTs, but provides agencies with funding to send their providers to trainings for other EBTs that may be more applicable to that agency's clients); (b) offering fiscal incentives for delivering therapy practices that are accepted as effective but perhaps not classified as an EBT (system; e.g., in addition to EBTs, the LACDMH PEI Plan now also supports the use of promising practices and community-defined evidence); and (c) engaging stakeholders and expert consultants in the development and refinement of mental health services policies (policy; e.g., LACDMH has now formed multiple partnerships with research collaborators to facilitate implementation of evidence-informed psychotherapy; Brookman-Frazee et al., 2016; Southam-Gerow et al., 2014).

Consistent with the proposition of the policy ecology model that sustained use of evidence-based mental health practices requires efforts across ecological levels (Raghavan et al., 2008), the provision of additional EBT trainings does not appear to be sufficient for encouraging routine use of EBTs in the community. Our results showed that clients whose providers were trained in more EBTs were more likely to receive procedures from a specific EBT, but only if their provider was trained in an EBT that matched the client's characteristics. Youth whose providers were not trained in an EBT that matched the client's presenting problem and age received off-label EBTs, modified EBTs, and minimal EBTs. These findings provide further support to the notion that well-intentioned EBT implementation efforts may not be yielding the intended public health impact of widespread use of EBTs with fidelity, and prompt the question of whether the goal of such efforts is implementation of EBTs or effective mental health care.

Although this study has several strengths, including its examination of EBT application and implementation following a county-supported EBT reform initiative, some caveats are in order. The first relates to the use of the Consultation Record as the source of information about session content. Specifically, each Consultation Record contained only a brief statement about the EBT or therapy practices covered in session and, accordingly, assumptions were made about the quality and fidelity of the treatment rendered—although study staff were instructed to assess both of these aspects of treatment during the semi-structured interviews that were used to collect the data for the Consultation Record. Additionally, our definitions of the four patterns of implementation described in this study (i.e., traditional EBT, off-label EBT, modified EBT, and minimal EBT) did not include considerations of practice sequencing (e.g., did the provider deliver praise before time out, as prescribed by PCIT?). Therefore, in conjunction with the assumptions made about treatment quality and fidelity, it is likely that these findings represent an

overestimate of providers' delivery of procedures from EBTs. Another limitation of this study relates to the assessment procedures, specifically that separate assessments were conducted by the research team and by the provider and that the results of these assessments were not shared across parties. Notably, youth's top three clinically elevated problem areas were considered in our analyses to reduce the likelihood of diagnostic disagreement between the research team and provider; however, if a provider were to conclude that a youth's presenting problem was not one of the three top problems identified by the research team, then that provider would have technically not engaged in off-label use of EBT – yet, this situation would point to other opportunities for improving the quality of community mental health services, such as the need to increase diagnostic agreement among assessors as well as to increase coordination between assessment, treatment selection, and treatment delivery. Additionally, this study did not examine client outcomes and thus cannot draw conclusions about the effectiveness of the psychotherapy delivered, whether that involved client receipt of traditional EBT, off-label EBT, modified EBT, or minimal EBT. Growing evidence suggests that individualized delivery of EBTs, guided by decision-making supports (e.g., measurement feedback systems), outperforms standard EBTs and usual care in community mental health settings (e.g., Chorpita et al., 2017; Weisz et al., 2012); however, the effectiveness of various types of community-implemented treatment represents a natural next line of inquiry.

Conclusion

The collective efforts of mental health services researchers, policymakers, and providers have undoubtedly advanced EBT implementation within community mental health services. However, our results suggest that EBT implementation efforts do not necessarily equate to use of EBTs as intended. Indeed, the expectation for EBTs to be applied as a unified treatment package

to every client may be unrealistic given the limitations of the evidence base and the training capacity of mental health service systems. It seems therefore that the implementation of EBTs, albeit a laudable endeavor, may perhaps be best thought of as a strategy for improving the quality of community mental health services rather than as a goal in and of itself—and, to remember that the goal is ultimately to improve the health and well-being of youth, families, and their communities.

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Table 1

Los Angeles County Supported EBTs and Their Designated Ages and Areas of Coverage.

Evidence-Based Treatment	**Age**	**Problem Area**	**Providers Trained**
Aggression Replacement Training (ART)	5 - 17	Conduct	0 (0%)
Alternatives for Families – Cognitive Behavioral Therapy (AF-CBT)	5 - 17	Trauma	0 (0%)
Brief Strategic Family Therapy (BST)	10 - 18	Conduct	0 (0%)
Caring for Our Families (CFOF)	5 - 11	Other	0 (0%)
Center for the Assessment and Prevention of Prodromal Sates (CAPPS)	16 - 25	Other	0 (0%)
Child-Parent Psychotherapy (CPP)*	0 - 6	Trauma	0 (0%)
Cognitive Behavioral Intervention for Trauma in School (CBITS)*	10 - 15	Trauma	2 (10%)
Cognitive Behavioral Therapy (CBT)	16 - 65	Anxiety, Depression, Trauma	0 (0%)
Crisis Oriented Recovery Services (CORS)	3+	Other	1 (5%)
Depression Treatment Quality Improvement (DTQI)	12 - 20	Depression	4 (19%)
Dialectic Behavior Therapy (DBT)	18+	Other	0 (0%)
Families Over Coming Under Stress (FOCUS)	5+	Other	0 (0%)
Functional Family Therapy (FFT)	10 - 18	Conduct	0 (0%)
Group Cognitive Behavioral Therapy of Major Depression (GCBT-MD)*	18+	Depression	0 (0%)
Incredible Years (IY)	0 - 12	Conduct	4 (19%)

Interpersonal Psychotherapy for Depression (IPT)	12+	Depression	3 (14%)
Loving Intervention Family Enrichment Program	4 - 19	Other	0 (0%)
Mental Health Integration Program (MHIP)	18+	Anxiety, Depression, Trauma	0 (0%)
Mindful Parenting Groups (MPG)	0 - 3	Other	0 (0%)
Multidimensional Family Therapy (MDFT)	12 - 18	Conduct	0 (0%)
Multisystemic Therapy (MST)	12 - 17	Conduct	0 (0%)
Parent-Child Interaction Therapy (PCIT)	2 - 7	Conduct	3 (14%)
Problem Solving Therapy (PST)	60+	Depression	1 (5%)
Program to Encourage Active Rewarding Lives for Seniors (PEARLS)	60+	Depression	0 (0%)
Prolonged Exposure – Post Traumatic Stress Disorder (PE)	18+	Trauma	0 (0%)
Promoting Alternative Thinking Strategies (PATHS)	5 - 12	Conduct	2 (10%)
Reflective Parenting Program (RPP)	0 - 12	Other	0 (0%)
Seeking Safety (SS)*	13 - 55	Trauma	11 (52%)
Strengthening Families Program (SFP)	3 - 16	Conduct	0 (0%)
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)*	3 - 18	Trauma	14 (67%)
Triple P Positive Parenting Program (Triple P)*	0 - 18	Conduct	6 (29%)
UCLA Ties Transition Model (UCLA TTM)	0 - 8	Other	0 (0%)

Note: * indicates evidence-based treatment (EBT) in which the Los Angeles County Department of Mental Health sponsored free training.

Table 2

Principal and all clinically-elevated problems for youth sample (n = 60).

Problem Area	**Principal**	**All**
Anxiety	11 (18%)	49 (82%)
Attention	0 (0%)	26 (43%)
Conduct	32 (53%)	48 (80%)
Depression	16 (27%)	43 (72%)
Elimination	0 (0%)	2 (3%)
Trauma	1 (2%)	14 (23%)

Table 3

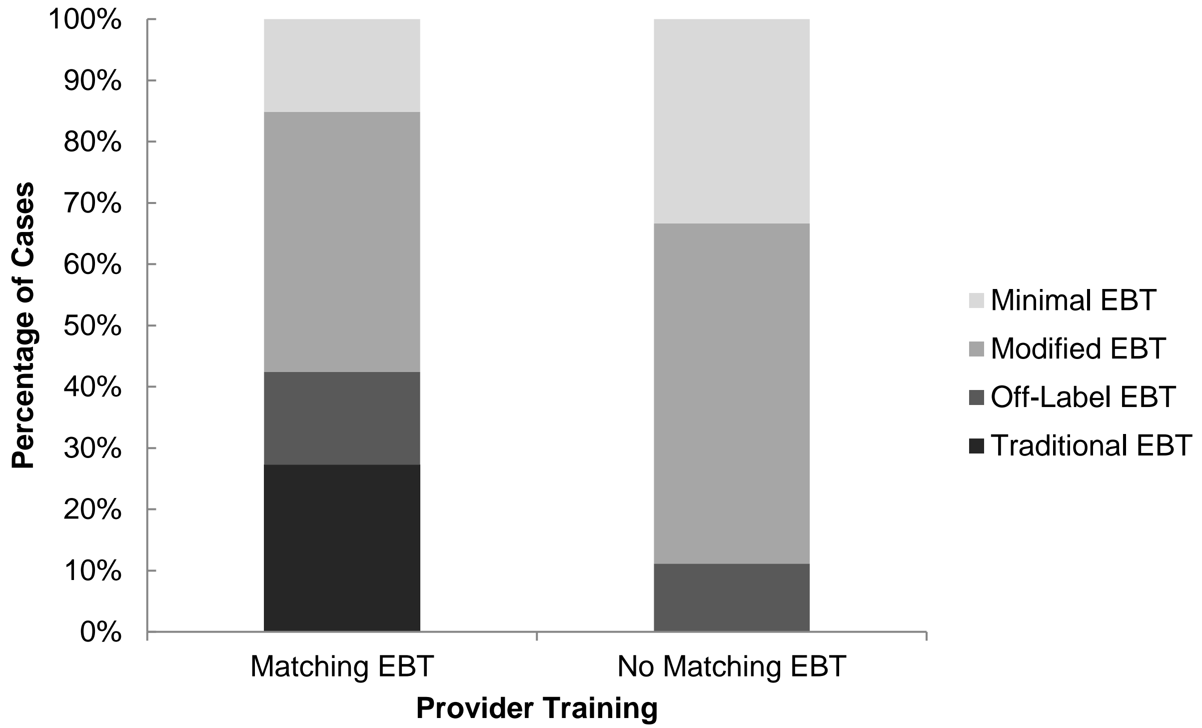
Patterns of evidence-based treatment (EBT) delivery.

Pattern of EBT Delivery	**Description**	**Case Exemplars**
Delivery of Traditional EBT	Procedures from a particular EBT that matched the youth's presenting problem(s) and age group were delivered in more than half of the youth's treatment sessions.	PCIT for youth, aged 2-7, with conduct problems was delivered in 97% of sessions with a 6-year-old girl with conduct problems.
Off-Label Use of EBT	Procedures from a particular EBT that did not match the youth's presenting problem(s) and/or age group were delivered in more than half of the youth's treatment sessions.	TF-CBT for youth, aged 3-18, with traumatic stress was delivered in 100% of sessions with a 6-year-old girl with depressive symptoms.
Delivery of Modified EBT	Procedures from unspecified EBTs (e.g., problem solving, communication skills) and/or multiple EBTs (e.g., TF-CBT and SS) were delivered in more than half of the youth's treatment sessions.	CBT for individuals, aged 16-65, with anxiety, depression, or traumatic stress was delivered in 8% of sessions and procedures from unspecified EBTs were delivered in 77% of sessions with a 9-year-old boy with conduct problems.
Delivery of Minimal EBT	Procedures from EBTs were delivered in less than half of the youth's treatment sessions.	CBT for individuals, aged 16-65, with anxiety, depression, or traumatic stress was delivered in 7% of sessions and procedures from unspecified EBTs were delivered in 14% of sessions with a 13-year-old boy with depressive symptoms.

Note: CBT = Cognitive Behavioral Therapy. PCIT = Parent-Child Interaction Therapy. SS = Seeking Safety. TF-CBT = Trauma-Focused Cognitive Behavioral Therapy.

Figure 1

Patterns of evidence-based treatment (EBT) delivery for cases seen by providers who were and were not trained in an EBT that matched their client's age and presenting problem.



CHAPTER 2:

Provider Perceptions about Engaging Underserved Populations in Community Mental Health Services

Abstract

This study explored providers' perceptions about barriers and facilitators to engaging underserved populations in psychotherapy. Responses were coded using an iterative thematic analysis based on grounded theory. Results revealed that many providers 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 providers felt that an organizational culture focused on productivity is detrimental to client engagement. Findings shed light on providers' perceived barriers to delivering high-quality care to underserved communities and illuminate potential engagement strategies.

Introduction

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, Costa, Weems, & Dalton, 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 & 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 counterparts (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 as few as 10-20% of Latinx individuals access any mental health or medical services for their mental health needs (Alegria et al., 2007). Asian Americans have also been found to have low rates of mental health service use (U.S. Department of Health and Human Services, 2001). Specifically, a national survey estimated that only 9% of Asian Americans with mental health needs sought treatment in the past year (Abe-Kim et al., 2007). 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 (Alegria et al., 2007; Kataoka, Zhang, & Wells, 2002) and youth from low-income families (Cunningham & 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 were smaller than for majority samples, although this difference was not significant (Weisz et al., 2013). Some meta-analyses suggest that culturally tailoring services may enhance the efficacy of EBTs for ethnic minorities (Benish, Quintana, & Wampold, 2011), but other meta-analyses indicate that culturally-adapted interventions may perform similarly as unadapted interventions (Huey & Polo, 2008). Although more research is needed to determine the extent to which culturally tailoring mental health interventions influences client outcomes (e.g., Huey & Jones, 2013; Huey, Tilley, Jones, & Smith, 2014), 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, Vallas, & Pumariega, 2010; Huey & 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 & 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, Rodriguez, Chorpita, & Daleiden, 2012). As an example, differences in ethnic and linguistic backgrounds between providers and clients may present obstacles to establishing trusting relationships (Bauer, Chen, & Alegria, 2010; Takeuchi, Sue, & Yeh, 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 & Sawitzky, 2006), which in turn leads to poorer quality services for clients (Albizu-Garcia, Rios, Juarbe, & Alegria, 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, Hurlburt, & Horwitz, 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, Gonzalez, Miranda, Chavira, & Lau, 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 solutions to engaging traditionally underserved communities in mental health services, relatively little is known about providers' perceptions of working with such populations. However, it is important to understand whether providers' perceived barriers to client engagement are consistent with those identified in the literature, as this would not only provide useful information about providers' 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 providers endorse challenges that largely reflect engagement problems prevalent among the general population (e.g., limited parent

participation; Haine-Schlagel & Walsh, 2015), then it is possible that traditionally underserved communities may benefit from use of existing engagement strategies (e.g., Becker, Boustani, Gellatly, & Chorpita, 2018). However, if providers 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 providers commonly nominate evidence-based engagement solutions, investigating provider 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 providers' perceptions of working with youth and families from traditionally underserved populations. Specifically, this study aimed to understand what providers perceived to be barriers or facilitators to engaging traditionally underserved youth and families. Given the limited existing research on provider perspectives regarding this aspect of care delivery, we did not formulate any a priori hypotheses. Direct feedback from providers was used to identify barriers to high quality care for individuals from traditionally underserved communities and to discover potentially effective and sustainable strategies for improving engagement.

Method

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

Participants

Mental health providers 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 providers who were present at these staff meetings, 116 providers expressed interest or potential interest in participating in the study. Fifty-five providers responded to scheduling inquiries made by the Principal Investigator and were ultimately interviewed about their experiences working with underserved populations. Providers were given a $10 gift card upon completing the interview.

Participating providers consisted of 15 clinicians, 14 supervisors, 13 “other” providers [e.g., parent partner (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)], 5 directors or assistant directors, 5 community wellness specialists (i.e., bachelor’s level providers who help clients develop coping and problem solving skills), and 4 referral managers (i.e., bachelor’s or master’s level providers who assist with managing and processing referrals). Of these providers, 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 providers reported being

bilingual in English and Spanish. The majority of providers were female (89%), and providers ranged in age from 25 to 64 years (*M* = 38.41, *SD* = 9.54). Providers were predominantly Master's level (73%) and had an average of 5.48 (*SD* = 7.54) years of clinical experience. They identified with a variety of primary theoretical orientations: 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.

Providers offered services in eight mental health clinics, which serve youth and families across more than 3,500 square miles. 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 providers in Los Angeles County, providers 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, individuals experiencing onset of serious psychiatric illness, youth in stressed families, trauma-exposed individuals, youth are risk for school failure, or youth at risk of experiencing juvenile justice involvement); provide short-term and time-limited (initially only for one 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 providers 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 & Brookman-Frazee, 2015).

Semi-Structured Interview

Information about providers' 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?") (Appendix B). Each semi-structured interview lasted approximately 45 minutes. 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-minute 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 participating

providers. 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 & Strauss, 1967; Strauss & Corbin, 1998) was used to identify themes in providers' 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 providers' 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 provider's response to a specific question from the semi-structured interview or the length of a provider's comment about a specific topic. For example, a provider'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 provider's comments about working with ethnic minority families, and (2) an excerpt containing the provider'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. 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. The final codebook listed 16 codes, which were organized into two dimensions: (1) content of provider responses, and (2) valence (Appendix C). The dimension of content of provider responses contained six themes: (1) client characteristics and engagement, (2) client-provider match, (3) provider 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 provider'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 provider states that it would be helpful for the agency hire more Spanish-speaking providers would be assigned codes of Agency Climate and Culture, Provider Characteristics, and Positive [valence]. See Table 1 for code titles and definitions.

Data Analyses

Twenty percent of interview transcripts (11 transcripts, 237 excerpts) were double-coded. Inter-rater reliability for excerpts 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 providers who made positive and/or negative comments about the influence of client characteristics, client-provider match, provider 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.

Client Characteristics and Engagement

The majority of providers (91%) made comments about client characteristics and/or engagement (see Figure 1). Many providers endorsed at least one barrier to working with specific client populations. Nearly half of the providers reported challenges in working with ethnic minority youth and families:

"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." Another provider 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 providers shared the challenges that are sometimes presented when working with youth and families receiving social services: "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 providers also mentioned feeling uncertain about how to work effectively with the diverse individuals referred for mental health services: "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." The minority of providers offered exclusively positive comments about working with specific client populations: "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."

Most providers also held negative or mixed perceptions about client engagement. Several providers mentioned difficulties building rapport with clients: "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." Providers also reported challenges with client participation and attendance: "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 family's overwhelmed, the parent's overwhelmed. And then so following up with an appointment and actually attending it is difficult." Few providers offered exclusively positive comments about client engagement: "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."

Client-Provider Match

Three-fourths of providers made comments about client-provider match, with predominantly mixed perceptions about matching clients with providers who have similar characteristics or backgrounds. Many providers suggested that clients should work with a provider who speaks their native language: "We don't have enough Spanish speaking therapists. And we have an interpretation 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 providers 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.” Conversely, some providers mentioned barriers to working with clients with similar characteristics or backgrounds. For instance, “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.’” Other providers endorsed mixed perceptions 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 providers mentioned client-provider matching having little to no impact on client engagement: “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.”

Provider Characteristics and Service Delivery

Provider characteristics and service delivery was the second most common theme discussed by providers (87%), after client characteristics and engagement. Most providers held mixed or positive perceptions about their work with underserved populations. Several providers mentioned that their clinical role facilitates client engagement: “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 providers also reported that being respectful, nonjudgmental, and personable is helpful for engaging individuals in mental health services: “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 provider 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.” Additionally, providers shared that they have found assessment and psychoeducation procedures to facilitate client engagement. For instance, “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 another provider, “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." Accessibility promotion, or strategies to make services more convenient and accessible, was commonly nominated as both a facilitator (e.g., "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.") and a challenge based on funding, availability, or program (e.g., "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."). Some providers also mentioned feeling uncertain about what they could do to engage individuals: "I think it's more like, we'll roll with the resistance, and like all these kinda things that you hear, but I've never had like an actual tangible tool…it's more like help them talk about it, help them process it, help them, but you can do that if they agree to even come." Another provider 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.'"

Implementation Supports

Eighty percent of providers mentioned at least one implementation support; supervision was the most frequently discussed implementation support (62%), followed by treatment team (45%) and training (44%). Many providers reported that they found supervision to be helpful in supporting efforts to engage clients from underserved populations: "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." Comments about consultation, resources, training, and the treatment team were made by fewer providers but were typically positively valenced. For instance, "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." As another example, "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." The minority of providers offered exclusively negatively valenced comments about these implementation supports: "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."

Agency Climate and Culture

Many providers (75%) shared perceptions of how the agency's climate and culture contributes to engagement of traditionally underserved populations in mental health services. Many providers 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, "[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, several providers 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 providers 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

Nearly half of providers (45%) discussed the mental health service system and sociopolitical context. The majority of providers who made comments about the service system and sociopolitical context endorsed negative perceptions. Many providers expressed frustration about service system policies and expectations: "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." Another provider 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 providers also voiced concerns about the impact of the current sociopolitical climate on client engagement. For example, "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," and "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." The minority of providers offered exclusively positively valenced comments about the mental health service system or sociopolitical context: "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 providers' 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 providers, agencies, and service systems to reduce disparities in access to and quality of mental health care.

Results suggest that most providers perceived some engagement challenges when working with 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, providers 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 & 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 dissemination culturally-adapted treatments and the mixed evidence for cultural tailoring (Huey et al., 2014), some have recommended that providers employ existing EBTs with traditionally underserved populations and consider cultural adaptations only if treatment barriers or opportunities arise (Huey et al., 2014; Huey & 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 & 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 providers in a variety of potential adaptations or cultural worldviews).

For example, to address some of the engagement concerns raised during provider interviews (e.g., client mistrust of mental health providers), it could be helpful to train providers 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 providers in common engagement strategies would also build upon providers' existing skillsets, without necessarily requiring providers 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 providers for facilitating treatment engagement was to match clients with providers with similar characteristics or backgrounds. Indeed, some studies indicate that linguistic and/or racial matching of clients and providers can improve clients' psychotherapy outcomes (e.g., Griner & Smith, 2006). However, as noted by some providers from this study and supported by at least one meta-analysis (Cabral & 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 providers 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. Providers' 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 paraprofessional providers might be particularly effective at engaging individuals from traditionally underserved populations given their contextual knowledge and shared experiences (Rusch, Walden, Gustafson, Lakind, & Atkins, 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 provider-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 providers 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 providers 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 providers' evidence-informed practice (Becker, Park, Boustani, & Chorpita, in press; Dorsey et al., 2013). As such, supervisors might help providers make decisions about when and how to culturally adapt treatment if indicated (e.g., Lau, 2006) or might facilitate multicultural supervision or providers' 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 providers would be receptive to receiving supervision, training, resources, and consultation that could improve their cultural responsiveness to traditionally underserved populations.

Many providers also described how organizational policies, procedures, and environments can influence their work with traditionally underserved populations. For instance, providers 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. These views are consistent with the literature on the impact of organizational culture and climate on work attitudes (Aarons & Sawitzky, 2006; Glisson & 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, Miller, & Aarons, 2011), 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 providers' 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 providers 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 provider 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 providers' perceptions of barriers and facilitators to engaging traditionally underserved populations, some caveats are in order. For instance, one limitation is that all participating providers were recruited from a single mental health agency in Los Angeles, CA. Provider participants were assigned to service areas spanning more than 3,500 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 providers working in other agencies, mental health service systems, or sociopolitical contexts. Another limitation is that providers typically discussed engagement barriers and facilitators in general terms.

Accordingly, more research is needed to understand what providers 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 solutions might map onto which barriers (e.g., when would covering psychoeducation be most helpful?). Relatedly, the efficacy of providers' suggestions for engaging traditionally underserved populations was untested in this study. Although many provider-nominated solutions were consistent with the literature, it is unknown whether all solutions would be effective in engaging traditionally underserved populations in mental health services. As such, fruitful avenues for future research include testing the effectiveness of provider-nominated solutions and exploring engagement strategies supported by practice-based evidence (e.g., Ammerman, Smith, & Calancie, 2014).

Conclusion

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, provider 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 providers' perceived engagement barriers and facilitators may serve as a useful guide for informing promising intervention directions.

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Table 1

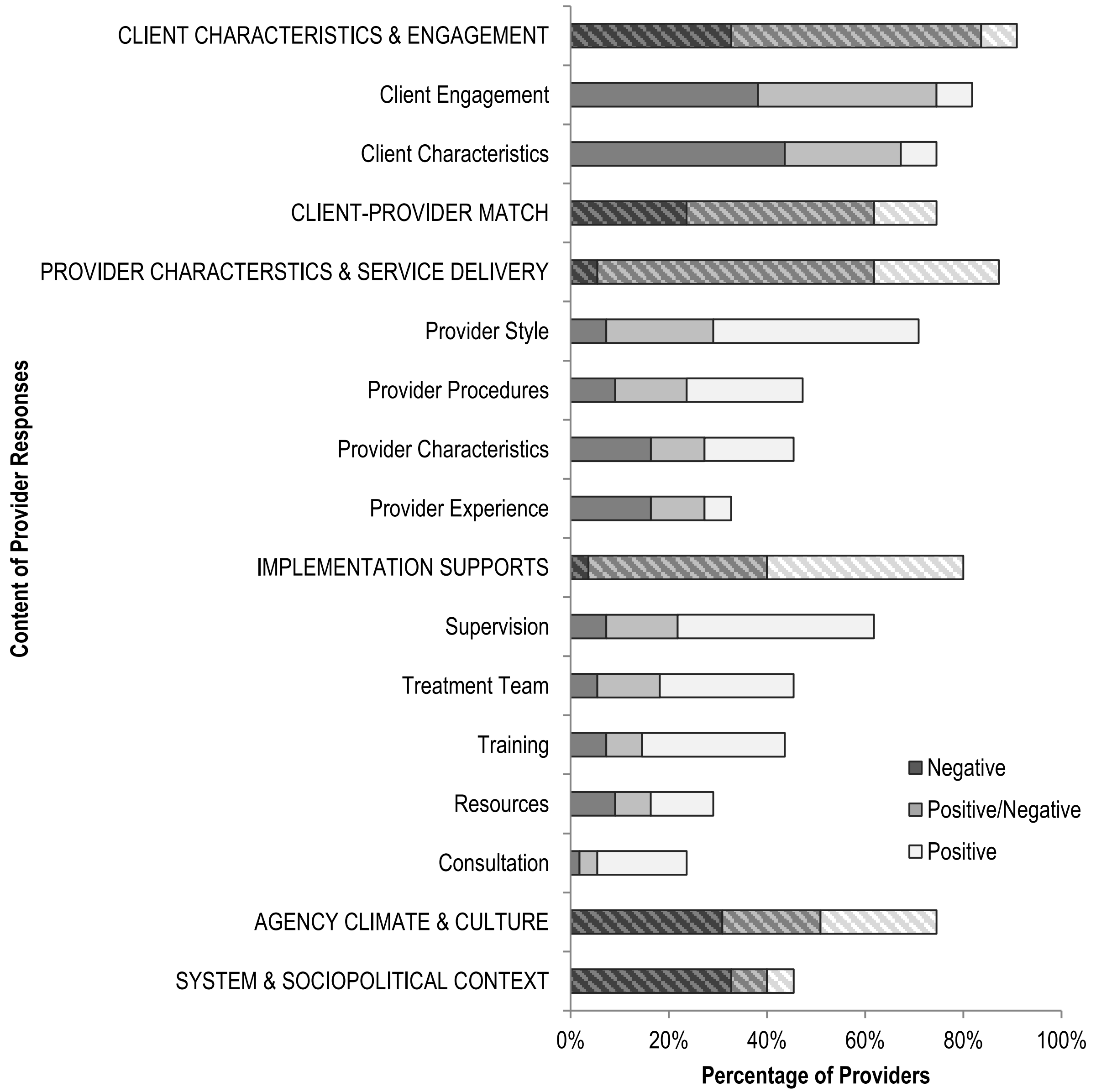
Code definitions and reliability statistics

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
Provider Characteristics and Service Delivery		
Provider Characteristics	Comments about providers' characteristics or backgrounds	.77
Provider Experience	Comments about providers' clinical experience	.80
Provider Procedures	Comments about what providers do with clients	.70
Provider Style	Comments about how providers 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

Figure 1

Content and Valence of Provider Responses by Subtheme and Code



CHAPTER 3:

A Review of Strategies for Incorporating Culture from Effective Psychosocial Treatments for Ethnic Minority Youth

Abstract

There are well-documented mental health disparities for ethnic minority youth, and there have been concerted efforts over recent years to identify and disseminate evidence-based psychosocial interventions for this underserved population. This review summarized the literature on effective psychosocial interventions for ethnic minority youth. Eighty-nine journal articles of randomized clinical trials with predominantly ethnic minority youth samples published between 1974 and 2017 were coded for sample characteristics (e.g., ethnicity, age, gender), treatment characteristics (e.g., treatment target, format, setting), and strategies for incorporating culture into treatment (e.g., case assignment to providers with similar backgrounds). Results showed that effective psychosocial interventions studied with ethnic minority youth samples tended to focus on disruptive behavior problems among Black and Latinx youth. Strategies for incorporating culture into treatment were included in one-third of effective psychosocial interventions. The most common types of strategies were tailoring the persons involved in the intervention (e.g., assigning cases to providers with similar backgrounds), the procedures (e.g., discussing issues of prejudice and discrimination), and the method of communication (e.g., using materials that depicted ethnic minority youth). Findings highlight the remarkable progress that has been made in identifying evidence-based psychosocial interventions for ethnic minority youth as well as gaps in the extant literature. Findings also suggest that selective and directed cultural adaptation may be a promising approach for enhancing the effectiveness and responsiveness of youth psychosocial treatments. Further research is needed to mitigate mental health disparities for ethnic minority youth, but the evidence base on effective psychosocial interventions for ethnic minorities is undoubtedly expanding.

Introduction

Since mental health professionals took on the task of disseminating evidence-based treatments (EBTs) more than 25 years ago (Task Force on Promotion and Dissemination of Psychological Procedures, 1995), there has been a proliferation of efforts to develop and identify efficacious mental health interventions (Chorpita et al., 2011). To date, there are more than 750 EBTs for a variety of youth mental health concerns (PracticeWise, 2019). Despite this astonishing number of EBTs and evidence indicating that these treatments outperform usual care (Weisz et al., 2013), EBTs are often underused in the community (Bruns et al., 2016). EBT use with ethnic minority youth is particularly low (Alegria, Vallas, & Pumariega, 2010), and findings regarding the relative efficacy of EBTs for ethnic minority youth compared with their European American peers has been mixed (Huey & Jones, 2013) – with some studies showing stronger treatment effects for European American youth (Rohde, Seeley, Kaufman, Clarke, & Stice, 2006; Silverman, Pina, & Viswesvaran, 2008); some studies showing stronger treatment effects for ethnic minority youth (Huey & Polo, 2008), and other studies showing similar treatment effects for European American and ethnic minority youth (Weisz, Jensen-Doss, & Hawley, 2006). Given the alarmingly high rates of unmet mental health needs among ethnic minority youth (Alegria et al., 2010), disseminating effective mental health interventions for this underserved population is a public health priority (National Institute of Mental Health, 2019).

A common perception is that many EBTs were developed for and tested with majority group populations and, thereby, may not generalize to ethnic minorities (Aisenberg, 2008). For instance, ethnic minority youth are likely to encounter several barriers to receiving effective mental health services that may not be addressed in generic EBT protocols. As an example, youth and families with low English proficiency may have difficulty finding a mental health

provider with appropriate language skills (Sentell, Shumway, & Snowden, 2007) – let alone such a provider who is trained in an EBT with resources that are available in the family's preferred language. Additionally, youth and families whose cultural heritage traditionally supports the use of treatment methods other than psychotherapy (e.g., physicians, herbalists, acupuncturists, ministers; Kung, 2004) may be wary of accepting help or treatment recommendations from mental health professionals. Health and mental health disparities experienced by ethnic minority groups may also instill mistrust of the healthcare system, which may impede consumers' participation in psychotherapy (Atdjian & Vega, 2005; Wilson & Yoshikawa, 2007). Furthermore, the stigma attached to mental illness may dissuade ethnic minority youth and families, who may already confront prejudice and discrimination because of their minority status, from accessing or engaging in mental health services to avoid being doubly stigmatized (Gary, 2005). In addition, ethnic minority youth and families who actually enroll in mental health services may be inclined to disengage from or drop out of treatment if their cultural identity is ignored, they feel misunderstood by their provider, or they perceive therapy to be misaligned with their values (Huey, 2010).

In light of these numerous barriers to providing effective psychotherapy to ethnic minority youth, mental health services research, practice, and policy initiatives have started to prioritize the identification and implementation of strategies for reducing disparities, including the development of culturally responsive psychotherapies (McGuire & Miranda, 2008). As a result, the evidence base on mental health treatments for ethnic minority youth has grown over recent years, from zero efficacious treatments in 1996 (Chambless, 1996) to 14 in 2019 (Pina,

Polo, & Huey, 2019)[3]. Although much of this evidence base is comprised of studies testing existing EBTs with more racially and ethnically diverse consumers (e.g., Huey & Polo, 2008), several treatments have explicitly incorporated culture – for example, by addressing culture-related stressors (e.g., intergenerational conflicts; Szapocznik et al., 1989), using handouts that depict ethnic minorities (e.g., Ginsburg & Drake, 2002), recruiting parent or community partners (e.g., Rowland et al., 2005), or matching clients with mental health providers with similar cultural backgrounds (e.g., Fantuzzo, Manz, Atkins, & Meyers, 2005) or language skills in the family's preferred language (Garza & Bratton, 2005). Notably, studies examining the efficacy of these culturally-adapted treatments have produced mixed results – with some studies indicating that culturally-adapted treatments are more efficacious for ethnic minorities than generic treatments (Benish, Quintana, & Wampold, 2011; Griner & Smith, 2006), and other studies findings that culturally-adapted treatments do not necessarily promote better clinical outcomes for ethnic minority youth (Huey & Polo, 2008). Although the expanding literature on culturally responsive psychotherapies for ethnic minority youth and families is important for improving our understanding of how to reduce mental health disparities, it also presents an increasingly complicated picture with regards to which strategies to employ with which clients.

One approach for simplifying the questions of whether and how to incorporate culture into treatment for youth and families who may benefit from culturally responsive psychotherapy is to summarize the existing literature based on common therapy strategies. Chorpita, Daleiden, and Weisz (2005) proposed a distillation model for this purpose – that is, to synthesize the ever growing evidence base on psychotherapy. A distillation model involves identifying features

[3] Treatments were considered to be efficacious if they demonstrated statistically significant superiority to a pill, psychological placebo, another active intervention, waitlist, or no intervention control or equivalence to an already well-established intervention in at least one experiment that involved a randomized controlled design testing a manualized treatment using reliable and valid measures with appropriate sample size and data analyses.

commonly found in successful treatments; and matching those treatment features to service seeking populations based on their presenting problem and background (e.g., age, ethnicity, gender). In other words, a distillation model identifies therapy strategies supported by the evidence base (i.e., distilling common elements) as well as the individuals most likely to benefit from these therapy strategies (i.e., matching common elements with clients), based on results and samples from clinical trials. Accordingly, using a distillation model to summarize the literature on psychotherapy for ethnic minority youth could not only provide insights into similarities and differences among interventions but could also offer mental health providers a library of ways to potentially incorporate culture into treatment when working with this population (without the burden of identifying and reading through dozens of empirical articles).

The current study reviewed the literature on mental health interventions for ethnic minority youth, using a distillation model to identify common strategies for incorporating culture into treatment as well as the populations with which such strategies may be beneficial. Specifically, this study aimed to: (1) summarize the characteristics of studies testing interventions for ethnic minority youth (e.g., sample characteristics, treatment characteristics); (2) identify strategies for incorporating culture into psychotherapy that are commonly featured in children's mental health services research (e.g., use of translated materials, assignment of cases to providers with similar backgrounds); and (3) determine which strategies are associated with improved symptomatology among ethnic minority youth.

Based on findings from previous meta-analyses on mental health interventions for ethnic minority youth (Huey & Polo, 2008; Pina et al., 2019), it is hypothesized that most of the ethnic minority youth participants included in this review will identify as Black or Latinx and most interventions will target disruptive behavior problems. It is expected that approximately half of

these interventions will feature strategies for incorporating culture into psychotherapy (e.g., Huey & Polo, 2008). These strategies are likely to involve: discussion of the family's cultural norms, beliefs, and values; racial, ethnic, or linguistic matching of provider and family; consultation with mental health professionals who are familiar with the family's culture; practices for increasing the family's treatment engagement; use of materials that are pertinent to the family's culture and background; and cultural sensitive training for providers (e.g., Griner & Smith, 2006). Given mixed results about the efficacy of culturally-adapted mental health interventions for ethnic minorities (e.g., Benish et al., 2011; Huey & Polo, 2008; Griner & Smith, 2006), it is hypothesized that strategies for incorporating culture into psychotherapy may be efficacious with only certain groups of the broader service-seeking population. For instance, family-directed treatments may be indicated for recently immigrated families to promote self-efficacy, given the often diminished sense of control that families feel when adjusting to life in the United States (e.g., Martinez & Eddy, 2005). This research has important public health implications, as it will synthesize current knowledge about mental health interventions for ethnic minority youth, making it easier to understand and apply strategies for incorporating culture in routine clinical practice. Furthermore, findings may help illuminate gaps in the existing treatment literature that, if filled, have the potential to reduce mental health disparities for ethnic minority communities.

Method

Search and Selection Criteria

Potential journal articles were identified using the PracticeWise Evidence-Based Services (PWEBS) Literature Database. The PWEBS Literature Database includes studies of psychotherapy interventions from 1965 to 2017 that were found through: (a) literature searches

using electronic databases (e.g., PsycINFO, SocIndex, PubMed); (b) reviews of articles featured in meta-analyses; (c) examinations of EBT databases (e.g., National Registry of Evidence-Based Programs and Practices, Cochran Reviews, Campbell Collaboration); (d) surveys of the table of contents of recently released journal issues; and (e) nominations from experts in children's mental health. To be included in the PWEBS Literature Database, articles have to: (a) describe a randomized clinical trial; (b) test at least one psychosocial intervention targeting a mental health problem, such as anxiety, attention problems or hyperactivity, autism, depression, disruptive behavior, eating problems, elimination problems, mania, substance use, suicidality, or traumatic stress; (c) have a youth sample with a mean age of 21 years of less; and (d) include youth presenting with or at-risk for a particular mental health problem. As of August 2017, there were 946 articles included in the PWEBS Literature Database.

All studies from the PWEBS Literature Database were screened for inclusion in the present review. Studies were required to have a predominantly ethnic minority sample, where at least 75% of participants identified as ethnic minorities. This threshold is consistent with other reviews of psychosocial interventions for ethnic minority youth (e.g., Huey & Polo, 2008; Pina et al., 2019). Ethnic minorities were defined as individuals who identified as: (a) African American or Black; (b) American Indian or Alaska Native; (c) Asian or Asian-American; (d) Hispanic or Latinx; (e) multiethnic; or (f) Native Hawaiian or other Pacific Islander. Studies conducted outside of North America were not included in this review, as the personal and treatment-seeking experiences of individuals from these ethnic groups would differ in other parts of the world.

The final sample consisted of 89 studies testing psychosocial interventions with samples of predominantly ethnic minority youth (Appendix E). Studies were published between 1974 and

2017. Each study compared at least two groups (i.e., intervention or control conditions within a study) (*M* = 2.35, *SD* = .78), for a total of 209 groups.

Coding and Reliability

All studies in the PWEBS Literature Database are coded using the PracticeWise Clinical Coding System (PracticeWise, 2008), which summarizes information related to study design, sample characteristics, treatment group characteristics, treatment interventions, and clinical outcomes. Each study is coded by two coders who have received extensive training in the coding system and who use a detailed coding manual. Inter-rater reliability among coders using this system has been reported to range from moderate to perfect (κ = .66-1.00; Chorpita & Daleiden, 2009) (McHugh, 2012). Any discrepancies between coders are resolved by an expert reviewer who also inspects all data for accuracy.

Studies included in this review were coded for additional information related to sample characteristics (e.g., youth's birth country) and strategies for incorporating culture into treatment (e.g., use of culturally-relevant materials) (Appendix D). Three doctoral students were trained by the Principal Investigator to apply these supplemental codes and were provided with a corresponding coding manual. Each doctoral student then independently coded one-third of the studies. All studies were independently double-coded by the Principal Investigator. The doctoral student coders and Principal Investigator met monthly to discuss and refine the coding manual and to resolve discrepancies through consensus. Inter-rater reliability was calculated using intraclass correlations based on a 2-way random effects model with measures of absolute agreement, using the mean of multiple raters. Inter-rater reliability for codes describing sample characteristics was moderate (*ICC* = .69), and inter-rater reliability for codes describing strategies for incorporating culture into treatment was good (*ICC* = .77) (Koo & Li, 2016).

Sample Characteristics

Information about youth participants' ethnicity, age, and gender were extracted from the PWEBS Literature Database. Youth participants' birth country (e.g., United States, Mexico) and language(s) spoken (e.g., English, Spanish) were coded for this review.

Treatment Characteristics

Treatment group characteristics – including type of group (e.g., active treatment, waitlist control, no treatment control, attention control); treatment family (e.g., cognitive behavior therapy, parent management training); setting (e.g., school, home, clinic); format (e.g., client individual, client group, parent individual, parent group); providers' education level (e.g., M.S.W., doctoral student, Ph.D.); and treatment target (e.g., disruptive behavior, depression, anxiety) – were extracted from the PWEBS Literature Database. Providers' ethnicity and language(s) spoken were coded for this review.

Strategies for Incorporating Culture

Each treatment group was coded for strategies for incorporating culture. Groups were considered to incorporate culture if they featured at least one strategy that was explicitly designed to attend to the needs, beliefs, or values of an ethnic minority group or to enhance the cultural responsiveness of treatment. Strategies for incorporating culture into treatment were categorized as relating to treatment process (i.e., how providers work with clients) and treatment content (i.e., what providers work on with clients). Process strategies involved incorporating culture into treatment through therapeutic style (i.e., how providers behave with clients; e.g., attending to issues of respect, allowing client to direct treatment), communication (i.e., how providers deliver the message; using materials that feature representations of individuals from a particular ethnic group), and change agents (i.e., persons involved in the intervention; e.g.,

consulting with cultural experts, assigning cases to providers with cultural responsiveness training). Content strategies involved incorporating culture into treatment through the intervention conceptualization (i.e., how information was framed; e.g., providing intervention rationale based on cultural concepts, beliefs, or norms), message (i.e., what was said by providers; using culturally-relevant proverbs, using educational labels), and procedures (i.e., what providers do with clients; e.g., discussing issues of prejudice and discrimination, focusing building rapport with clients). Specific strategies for incorporating culture into treatment were identified through a literature review on interventions for ethnic minorities and on culturally-adapted interventions performed by the Principal Investigator and through consultation with experts in culture and mental health. See Table 1 for the list of strategies for incorporating culture and their code definitions.

"Winning" Status

Clinical outcomes associated with each treatment group were extracted from the PWEBS Literature Database. Treatment groups that produced significantly better clinical outcomes than one or more treatment groups – as indicated by a Group x Time interaction or a between-group difference observed at the post-treatment assessment – were classified as "winning" groups. "Wins" were chosen as an indicator of treatment effectiveness for this review because: (a) they signify greater efficacy relative to another treatment group, without requiring homogeneity among comparison groups; and (b) they are the primary measure of effectiveness used in studies employing the distillation and matching model (e.g., Becker, Boustani, Gellatly, & Chorpita, 2018; Chorpita et al., 2011; Rith-Najarian et al., 2019).

Results

Sample Characteristics

Across the 89 studies reviewed, there were 9,131 youth participants (*range*: 12-531 participants per study). At least one youth participant identified as Black or African American in 72% of studies, Latinx or Hispanic in 72% of studies, White or Caucasian in 48% of studies, multiethnic in 21% of studies, Asian or Asian-American in 13% of studies, Native Hawaiian or other Pacific Islander in 7% of studies, American Indian or Alaska Native in 6% of studies, and other race or ethnicity in 26% of studies. At least 75% of youth participants identified as Black or African American in 25% of studies, Latinx or Hispanic in 21% of studies, American Indian or Alaska Native in 2% of studies, Asian or Asian-American in 1% of studies, multiethnic in 1% of studies, and other race or ethnicity in 1% of studies. Of the 12 studies that reported youth immigration status, 7 studies included at least one youth participant who had immigrated to the United States. Twenty-seven studies reported youth language, and at least one youth participant spoke English in 26 studies and Spanish in 19 studies. Youth participants ranged in age from 0-21 years; studies had at least one youth participant between the ages of 0 and 5 (30% of studies), 6 and 12 (63%), 13 and 18 (49%), and 19 and 21 (4%). The majority of studies (80%) included both male and female youth participants; 9% of studies included only male participants, 6% of studies included only female participants; youth gender was not reported in 6% of studies.

Treatment Characteristics

Studies compared psychosocial interventions against active treatments (65% of studies), attention or placebo controls (21%), waitlist (16%), and no treatment (15%). Active treatments included usual care (21 studies), cognitive behavior therapy (19 studies), parent management training (12 studies), family therapy (7 studies), motivational interviewing and engagement (6

studies), and several other types of interventions (e.g., multisystemic therapy, anger management, play therapy, case management). The majority of studies (83%) reported at least one treatment setting; the most common treatment settings were school (40 studies), home (24 studies), clinic (22 studies), and the community (e.g., recreation center; 14 studies). Of the 77 studies that reported at least one treatment format, 38 studies involved group therapy with youth, 37 studies involved individual therapy with youth, 17 studies involved individual therapy with youth and caregivers, 16 studies involved individual therapy with caregivers, 15 studies involved family therapy, 9 studies involved group therapy with caregivers, and 13 studies involved other treatments formats (e.g., group therapy with teachers). Provider educational level was reported in 82% of studies; 45 studies included at least one provider who attained a Master's degree, 30 studies included at least one provider who attained a doctoral degree (e.g., Ph.D., Psy.D., M.D.), and 24 studies included at least one graduate student provider. Studies were designed to address a variety of problems, including disruptive behavior (30% of studies), substance use (17%), anxiety (12%), trauma (10%), depression (7%), poor treatment engagement (4%), inattention or hyperactivity (4%), autism (2%), and other problems (e.g., social withdrawal, crises; 14%). In the 28 studies that reported provider ethnicity, at least one provider identified as Black or African American in 14 studies, Latinx or Hispanic in 13 studies, White or Caucasian in 12 studies, Asian or Asian-American in 4 studies, American Indian or Alaska Native in 2 studies, and American Indian or Alaska Native in 1 study. Seventeen studies reported provider language. At least one provider spoke English in 16 studies and Spanish in 15 studies.

Strategies for Incorporating Culture

Forty-nine treatment groups featured at least one strategy for incorporating culture into the intervention (Table 1). These treatment groups included an average of 2.63 strategies for

responding to cultural considerations (*SD* = 2.30). The most common type of strategy was selecting a change agent who treatment developers believed could enhance the cultural responsiveness of the intervention (33 groups). Tailoring communication (19 groups) was the second most common type of strategy for incorporating culture into treatment. Interventions were also designed to incorporate culture through the use of specific procedures (16 groups). Relatively fewer studies tested interventions that incorporated culture through messages (10 groups), therapeutic style (8 groups), and treatment conceptualization (6 groups).

Winning Groups

Of the 209 treatment groups included in this review, 67 groups outperformed a comparison group and were thereby assigned a "win." Winning groups included at least one youth participant who identified as Black or African American (73% of groups), Latinx or Hispanic (67%), White or Caucasian (46%), multiethnic (18%), Asian or Asian-American (12%), Native Hawaiian or other Pacific Islander (4%), American Indian or Alaska Native (4%), and other race or ethnicity (25%). Only 6% of winning groups included at least one youth participant who was born outside of the United States; 24% of winning groups included at least one youth participant who was monolingual or bilingual in Spanish. Winning groups had at least one youth participant between the ages of 0 and 5 (34%), 6 and 12 (66%), 13 and 18 (55%), and 19 and 21 (4%); 93% of winning groups included male participants, and 78% included female participants.

Winning groups involved cognitive behavior therapy (16%), parent management training (12%), family therapy (9%), motivational interviewing and engagement (7%), exposure (7%), anger control (6%). The most common treatment settings were school (44% of winning groups), clinic (22%), the community (18%), and home (16%). The formats of winning groups included

group therapy with youth (34%), individual therapy with youth (32%), family therapy (18%), individual therapy with youth and caregivers (12%), individual therapy with caregivers (12%), group therapy with caregivers (9%), and other formats (12%). Across the 48 winning groups that reported provider educational level, groups were led by Master's level providers (54%), doctoral level providers (35%), graduate students (29%) and other providers (e.g., teachers, school staff). Winning groups targeted disruptive behavior (36%), anxiety (16%), substance use (7%), trauma (6%), depression (6%), poor treatment engagement (6%), inattention or hyperactivity (4%), autism (3%), and other problems (15%).

Strategies in Winning Groups

Of the winning groups, 33% included a strategy for incorporating culture into the intervention (Table 1). The change agent was tailored in 22% of winning groups, procedure in 15% of winning groups, communication in 12% of winning groups, message in 10% of winning groups, conceptualization in 4% of winning groups, and style in 3% of winning groups. The strategies most frequently included in winning groups were selecting specific procedures (11% of winning groups), matching clients with providers of similar backgrounds (9%), and using culturally-relevant materials (7%).

Information about the study and sample characteristics of winning interventions that featured each type of strategy for incorporating culture is provided in Table 2. For example, the change agent was tailored in winning groups that targeted disruptive behavior, inattention, depression, substance use, anxiety, and other problems. Inventions that incorporated culture though the change agent were effective across samples of Latinx or Hispanic, Black or African American, White or Caucasian, other ethnicity, multiethnic, Asian or Asian-American, Native

Hawaiian or other Pacific Islander, and American Indian or Alaska Native youth, aged 1-17, of male and female gender.

Information about the treatment characteristics of winning interventions that featured each type of strategy for incorporating culture is provided in Table 3. For example, interventions that incorporated culture though the change agent were delivered in school, clinic, home, community, and other settings by undergraduate student, graduate student, master's level, doctoral level, teacher, school, and other providers. The change agent was tailored in winning groups that used client group, client individual, parent group, parent individual, family, parent and child, and other formats.

Discussion

This review summarized information about psychosocial treatments for ethnic minority youth, using a distillation model. By better understanding the current state of the literature on effective psychotherapies for ethnic minority youth, we hoped to illuminate areas requiring further study and to discover whether and how these interventions incorporate culture into treatment.

This review identified 89 studies that have tested a psychosocial treatment with ethnic minority youth. Across these studies, 67 treatment groups were shown to have superior clinical outcomes to a comparison group. These interventions primarily targeted disruptive behavior, anxiety, and other problems, such as child maltreatment and social withdrawal. Most of these interventions were tested with Black and Latinx participants. These findings are consistent with those of other reviews indicating that the literature on evidence-based psychosocial treatments for ethnic minority youth has focused on developing and testing treatments for Black and Latinx youth with disruptive behavior problems (Huey & Polo, 2008; Pina et al., 2019). These efforts

have likely been warranted given that (a) disruptive behavior is the most prevalent presenting problem among youth in public sectors of care (Garland et al., 2001), and (b) Black and Latinx individuals belong to the two most common ethnic minority groups seen in public mental health settings (Garland et al., 2011; Merikangas et al., 2011; Yeh et al., 2005). However, relatively few studies to date have tested psychosocial treatments for Black and Latinx youth with other presenting problems or for other ethnic minority youth with mental health needs. Given the sizable proportion of Black and Latinx youth with mood and substance use problems (Merikangas et al., 2010), as well as Asian, American Indian or Alaska Native, and Native Hawaiian or Pacific Islander youth with mental health needs (U.S. Department of Health and Human Services, 2011), these gaps in the literature present a significant public health issue.

These shortcomings in the evidence base prompt the question of whether mental health interventions need to be rigorously tested with all populations prior to use. On one hand, evaluating the generalizability of existing EBTs to ethnic minorities facilitates efforts to identify effective mental health treatments for this underserved population. In addition, building a compendium of mental health treatments supported for use with ethnic minority youth could help providers select and implement high-quality, effective interventions when working with these consumers. On the other hand, developing and testing mental health interventions requires significant time and resources. Given the already extensive evidence base on mental health interventions for a variety of child psychopathologies (Chorpita et al., 2011), conducting additional trials on these interventions may have a diminishing return on investment. This is not to say that the field should discontinue conducting clinical trials for mental health interventions. Testing mental health interventions, particularly those that address notable barriers to treatment (e.g., poor treatment engagement; Becker, Park, Boustani, & Chorpita, in press), with

increasingly diverse samples is a laudable and worthwhile direction (National Institute of Mental Health, 2019). Yet, it is also worth considering how the existing evidence base can be leveraged to provide effective mental health services to ethnic minority youth.

Experts in culture and mental health have begun to recommend the use of generic or, when available, culturally tailored EBTs with ethnic minority youth and the adaptation of such treatments only if barriers or opportunities arise (American Psychological Association, 2017; Pina et al., 2019; Pumariega et al., 2013). This review found that only one-third of the interventions supported for use with ethnic minority youth incorporated culture into the treatment design. This finding illustrates that cultural tailoring is not necessary for mental health treatments to be efficacious for ethnic minority youth but that it may be beneficial in some cases. There were also several interventions that employed strategies for incorporating culture into treatment that did not outperform comparison groups. These mixed results on the efficacy of cultural tailoring are consistent with other reviews (Huey et al., 2014) and emphasize the need to be selective (i.e., adapting treatment only when the youth or family is not responding as expected to an EBT delivered with fidelity and at an optimal dose) and directed (i.e., adapting treatment based on evidence from scientific literature, theory, and provider expertise) about cultural tailoring (Lau, 2006).

To guide decisions around selecting when and directing how to culturally tailor treatment, this review identified 24 strategies for incorporating culture that were featured in effective mental health treatments for ethnic minority youth. The most common type of strategy was tailoring the persons involved in psychotherapy. These strategies were featured in effective interventions delivered by providers from diverse educational backgrounds (i.e., Master's and doctoral level providers, graduate and undergraduate students, teachers, and school staff), across

various settings (i.e., school, clinic, home, community), using different formats (i.e., client group, client individual, family, parent group, parent individual, parent and child), and targeting various mental health problems (i.e., disruptive behavior, inattention, depression, substance use, anxiety, and other problems). Such findings are promising as they suggest that strategies for incorporating culture into treatment may not be protocol-specific but may be successfully employed across a variety of treatment protocols. The absence of a clear pattern of sample or treatment characteristics associated with these strategies also indicates that there is not a universal strategy for enhancing the cultural responsiveness of treatment (e.g., use Strategy A with Population A) – rather decisions about when and how to culturally tailor treatment must likely consider contextual factors, such as the client's engagement in treatment or the client's response to treatment, in addition to client and treatment characteristics.

This review has several strengths, including its inclusion of 89 studies on mental health interventions for ethnic minority youth and its identification of strategies for incorporating culture into treatment; however, there are some limitations. One limitation is that the sample characteristics, treatment characteristics, and strategies for incorporating culture were coded from journal articles of randomized clinical trials, and the information presented in this review are, thus, limited to the information reported in those manuscripts. For instance, it is possible that some mental health interventions may have featured strategies for incorporating culture that were not explicitly mentioned in the manuscript and, accordingly, may not be reflected in this review. Relatedly, several journal articles referred readers to treatment manuals for additional information about the interventions under investigation. Perhaps unsurprisingly, treatment manuals often have more comprehensive descriptions of interventions than journal articles (Knudsen, Boustani, Chu, Wesley, & Chorpita, 2018); however, coding treatment manuals was

outside of the scope of this review. As such, the identified treatment characteristics and strategies for incorporating culture into treatment likely reflect the most notable treatment design features but may not reflect all aspects of the treatment design. Another limitation is that relatively few interventions featured strategies for incorporating culture into treatment. For example, strategies for enhancing the cultural responsiveness of psychotherapy through therapeutic style were featured in only eight interventions and were associated with only two effective interventions. Therapeutic style has been deemed by providers to be one of the most important aspects of providing culturally responsive care (Park et al., under review); yet, given the current evidence base, it is difficult to conclude whether this type of strategy for incorporating culture is understudied, underreported, ineffective, or potentially all of the above.

Future Directions for Research

The current evidence base reflects remarkable efforts in the development and testing of effective mental health interventions for ethnic minority youth. The number of randomized clinical trials including ethnic minority samples has greatly increased over the past 25 years (Huey et al., 2014), and a recent review identified 14 evidence-based treatments for ethnic minority youth with mental health needs (Pina et al., 2019). However, the fact remains that the majority of intervention studies include predominantly Caucasian or European American samples. To facilitate the delivery of high-quality, effective psychotherapy for the diverse youth and families in public sectors of care (Garland et al., 2011; Merikangas et al., 2011; Yeh et al., 2005), there must be continued efforts to recruit ethnic minority participants in mental health services research.

Specifically, future research should make concerted efforts to identify effective mental health interventions for Asian, American Indian, and Pacific Islander youth, as youth from these

ethnic groups make up a considerable proportion of the service-seeking population but are largely absent from the literature on mental health interventions (Pina et al., 2019). It is possible that these ethnic groups remain understudied in mental health services research because of disparities in access to care (Abe-Kim et al., 2007); however, an argument could be made that these mental health disparities call for future research to not only improve the quality of care for Asian, American Indian, and Pacific Islander youth but to also address barriers to treatment for these ethnic groups (Alegria et al., 2010).

Future research should also continue to explore when and how to culturally tailor psychotherapy to best meet the needs of ethnic minority youth and to optimize treatment outcomes for this population. A growing number of mental health interventions feature selective and directed cultural adaptations (Lau, 2006; Pina et al., 2019), which appear to be a promising approach for enhancing the effectiveness and cultural responsiveness of psychotherapy for ethnic minority youth (e.g., Coard, Wallace, Stevenson, & Brotman, 2004; Lau, Fung, Ho, Liu, & Gudino, 2011; McCabe, Yeh, Garland, Lau, & Chavez, 2005). Accordingly, further study of selective and directed cultural adaptations, particularly for traditionally underserved populations, is likely to be a worthwhile endeavor.

Notably, many of the mental health interventions that include selective and directed cultural adaptations are designed prior to implementation. As such, these interventions can address group-specific concerns, such as issues related to English fluency among Spanish-speaking clients; however, these interventions may not be designed to handle client-specific concerns or intragroup differences, which may require treatment to be adapted in real-time (Chorpita & Daleiden, 2014). A promising future research direction may, therefore, be to study and build decision-making support systems for helping mental health providers make real-time,

selective and directed cultural adaptations. These decision-making support systems would need to help providers assess for treatment barriers or opportunities ripe for adaptation (e.g., when a client is not responding as expected to an EBT) and select evidence-informed solutions for responding to those treatment barriers or opportunities (Park, Becker, Boustani, & Chorpita, under review). As such, more research is needed to identify barriers to treatment (e.g., mental health stigma, mistrust of health and mental health institutions, availability of providers with appropriate language skills; Atdjian & Vega, 2005; Gary, 2005; Sentell, Shumway, & Snowden, 2007; Wilson & Yoshikawa, 2007), identify effective solutions (e.g., assigning cases to providers with similar backgrounds; using culturally-relevant examples, proverbs, and sayings), and map barriers with corresponding solutions (e.g., Strategy B can address Barrier B).

Conclusion

Findings from this review highlight the laudable efforts that have been made to identify effective psychosocial interventions for ethnic minority youth and illuminate gaps in the current evidence base, such as EBTs for Asian, American Indian, and Pacific Islander youth. Findings also suggest that cultural tailoring may not be necessary to address the mental health needs of ethnic minority youth but that it may be helpful under certain circumstances. Although significant progress has been made toward identifying and disseminating effective psychosocial interventions for ethnic minority youth, concerted efforts still need to be made to mitigate mental health disparities for this underserved population.

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Table 1

Culturally-Relevant Strategies, Definitions, and Occurrences

Strategy for Incorporating Culture	Definition	Groups	Winning Groups
Style	**How provider behaves with client**	**8**	**2**
Client-directed	Style that involves client directing the course of treatment	1	0
Collaborative	Style that involves provider and client collaborating	3	0
Directive	Style that involves provider taking an authoritative stance or making directive statements	0	0
Other	Styles that do not fit with other categories (e.g., nonjudgmental, interpersonally effective)	2	0
Personal or informal	Style that involves provider facilitating warm, personal, or informal interactions with client	0	0
Respectful	Style that involves provider showing respect to client or attending to issues of respect	3	2
Communication	**How provider delivers the message**	**19**	**8**
Didactics	Communication through instructional lessons	0	0
Game	Communication through playing a game	0	0
Materials: Culturally-relevant	Communication that involves culturally-relevant materials (e.g., handouts with representations of Mexican-American families)	9	5
Materials: Simplified	Communication that involves simplified materials (e.g., worksheets for parents written at a low reading level)	2	2
Materials: Translated	Communication that involves materials translated in client's native or preferred language	8	3

Other	Communications that do not fit with other categories (e.g., user-friendly materials, interactive learning)	5	2
Storytelling	Communication through storytelling	0	0
Video or technology	Communication through videos or other technologies	1	0
Change Agent	**Person(s) involved in the intervention**	**33**	**15**
Community members	Community members (e.g., teachers, neighbors) participated in intervention for client	1	1
Consultation with consumers	Intervention was informed by consultation with consumers	3	2
Consultation with experts	Intervention was informed by consultation with cultural experts	6	3
Consultation with paraprofessionals	Intervention was informed by consultation with paraprofessionals	2	1
Family members	Family members participated in intervention for client	7	5
Group format	Intervention was implemented in a group	1	0
Other	Change agents that do not fit with other categories (e.g., interpreter, family advocate)	3	2
Peers	Peers participated in intervention for client	1	1
Provider: Culturally-matched	Client was matched with providers with similar characteristics (e.g., ethnicity, language skills) or background (e.g., from the same neighborhood)	18	6
Provider: Culturally-trained	Providers received cultural training	8	3
Conceptualization	**How information was framed**	**6**	**3**

Culturally-relevant rationale	Rational for intervention based on cultural concepts, beliefs, or norms	6	3
Focus on strengths	Intervention aimed to build on or enhance client strengths	0	0
Other	Conceptualizations that do not fit with other categories	0	0
Values consistent	Intervention attended to cultural themes and values	0	0
Message	**What was said by provider**	**10**	**7**
Culturally-relevant label or example	Use of culturally-relevant labels, sayings, proverbs, or examples	6	4
Educational label	Use of education labels (e.g., referring to therapy as an "educational program")	2	1
Other	Messages that do not fit with other categories (e.g., providers referred to as "entenadores")	1	1
Procedures	**What providers asked clients to do**	**16**	**10**
Emphasized engagement	Procedures for increasing client engagement in the intervention	4	4
Individualized procedures	Procedures that have been individualized for a specific client or family	4	3
Modified duration	Procedures that have been adapted from an original protocol to be completed in more or fewer days	1	1
Modified frequency	Procedures that have been adapted from an original protocol to be delivered more or less frequently	0	0
Modified setting	Procedures that have been adapted from an original protocol to be completed in another setting (e.g., clinic, school, church)	1	0

Modified time	Procedures that have been adapted from an original protocol to be completed in more or less session time	2	2
Other	Procedures that do not fit with the other categories (e.g., connected families with community resources)	1	1
Selected specific procedures	At least one procedure in the intervention was designed to incorporate culture, enhance cultural responsiveness, or address culturally-related stressors	12	7

Note: Total groups designed to incorporate culture = 49. Total winning groups designed to incorporate culture = 22.

Table 2

Study and Sample Characteristics of Winning Treatment Groups

Strategy for Incorporating Culture	**Most Recent Year**	**Treatment Target**	**Ethnicity**	**Age**	**Gender**
Style	1999	Depression	Other	13-17	Male, Female
Communication	2015	Disruptive behavior, Anxiety, Attention	Latinx, Black, White, Other, Multiethnic, Asian, Pacific Islander	1-13	Male, Female
Change Agent	2015	Disruptive behavior, Attention, Depression, Substance use, Anxiety, Other	Latinx, Black, White, Other, Multiethnic, Asian, Pacific Islander, Native American	1-17	Male, Female
Conceptualization	2015	Disruptive behavior, Substance use	Latinx, Black, Multiethnic, Native American	8-14	Male, Female
Message	2009	Depression, Disruptive behavior, Anxiety, Attention, Substance use	Latinx, Other, Black, Native American	3-17	Male, Female
Procedures	2015	Disruptive behavior, Depression, Attention, Engagement, Other, Substance use	Latinx, Other, Black, White, Mutliethnic, Asian, Pacific Islander, Native American	1-17	Male, Female

Note: Treatment target, ethnicity, age, and gender are listed in descending order of frequency for which each strategy appeared in winning groups.

Table 3

Treatment Characteristics of Winning Groups

Strategy for Incorporating Culture	**Setting**	**Format**	**Provider**
Style	Clinic	Client individual	Not reported
Communication	School, Clinic, Home, Community	Client individual, Client group, Parent group, Parent and child, Family	Graduate student, MA, Teacher, School
Change Agent	School, Clinic, Home, Community, Other	Client group, Family, Client individual, Parent group, Parent individual, Parent and child, Other	MA, Graduate student, MSW, PhD, Other, MD, Undergraduate student, Teacher, School
Conceptualization	School, Clinic	Client group, Parent group	MA, School, Teacher, Other
Message	Clinic, School	Client group, Client individual, Parent group, Parent and child	Graduate student, Other
Procedures	Clinic, Home, Community, Other	Client individual, Family, Client group, Parent group, Parent individual, Parent and child, Other	Graduate student, MSW, MA, Other, MD, Undergraduate student

Note: Setting, format, and provider are listed in descending order of frequency for which each strategy appeared in winning groups.

Evidence-Based Treatment Procedures Coding Manual

This coding manual was developed to codify the content of treatment sessions in the Community Implemented Treatment (CIT) arm of the Child STEPs in California randomized effectiveness trial. This manual consists of instructions for completing the coding sheet, evidence-based treatment codes, and practice element codes. This manual is meant to serve as a guide for coding write-in interventions from Consultation Records used in the Child STEPs in California trial. Coders should consult the manual regularly when coding these data. Information on evidence-based treatments was gathered from the Mental Health Services Act: Three Year Program and Expenditure Plan, Fiscal Years 2014-15 through 2016-17 (Los Angeles County Board of Supervisors, 2015). Practice element content is owned by PracticeWise, LLC and should therefore not be copied or reproduced for uses other than those related to this study.

Completing the Coding Sheet

The coding sheet is an Excel spreadsheet with 14 columns: (1) Session ID, (2) Youth Attendance, (3) Caregiver Attendance, (4) Teacher Attendance, (5) Focus of Session, (6) Write-in Intervention, (7) Caregiver Participation, (8) Evidence-based Treatment Codes , (9-13) Practice Element Codes, (13) Coverage of Neither Evidence-based Treatment nor Practice Element (i.e., Other).

Evidence-based Treatment and Practice Element codes should be based on the information in the Write-in Intervention column. Additional information is provided to help coders distinguish between similar interventions (e.g., the attendance information may help distinguish the write-in intervention of "psychoeducation").

Coders may select up to one evidence-based treatment code and up to five practice element codes to describe a session. If a write-in intervention does not fit with any of the evidence-based treatment or practice element codes, the write-in intervention should be coded as "Neither." Do not force techniques into one of the evidence-based treatment or practice element codes if they do not seem justified, such as trying to code Talk Therapy as "Supportive Listening" if supportive listening was not specifically mentioned. In this case, code Talk Therapy under "Neither." Relatedly, if there is not enough information to determine whether the write-in intervention is a practice element or part of an evidence-based treatment (e.g., "activity related to bullying," "behavioral treatment," "empathy building"), the intervention should be coded as "Neither." *Assessments should be coded as "Neither."*

Example Codes:

Session ID	Attend Youth	Attend CG	Session Focus	Write-in Intervention	CG Participation	EBT_1	EBP_1	EBP_2	EBP_3	Neither
1	1	0	Anxiety	Art therapy	N/A					Neither

2	1	1	Reinforced strategies for improving compliance	Direct commands and PRIDE skills	Full Session (100%)	PCIT				
3	0	1	Conduct	Parent Management	Full Session (100%)		Other			
4	1	0	Affective Education	PATH	N/A	PATHS				
5	1	0	Anger and defiance	Play therapy to help identify angry feelings; renewed anger management tools; breathing exercises	N/A		Play Therapy	Anger Management	Relaxation	
6	1	0	Anxiety within classroom	Psychoed on anxiety; practiced relaxation skills	N/A		Psychoeducation - Youth	Relaxation Skills		

Evidence-based Treatment Codes

The following is a list of highly implemented evidence-based programs within the Los Angeles County Prevention and Early Intervention (PEI) Plan.

Aggression Replacement Training (ART)

ART is a multimodal psycho-educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. Its goal is to improve social skills, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger control training, and training in moral reasoning. Skillstreaming teaches pro-social skills. In anger control training, youths are taught how to respond to their hassles. Training in moral reasoning is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others.

Child-Parent Psychotherapy (CPP)

CPP is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive behavioral, and social-learning theories into a dyadic treatment approach. CPP is designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of domestic violence. CPP is intended as an early intervention for young children that may be at risk for acting-out and experiencing symptoms of depression and trauma.

Crisis Oriented Recovery Services (CORS)

A short-term intervention designed to provide immediate crisis intervention, address identified case management needs, and assure hard linkage to ongoing services. The primary objective is to assist individuals in resolving and/or coping with psychosocial crises by mitigating additional stress or psychological harm. CORS promotes the development of coping strategies that individuals can utilize to help restore them to their previous level of functioning prior to the crisis event.

Individual Cognitive Behavioral Therapy (Ind CBT)

CBT is intended as an early intervention for individuals who either have or may be at risk for symptoms related to the early onset of anxiety, depression, and the effects of trauma that impact various domains of daily living. CBT incorporates a wide variety of treatment strategies including psychoeducation, skills acquisition, contingency management, Socratic questioning, behavioral activation, exposure, cognitive modification, acceptance and mindfulness strategies and behavioral rehearsal.

Interpersonal Psychotherapy for Depression (IPT)

IPT is a short-term therapy (8-20 weeks) that is based on an attachment model, in which distress is tied to difficulty in interpersonal relationships. IPT targets the TAY population suffering from non-psychotic, uni-polar depression. IPT targets not only symptoms, but improvement in interpersonal functioning, relationships, and social support. Therapy focuses on one or more interpersonal problem areas, including interpersonal disputes, role transitions, and grief and loss issues.

Parent-Child Interaction Therapy (PCIT)

Highly specified, step-by-step, live-coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. The emphasis is on changing negative parent/caregiver-child patterns.

Providing Alternative Thinking Strategies (PATHS)

Promoting Alternative Thinking Strategies (PATHS) and PATHS Preschool are school-based preventive interventions for children in elementary school or preschool. The interventions are designed to enhance areas of social-emotional development such as self-control, selfesteem, emotional awareness, social skills, friendships, and interpersonal problem-solving skills while reducing aggression and other behavior problems. Skill concepts are presented through direct instruction, discussion, modeling, storytelling, role-playing activities, and video presentations. The elementary school PATHS Curriculum is available in two units: the PATHS Turtle Unit for kindergarten and the PATHS Basic Kit for grades 1-6. The curriculum includes 131 20- to 30-minute lessons designed to be taught by regular classroom teachers approximately 3 times per week over the course of a school year. PATHS Preschool, an adaptation of PATHS for children 3 to 5 years old, is designed to be implemented over a 2- year period. Its lessons and activities highlight writing, reading, storytelling, singing, drawing, science, and math concepts and help students build the critical cognitive skills necessary for school readiness and academic success. The PATHS Preschool program can be integrated into existing learning environments and adapted to suit individual classroom needs.

Seeking Safety (SS)

Designed for flexible use with diverse populations and settings (outpatient, inpatient, residential) and can be conducted in group or individual format. Treatment is intended for individuals or groups who are trauma-exposed, experiencing symptoms of trauma(s) and/or abusing substance. Seeking Safety has been used with people who have a trauma history, but do not meet criteria for PTSD.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

An early intervention for children and TAY populations who may be at risk for symptoms of depression and psychological trauma due to experiencing any number of traumatic events. Services are specialized mental health services delivered by clinical staff, as part of multidisciplinary treatment teams. Program is intended to reduce symptoms of depression and psychological trauma.

Triple P Positive Parenting Program (Triple P)

Triple P is intended for the prevention and early intervention of social, emotional and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. An EBP parenting program and system for delivering parenting information to large and small populations. DMH is implementing Level 4 and Level 5 trainings at most clinics, emphasizing broad focus parenting skills training and behavioral family interventions. Target population is towards parents/caregivers of children ages 0-16 years.

Practice Element Codes

The following is a list of practice elements, or discrete clinical strategies or practices:

Accessibility Promotion

Activity Scheduling

Anger Management

Assertiveness Training

Attending

Behavioral Contracting

Case Management

Caregiver Coping

Cognitive

Commands

Communication Skills

Crisis Management

Differential Reinforcement

Educational Support

Exposure

Family Engagement

Family Therapy

Goal Setting

Insight Building

Maintenance/Relapse Prevention

Medical Care or Recommendation

Mentoring

Mindfulness

Modeling

Monitoring

Motivational Enhancement

Narrative

Natural and Logical Consequences

Nutritional Care or Recommendation

Peer Pairing

Performance Feedback

Personal Safety Skills

Play Therapy

Praise

Problem Solving

Psychoeducation-Child

Psychoeducation-Caregiver

Relationship/Rapport Building

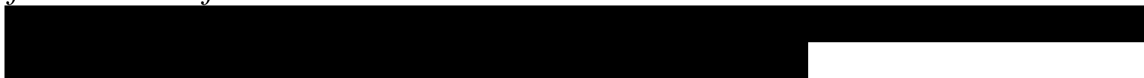
Relaxation

Response Cost

Response Prevention

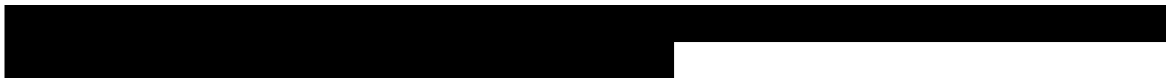
Self-Monitoring

Self-Reward/Self-Praise



Social Skills Training

Stimulus/Antecedent Control



Support Networking

Supportive Listening

Talent or Skill Building

Tangible Rewards

Time Out

Other

The "Other" field exists for mentioned evidence-based treatment components that do not fall under any other category above (e.g., Routines).

Stated evidence-based techniques that seem too general should be coded in this field, such as "parent management training." General parenting skills should not be coded as "Other," but rather as "Neither."

Appendix B (Study 2): Cultural Facilitators and Barriers Semi-Structured Interview

Understanding Facilitators and Barriers to Treating Diverse Youth and Families in Community Mental Health Settings

Semi-Structured Interview

INTRODUCTORY SCRIPT

Hello,

Thank you for agreeing to be interviewed. I know you are quite busy and I appreciate you making the time.

My name is [NAME OF INTERVIEWER], and I am a researcher at UCLA. Our research team has partnered with your agency to understand the diversity issues that arise in your work as a mental health supervisor/provider. We hope our conversation today will help us to further understand any issues that you are facing in order to improve organizational support, training, and resources in the areas of diversity and cultural responsiveness.

The purpose of the questions I will be asking you today is to help us learn about your work with diverse children and families.

As stated in the consent form that you signed agreeing to be interviewed, we estimate that today's interview will take approximately one hour. I will be recording our interview so that I can be a better listener and spend less time writing notes while we talk. Later, this interview will be transcribed by someone on our research team and maintained on a secure and encrypted server. This interview and its transcription will not be shared with your agency. Instead, the Clinical Practice, Training, and Research and Evaluation Department will be receiving de-identified reports (i.e., reports that do not include participant names or employee ID's), which will be used to enhance and improve clinical training and support around issues of diversity and cultural responsiveness. If appropriate, these summaries may inform policies and procedures at the agency to improve organizational support of diversity and inclusion.

We have tried to make our questions respectful and clear. However, if you feel uncomfortable with any question, you may choose not to answer. All the questions in this interview are considered optional, and your refusal to answer questions will not impact your employment status at [redacted] or your eligibility to receive study compensation.

Please feel free to ask me to explain or repeat myself at any time while we are talking or after the interview. You are free to stop the interview and change your mind about participating at any time.

After completing the interview, you will receive a $10 gift card.

When the study is complete, UCLA and your agency may submit a summary of findings to a mental health journal in the form of a research article for publication. The findings of this study are anticipated to be relevant and of great interest to mental health service researchers, providers and community members.

Do you have any questions before we get started?

INTERVIEW

Interview with [PARTICIPANT ID] at [SITE ID] is being conducted by [NAME OF INTERVIEWER] on [DATE] at [TIME].

GENERAL

1. What does diversity mean to you as a mental health provider?

2. How would you describe your current work with diverse populations? (What have been your experiences working with diverse or underserved children and families in the community?)

3. Do you feel there are adequate resources in the community to support the mental health needs of underserved consumers and families? Please tell me more about that.

4. Do you believe that the agency's current practices related to training and program evaluation meet the diverse needs of the populations you're serving? Please tell me more about that.

ENGAGEMENT

5. When working with consumers and families of diverse cultural backgrounds, what have been the barriers in engaging them? Please tell me more about that. (For supervisors, ask if their supervisees have encountered barriers when working with consumers and families of diverse cultural backgrounds).

    a. What do you think would be helpful for improving engagement with consumers and families of diverse cultural backgrounds?

    b. How might your supervisor (or department managers) support you in improving engagement with consumers or families of diverse cultural backgrounds?

    c. How might your treatment team support you in improving engagement with consumers or families of diverse cultural backgrounds?

d. How might the agency support you in improving engagement with consumers or families of diverse cultural backgrounds?

e. What has worked well for you in addressing these barriers? (What [therapy] strategies do you think would be helpful for improving engagement with consumers or families of diverse cultural backgrounds?)

TRANSLATION SERVICES

1. Do you use **translation services** when working with a client who does not speak the same language as you? (For supervisors, do you encourage your supervisees to use translation services when working with a client who does not speak the same language as them?) Why or why not?

    a. What languages have you (or your supervisees) needed translation services for?

    b. What do you see as the pros and cons of using translation services?

        i. How could it be improved?

    c. Have you (or your supervisees) ever relied on other methods of translation instead of translation services (e.g. relying on another clinician, a relative of the client, Google Translate, other)? If so, please share why you (or your supervisee) chose that instead of translation services?

        i. How is this method better than translation services?

        ii. How is this method worse than translation services?

2. What suggestions do you have for your agency or site leadership about how to handle concerns with translation services?

SERVING IMMIGRANT POPULATIONS

1. Many individuals have been impacted by recent changes related to national immigration policy (e.g., the expansion or increase of Immigrations and Customs Enforcement and border patrol operations). Have these policy changes impacted the consumers and families that you (or your supervisees) work with? If so, how?

   Have your (or your supervisees') clients been affected by any other recent changes in the social and political climate? *If examples are requested: rescinding of protections for transgender students, proposed healthcare bill.* If so, how?

   a. (If unclear) How have families been responding to these changes? Can you give examples?

   b. How has this impacted your clinical work?

   c. Do you feel prepared to handle the issues that families have been coming in with? Why or why not? (For supervisors, do you feel prepared to

   d. How confident are you in your ability to address the needs of these families?

2. What suggestions do you have for your agency or your site leadership about how to help clients and clinicians/ supervisors/ community wellness specialists/ referral managers navigate these recent changes?

   a. How could training be improved to help clinicians/ supervisors/ community wellness specialists/ referral managers know how to work with families who ask for help navigating the current socio-cultural climate?

   b. If leadership were to create resources, what resources would be most helpful? What would be the best way to distribute these resources?

DIVERSITY TRAINING

1. Have you ever participated in a diversity or cultural competency training[4]? If so, when and where? Please share your thoughts about it?

[4] Gather information about each previously attended diversity training.

a. What did you like about previous trainings on diversity and cultural competency?

b. What could have been improved in previous trainings on diversity and cultural competency?

c. How would an agency diversity training benefit your or enhance your work?

2. (If the interviewee has not participated in a diversity training or not covered in previous question) What do you think should be covered or provided in a diversity training at your agency? What would you like to learn more about in terms of cultural competency?

WRAP UP

Before we wrap up, is there anything that you would like to tell me that I haven't already asked about?

Thank you for taking the time to meet with me today. We value your time and opinion. Do you have any additional questions or concerns?

Give gift card.

Notes:

Appendix C (Study 2): Cultural Facilitators and Barriers Coding Manual

Coding Instructions

You will be coding transcripts of semi-structured interviews. These transcripts will focus on responses to the following two sections of the semi-structured interview: (1) How would you describe your current work with diverse populations? (2) What working with consumers and families of diverse cultural backgrounds, what have been the barriers in engaging them? What has worked well for you in addressing these barriers? Have your coding manual in front of you and reference it often as you code the semi-structured interview transcript. Transcripts should be coded using Dedoose, an application for analyzing qualitative research.

Transcript Excerpts

Transcript excerpts will be predetermined by the lead coder. Transcript excerpts will only feature provider responses. Examples of excerpts:

- "So I think that definitely helps just going with that open mind."
- "I worked, um, in my previous job, I worked with, um, a lot of LGBTQs. So I think, um, I haven't had that training here, so I think that would be beneficial, not just for me but I think for the staff in general."
- "I think sometimes, um, when you have conversation like that, it can be uncomfortable. Um, having conservation about maybe LGBTQ, being homeless, about financial situations, gender, or even religion can be tough too, for some people."

Although only transcript excerpts should be coded, coders must read the entire transcript as other parts of the transcript may provide important context for assigning codes.

Code Assignment

Each transcript excerpt should be assigned at least one Topic code and one Valence code, although more than one Topic code may be assigned to the same excerpt. Coders should focus on capturing the content of the excerpt with the most relevant code(s). Many times, one Topic code will be sufficient for characterizing an excerpt. Coders can assign codes to excerpts by right-clicking the excerpt and selecting "Add Code(s)" or by selecting the excerpt and dragging and dropping code(s) into the "Selection Info" pane on Dedoose.

Time Considerations

Coding one transcript should take approximately 45 minutes. Please try to only begin coding a transcript if you know that you will have time to finish it. Rushing may compromise the reliability of coding, so do not rush. In addition, coding for too long continuously, or while very tired may compromise reliability. We recommend that coders take at least a short break between coding separate transcripts and do not code more than two transcripts in one sitting.

Basic Structure of Codes

Construct	Specifier	Sub-codes
Characteristics	Client Characteristics Client-Provider Match/ Mismatch Staff Characteristics	Diverse Gender/ Sexual Minority Homeless Education Immigration Language Race/ Ethnicity Religion SES Other
Client Engagement	N/A	N/A
Implementation Supports	Consultation Resources Supervision Training Treatment Team	Frequency Structure Topic Other
Organization	Agency System	Climate Culture Other
Staff Service Delivery	Experience	N/A
	Procedures	Appointment Reminders Cultural Assessment Psychoeducation Supportive Listening/ Validation Other
	Style	Client-Driven Developmental/ Open-Minded/ Respectful Personable Strengths-Focused Supportive Listening/ Validation Other
Other	N/A	N/A

Valence
Positive
Neutral
Negative

Code Definitions

<table>
<tr><th>Topic</th><th>Specifier</th><th>Sub-codes</th></tr>
<tr><td rowspan="3">Characteristics: Comments about an individual’s demographics or background.</td><td>Client Characteristics: Comments about individuals who a provider or the agency might serve.</td><td rowspan="3">Diverse: Comments about “diverse” individuals or intragroup differences.
Gender/ Sexual Minority: Comments about individuals who identify as lesbian, gay, bisexual, queer, or transgender.
Homeless: Comments about individuals who are homeless.
Education: Comments about individuals of a specific education level.
Immigration: Comments about individuals with a specific immigration status or documentation, generational status, or level of acculturation.
Language: Comments about individuals who speak a specific language.
Race/ Ethnicity: Comments about individuals of a specific race, ethnicity, or country of origin.
Religion: Comments about individuals who follow a specific religion or who are religious/ not religious.
SES: Comments about individuals of a specific socioeconomic status.
Other: Comments about individuals with a specific characteristic that does not fit with the above sub-codes (e.g., relationship status).

Comments about staff’s experience or lack of experience working with a specific subset of the population should be double-coded as Characteristics/ Client Characteristics/ Sub-code and Staff Service Delivery/ Experience.

Comments about training related to working with a specific subset of the population should be double-coded as Characteristics/ Client Characteristics/ Sub-code and Implementation Supports/ Training/ Sub-code.

Comments about staff’s characteristics or background facilitating or hindering understanding of clients’ cultural norms, beliefs, and values (as perceived by staff or client) should be coded as Characteristics/ Client-Provider Match/Mismatch.

Comments about staff interpreting or translating services should be coded as Characteristics/ Staff Characteristics/ Language.

Comments about staff internalizing engagement challenges should be coded as Characteristics/ Staff Characteristics/ Other.</td></tr>
<tr><td>Client-Provider Match/ Mismatch: Comments about match or mismatch between client characteristics and provider characteristics. Both client and provider characteristics should be mentioned for this code.</td></tr>
<tr><td>Staff Characteristics: Comments about respondent’s characteristics or characteristics of other staff employed by the agency.</td></tr>
</table>

<table>
<tr>
<td rowspan="1">Client Engagement: Comments about clients' treatment engagement.

Do <u>not</u> double-code with Procedures or Style sub-codes. Comments about staff actively attempting to engage clients should be coded as Procedures or Style.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td rowspan="5">Implementation Supports: Comments about infrastructure for supporting service delivery.</td>
<td>Consultation: Comments about staff consulting with another professional about a client.</td>
<td rowspan="5">Frequency: Comments about the frequency of consultation, administration of resources (or quantity of resources), supervision, training, or treatment team meetings.
Structure: Comments about the structure, set-up, or procedures of a specific implementation support (e.g., level of support, including giving ideas; level of cohesiveness; individual versus group; didactic versus interactive discussion; how well the discussion flows).
Topic: Comments about the topic of consultation, resources, supervision, training, or treatment team meetings.
Comments about training related to working with a specific subset of the population should be double-coded as Characteristics/ Client Characteristics/ Sub-code and Implementation Supports/ Training/ Topic.
Other: Comments about aspects of consultation, resources, supervision, training, or treatment team meetings that do not fit with the above sub-codes (e.g., giving advice).</td>
</tr>
<tr>
<td>Resources: Comments about resources or information.</td>
</tr>
<tr>
<td>Supervision: Comments about supervisors or supervision.</td>
</tr>
<tr>
<td>Training: Comments about training for staff (e.g., leadership, supervisors, providers, administrators). Do <u>not</u> code for recipient of training.</td>
</tr>
<tr>
<td>Treatment Team: Comments about members of the treatment team or treatment team meetings.</td>
</tr>
<tr>
<td rowspan="2">Organization: Comments about work environment, policies, or expectations</td>
<td>Agency: Comments about the environment, policies, or expectations of the agency.</td>
<td rowspan="2">Climate: Comments about perceptions of and emotional responses to the agency. Comments related to staff turnover or staff's reactions to policies and procedures should be classified under this code.
Culture: Comments about norms and expectations. Comments related to policies, procedures, and outreach events should be classified under this code.
Other: Comments about the agency of system that do not fit with the above sub-codes.</td>
</tr>
<tr>
<td>System: Comments about the environment, policies, or expectations of LACDMH.</td>
</tr>
</table>

<table>
<tr>
<td rowspan="2">Staff Service Delivery: Comments related to what staff do with clients, how they behave with clients, and their self-efficacy in working with clients.</td>
<td>Experience: Comments about staff's perceived level of experience working with clients. Comments related to staff's familiarity with a certain population should be classified under this code.

Comments about staff's experience or lack of experience working with a specific subset of the population should be double-coded as Characteristics/ Client Characteristics/ Sub-code and Staff Service Delivery/ Experience.</td>
<td>N/A</td>
</tr>
<tr>
<td>Procedures: Comments about what staff do with clients.

Do <u>not</u> double-code with Engagement.</td>
<td>Appointment Reminders: Comments about providing information about the day, time, and location of next therapeutic contact via mail, text, phone, email, etc.
Cultural Assessment: Comments about assessing clients' cultural norms, values, and beliefs (e.g., staff asking clients about their cultural identity, staff searching the Internet for cultural information, staff asking their friends and relatives for cultural information). Comments about incorporating culture into treatment should also be classified under this code.
Psychoeducation: Comments about educating clients about mental health problems or mental health services (e.g., structure of treatment, treatment approach, roles of each person involved in treatment, mandating reporting, etc.).
Other: Comments about clinical procedures that do not fit with the above sub-codes.</td>
</tr>
</table>

	Style: Comments about how staff behave with clients. Comments related to stylistic adjustments made to encourage engagement should be classified under this code. *Do not double-code with Engagement.*	***Client-Driven:*** Comments about allowing clients to direct treatment decisions, collaborating with clients about treatment decisions, or empowering clients to make treatment decisions or use therapy skills should also be classified under this code. ***Developmental/ Open-Minded/ Respectful:*** Comments about staff being open-minded, respectful, or nonjudgmental or meeting clients where they are at. Comments that mention staff being humble about their knowledge or clients' culture and willing to learn about clients' cultural norms, beliefs, and values should also be classified under this code. ***Personable:*** Comments about staff being personable, being relatively informal, or using self-disclosure. ***Strengths-Focused:*** Comments about staff focusing on clients' strengths. ***Supportive Listening/ Validation:*** Comments about using supportive listening, validation, or normalization. ***Other**:* Comments about how staff behave with clients that do not fit with the above sub-codes (e.g., checking in about client's understanding of therapy concepts).
Other: Comments that do not fit with any of the above constructs.		

Valence *When coding valence, try to be as objective as possible. Do not make assumptions based on what you perceive to be the respondent's tone or motivation.* *Excerpts that convey ambivalence or that describe an effective solution to a barrier should be coded as both Positive and Negative.*
Positive: Comments with positive valence. Statements about an existing facilitator (e.g., "my supervisor is helpful"), improvements, and solutions to barriers should also be classified under this code.
Neutral: Comments with neutral valence. Suggestions should typically be coded as having Neutral valence, unless paired with a positive or negative comment.
Negative: Comments with negative valence.

Appendix D (Study 3): Cultural Tailoring Strategies Coding Manual

INTRODUCTION

This manual is designed for the purpose identifying strategies for culturally tailoring interventions in an efficient, standardized, and reliable manner. Information about strategies for culturally tailoring interventions will be coded from journal articles of randomized clinical trials and associated primary sources (e.g., treatment manuals, books, chapters). Within journal articles, this information is likely to appear in the Method section; however, coders should read the entire journal article, as codeable information may appear in other sections (e.g., a brief description of the intervention may be included in the Introduction section; demographic data may be presented in the Results section). Randomized clinical trials. with samples of predominantly (≥75%) ethnic minority youth, will be identified using the PracticeWise Evidence-Based Youth Mental Health Services Literature Database (PWEBS). Instructions for completing the coding packet and definitions of codes are below. Coders should consult the manual regularly.

CODING PROCEDURE

1. Receive coding assignment via email. Note the paper ID, reference, and group names.
2. Open a PDF of the journal article or primary source.
3. Open a blank coding sheet. Rename coding sheet: Cultural Strategies Codesheet_[Paper ID]_[Initials]. For example, if Alayna Park is coding Paper ID #101, then the file name should be "Cultural Strategies Codesheet_101_AP."
4. Complete the coding packet, adhering to the instructions detailed in the following pages of this coding manual. It is often helpful to annotate the PDF of the journal article or primary source as you code.
5. Upload completed coding packet to UCLA Box\ Cultural Strategies Coding\Completed Codesheets.

COMPLETING THE STUDY CODING SHEETS

Coder Initials

The first item to complete is to put your initials in the appropriate space at the top right ride of the page.

Reference

Write the full reference of the article.

EXAMPLE

STUDY Coding Sheets – SAMPLE
Coder Initials: *AP*
Reference: Chorpita, B. F., Daleiden, E. L., Park, A. L., Ward, A. M., Levy, M. C., Cromley, T., . . . Krull, J. L. (2017). Child STEPs in California: A cluster randomized effectiveness trial comparing modular treatment with community implemented treatment for youth with anxiety, depression, conduct problems, or traumatic stress. *Journal of Consulting and Clinical Psychology, 85*(1), 13-25. doi:http://dx.doi.org/10.1037/ccp0000133

OPTIONAL PANEL ON STUDY CODING SHEETS – SAMPLE

This panel is completed only if the variables of interest cannot be coded on the group sheets. For example, if youth language and youth immigration status (but not therapist language) are reported independently for the treatment group and the control group, these could be coded only on the group coding sheets. Therapist language, however, would need to be coded on the study coding sheet.

YOUTH DEMOGRAPHICS

When indicating demographic data here, report demographic data associated with children and/or adolescents. If demographic data for families are reported, complete relevant sections for *both* youth and caregivers (e.g., a study that includes "immigrant families" should have Youth Immigration Status and Caregiver Immigration Status checked "yes").

Language

If youth language is not reported, skip this section. Otherwise, check "yes" and complete the section. Place a check mark for all languages spoken by child or adolescent participants. This is not exclusive to language(s) in which the treatment was delivered but should include information related to youth's native language, primary language, language spoken at home, etc. Youth language may be inferred from the language of administered measures (e.g., if questionnaires written in French were administered to youth, then the coder should check "French" for youth language). If youth are reported as being bilingual and only one language (e.g., Spanish) is mentioned, coders may infer that the other language in English.

EXAMPLE

A study describes youth participants as being bilingual in English and Spanish.

Language Reported: ☒Yes	
English	☒
Spanish	☒
Chinese (including Mandarin and Cantonese)	☐
French	☐
Tagalog	☐
Vietnamese	☐
Korean	☐
German	☐
Other:	☐

Immigration Status

If youth immigration status is not reported, skip this section. Otherwise, check "yes" and complete the section. The first column to the right of each label ("at least 1") should be checked for all immigration statuses mentioned as included. If exact counts are provided, write those in the "N" column. If percentages are provided, write those in the "%" column. There is no need for coders to manually calculate percentages for actual counts or vice versa. Coders should only code the information that is printed in the article.

EXAMPLE

A study describes that 15 children were born in the USA and the remaining 4 children were born in Japan.

Immigration Status Reported: ☒Yes	At least 1 (✓)	N *if available*	% *if available*
Born in USA	☒	15	
Born in other country: *Japan*	☒	4	

Acculturation

If youth acculturation (including years lived in the United States) is mentioned in the study, check the "yes" box and complete this section. Otherwise, skip the section. If acculturation criteria are described as part of study design inclusion criteria, then code under column "I." There is no need to code exclusion, because that is implied. For example, if the study says "we excluded all adolescents with an acculturation score above 3.4," then write 3.4 in the maximum "I" column for Acculturation. Also code the observed minimum and maximum acculturation scores in the "Observed" column, if the information is available (if "low" acculturation is stated, write "low" in the minimum column. Finally, report the instrument used to determine acculturation. If description statistics (e.g., means and standard deviations) on an acculturation measure are reported, then check the "yes" box and report the instrument used – the descriptive statistics should *not* be entered.

EXAMPLE

A study describes excluding adolescents who scored above 3.4 on the Stephenson Multigroup Acculturation Scale.

Acculturation Reported: ☒Yes	I		Observed
Acculturation Minimum			
Acculturation Maximum	*3.4*		
If yes, instrument used:	*Stephenson Multigroup Acculturation Scale*		

CAREGIVER DEMOGRAPHICS

When indicating demographic data here, report demographic data associated with parents or caregiver participants. If demographic data for families are reported, complete relevant sections for *both* youth and caregivers (e.g., a study that includes "immigrant families" should have Youth Immigration Status and Caregiver Immigration Status checked "yes").

Ethnicity

If parent or caregiver ethnicity is not reported, skip this section. Otherwise, check "yes" and complete the section. The first column to the right of each label ("at least 1") should be checked for all ethnicities mentioned as included. If exact counts are provided, write those in the "N" column. If percentages are provided, write those in the "%" column. There is no need for coders to manually calculate percentages from actual counts or vice versa. Coders should only rate information that is printed in the article. Data on participants' nationalities (e.g., Australian, European, etc.) are not coded, even if this information is explicitly stated in the article. Nationality and ethnicity are different constructs; we are coding only ethnicity information at this time. Also, if "Other" ethnicities are reported in combination with an ethnicity category (e.g., "5% were American Indian/Other"), report this in the Other ethnicity category, and write it as "American Indian/Other," and enter "5%" in the Other field. Do not write "5%" in the American Indian or Alaska Native category, as it is not possible to determine how many American Indian or Alaska Native youth were included in the study due to the authors lumping the categories of "American Indian or Alaska Native" "Other" together. However, since this means that at least one youth was American Indian or

Alaska Native, also check “at least 1” in the American Indian or Alaska Native ethnicity category to capture that there was at least one American Indian or Alaska Native youth in the study. Information about family ethnicity (e.g., “76 Hispanic *families* participated in this study”) should be entered in this section.

EXAMPLE

A study describes caregivers who identify as non-Hispanic White, Black, Latinx, and American Indian/Other as part of the sample, and percentages are given, but not counts.

Ethnicity Reported: ☒Yes ☐No	At least 1 (✓)	N *if available*	% *if available*
White	☒		14
Black or African American	☒		78
Hispanic or Latino	☒		7
Asian	☐		
Native Hawaiian or Pacific Islander	☐		
American Indian or Alaska Native	☒		
Other: *American Indian/Other*	☒		5
Multiethnic	☐		
Unknown	☐		

Language

If parent or caregiver language is not reported, skip this section. Otherwise, check “yes” and complete the section. Place a check mark for all languages spoken by parent or caregiver participants. This is not exclusive to language(s) in which the treatment was delivered but should include information related to caregiver’s native language, primary language, language spoken at home, etc. Caregiver language may be inferred from the language of administered measures (e.g., if questionnaires written in French were administered to caregivers, then the coder should check “French” for caregiver language). If caregivers are reported as being bilingual and only one language (e.g., Spanish) is mentioned, coders may infer that the other language in English.

Immigration Status

If parent or caregiver immigration status is not reported, skip this section. Otherwise, check “yes” and complete the section. The first column to the right of each label (“at least 1”) should be checked for all immigration statuses mentioned as included. If exact counts are provided, write those in the “N” column. If percentages are provided, write those in the “%” column. There is no need for coders to manually calculate percentages for actual counts or vice versa. Coders should only code the information that is printed in the article.

Acculturation

If parent or caregiver acculturation (including years lived in the United States) is mentioned in the study, check the “yes” box and complete this section. Otherwise, skip the section. If acculturation criteria are described as part of study design inclusion criteria, then code under column “I.” Finally, report the instrument used to determine acculturation. If description statistics (e.g., means and standard deviations) on an acculturation measure are reported, then check the “yes” box and report the instrument used – the descriptive statistics should *not* be entered.

THERAPIST DEMOGRAPHICS

When indicating demographic data here, report demographic data associated with therapist participants.

Ethnicity

If therapist ethnicity is not reported, skip this section. Otherwise, check "yes" and complete the section. The first column to the right of each label ("at least 1") should be checked for all ethnicities mentioned as included. If exact counts are provided, write those in the "N" column. If percentages are provided, write those in the "%" column.

Language

If therapist language is not reported, skip this section. Otherwise, check "yes" and complete the section. Place a check mark for all languages spoken by therapist participants. If therapists are reported as being bilingual and only one language (e.g., Spanish) is mentioned, coders may infer that the other language in English. Do **not** code languages spoken by assessors or other research staff.

COMPLETING THE GROUP CODING SHEETS

Complete a separate **Group Coding Sheet - Sample** for each group in the study, including waitlists and placebo controls. Thus a study that tests an active treatment against a waitlist would require two group coding sheets. Complete a separate **Group Coding Sheet – Cultural Strategies** for Active Treatment, Combined Treatment, Other Control, and Other groups only.

CODING THE GROUP CODING SHEETS – SAMPLE

Group Name

Write the name of the group. For example, "Coping Cat," "Cognitive Behavior Therapy with Parents," or "Goal Setting plus Self-Instruction."

YOUTH DEMOGRAPHICS

Code as described for Study Coding Sheets – Sample.

CAREGIVER DEMOGRAPHICS

Code as described for Study Coding Sheets – Sample.

THERAPIST DEMOGRAPHICS

Code as described for Study Coding Sheets – Sample.

CODING THE GROUP CODING SHEET – CULTURAL STRATEGIES

The cultural strategies coding sheet is used to code information about cultural tailoring of interventions. This information can come from a primary source, such as a treatment manual or chapter, or it can come from a secondary source, such as a description of the intervention in an article.

Group Name

Write the name of the group.

Cultural Tailoring

If cultural tailoring is not reported, select "no" from the drop-down list and skip this section. Otherwise, select "yes" and complete the section. Cultural tailoring may include, but is not limited to, strategies that attend to the needs, beliefs, or values of a cultural group; culturally-responsive strategies; or cultural

adaptations to an intervention. *If cultural tailoring is reported for the study (e.g., all therapists received cultural training), select relevant cultural strategies across all groups.* Support for an intervention with a cultural group (e.g., “cognitive behavior therapy has been shown to be efficacious for Hispanic adolescents with depression”) should not be coded as cultural tailoring. Intervention adaptations made for reasons other than to enhance cultural responsiveness (e.g., “the intervention included two new practices developed specifically for this study”) should also not be coded as cultural tailoring.

EXAMPLE

A study states that the intervention was designed to be consistent with the values of Mexican-American families.

yes	**Cultural Tailoring Reported**	
Cultural Strategy Codes (select 'yes" for all that apply)		
	Style Tailored - *How therapists behave with the client*	
	Client-directed	
	Collaborative	
	Directive	
	Other	
	Personal or informal	
	Respectful	

Style Tailored

If therapist style, or how therapist behaves with client, was tailored for a specific cultural group or to improve the cultural responsiveness of an intervention, select “yes” from the drop-down list and complete the section. Otherwise, select “no” and skip this section. If therapist style is mentioned outside of the context of cultural tailoring (e.g., “therapists were trained to use Socratic questioning”), select “no” for style tailored.

Client-directed

Style that involves client directing the course of treatment. For example, “clients were allowed to direct the course of treatment, which is consistent with Hispanic values.”

Collaborative

Style that involves therapist and client collaboration. This includes Socratic questioning.

Directive

Style that involves therapist taking an authoritative stance or making directive statements.

Other

The “Other” field exists for styles that do not fall under any other Style categories.

Personal or informal

Style that involves warm, personal, or informal interactions between therapist and client.

Respectful

Style that involves therapist showing respect to client or attending to issues of respect. For example, “therapists were trained to show respecto to clients.”

Communication Tailored

If therapist communication, or how therapist delivers the message, was tailored for a specific cultural group or to improve the cultural responsiveness of an intervention, select “yes” from the drop-down list and complete the section. Otherwise, select “no” and skip this section. If therapist communication is

mentioned outside of the context of cultural tailoring (e.g., “this study tested a computer-based intervention”), select “no” for communication tailored.

Didactics
Communication through instructional lessons. For example, “didactic format was used to decrease stigma of psychotherapy for ‘locos.’”

Game
Communication through playing a game.

Materials: Culturally-relevant
Communication that involves culturally-relevant materials (e.g., handouts, worksheets, pamphlets), such as handouts with graphics reflecting a specific cultural background. For example, “representations of Mexican-American families were added to handouts.”

Materials: Simplified
Communication that involves simplified materials, such as handouts for parents that are written at an elementary school reading level.

Materials: Translated
Communication that involves materials translated in client’s native or preferred language. For example, “all materials were available in both English and Spanish.”

Other
The “Other” field exists for communication methods that do not fall under any other Communication categories.

Storytelling
Communication through storytelling – either therapist engaging in storytelling with client or client engaging in storytelling activity.

Video or technology
Communication through videos or other technologies.

Change Agent Tailored
If change agent, or person(s) involved in the intervention, was tailored for a specific cultural group or to improve the cultural responsiveness of an intervention, select “yes” from the drop-down list and complete the section. Otherwise, select “no” and skip this section. If change agent is mentioned outside of the context of cultural tailoring (e.g., “children and their parents attended all sessions”), select “no” for change agent tailored.

Community members
Community members (e.g., teachers, neighbors) participated in intervention for client.

Consultation with consumers
Intervention was informed by consultation with consumers. For example, “the intervention was adapted based on recommendations from a focus group with Asian-American mothers.”

Consultation with experts
Intervention was informed by consultation with cultural experts.

Consultation with paraprofessionals
Intervention was informed by consultation with paraprofessionals.

Family members
Family members participated in intervention for client. This includes interventions that encouraged parent or caregiver participation to better fit the values of a cultural group or to address common cultural stressors.

Group format
Intervention was implemented in a group. For example, "the group format has been advocated for by African-American women."

Other
The "Other" field exists for change agents that do not fall under any other Change Agent categories. For example, interpreters who are present in therapy sessions should be coded as "Other: Interpreter."

Peers
Peers participated in intervention for client.

Therapist: Culturally-matched
Client was matched with therapist with similar characteristics (e.g., ethnicity, language skills) or background (e.g., from the same neighborhood). Only code if clients were intentionally assigned to therapists with similar characteristics and backgrounds. For example, this code should be checked for statements, such as "clients were assigned to therapists who were fluent in clients' preferred language." This code should not be checked for statements, such as "47% of youth reported that their primary language was Spanish" and "all therapists were bilingual in English and Spanish."

Therapist: Culturally-trained
Therapists received cultural training. For example, "therapists attended a training on the cultural norms," or "all therapists received training in cultural sensitivity." Therapist training in a culturally tailored intervention is not sufficient for use of this code.

Conceptualization Tailored
If the conceptualization, or how information was framed, was tailored for a specific cultural group or to improve the cultural responsiveness of an intervention, select "yes" from the drop-down list and complete the section. Otherwise, select "no" and skip this section. If the conceptualization is mentioned outside of the context of cultural tailoring (e.g., "this intervention aimed to increase competencies"), select "no" for conceptualization tailored.

Culturally-relevant rationale
Rationale for intervention based on cultural concepts, beliefs, or norms. For example, "the rationale was to expose youth to successful role models with similar ethnic and cultural backgrounds."

Focus on strengths
Intervention aimed to build on or enhance client strengths. For example, "a competency-based approach may be better received by ethnic minority children and families."

Other
The "Other" field exists for conceptualizations that do not fall under any other Conceptualization categories.

Values consistent
Intervention attended to cultural themes and values. For example, "interpersonal psychotherapy addresses interpersonal values of Puerto Rican adolescents."

Message Tailored
If the message, or what was said by therapist, was tailored for a specific cultural group or to improve the cultural responsiveness of an intervention, select “yes” from the drop-down list and complete the section. Otherwise, select “no” and skip this section. If the message is mentioned outside of the context of cultural tailoring (e.g., “therapists referred to anxiety as ‘stress’”), select “no” for message tailored.

Culturally-relevant label or example
Use of culturally-relevant labels, sayings, proverbs, or examples. For example, “the intervention was named after the Spanish word for “win,” or “the intervention uses African proverbs.”

Educational label
Use of educational labels, such as referring to therapy as an “educational program” or calling therapists “teachers.”

Other
The “Other” field exists for messages that do not fall under any other Message categories.

Procedures Tailored
If the procedures, or what therapists asked clients to do, were tailored for a specific cultural group or to improve the cultural responsiveness of an intervention, select “yes” from the drop-down list and complete the section. Otherwise, select “no” and skip this section. If procedures are mentioned outside of the context of cultural tailoring (e.g., “the intervention involved psychoeducation, exposure, and relaxation skills,” “the intervention was 16 sessions”), select “no” for procedures tailored.

Emphasized engagement
Procedures for increasing client engagement in the intervention. For example, “an entire session was dedicated to rapport building, given the high rates of drop out among ethnic minority families.” Use of an engagement outcome measure is not sufficient for use of this code.

Individualized procedures
Procedures that have been individualized for a specific client or family. For example, “multisystemic therapy allowed therapists to accommodate the diverse needs of youth and families through the development of individualized culturally responsive plans for each family.”

Modified duration
Procedures that have been adapted from an original protocol to be completed in more or fewer days. Indicate whether the duration has been increased (e.g., 126 days to 154 days) or decreased (154 days to 126 days).

Modified frequency
Procedures that have been adapted from an original protocol to be delivered more or less frequently. Indicate whether the frequency has been increased (e.g., weekly to daily) or decreased (daily to weekly).

Modified setting
Procedures that have been adapted from an original protocol to be completed in another setting (e.g., clinic, school, church).

Modified time
Procedures that have been adapted from an original protocol to be completed in more or less session time. Indicate whether the time has been increased (e.g., 60 minutes to 90 minutes) or decreased (90 minutes to 60 minutes).

Other
The “Other” field exists for procedures that do not fall under any other Procedure categories.

Selected specific procedures

At least one procedure in the intervention was designed to incorporate culture, enhance cultural responsiveness, or address culturally-related stressors. For example, “cognitive restructuring was used to help Asian-American parents manage upsetting thoughts about children’s bids autonomy” or “the group leader elicited parents’ views on potential cultural barriers.”

Notes

Enter any notes about cultural tailoring strategies here. If you are uncertain whether a strategy was culturally tailored, then enter it as a note.

Appendix E (Study 3): Literature Reviews of Psychosocial Interventions for Ethnic Minority Youth

Study	Sample Characteristics	Treatment Characteristics
	Anxiety	
Carbonell, D. M., & Parteleno-Barehmi, C. (1999). Psychodrama groups for girls coping with trauma. *International Journal of Group Psychotherapy, 49*, 285-306.	*N* = 28 *Age/Grade* = 11-13 years *Gender* = 100% girls *Ethnicity* = 54% Latina, 42% African American, 4% Haitian	**Psychodrama Treatment [a]:** *Treatment Family* = Psychodrama; *Format* = Client Group; *Setting* = School; *Providers* = MSW **Control Group**
Chu, B. C., Crocco, S. T., Esseling, P., Areizaga, M. J., Lindner, A. M., & Skriner, L. C. (2016). Transdiagnostic group behavioral activation and exposure therapy for youth anxiety and depression: Initial randomized controlled trial. *Behaviour Research and Therapy, 76*, 65-75.	*N* = 35 *Age/Grade* = 12-14 years *Gender* = 71% female *Ethnicity* = 43% African-American, 37% Hispanic, 14% White non-Hispanic, 6% multiple ethnicities	**Group Behavioral Activation Therapy (GBAT) [a]:** *Treatment Family* = Behavioral Activation and Exposure; *Format* = Client Individual, Client Group; *Setting* = School; *Providers* = MA, Doctoral Student, PhD **Waitlist Control**
Costantino, G., Malgady, R. G., & Rogler, L. H. (1986). Cuento therapy: A culturally sensitive modality for puerto rican children. *Journal of Consulting and Clinical Psychology, 54*, 639-645.	*N* = 210 *Age/Grade* = 5-11 years *Gender* = 57% male, 43% female *Ethnicity* = 100% Puerto Rican	**Original Cuento Therapy [b]:** *Treatment Family* = Cultural Storytelling; *Format* = Multiple Family; *Setting* = School; *Providers* = Other **Adapted Therapy [b]:** *Treatment Family* = Cultural Storytelling; *Format* = Multiple Family; *Setting* = School; *Providers* = Other **Art/Play Therapy:** *Treatment Family* = Play Therapy; *Format* = Multiple Family; *Setting* = School; *Providers* = Other **No Treatment**

Costantino, G., Malgady, R. G., & Rogler, L. H. (1994). Storytelling through pictures: Culturally sensitive psychotherapy for hispanic children and adolescents. *Journal of Clinical Child Psychology, 23*, 13-20.	*N* = 90 *Age/Grade* = 9-13 years *Gender* = Males and females *Ethnicity* = 100% Hispanic	**Experimental Intervention [ab]:** *Treatment Family* = Cultural Storytelling; *Format* = Client Group; *Setting* = School; *Providers* = Doctoral Student **Attention Control:** *Treatment Family* = Attention; *Format* = Client Group; *Setting* = School; *Providers* = Doctoral Student, Teacher
Ehrenreich-May, J., Rosenfield, D., Queen, A. H., Kennedy, S. M., Remmes, C. S., & Barlow, D. H. (2017). An initial waitlist-controlled trial of the unified protocol for the treatment of emotional disorders in adolescents. *Journal of Anxiety Disorders, 46*, 46-55.	*N* = 51 *Age/Grade* = 12-17 years *Gender* = 57% female *Ethnicity* = 59% Hispanic/Latino, 24% Non-Hispanic White, 8% African American, 8% "Other," 2% Asian American	**Unified Protocol for the Treatment of Emotional Disorders in Adolescents (UP-A) [a]:** *Treatment Family* = Cognitive Behavior Therapy; *Providers* = Doctoral Student, PhD **Waitlist Control**
Fung, J., Guo, S., Jin, J., Bear, L., & Lau, A. (2016). A pilot randomized trial evaluating a school-based mindfulness intervention for ethnic minority youth. *Mindfulness, 7*, 819-828.	*N* = 19 *Age/Grade* = 12-14 years *Gender* = 59% girls, 41% boys *Ethnicity* = 53% Latino, 47% Asian-American	**Learning to BREATHE (L2B):** *Treatment Family* = Mindfulness; *Format* = Client Group; *Setting* = School; *Providers* = Doctoral Student **Waitlist Control**
Ginsburg, G. S., & Drake, K. L. (2002). School-based treatment for anxious African-American adolescents: A controlled pilot study. Journal of the *American Academy of Child & Adolescent Psychiatry, 41*, 768-775.	*N* = 12 *Age/Grade* = 14-17 years *Gender* = 83% female, 13% male *Ethnicity* = 100% African American	**Cognitive Behavior Therapy [ab]:** *Treatment Family* = Cognitive Behavior Therapy; *Format* = Client Group; *Setting* = School; *Providers* = Doctoral Student Attention-Support Control: *Treatment Family* = Other **Control;** *Format* = Client Group; *Setting* = School; *Providers* = Doctoral Student
Ginsburg, G. S., Becker, K. D., Drazdowski, T. K., & Tein, J. (2012). Treating anxiety disorders in inner city schools: Results from a pilot randomized controlled trial comparing CBT and usual care. *Child & Youth Care Forum*, *41*, 1-19.	*N* = 32 *Age/Grade* = 7-17 *Gender* = 63% female *Ethnicity* = 84% African American	**Cognitive Behavioral Therapy:** *Treatment Family* = Cognitive Behavior Therapy; *Format* = Client Individual; *Setting* = School; *Providers* = MSW, MA **Usual Care:** *Treatment Family* = Usual Care; *Format* = Client Individual; *Setting* = School; *Providers* = MSW, MA

Lewis, S. (1974). A comparison of behavior therapy techniques in the reduction of fearful avoidance behavior. *Behavior Therapy, 5*, 648-655.	*N* = 50 *Age/Grade* = 5-12 years *Gender* = 100% male *Ethnicity* = 100% black	**Modeling and Participation [a]:** *Treatment Family* = Exposure; *Format* = Client Individual; *Setting* = Community Field **Modeling [a]:** *Treatment Family* = Modeling; *Format* = Client Individual; *Setting* = Community Field **Participation [a]:** *Treatment Family* = Exposure; *Format* = Client Individual; *Setting* = Community Field **Control Group:** *Treatment Family* = Other Control; *Format* = Client Individual; *Setting* = Community Field
Malgady, R. G., Rogler, L. H., & Costantino, G. (1990). Hero/heroine modeling for Puerto Rican adolescents: A preventive mental health intervention. *Journal of Consulting and Clinical Psychology, 58*, 469-474.	*N* = 90 *Age/Grade* = 12-15 years *Gender* = 55% female, 45% male *Ethnicity* = 100% Puerto Rican	**Hero/Heroine Intervention [b]:** *Treatment Family* = Modeling; *Format* = Client Group; *Setting* = School; *Providers* = Doctoral Student, Teacher **Control:** *Treatment Family* = Attention; *Format* = Client Group; *Setting* = School; *Providers* = Doctoral Student, Teacher
Wilson, N. H., & Rotter, J. C. (1986). Anxiety management training and study skills counseling for students on self-esteem and test anxiety and performance. *School Counselor, 34*, 18-31.	*N* = 60 *Age/Grade* = 6th-7th grades *Gender* = 56% boys, 44% girls *Ethnicity* = 89% Black, 11% White	**Modified Anxiety Management Training [a]:** *Treatment Family* = Exposure; *Format* = Client Group; *Setting* = School **Anxiety Management Training [a]:** *Treatment Family* = Exposure; *Format* = Client Group; *Setting* = School **Study Skills Counseling [a]:** *Treatment Family* = Education; *Format* = Client Group; *Setting* = School **Attention Placebo Control:** *Treatment Family* = Other Control; *Format* = Client Group; *Setting* = School No Treatment

Attention/ Hyperactivity		
Matos, M., Bauermeister, J. J., & Bernal, G. (2009). Parent-child interaction therapy for Puerto Rican preschool children with ADHD and behavior problems: A pilot efficacy study. *Family Process, 48*, 232-252.	*N* = 32 *Age/Grade* = 4-6 years *Gender* = not reported *Ethnicity* = 100% Puerto Rican	**Parent Child Interaction Therapy (PCIT) [ab]:** *Treatment Family* = Parent Management Training; *Format* = Parent & Child; *Setting* = Clinic; *Providers* = Doctoral Student **Psychoeducational Treatment:** *Treatment Family* = Psychoeducation
Nelson, W. J., & Birkimer, J. C. (1978). Role of self-instruction and self-reinforcement in the modification of impulsivity. *Journal of Consulting and Clinical Psychology, 46*, 183.	*N* = 48 *Age/Grade* = 2nd-3rd grades *Gender* = Males and females *Ethnicity* = 100% black	**Self-Instruction/Self-Reinforcement [a]:** *Treatment Family* = Self Verbalization **Self-Instruction:** *Treatment Family* = Self Verbalization No Self-Verbalization Controls: *Treatment Family* = Other Control **Assessment Controls**
Semple, R. J., Lee, J., Rosa, D., & Miller, L. F. (2010). A randomized trial of mindfulness-based cognitive therapy for children: Promoting mindful attention to enhance social-emotional resiliency in children. *Journal of Child and Family Studies, 19*, 218-229.	*N* = 25 *Age/Grade* = 9-13 years *Gender* = 60% girls, 40% boys *Ethnicity* = 60% Latino, 24% African American, 16% Caucasian	**Mindfulness-Based Cognitive Therapy-Children:** *Treatment Family* = Mindfulness; *Format* = Client Group, Parent & Child **Control**
Sibley, M. H., Pelham, W. E., Jr., Derefinko, K. J., Kuriyan, A. B., Sanchez, F., & Graziano, P. A. (2013). A pilot trial of supporting teens' academic needs daily (STAND): A parent-adolescent collaborative intervention for ADHD. *Journal of Psychopathology and Behavioral Assessment, 35*, 436-449.	*N* = 36 *Age/Grade* = 11-15 years *Gender* = 72.3% male *Ethnicity* = 61.2% Hispanic any race; 25.0% White non-hispanic; 8.4% Black non-hispanic; 5.6% Mixed race	**Supporting Teens' Academic Needs Daily (STAND) [ab]:** *Treatment Family* = Motivational Interviewing, Engagement and Parent Management Training; *Format* = Parent Group, Family; *Setting* = Clinic; *Providers* = MA Student, Doctoral Student, PhD **Treatment As Usual [b]:** *Treatment Family* = Usual Care

Autism		
Siller, M., Hutman, T., & Sigman, M. (2013). A parent-mediated intervention to increase responsive parental behaviors and child communication in children with ASD: A randomized clinical trial. *Journal of Autism and Developmental Disorders, 43*, 540-555.	*N* = 70 *Age/Grade* = FPI: 2.75-6.83; PAC: 2.67-6.33 *Gender* = Not reported *Ethnicity* = 44% Hispanic/Latino; 20% White; 19% Asian; 10% Mixed; 7% Black	**Experimental:** *Treatment Family* = Joint Attention, Engagement; *Format* = Parent & Child, Parent Individual; *Setting* = Home; *Providers* = Doctoral Student, PhD **Control:** *Treatment Family* = Parent Psychoeducation
Wong, C. S. (2013). A play and joint attention intervention for teachers of young children with autism: A randomized controlled pilot study. *Autism, 17*, 340-357.	*N* = 33 *Age/Grade* = 3-6 years *Gender* = 88% male, 12% female *Ethnicity* = 46% African American, 39% Hispanic	**Symbolic Play Only [a]:** *Treatment Family* = Play Therapy; *Format* = Other *Format*; *Setting* = School **Joint Attention Only [a]:** *Treatment Family* = Joint Attention, Engagement; *Format* = Other *Format*; *Setting* = School **Waitlist**
Depression		
Asarnow, J. R., Jaycox, L. H., Duan, N., LaBorde, A. P., Rea, M. M., Murray, P., . . . Wells, K. B. (2005). Effectiveness of a quality improvement intervention for adolescent depression in primary care clinics: A randomized controlled trial. *JAMA: Journal of the American Medical Association, 293*, 311-319.	*N* = 418 *Age/Grade* = 13-21 years *Gender* = 78% female *Ethnicity* = 56% Hispanic/Latino, 14% Mixed, 13% African American, 13% White, 3% Other, 1% Asian	**Quality Improvement [a]:** *Treatment Family* = Combined Treatment; *Setting* = Clinic; *Providers* = MA, MD, PhD **Usual Care:** *Treatment Family* = Combined Treatment
Carbonell, D. M., & Parteleno-Barehmi, C. (1999). Psychodrama groups for girls coping with trauma. *International Journal of Group Psychotherapy, 49*, 285-306.	*N* = 28 *Age/Grade* = 11-13 years *Gender* = 100% girls *Ethnicity* = 54% Latina, 42% African American, 4% Haitian	**Psychodrama Treatment [a]:** *Treatment Family* = Psychodrama; *Format* = Client Group; *Setting* = School; *Providers* = MSW **Control Group**

Fung, J., Guo, S., Jin, J., Bear, L., & Lau, A. (2016). A pilot randomized trial evaluating a school-based mindfulness intervention for ethnic minority youth. *Mindfulness, 7*, 819-828.	*N* = 19 *Age/Grade* = 12-14 years *Gender* = 59% girls, 41% boys *Ethnicity* = 53% Latino, 47% Asian-American	**Learning to BREATHE (L2B):** *Treatment Family* = Mindfulness; *Format* = Client Group; *Setting* = School; *Providers* = Doctoral Student **Waitlist Control**
Rosselló, J., & Bernal, G. (1999). The efficacy of cognitive-behavioral and interpersonal treatments for depression in Puerto Rican adolescents. *Journal of Consulting and Clinical Psychology, 67*, 734-745.	*N* = 71 *Age/Grade* = 13-17 years *Gender* = 54% female, 46% male *Ethnicity* = 100% Puerto Rican	**Cognitive Behavior Therapy [ab]:** *Treatment Family* = Cognitive Behavior Therapy; *Format* = Client Individual; *Setting* = Clinic; *Providers* = Doctoral Student **Interpersonal Psychotherapy for Adolescents [ab]:** *Treatment Family* = Interpersonal Therapy; *Format* = Client Individual; *Setting* = Clinic **Waitlist**
Young, J. F., Mufson, L., & Davies, M. (2006). Efficacy of interpersonal psychotherapy-adolescent skills training: An indicated preventive intervention for depression. *Journal of Child Psychology and Psychiatry, 47*, 1254-1262.	*N* = 41 *Age/Grade* = 11-16 years *Gender* = 85% female *Ethnicity* = 93% Hispanic	**Interpersonal Psychotherapy - Adolescent Skills Training [a]:** *Treatment Family* = Interpersonal Therapy; *Format* = Client Individual, Client Group; *Setting* = School; *Providers* = MSW, MA, PhD **School Counseling:** *Treatment Family* = Client Centered Therapy; *Format* = Client Individual, Client Group; *Setting* = School; *Providers* = MSW, Other
Young, J. F., Mufson, L., & Gallop, R. (2010). Preventing depression: A randomized trial of interpersonal psychotherapy-adolescent skills training. *Depression and Anxiety, 27*, 426-433.	*N* = 57 *Age/Grade* = 13-17 years *Gender* = 60% female *Ethnicity* = 74% Hispanic; 39% African American	**Interpersonal Psychotherapy - Adolescent Skills Training [a]:** *Treatment Family* = Interpersonal Therapy; *Format* = Client Individual, Client Group, Multiple Family; *Setting* = School; *Providers* = MA, MD, PhD **School Counseling:** *Treatment Family* = Usual Care; *Format* = Client Individual; *Setting* = School; *Providers* = Other

Disruptive Behavior		
Apsche, J. A., Bass, C. K., Jennings, J. L., Murphy, C. J., Hunter, L. A., & Siv, A. M. (2005). Empirical comparison of three treatments for adolescent males with physical and sexual aggression: Mode deactivation therapy, cognitive behavior therapy and social skills training. *International Journal of Behavioral Consultation and Therapy, 1*, 101-113.	*N* = 60 *Age/Grade* = M_{CBT}: 16.5, M_{SST}: 16.1, M_{MDT}: 16.5 *Gender* = 100% males *Ethnicity* = 72% African American, 22% European American, 7% Hispanic American	**Cognitive Behavioral Therapy:** *Treatment Family* = Cognitive Behavior Therapy; *Setting* = Community Residential **Social Skills Training:** *Treatment Family* = Social Skills; *Setting* = Community Residential **Mode Deactivation Therapy [a]:** *Treatment Family* = Cognitive Behavior Therapy; *Setting* = Community Residential
Bratton, S. C., Ceballos, P. L., Sheely-Moore, A., Meany-Walen, K., Pronchenko, Y., & Jones, L. D. (2013). Head start early mental health intervention: Effects of child-centered play therapy on disruptive behaviors. *International Journal of Play Therapy, 22*, 28-42.	*N* = 54 *Age/Grade* = 3-4 years *Gender* = approximately two-thirds male *Ethnicity* = 42% African American, 39% Hispanic, 18% Caucasian	**Child Centered Play Therapy (CCPT) [ab]:** *Treatment Family* = Play Therapy; *Format* = Client Individual; *Setting* = School; *Providers* = MA **Reading Mentor (Active Control) [b]:** *Treatment Family* = Other Control; *Format* = Client Individual; *Setting* = School; *Providers* = Pre-BA
Brotman, L. M., Klein, R. G., Kamboukos, D., Brown, E. J., Coard, S. I., & Sosinsky, L. S. (2003). Preventive intervention for urban, low-income preschoolers at familial risk for conduct problems: A randomized pilot study. *Journal of Clinical Child and Adolescent Psychology, 32*, 246-257.	*N* = 30 *Age/Grade* = 2-5 years *Gender* = 63% male *Ethnicity* = 67% African American, 33% Hispanic American	**Prevention Program (Intervention) [a]:** *Treatment Family* = Parent Management Training; *Format* = Client Group, Parent & Child, Parent Group; *Setting* = Clinic, Home; *Providers* = BA, MSW, Doctoral Student **No Intervention**

Carrasco, J. M., & Fox, R. A. (2012). Varying treatment intensity in a home-based parent and child therapy program for families living in poverty: A randomized clinic trial. *Journal of Community Psychology, 40*, 621-630.	*N* = 60 *Age/Grade* = 0-5 years *Gender* = 70% male, 30% female *Ethnicity* = 60% African American, 17% Latino, 13% mixed ethnicity, 10% Caucasian	**Parenting Young Children Program:** Intensive Treatment: *Treatment Family* = Parent Management Training; *Format* = Client Individual, Parent & Child; *Setting* = Home; *Providers* = MA, Doctoral Student **Parenting Young Children Program: Standard Treatment:** *Treatment Family* = Parent Management Training; *Format* = Client Individual, Parent & Child; *Setting* = Home; *Providers* = MA, Doctoral Student
Chorpita, B. F., Daleiden, E. L., Park, A. L., Ward, A. M., Levy, M. C., Cromley, T., . . . Krull, J. L. (2017). Child STEPs in California: A cluster randomized effectiveness trial comparing modular treatment with community implemented treatment for youth with anxiety, depression, conduct problems, or traumatic stress. *Journal of Consulting and Clinical Psychology, 85*, 13-25.	*N* = 138 *Age/Grade* = 5-15 years *Gender* = 55% boys, 45% girls *Ethnicity* = 78% Latino/a, 10% African American, 8% Multiethnic, 4% Caucasian	**Modular Approach to Therapy for Children [a]:** *Treatment Family* = Cognitive Behavior Therapy and Parent Management Training; *Setting* = Clinic; *Providers* = MSW, MA, PhD **Community Implemented Treatment:** *Treatment Family* = Usual Care; *Setting* = Clinic; *Providers* = MSW, MA, PhD
Forman, S. G. (1980). A comparison of cognitive training and response cost procedures in modifying aggressive behavior of elementary school children. *Behavior Therapy, 11*, 594-600.	*N* = 18 *Age/Grade* = 8-11 years *Gender* = 78% male, 22% female *Ethnicity* = 88% black, 12% white	**Cognitive Restructuring:** *Treatment Family* = Cognitive Behavior Therapy; *Format* = Client Group; *Setting* = School; *Providers* = Doctoral Student **Response Cost [a]:** *Treatment Family* = Contingency Management; *Format* = Client Group; *Setting* = School; *Providers* = Teacher, Other **Placebo Control:** *Treatment Family* = Other Control; *Format* = Client Group; *Setting* = School; *Providers* = Other

Fraser, M. W., Day, S. H., Galinsky, M. J., Hodges, V. G., & Smokowski, P. R. (2004). Conduct problems and peer rejection in childhood: A randomized trial of the making choices and strong families programs. *Research on Social Work Practice, 14*, 313-324	*N = 86* *Age/Grade* = 6-12 years *Gender* = 63% male, 37% female *Ethnicity* = 85% African American, 15% White not Latino	**Strong Families And Making Choices [ab]:** *Treatment Family* = Parent Management Training and Self-Verbalization; *Format* = Client Group, Parent Individual; *Setting* = Home, School, Community Field; *Providers* = Other **Waitlist**
Garza, Y., & Bratton, S. C. (2005). School-based child-centered play therapy with Hispanic children: Outcomes and cultural consideration. *International Journal of Play Therapy, 14*, 51-80.	*N* = 29 *Age/Grade* = 5-11 years *Gender* = 59% male, 41% female *Ethnicity* = 100% Hispanic	**Child-Centered Play Therapy [ab]:** *Treatment Family* = Play Therapy; *Format* = Client Individual; *Setting* = School; *Providers* = MA **Curriculum-Based Small Group Counseling [b]:** *Treatment Family* = Play Therapy; *Format* = Client Group; *Setting* = School; *Providers* = MA
Glick, B., & Goldstein, A. P. (1987). Aggression replacement training. *Journal of Counseling & Development, 65*, 356-362.	*N* = 51 *Age/Grade* = 13-21 years *Gender* = 100% male *Ethnicity* = 59% Black, 35% Hispanic; 4% Oriental; 2% White	**Aggression Replacement Training [a]:** *Treatment Family* = Anger Control; *Format* = Client Group; *Setting* = Corrections Facility **Non-Aggression Replacement Training Controls:** *Treatment Family* = Other Control; *Setting* = Corrections Facility
Gross, D., Fogg, L., Webster-Stratton, C., Garvey, C., Julion, W., & Grady, J. (2003). Parent training of toddlers in day care in low-income urban communities. *Journal of Consulting and Clinical Psychology, 71*, 261-278.	*N* = 208 *Age/Grade* = 2-3 years *Gender* = not reported *Ethnicity* = 57% African American, 29% Latino, 6% Other, 4% Multiethnic, 3% White	**Parent and Teacher Training [b]:** *Treatment Family* = Parent Management Training and Classroom Management; *Format* = Parent Group, Other *Format*; *Setting* = Day Care; *Providers* = Other **Parent Training [b]:** *Treatment Family* = Parent Management Training; *Format* = Parent Group; *Setting* = Day Care; *Providers* = Other **Teacher Training [b]:** *Treatment Family* = Contingency Management; *Format* = Other *Format*; *Setting* = Day Care; *Providers* = Other **Waitlist Control**

Harris, S. E., Fox, R. A., & Love, J. R. (2015). Early pathways therapy for young children in poverty: A randomized controlled trial. *Counseling Outcome Research and Evaluation, 6*, 3-17.	*N* = 199 *Age/Grade* = M: 2.88 years *Gender* = 70% male *Ethnicity* = 41% Latino/a, 39% African American	**Early Pathways Program [ab]:** *Treatment Family* = Parent Management Training; *Format* = Family; *Setting* = Home; *Providers* = MA Student, Doctoral Student **Waitlist Control**
Hogue, A., Dauber, S., Henderson, C. E., Bobek, M., Johnson, C., Lichvar, E., & Morgenstern, J. (2015). Randomized trial of family therapy versus nonfamily treatment for adolescent behavior problems in usual care. *Journal of Clinical Child and Adolescent Psychology, 44*, 954-969.	*N* = 205 *Age/Grade* = 12-18 years *Gender* = 52% male *Ethnicity* = 59% Hispanic American, 21% African American. 15% more than one race, 6% other	**Non-Family Therapy Care (UC-Other):** *Treatment Family* = Usual Care; *Format* = Client Individual, Client Group, Family; *Setting* = Clinic **Usual Care Family Therapy (UC-FT) [a]:** *Treatment Family* = Family Therapy; *Format* = Client Individual, Family; *Setting* = Clinic; *Providers* = MA Student, MSW, MA
Hudley, C., & Graham, S. (1993). An attributional intervention to reduce peer-directed aggression among African-American boys. *Child Development, 64*, 124-138.	*N* = 101 *Age/Grade* = 3rd-5th grades *Gender* = 100% boys *Ethnicity* = 100% African American	**Attributional Intervention [a]:** *Treatment Family* = Cognitive Behavior Therapy; *Format* = Client Group; *Setting* = School; *Providers* = School **Attention Training:** *Treatment Family* = Other Control; *Format* = Client Group; *Setting* = School; *Providers* = School **No Treatment**

Huey, W. C., & Rank, R. C. (1984). Effects of counselor and peer-led group assertive training on black adolescent aggression. *Journal of Counseling Psychology, 31*, 95-98.	*N* = 48 *Age/Grade* = 8th-9th grade *Gender* = 100% male *Ethnicity* = 100% black	**Counselor-Led Assertiveness** [ab]: *Treatment Family* = Assertiveness Training; *Format* = Client Group; *Setting* = School; *Providers* = Other **Peer-Led Assertiveness** [ab]**:** *Treatment Family* = Assertiveness Training; *Format* = Client Group; *Setting* = School; *Providers* = Peer **Counselor-Led Discussion:** *Treatment Family* = Group Therapy; *Format* = Client Group; *Setting* = School; *Providers* = Other **Peer-Led Discussion:** *Treatment Family* = Group Therapy; *Format* = Client Group; *Setting* = School; *Providers* = Peer No Treatment
Leff, S. S., Paskewich, B. S., Waasdorp, T. E., Waanders, C., Bevans, K. B., & Jawad, A. F. (2015). Friend to friend: A randomized trial for urban African American relationally aggressive girls. *Psychology of Violence, 5*, 433-443.	*N* = 144 *Age/Grade* = 3rd-5th grades *Gender* = 100% girls *Ethnicity* = 94% African American or biracial including African American	**Friend to Friend (F2F)** [ab]**:** *Treatment Family* = Social Skills; *Format* = Client Group; *Setting* = School; *Providers* = MA, Teacher, School **Homework, Study Skills, and Organization (HSO):** *Treatment Family* = Other Control; *Format* = Client Group; *Setting* = School; *Providers* = MA, Teacher, School
Linares, L. O., Montalto, D., Li, M., & Oza, V. S. (2006). A promising parenting intervention in foster care. *Journal of Consulting and Clinical Psychology, 74*, 32-41.	*N* = 128 *Age/Grade* = 3-10 years *Gender* = not reported *Ethnicity* = 57% Latino, 33% African American	**Incredible Years and Co-Parenting** [b]**:** *Treatment Family* = Parent Management Training and Family Therapy; *Format* = Parent Group, Family; *Providers* = Other **Usual Care:** *Treatment Family* = Usual Care
Lochman, J. E., Boxmeyer, C., Powell, N., Qu, L., Wells, K., & Windle, M. (2009). Dissemination of the coping power program: Importance of intensity of counselor training. *Journal of Consulting and Clinical Psychology, 77*, 397-409.	*N* = 531 *Age/Grade* = 4th-5th grade *Gender* = 65% boys *Ethnicity* = 84% African American, 14% Caucasian, 2% other race/ethnicity	**Coping Power-Training Plus Feedback** [a]**:** *Treatment Family* = Anger Control; *Format* = Client Individual, Client Group, Parent Group; *Setting* = School; *Providers* = MA **Coping Power-Basic Training:** *Treatment Family* = Anger Control; *Format* = Client Individual, Client Group, Parent Group; *Setting* = School; *Providers* = BA, MA, PhD **Comparison Condition**

Lochman, J. E., Coie, J. D., Underwood, M. K., & Terry, R. (1993). Effectiveness of a social relations intervention program for aggressive and nonaggressive, rejected children. *Journal of Consulting and Clinical Psychology, 61*, 1053-1058.	*N* = 52 *Age/Grade = 4th grade* *Gender* = 52% boys, 48% girls *Ethnicity* = 100% Black	**Social Relations Intervention:** *Treatment Family* = Anger Control; *Format* = Client Individual, Client Group; *Setting* = School; *Providers* = Doctoral Student, PhD **No Treatment**
Martinez, C. R., Jr., & Eddy, J. M. (2005). Effects of culturally adapted parent management training on Latino youth behavioral health outcomes. *Journal of Consulting and Clinical Psychology, 73*, 841-851.	*N* = 73 *Age/Grade* = M: 12.74 years *Gender* = 56% boys, 44% girls *Ethnicity* = 100% Latino	**Parent Management Training [ab]:** *Treatment Family* = Parent Management Training; *Format* = Parent Group; *Setting* = Clinic **Control Group**
McCabe, K., & Yeh, M. (2009). Parent-child interaction therapy for Mexican Americans: A randomized clinical trial. *Journal of Clinical Child and Adolescent Psychology, 38*, 753-759.	*N* = 58 *Age/Grade* = 3-7 years *Gender* = 71% male *Ethnicity* = 100% Mexican American	**Guiando a Ninos Activos (GANA) [ab]:** *Treatment Family* = Parent Management Training; *Setting* = Clinic; *Providers* = MA Student, Doctoral Student **Parent Child Interaction Therapy (PCIT) [a]:** *Treatment Family* = Parent Management Training; *Setting* = Clinic; *Providers* = MA Student, Doctoral Student **Treatment As Usual:** *Treatment Family* = Usual Care; *Setting* = Clinic; *Providers* = MA Student, Doctoral Student
Price, J. M., Roesch, S., Walsh, N. E., & Landsverk, J. (2015). Effects of the KEEP foster parent intervention on child and sibling behavior problems and parental stress during a randomized implementation trial. *Prevention Science, 16*, 685-695.	*N = 335* *Age/Grade = 5-12* *Gender* = 52% male, 48% female *Ethnicity* = 49% Hispanic,17% African-American, 17% Mixed ethnicity, 15% Caucasian, 1% Asian/Pacific Islander, 1% Native American	**Keeping Foster Parents Trained and Supported [ab]:** *Treatment Family* = Parent Management Training; *Format* = Parent Group; *Setting* = Home, Community Field **Usual Care:** *Treatment Family* = Usual Care

Santisteban, D. A., Coatsworth, J. D., Perez-Vidal, A., Kurtines, W. M., Schwartz, S. J., LaPerriere, A., & Szapocznik, J. (2003). Efficacy of brief strategic family therapy in modifying Hispanic adolescent behavior problems and substance use. *Journal of Family Psychology, 17*, 121-133.	*N* = 126 *Age/Grade* = 12-18 years *Gender* = 75% male *Ethnicity* = 100% Hispanic	**Brief Strategic Family Therapy [a]:** *Treatment Family* = Family Therapy; *Format* = Family; *Setting* = Clinic; *Providers* = Doctoral Student, PhD **Participatory-Learning Group Control:** *Treatment Family* = Education; *Format* = Client Group; *Setting* = Clinic; *Providers* = MA, Doctoral Student, PhD
Scherer, D. G., Brondino, M. J., Henggeler, S. W., Melton, G. B., & Hanley, J. H. (1994). Multisystemic family preservation therapy: Preliminary findings from a study of rural and minority serious adolescent offenders. *Journal of Emotional and Behavioral Disorders, 2*, 198-206.	*N* = 55 *Age/Grade* = 11-17 years *Gender* = 82% boys, 18% girls *Ethnicity* = 78% African American, 22% White	**Multisystemic Family Preservation Therapy [a]:** *Treatment Family* = Multisystemic Therapy; *Format* = Client Individual, Parent & Child, Parent Individual, Family; *Setting* = Home, School, Community Field; *Providers* = MSW, MA **Department of Juvenile Justice Services:** *Treatment Family* = Usual Care; *Setting* = Community Probation; *Providers* = PO
Snyder, K. V., Kymissis, P., & Kessler, K. (1999). Anger management for adolescents: Efficacy of brief group therapy. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*, 1409-1416.	*N* = 50 *Age/Grade* = 13-18 years *Gender* = 56% male, 44% female *Ethnicity* = 50% African-American, 22% White, 16% Hispanic, 10% Mixed, 2% Asian	**Treatment Group [a]:** *Treatment Family* = Assertiveness Training; *Format* = Client Group; *Setting* = Hospital **Control Group:** *Treatment Family* = Other Control; *Format* = Client Group; *Setting* = Hospital
Szapocznik, J., Santisteban, D., Rio, A., Perez-Vidal, A., Santisteban, D., & Kurtines, W. M. (1989). Family effectiveness training: An intervention to prevent drug abuse and problem behaviors in Hispanic adolescents. *Hispanic Journal of Behavioral Sciences, 11*, 4-27.	*N* = 79 *Age/Grade* = 6-12 years *Gender* = 71% male *Ethnicity* = 100% Hispanic	**Family Effectiveness Training [ab]:** *Treatment Family* = Family Therapy; *Format* = Family; *Providers* = MSW, MA **Minimal Contact Control:** *Treatment Family* = Other Control

Winsberg, B. G., Bialer, I., Kupietz, S., Botti, E., & Balka, E. B. (1980). Home vs hospital care of children with behavior disorders: A controlled investigation. *Archives of General Psychiatry, 37*, 413-418.	*N* = 49 *Age/Grade* = 5-13 years *Gender* = 84% boys, 16% girls *Ethnicity* = 59% black, 29% Hispanic, 12% white	**Community Care:** *Treatment Family* = Usual Care; *Setting* = Home, School, Community Field; *Providers* = PhD, Other **Hospital Care**: *Treatment Family* = Usual Care; *Format* = Client Individual, Family; *Setting* = Hospital; *Providers* = PhD, Other
Wyman, P. A., Cross, W., Hendricks Brown, C., Yu, Q., Tu, X., & Eberly, S. (2010). Intervention to strengthen emotional self-regulation in children with emerging mental health problems: Proximal impact on school behavior. *Journal of Abnormal Child Psychology, 38*, 707-720.	*N* = 226 *Age/Grade* = Kindergarten-3rd grade *Gender* = 55% male *Ethnicity* = 62% Black, 26% Hispanic, 8% White, 4% other	**Rochester Resilience Project [a]:** *Treatment Family* = Self Control Training; *Format* = Client Individual; *Setting* = School; *Providers* = School **Waitlist Control**
	Engagement	
McKay, M. M., Nudelman, R., McCadam, K., & Gonzales, J. (1996). Evaluating a social work engagement approach to involving inner-city children and their families in mental health care. *Research on Social Work Practice, 6*, 462-472.	*N* = 107 *Age/Grade* = M: 9.3 years *Gender* = Approximately two-thirds male *Ethnicity* = 81% African American, 11% Latino, 7% White	**Intake With Engagement [a]:** *Treatment Family* = Motivational Interviewing, Engagement; *Setting* = Clinic; *Providers* = MA Student **Intake As Usual [b]:** *Treatment Family* = Usual Care; *Setting* = Clinic; *Providers* = PhD
McKay, M. M., Stoewe, J., McCadam, K., & Gonzales, J. (1998). Increasing access to child mental health services for urban children and their caregivers. *Health & Social Work, 23*, 9-15.	*N* = 109 *Age/Grade* = 1-14 years *Gender* = 69% girls, 31% boys *Ethnicity* = Almost two-thirds African American, 12% Latino, remainder white	**Telephone Engagement [ab]:** *Treatment Family* = Motivational Interviewing, Engagement; *Format* = Parent Individual, Other *Format*; *Providers* = MSW **Usual Intake Procedure:** *Treatment Family* = Usual Care; *Format* = Parent Individual, Other *Format*; *Providers* = MSW

Santisteban, D. A., Szapocznik, J., Perez-Vidal, A., Kurtines, W. M., Murray, E. J., & LaPerriere, A. (1996). Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness. *Journal of Family Psychology, 10*, 35-44.	*N* = 193 *Age/Grade* = 12-18 years *Gender* = 70% male *Ethnicity* = 100% Hispanic	**Engagement Family Therapy [a]:** *Treatment Family* = Motivational Interviewing, Engagement; *Providers* = MA, MD, PhD **Engagement as Usual:** *Treatment Family* = Usual Care; *Providers* = MA, MD, PhD
Szapocznik, J., Perez-Vidal, A., Brickman, A. L., Foote, F. H., Santisteban, D., Hervis, O., & Kurtines, W. M. (1988). Engaging adolescent drug abusers and their families in treatment: A strategic structural systems approach. *Journal of Consulting and Clinical Psychology, 56*, 552-557.	*N* = 108 *Age/Grade* = 12-21 years *Gender* = 67% boys *Ethnicity* = 100% Hispanic	**Strategic Structural Engagement [a]:** *Treatment Family* = Family Therapy; *Format* = Family; *Providers* = PhD **Engagement as Usual:** *Treatment Family* = Usual Care; *Format* = Family; *Providers* = PhD
	Other	
Anisfeld, E., Casper, V., Nozyce, M., & Cunningham, N. (1990). Does infant carrying promote attachment? An experimental study of the effects of increased physical contact on the development of attachment. *Child Development, 61*, 1617-1627.	*N* = 49 *Age/Grade* = 2-3 days *Gender* = 53% male *Ethnicity* = 51% Hispanic, 49% black	**Soft Baby Carriers [a]:** *Treatment Family* = Other **Infant Seats:** *Treatment Family* = Other Control

Evans, M. E., Boothroyd, R. A., Armstrong, M. I., Greenbaum, P. E., Brown, E. C., & Kuppinger, A. D. (2003). An experimental study of the effectiveness of intensive in-home crisis services for children and their families: Program outcomes. *Journal of Emotional and Behavioral Disorders, 11*, 93-104.	*N* = 238 *Age/Grade* = 5-17 years *Gender* = 53% boys, 47% girls *Ethnicity* = 59% Hispanic, 34% Black, 6% White, 2% Other	**Enhanced Home-Based Crisis Intervention** [b]**:** *Treatment Family* = Family Preservation, Crisis Management; *Format* = Client Individual, Parent & Child, Parent Individual, Family; *Setting* = Home; *Providers* = MD, Other **Home-Based Crisis Intervention:** *Treatment Family* = Family Preservation, Crisis Management; *Format* = Client Individual, Parent & Child, Parent Individual, Family; *Setting* = Home; *Providers* = MD, Other **Crisis Care Management** [a]**:** *Treatment Family* = Case Management; *Format* = Client Individual, Parent & Child, Parent Individual, Family; *Setting* = Home; *Providers* = MD, Other
Fantuzzo, J., Manz, P., Atkins, M., & Meyers, R. (2005). Peer-mediated treatment of socially withdrawn maltreated preschool children: Cultivating natural community resources. *Journal of Clinical Child and Adolescent Psychology, 34*, 320-325.	*N* = 82 *Age/Grade* = M: 4.35 years *Gender* = 50% male *Ethnicity* = 100% African American	**Resilient Peer Treatment** [a]**:** *Treatment Family* = Peer Pairing; *Format* = Client Group; *Setting* = School **Attention Control:** *Treatment Family* = Other Control; *Format* = Other Format; *Setting* = School
Fantuzzo, J., Sutton-Smith, B., Atkins, M., Meyers, R., Stevenson, H., Coolahan, K., . . . Manz, P. (1996). Community-based resilient peer treatment of withdrawn maltreated preschool children. *Journal of Consulting and Clinical Psychology, 64*, 1377-1386.	*N* = 46 *Age/Grade* = 3-5 years *Gender* = 59% girls, 41% boys *Ethnicity* = 100% African American	**Resilient Peer Treatment** [a]**:** *Treatment Family* = Peer Pairing; *Format* = Client Group; *Setting* = School; *Providers* = Other **Attentional Control:** *Treatment Family* = Other Control; *Format* = Client Group; *Setting* = School; *Providers* = Other

Henggeler, S. W., Melton, G. B., Brondino, M. J., Scherer, D. G., & Hanley, J. H. (1997). Multisystemic therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. *Journal of Consulting and Clinical Psychology, 65*, 821-833.	*N* = 155 *Age/Grade* = 11-17 years *Gender* = 82% male *Ethnicity* = 81% African American, 19% Caucasian	**Multisystemic Therapy (MST)** [b]**:** *Treatment Family* = Multisystemic Therapy; *Format* = Home, Community Field; *Setting* = MSW, MA **Usual Juvenile Justice Services:** *Treatment Family* = Usual Care
Juffer, F., Bakermans-Kranenburg, M., & van IJzendoorn, M. H. (2005). The importance of parenting in the development of disorganized attachment: Evidence from a preventive intervention study in adoptive families. *Journal of Child Psychology and Psychiatry, 46*, 263-274.	*N* = 130 *Age/Grade* = 2-23 weeks *Gender* = 51% boys, 49% girls *Ethnicity* = 60% Sri Lankan, 30% South Korean, 10% Colombian	**Personal Book and Video Feedback** [a]**:** *Treatment Family* = Attachment Therapy; *Format* = Parent & Child, Parent Individual, Self-Administered, Other *Format*; *Setting* = Home **Personal Book** [a]**:** *Treatment Family* = Attachment Therapy; *Format* = Self-Administered, Other *Format*; *Providers* = Self **Control:** *Treatment Family* = Other Control; *Format* = Self-Administered, Other *Format*; *Providers* = Self
Kutash, K., Duchnowski, A. J., Green, A. L., & Ferron, J. M. (2011). Supporting parents who have youth with emotional disturbances through a parent-to-parent support program: A proof of concept study using random assignment. *Administration and Policy in Mental Health and Mental Health Services Research, 38*, 412-427.	*N* = 115 *Age/Grade* = M_{PC}: 14.43; $M_{Comparison}$: 14.82 *Gender* = 76% male *Ethnicity* = 56% Black/non-Hispanic; 24% White/non-Hispanic; 11% Hispanic; 9% other	**Parent Connector:** *Treatment Family* = Family Empowerment and Support; *Format* = Other *Format*; *Setting* = School; *Providers* = Other **Comparison Group:** *Treatment Family* = Psychoeducation; *Setting* = School
Lieberman, A. F., Weston, D. R., & Pawl, J. H. (1991). Preventive intervention and outcome with anxiously attached dyads. *Child Development, 62*, 199-209.	*N* = 100 *Age/Grade* = 11-14 months *Gender* = 44% male *Ethnicity* = 100% Latino	**Intervention:** *Treatment Family* = Attachment Therapy; *Format* = Parent & Child; *Setting* = Home; *Providers* = MSW, MA **Control Group**

Rowland, M. D., Halliday-Boykins, C., Henggeler, S. W., Cunningham, P. B., Lee, T. G., Kruesi, M. J. P., & Shapiro, S. B. (2005). A randomized trial of multisystemic therapy with Hawaii's Felix class youths. *Journal of Emotional and Behavioral Disorders, 13*, 13-23.	*N* = 31 *Age/Grade* = 9-17 years *Gender* = 58% male *Ethnicity* = 84% multiracial, 10% Caucasian, 7% Asian American and Pacific Islander	**Multisystemic Therapy for Serious Emotional Disturbance (MST-SED)** [ab]**:** *Treatment Family* = Multisystemic Therapy; *Setting* = Home, Community Field, Other *Setting*; *Providers* = Pre-BA, MSW, MA, MD, Other **Usual Services:** *Treatment Family* = Usual Care; *Setting* = Clinic, Home, School, Community Residential, Community Field, Hospital, Partial Hospital, Corrections Facility, Other *Setting*
Swenson, C. C., Schaeffer, C. M., Henggeler, S. W., Faldowski, R., & Mayhew, A. M. (2010). Multisystemic therapy for child abuse and neglect: A randomized effectiveness trial. *Journal of Family Psychology, 24*, 497-507.	*N* = 86 *Age/Grade* = 10-17 *Gender* = 56% female *Ethnicity* = 69% Black, 22% White, 9% other	**Multisystemic Therapy for Child Abuse and Neglect** [a]**:** *Treatment Family* = Multisystemic Therapy; *Setting* = Home, School, Community Field; *Providers* = MSW, MA **Enhanced Outpatient Treatment:** *Treatment Family* = Usual Care; *Setting* = Clinic; *Providers* = MSW, MA
Szapocznik, J., Rio, A., Murray, E., Cohen, R., Scopetta, M., Rivas-Vazquez, A., . . . Kurtines, W. (1989). Structural family versus psychodynamic child therapy for problematic Hispanic boys. *Journal of Consulting and Clinical Psychology, 57*, 571-578.	*N* = 69 *Age/Grade* = 6-12 years *Gender* = 100% boys *Ethnicity* = 100% Hispanic	**Structural Family Therapy** [a]**:** *Treatment Family* = Family Therapy; *Format* = Client Individual, Parent Individual, Family; *Providers* = MSW, PhD **Individual Psychodynamic:** *Treatment Family* = Psychodynamic; *Format* = Client Individual, Parent Individual; *Providers* = MSW, PhD **Recreational Control Condition:** *Treatment Family* = Other Control; *Format* = Client Group; *Providers* = BA
Teti, D. M., Black, M. M., Viscardi, R., Glass, P., O'Connell, M. A., Baker, L., . . . Hess, C. R. (2009). Intervention with African American premature infants: Four-month results of an early intervention program. *Journal of Early Intervention, 31*, 146-166.	*N* = 173 *Age/Grade* = 3-4 months *Gender* = 61% female *Ethnicity* = 100% African American	**Intervention** [b]**:** *Treatment Family* = Massage; *Format* = Parent & Child; *Setting* = Home; *Providers* = MA Student, Doctoral Student **Control:** *Treatment Family* = Other Control; *Setting* = Home

Walkup, J. T., Barlow, A., Mullany, B. C., Pan, W., Goklish, N., Hasting, R., . . . Reid, R. (2009). Randomized controlled trial of a paraprofessional-delivered in-home intervention for young reservation-based American Indian mothers. *Journal of the American Academy of Child & Adolescent Psychiatry, 48*, 591-601.	*N* = 167 *Age/Grade* = 14-22 years *Gender* = Not reported *Ethnicity* = 100% American Indian	**Family Spirit Intervention [b]:** *Treatment Family* = Parent Psychoeducation; *Format* = Parent Individual; *Setting* = Home, Other *Setting*; *Providers* = Other **Breast Feeding Nutrition Group [b]:** *Treatment Family* = Other Control; *Format* = Parent Individual; *Setting* = Home, Other *Setting*; *Providers* = Other
	Substance Use	
Burrow-Sanchez, J., & Wrona, M. (2012). Comparing culturally accommodated versus standard group CBT for Latino adolescents with substance use disorders: A pilot study. *Cultural Diversity and Ethnic Minority Psychology, 18*, 373-383.	*N* = 35 *Age/Grade* = 13-18 years *Gender* = 94% male *Ethnicity* = 100% Latino	**Accommodated CBT (A-CBT) [b]:** *Treatment Family* = Cognitive Behavior Therapy; *Format* = Client Group, Parent Individual, Other *Format*; *Providers* = Doctoral Student **Standard CBT (S-CBT) [b]:** *Treatment Family* = Cognitive Behavior Therapy; *Format* = Client Group; *Setting* = Clinic; *Providers* = Doctoral Student
Collier, C. R., Czuchry, M., Dansereau, D. F., & Pitre, U. (2001). The use of node-link mapping in the chemical dependency treatment of adolescents. *Journal of Drug Education, 31*, 305-317.	*N* = 48 *Age/Grade* = 14-18 years *Gender* = 100% male *Ethnicity* = 48% African American; 35% Mexican American; 17% White	**Mapping Enhanced Treatment:** *Treatment Family* = Motivational Interviewing, Engagement; *Format* = Client Group; *Setting* = Community Residential; *Providers* = BA, MSW **Traditional Treatment:** *Treatment Family* = Usual Care; *Format* = Client Group; *Setting* = Community Residential; *Providers* = BA, MSW

Dakof, G. A., Henderson, C. E., Rowe, C. L., Boustani, M., Greenbaum, P. E., Wang, W., . . . Liddle, H. A. (2015). A randomized clinical trial of family therapy in juvenile drug court. *Journal of Family Psychology, 29*, 232-241.	*N* = 112 *Age/Grade* = 13-18 years *Gender* = 88% male, 11% female *Ethnicity* = 59% Hispanic, 35% African American, 5% Other	**Multidimensional Family Therapy (MDFT):** *Treatment Family* = Multidimensional Family Therapy; *Format* = Client Individual, Parent & Child, Parent Individual, Family; *Setting* = Clinic, Home, Community Field; *Providers* = MSW, MA **Adolescent Group Therapy (AGT):** *Treatment Family* = Motivational Interviewing, Engagement and Cognitive Behavior Therapy; *Format* = Client Individual, Client Group; *Setting* = Clinic; *Providers* = MSW, MA
Grenard, J. L., Ames, S. L., Wiers, R. W., Thush, C., Stacy, A. W., & Sussman, S. (2007). Brief intervention for substance use among at-risk adolescents: A pilot study. *Journal of Adolescent Health, 40*, 188-191.	*N* = 18 *Age/Grade* = *M:* 16.1 *Gender* = 33% female *Ethnicity* = 56% Latino; 25% Mixed; 12% African American; 6% Caucasian	**Intervention [a]:** *Treatment Family* = Motivational Interviewing, Engagement; *Format* = Client Individual; *Setting* = School **Care As Usual Control**
Himelstein, S., Saul, S., & Garcia-Romeu, A. (2015). Does mindfulness meditation increase effectiveness of substance abuse treatment with incarcerated youth? A pilot randomized controlled trial. *Mindfulness, 6*, 1472-1480.	*N* = 27 *Age/Grade* = 14-18 years *Gender* = 100% male *Ethnicity* = 70% Hispanic; 14% African American; 6% Caucasian; 5% Pacific Islander; 5% mixed-ethic descent	**Psychotherapy Plus Mindfulness Meditation:** *Treatment Family* = Mindfulness; *Format* = Client Individual, Client Group; *Setting* = Corrections Facility; *Providers* = MA, PhD **Psychotherapy Only (TAU):** *Treatment Family* = Motivational Interviewing, Engagement and Cognitive Behavior Therapy; *Format* = Client Individual, Client Group; *Setting* = Corrections Facility; *Providers* = MA, PhD
Hogue, A., Liddle, H. A., Becker, D., & Johnson-Leckrone, J. (2002). Family-based prevention counseling for high-risk young adolescents: Immediate outcomes. *Journal of Community Psychology, 30*, 1-22.	*N* = 124 *Age/Grade* = 11-14 years *Gender* = 44% boys, 56% girls *Ethnicity* = 97% African American, 1% Hispanic, 2% other	**Multidimensional Family Therapy (MDFT) [b]:** *Treatment Family* = Multidimensional Family Therapy; *Format* = Client Individual, Parent & Child, Parent Individual, Family, Other *Format*; *Setting* = Clinic, Home, Community Field; *Providers* = MA, PhD **Control Group**

Liddle, H. A., Dakof, G. A., Turner, R. M., Henderson, C. E., & Greenbaum, P. E. (2008). Treating adolescent drug abuse: A randomized trial comparing multidimensional family therapy and cognitive behavior therapy. *Addiction, 103*, 1660-1670.	*N* = 224 *Age/Grade* = 12-17 years *Gender* = 81% male, 19% female *Ethnicity* = 72% African American, 18% White non-Hispanic, 10% Hispanic	**Multidimensional Family Therapy (MDFT):** *Treatment Family* = Multidimensional Family Therapy; *Format* = Client Individual, Parent Individual, Family; *Setting* = Clinic; *Providers* = MA, PhD **Cognitive Behavior Therapy:** *Treatment Family* = Cognitive Behavior Therapy; *Format* = Client Individual, Parent & Child; *Setting* = Clinic; *Providers* = MA, PhD
Liddle, H. A., Rowe, C. L., Dakof, G. A., Ungaro, R. A., & Henderson, C. E. (2004). Early intervention for adolescent substance abuse: Pretreatment to posttreatment outcomes of a randomized clinical trial comparing multidimensional family therapy and peer group treatment. *Journal of Psychoactive Drugs, 36*, 49-63.	*N* = 80 *Age/Grade* = 11-15 years *Gender* = 73% male, 27% female *Ethnicity* = 42% Hispanic, 38% African American, 11% Haitian or Jamaican, 3% non-Hispanic White, 4% other	**Multidimensional Family Therapy (MDFT)** [a]**:** *Treatment Family* = Multidimensional Family Therapy; *Format* = Client Individual, Parent & Child, Parent Individual, Family, Other *Format*; *Setting* = Clinic, Home, School, Community Field; *Providers* = MSW, MA **Peer Group Therapy:** *Treatment Family* = Group Therapy; *Format* = Client Group; *Setting* = Clinic, Home; *Providers* = MSW, MA
Lochman, J. E., & Wells, K. C. (2002). The coping power program at the middle-school transition: Universal and indicated prevention effects. *Psychology of Addictive Behaviors, 16*, S40-S54.	*N* = 245 *Age/Grade* = 5th grade *Gender* = 66% boys *Ethnicity* = 78% Hispanic, 19% Caucasian, 2% other, 1% Hispanic	**Universal Intervention Classroom and Indicated Intervention** [a]**:** *Treatment Family* = Anger Control; *Format* = Client Individual, Client Group, Parent Group, Other *Format*; *Setting* = School, Community Field, Other *Setting* **Usual Services:** *Treatment Family* = Other Control
Noel, P. E. (2006). The impact of therapeutic case management on participation in adolescent substance abuse treatment. *The American Journal of Drug and Alcohol Abuse, 32*, 311-327.	*N* = 90 *Age/Grade* = M: 16 years *Gender* = 100% female *Ethnicity* = 53% Hispanic, 36% African American, 11% Asian, Caucasian, Native American, or mixed race	**Therapeutic Case Management** [b]**:** *Treatment Family* = Case Management; *Format* = Client Individual; *Setting* = Community Field; *Providers* = MSW **No Case Management:** *Treatment Family* = Psychoeducation; *Providers* = MSW

Prado, G., Pantin, H., Briones, E., Schwartz, S. J., Feaster, D., Huang, S., . . . Szapocznik, J. (2007). A randomized controlled trial of a parent-centered intervention in preventing substance use and HIV risk behaviors in Hispanic adolescents. *Journal of Consulting and Clinical Psychology, 75*, 914-926.	*N* = 266 *Age/Grade* = M: 13.4 years *Gender* = 52% girls, 48% boys *Ethnicity* = 100% Hispanic	**Familias Unidas & Parent-Preadolescent Training for HIV Prevention (PATH) [b]:** *Treatment Family* = Communication Skills; *Format* = Parent & Child, Parent Group, Multiple Family; *Providers* = MA, PhD **English for Speakers of Other Languages And Parent-Preadolescent Training for HIV Prevention (PATH) [b]:** *Treatment Family* = Education; *Format* = Parent & Child, Parent Group, Multiple Family; *Providers* = MA, PhD **English for Speakers of Other Languages & HeartPower! For Hispanics (HEART):** *Treatment Family* = Education; *Format* = Parent Group; *Providers* = MA, PhD
Robbins, M. S., Szapocznik, J., Dillon, F. R., Turner, C. W., Mitrani, V. B., & Feaster, D. J. (2008). The efficacy of structural ecosystems therapy with drug-abusing/dependent African American and Hispanic American adolescents. *Journal of Family Psychology, 22*, 51-61.	*N* = 190 *Age/Grade* = 12-17 years *Gender* = 78% boys *Ethnicity* = 59% Hispanic, 41% African American	**Structural Ecosystems Therapy (SET) [ab]:** *Treatment Family* = Family Therapy; *Format* = Family, Other *Format*; *Setting* = Clinic, Home, School, Community Field; *Providers* = MSW, MA, PhD **Family-Process Only Condition (FAM) [b]:** *Treatment Family* = Family Therapy; *Format* = Family; *Providers* = MSW, MA, Doctoral Student **Community Services (Control):** *Treatment Family* = Usual Care
Schaeffer, C. M., Henggeler, S. W., Ford, J. D., Mann, M., Chang, R., & Chapman, J. E. (2014). RCT of a promising vocational/employment program for high-risk juvenile offenders. *Journal of Substance Abuse Treatment, 46*, 134-143.	*N* = 97 *Age/Grade* = 15-18 years *Gender* = 83% male *Ethnicity* = 52% White/Hispanic; 28% Black; 17% White/Non-Hispanic;3% mixed race	**Community Restitution-Apprenticeship-Focused Training (CRAFT):** *Treatment Family* = Therapeutic Vocational Training; *Format* = Client Individual, Client Group; *Setting* = Home, School **Education as Usual:** *Treatment Family* = Usual Care

Schinke, S. P., Orlandi, M. A., Botvin, G. J., Gilchrist, L. D., Trimble, J. E., & Locklear, V. S. (1988). Preventing substance abuse among American-Indian adolescents: A bicultural competence skills approach. *Journal of Counseling Psychology, 35*, 87-90.	*N* = 137 *Age/Grade* = M: 11.8 years *Gender* = 54% girls *Ethnicity* = 100% American-Indian	**Substance Abuse Prevention [ab]:** *Treatment Family* = Cognitive Behavior Therapy; *Format* = Client Group; *Providers* = Other **Control Group**
Szapocznik, J., Kurtines, W. M., Foote, F. H., Perez-Vidal, A., & Hervis, O. (1983). Conjoint versus one-person family therapy: Some evidence for the effectiveness of conducting family therapy through one person. *Journal of Consulting and Clinical Psychology, 51*, 889-899.	*N* = 37 *Age/Grade* = 12-20 years *Gender* = 78% male, 22% female *Ethnicity* = 100% Hispanic American	**Conjoint Family Therapy:** *Treatment Family* = Family Systems Therapy; *Format* = Family; *Providers* = MSW **One-Person Family Therapy (OPFT):** *Treatment Family* = Family Therapy; *Format* = Family One Family Member; *Providers* = MSW
	Traumatic Stress	
Carrion, V. G., Kletter, H., Weems, C. F., Berry, R. R., & Rettger, J. P. (2013). Cue-centered treatment for youth exposed to interpersonal violence: A randomized controlled trial. *Journal of Traumatic Stress, 26*, 654-662.	*N* = 65 *Age/Grade* = 8-17 years *Gender* = 60% boys, 40% girls *Ethnicity* = 51% African American, 40% Hispanic/Latino, 8% Mixed ethnicity, 2% Pacific Islander	**Cue-Centered Treatment (CCT) [a]:** *Treatment Family* = Cognitive Behavior Therapy; *Format* = Client Individual, Parent & Child; *Setting* = School; *Providers* = MA, PhD **Waitlist**
Chemtob, C. M., Nakashima, J., & Carlson, J. G. (2002). Brief treatment for elementary school children with disaster-related posttraumatic stress disorder: A field study. *Journal of Clinical Psychology, 58*, 99-112.	*N* = 32 *Age/Grade* = 6-12 years *Gender* = 69% girls, 31% boys *Ethnicity* = 31% Hawaiian or part Hawaiian, 28% Filipino, 19% Caucasian, 13% Japanese, 9% mixed	**Eye Movement Desensitization and Reprocessing:** *Treatment Family* = Eye Movement Desensitization and Reprocessing; *Setting* = School; *Providers* = PhD **Delayed Treatment Control**

Chemtob, C. M., Nakashima, J., & Hamada, R. S. (2002). Psychosocial interventions for postdisaster trauma symptoms in elementary school children: A controlled community field study. *Archives of Pediatrics and Adolescent Medicine, 156*, 211-216.	*N = 248* *Age/Grade* = 6-12 years *Gender* = 61% girls *Ethnicity* = 30% Hawaiian or part-Hawaiian, 25% white, 20% Filipino, 9% Japanese	**Individual Treatment:** *Treatment Family* = Expressive Play; *Format* = Client Individual; *Setting* = School; *Providers* = MSW, MA **Group Treatment:** *Treatment Family* = Expressive Play; *Format* = Client Group; *Setting* = School; *Providers* = MSW, MA
Foa, E. B., McLean, C. P., Capaldi, S., & Rosenfield, D. (2013). Prolonged exposure vs supportive counseling for sexual abuse–related PTSD in adolescent girls: A randomized clinical trial. *JAMA: Journal of the American Medical Association, 310*, 2650-2657.	*N* = 61 *Age/Grade* = M: 15.3 years *Gender* = 100% girls *Ethnicity* = 56% Black, 18% White, 16% Hispanic, 7% other or no response, 3% biracial	**Prolonged Exposure-A Program [a]:** *Treatment Family* = Cognitive Behavior Therapy with Parents; *Format* = Client Individual; *Providers* = MA **Supportive Counseling:** *Treatment Family* = Client Centered Therapy; *Format* = Client Individual; *Providers* = MA
Ford, J. D., Steinberg, K. L., Hawke, J., Levine, J., & Zhang, W. (2012). Randomized trial comparison of emotion regulation and relational psychotherapies for PTSD with girls involved in delinquency. *Journal of Clinical Child and Adolescent Psychology, 41*, 27-37.	*N* = 59 *Age/Grade* = 13-17 years *Gender* = 100% girls *Ethnicity* = 59% Latina or Mixed Race, 16% Black (African/Caribbean American), 25% White (European American)	**Trauma Affect Regulation: Guide for Education and Therapy (TARGET) [a]:** *Treatment Family* = Cognitive Behavior Therapy; *Format* = Client Individual; *Providers* = MSW, MA, PhD **Enhanced Treatment as Usual:** *Treatment Family* = Advice, Encouragement; *Format* = Client Individual; *Providers* = MSW, MA, PhD
Jaycox, L. H., Langley, A. K., Stein, B. D., Wong, M., Sharma, P., Scott, M., & Schonlau, M. (2009). Support for students exposed to trauma: A pilot study. *School Mental Health: A Multidisciplinary Research and Practice Journal, 1*, 49-60.	*N* = 76 *Age/Grade* = M: 11.7 *Gender* = 51% female, 49% male *Ethnicity* = 88% Hispanic/White, 8% Hispanic/African American, 3% non-Hispanic/African American, 1% non-Hispanic/White	**Support for Students Exposed to Trauma (SSET):** *Treatment Family* = Cognitive Behavior Therapy; *Format* = Client Group; *Setting* = School; *Providers* = Teacher, School, Other **Waitlist Control**

Lieberman, A. F., Van Horn, P., & Ippen, C. G. (2005). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*, 1241-1248.	*N* = 75 *Age/Grade* = 3-5 years *Gender* = 52% girls, 48% boys *Ethnicity* = 39% mixed ethnicity, 28% Latino, 15% African American, 9% white, 7% Asian, 3% other	**Case Management plus Individual Psychotherapy:** *Treatment Family* = Case Management; *Format* = Client Individual, Parent Individual, Other *Format*; *Setting* = Clinic; *Providers* = PhD, Other **Child-Parent Psychotherapy [ab]:** *Treatment Family* = Exposure; *Format* = Parent & Child, Parent Individual; *Providers* = MA, PhD
Salloum, A., & Overstreet, S. (2008). Evaluation of individual and group grief and trauma interventions for children post disaster. *Journal of Clinical Child and Adolescent Psychology, 37*, 495-507.	*N* = 56 *Age/Grade* = 7-12 years *Gender* = 63% male, 38% female *Ethnicity* = 89% African American, 4% Caucasian, 4% African American/Native American, 2% Hispanic	**Project Loss And Survival Team (LAST)-Individual [b]:** *Treatment Family* = Cognitive Behavior Therapy with Parents; *Format* = Client Individual, Parent Individual, Other *Format*; *Setting* = Home, School; *Providers* = MSW **Project Loss And Survival Team (LAST)-Group [b]:** *Treatment Family* = Cognitive Behavior Therapy with Parents; *Format* = Client Individual, Client Group, Parent Individual; *Setting* = Home, School; *Providers* = MSW
Salloum, A., & Overstreet, S. (2012). Grief and trauma intervention for children after disaster: Exploring coping skills versus trauma narration. *Behaviour Research and Therapy, 50*, 169-179.	*N* = 70 *Age/Grade* = 6-12 years *Gender* = 56% male, 44% female *Ethnicity* = 100% African American	**Grief And Trauma Intervention With Coping Skills And Trauma Narrative Processing (GTI-CN):** *Treatment Family* = Cognitive Behavior Therapy with Parents; *Format* = Client Individual, Client Group, Parent Individual; *Setting* = Home, School; *Providers* = MSW **Grief And Trauma Intervention With Coping Skills Only (GTI-C):** *Treatment Family* = Cognitive Behavior Therapy with Parents; *Format* = Client Individual, Client Group, Parent Individual; *Setting* = Home, School; *Providers* = MSW

Note: Groups without treatment characteristic information are waitlist or no treatment control groups. [a] = Winning group. [b] = Group included strategy for incorporating culture into treatment.