Interventions Shown to Be Effective with Children and Families of Color and LGBTQ2SI+ Persons Who May Be Served with Family First Funding

Research Brief (Second Edition) Executive Summary

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Sections of the full report are based on material from the Casey Title IV-E Waiver Interventions Research Brief. (See https://www.casey.org/title-iv-e-research/). Special thanks to the intervention developers and their researchers for identifying relevant studies; and our Casey colleagues for their review of prior versions of this summary. And we appreciate the advice and resources from Gerald Mallon (Hunter College) and Ronita Nath (The Trevor Project).

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Contents

Introduction

Overview

The Family First Prevention Services Act (FFPSA) was signed into law in February 2018 under the Bipartisan Budget Act of 2018, Division E, Title VII.[1] The FFPSA reorganized federal funding for child welfare to improve supports that strengthen families and reduce inappropriate placements in foster care and group homes. The services to be reimbursed under that law must meet certain criteria to show evidence of effectiveness.[2] One aim of the FFPSA is to ensure that child safety is addressed in context with other challenges facing families in high-risk situations—including risk factors in the communities they live in. Child welfare services are concerned with long-term child outcomes *and* with building on the strengths of healthy communities that support families. Thus, under the FFPSA, the child welfare service population covers both at-risk families *and* their broad, diverse natural supports and communities.[3]

System reform strategies in the areas of practice, administration, and policy have changed the conditions for maltreated children and have accelerated permanency planning, thereby safely reducing the number of children in foster care.[4] Some of these strategies have used evidence-based practices (EBPs), wherein funding for child welfare services is allocated differently to create better futures and outcomes for children. But cost-savings resulting from foster care reductions and other program reforms should be reinvested in high-quality, evidence-based, and culturally informed services for the parents and children who need them.[5]

To that end, the full report provides information about three areas:

(1) Evidence standards set by the FFPSA of 2018

(2) How certain interventions have been rated by the Title IV-E FFPSA Prevention Clearinghouse

(3) Which interventions rated as *Promising*, *Supported*, or *Well-Supported* by the Prevention Services Clearinghouse have been shown to be effective with children and families of color and LGBTQ2SI+ persons.[6]

Note that this is a very dynamic situation, and the Prevention Services Clearinghouse is adding and updating intervention ratings frequently. For example, in 2020, Washington, DC received federal approval for the practice of Motivational Interviewing to be partially reimbursed via FFPSA as a ***case management tool***, in addition to its use as a substance abuse treatment service. Updates of this summary will be issued periodically to keep this document as accurate as possible.

One caution should be noted: We do not provide a systematic evaluation of the quality of the research studies, but we do assess credible evidence in those studies to ascertain whether the intervention is effective with families of color and, where possible, effective with LGBTQ2SI+ persons. Research indicates that LGBTQ2SI+ youth and youth of color are over-represented in out-of-home care in certain program sectors and in

communities.[7] This area warrants additional study, and we will strive to add more information in future editions about FFPSA-rated interventions that have evidence of effectiveness with both population groups.

Issues With Culturally Relevant Interventions

Issues of race and ethnicity must be considered when choosing an intervention, in addition to factors such as treatment needs, economic class, gender, and sexual identity. Yet further clarification is needed to highlight which child welfare interventions are effective across different kinds of groups. Many child welfare interventions have been created by white developers and researchers using participant samples that are largely comprised of white people. There is a clear need to rigorously evaluate culturally specific interventions to build up their evidence base (e.g., Culturally Modified Trauma-Focused Treatment [CM-TFT], Community Outreach Program Esperanza [COPE], Positive Indian Parenting Program).

Fortunately, many of the current interventions with a strong evidence base "travel well" across different racial/ethnic and sexual identity groups because of the core components of their intervention model (e.g., being youth and family-centered, carefully listening to family perspectives, building upon family social support networks, and incorporating a strengths-oriented assessment). But many interventions have needed modifications, such as Incredible Years, where the developers revised their video material to make those materials more relevant for different family situations. So, the need for modification depends on the intervention, which populations are to be served, characteristics of the interventionists such as their race and gender, and their relationship to the population, and where the intervention takes place.

Modifying a program with new examples to help it be more culturally relevant is allowed by the Clearinghouse. But more significant changes mean that the modified program will be viewed as a "new" intervention that must be evaluated separately. This requires a new line of evaluation research for each culturally modified intervention. ***Because of this requirement, we need more focused support for Black, indigenous, and other people of color as well as LGBTQ2SI+ persons to document and evaluate those interventions that have been adapted to meet their needs.*** (See Figures 1 and 2, which are abstracted from the Prevention Services Clearinghouse handbook. Note that a new version of the Handbook was recently published for public comment.)

In addition, Dee Bigfoot, an American Indian clinical researcher, has noted that ***how*** an intervention is implemented needs to be considered: we need to consider not only the nature of the intervention in terms of its clinical focus and strategies, but also consider the required behaviors of the provider(s).[8]

Note that the Clearinghouse has been encouraged to revise their approach to how cultural adaptations are considered and what kinds of evidence should be considered. For example, the state of Maryland in their comments on the draft handbook procedures urged the federal government to incorporate other ways of evidence-building and a more diverse set of experts to rate interventions -- "informed by AI/AN cultural and ethical frameworks or methodologies that are interconnected, relational, and non-linear such as:

a. *Storytelling:* This is a traditional way of sharing knowledge in many tribal cultures. It involves sharing stories as a means of transmitting cultural knowledge, values, and lessons.

b. *Community-Based Participatory Research (CBPR):* This approach involves the tribal community in all aspects of the research process, ensuring that the research is meaningful, respectful, and beneficial to the community.

c. *Land-Based Learning:* This involves learning from the land and nature, which is common practice in many tribal cultures.

d. *Sharing Circles:* Similar to focus groups, sharing circles are a qualitative indigenous research method where participants are encouraged to share and learn from their thoughts and experiences."[9]

FIGURE 1. ADAPTIONS TO PROGRAMS OR SERVICES

Many manualized programs have formal adaptations available (i.e., alternative manualized versions of the original program designed to address particular issues or populations). When programs and services that are identified for inclusion in the Prevention Services Clearinghouse have multiple formal adaptations or multiple treatment manuals available, each is reviewed as a separate program or service.

Programs or services that go by different names in different local implementations but that clearly use the same manual are considered to be the same program for purposes of review. Minor modifications to programs or services that are not considered formal adaptations are addressed in Section 4.1.6 below.

In order to maximize the number of different programs reviewed, the Prevention Services Clearinghouse may select one program adaptation for review when multiple formal adaptations are available. In most cases, the Prevention Services Clearinghouse will select the standard, original, or most comprehensive or complete version of a program or service; however, it may also consider other adaptations.

Source: Prevention Services Clearinghouse handbook, p. 4.

Issues with Interventions for LGBTQ2SI+ Youth and Families

Because LGBTQ2SI+ youth are over-represented in out-of-home care and because of the detrimental impact of minority stress[10] on the mental well-being of LGBTQ2SI+ youth, Bocchicchio and others emphasize the importance of examining and bolstering the availability of evidence-based treatments for this community.[11] Unfortunately, as our review shows, the evaluation studies do not focus on these youth or are unable to analyze the data because of data collection limitations such as the inability to obtain sexual identity data from current management information systems. We learned of these challenges via conversations with intervention developers and evaluators, and from comprehensive literature reviews that have been completed. It is ironic that there is some evidence that cognitive behavioral therapy can be adapted and is effective with many non-white ethnic groups who are LGBTQ2SI+, and yet CBT has not yet been rated as *Promising* or higher by the Prevention Clearinghouse.[12]

FIGURE 2. EXAMPLES OF PROGRAM AND SERVICE ADAPTATIONS WITHIN A STUDY FOR THE PURPOSE OF STUDY REVIEW

Eligible Adaptations	Adaptations That Result in Different Program or Service
• Modestly changing session frequency or duration • Delivering the intervention in the home compared to an office-based delivery • Making small changes to increase the cultural relevancy of the intervention (e.g., changing examples to match the cultural background of subjects; providing the intervention in a different language) without changing program components • Delivering the program by slightly different types of professionals than those described in the manual or original research on the program or service (e.g., using social workers instead of counselors to deliver the program)	• Changing from individual to group therapy • Adding any new modules or session content • Subtracting any modules or session content that was part of the original intervention • Radically changing content for different cultural groups, such as to reflect particular issues experienced by those groups • Delivery of the program by substantially different providers than described in the manual (e.g., using para-professionals instead of nurses to deliver the program)

Source: Prevention Services Clearinghouse handbook, p. 15.

Effectiveness of FFPSA Interventions with Families of Color and LGBTQ2SI+ Persons

Overview

While there is evidence of culturally and linguistically relevant child welfare, home visiting, parent training, and mental health services, more interventions need to be evaluated with children and families of color in child welfare and community-based family support.[13] Table 1 presents each intervention listed in the Prevention Services Clearinghouse alongside its overall evidence rating, and whether research has found the intervention to be effective with certain racial/ethnic and LGBTQ2SI+ groups. Note that the interventions vary in terms of how widely they have been used in child welfare, in the available information on their use with families of color, and in the degree to which the effects with families served by child welfare have been measured.

Appendix A in the full report contains more detailed information about each intervention, including target groups (e.g., ages 12-17), issues addressed (e.g., substance use), treatment duration (e.g., 12 weeks), treatment dosage (e.g., weekly meetings), and known levels of support for different racial and ethnic groups. Appendix A also provides a second organization's rating of effectiveness for nearly every intervention, which may serve as a supplementary source of information, particularly when an intervention has not yet been rated by the Prevention Services Clearinghouse. When possible, we drew these

supplemental ratings from the California Evidence-Based Clearinghouse for Child Welfare (CEBC).[14]

But for other intervention ratings, we drew from the "BLUEPRINTS" intervention registry or the Office of Juvenile Justice and Delinquency Prevention's (OJJDP) Model Programs Guide (MPG).

In addition, we contacted the developers of each of the FFPSA-rated interventions and their primary researchers to see if there were additional studies of effectiveness that could be cited. We received feedback from nearly all of these people. Note that we included evidence of effectiveness if the study included at least 30 children or parents of a particular ethnic group of color or LGBTQ2SI+ and studies that reported a statistically significant effect for the intervention group. With a few exceptions noted in the tables, small sample studies with modest numbers (i.e., less than 30 participants) of any ethnic group of color or LGBTQ2SI+ persons were not considered.

Limitations

In some cases, the evidence base for the effectiveness of a particular intervention within a child welfare environment is sparse, so we rely on the research evidence indicating that the intervention is effective for a particular problem or area of functioning, and where various meta-analyses have reported adequate intervention effect sizes.[15]

There may be additional studies involving non-white ethnic groups but those were not available to us. As we have additional time, we will use additional university-based search engines to supplement this review. Note that Chapin Hall has also published two briefs on elevating culturally specific evidence-based practices.[16]

Finally, with the help of some national LGBTQ experts, we were able to draw upon some comprehensive literature reviews to determine which of these FFPSA-rated interventions are effective with LGBTQ2SI+ persons. In addition, we requested this information from all the intervention developers and have included in Appendix A in the full report any LGBTQ2SI+-related information provided to us. In future editions of this document, as the literature grows in this area, we hope to include a more comprehensive review of the research for these interventions related to LGBTQ2SI+ youth and families.

TABLE 1. INTERVENTIONS RATED BY THE PREVENTION SERVICES CLEARINGHOUSE WITH EVIDENCE OF EFFECTIVENESS FOR CHILDREN AND FAMILIES OF COLOR AND LGBTQ2SI+ PERSONS

(Interventions marked with a P [preliminary] have some evidence of effectiveness for LGBTQ2SI+ persons but did not meet our sample size standard or other criteria for inclusion.)

*Promising, ** Supported, ***Well-Supported								
Intervention and Rating	**American Indian or Alaskan Native**	**Asian/ Pacific Islander**	**Bi-Racial or Multi-Racial**	**African American**	**Latinx/ Hispanic**	**Native Hawaiian or Pacific Islander**	**Other**	**LGBTQ2SI+**
Adolescent Community Reinforcement Approach*				X	X			
Aggression Replacement Training®*							X[1]	
Arizona Kinship Support Services**							X[2]	
Attachment-Based Family Therapy* (ABFT)				X				P[3]
Brief Strategic Family Therapy (BFST)***			X	X	X			
Bounce Back*					X			
Child-Centered Play Therapy*				X				
Child First** (formerly Child and Family Interagency Resource, Support, and Training)					X			
Child-Parent Psychotherapy*			X	X	X			
Child-Parent Relationship Therapy*		X			X			
Cognitive Behavioral Intervention for Trauma in Schools*		X		X	X			
Colorado Kinnected Kinship Navigator Program (Colorado Kinnected)*					X			
Common Sense Parenting- School Age*				X	X		X	

[1] Aggression Replacement Training had evidence that it was effective for Turkish people.

[2] Arizona Kinship Support Services had data that it was effective for Non-White, non-Hispanic people.

[3] A small sample study with 8 participants completing all sessions showed effects in three areas of child functioning.

*Promising, ** Supported, ***Well-Supported								
Intervention and Rating	**American Indian or Alaskan Native**	**Asian/ Pacific Islander**	**Bi-Racial or Multi-Racial**	**African American**	**Latinx/ Hispanic**	**Native Hawaiian or Pacific Islander**	**Other**	**LGBTQ2SI+**
Community Reinforcement Approach + Vouchers (CRA = Vouchers)					X[4]			P[5]
Effective Black Parenting Program (EBPP)				X				
Eye Movement Desensitization and Reprocessing – Standard Protocol**							X[6]	
Families and Schools Together-Elementary School Level (FAST®)*	X				X			
Familias Unidas***					X			X
Families Facing the Future (formerly Focus on Families)**								
Families First (Utah Youth Village Model)					X[7]			
Family Centered Treatment**				X	X			
Family Check-up®***				X	X			
Family Spirit*	X							
Foster Kinship Navigator Program*		X		X	X	X		
Fostering Healthy Futures for Preteens**				X	X			
Functional Family Therapy (FFT)***				X	X			
Healthy Families America***	X	X	X	X	X	X		
Homebuilders—Intensive Family Preservation and Reunification Services***	X			X	X	X		
Incredible Years—School Age Basic Program*		X		X			X	

[4] Study conducted in Spain.

[5] The CRA approach without vouchers showed effectiveness with lesbian and gay youth.

[6] EMDR has been proven effective by studies in countries other than the United States.

[7] About 55 Latino youth were in the treatment sample and a large number were in the comparison group, but outcomes for that specific ethnic group were not reported.

*Promising, ** Supported, ***Well-Supported								
Intervention and Rating	**American Indian or Alaskan Native**	**Asian/ Pacific Islander**	**Bi-Racial or Multi-Racial**	**African American**	**Latinx/ Hispanic**	**Native Hawaiian or Pacific Islander**	**Other**	**LGBTQ2SI+**
Intensive Care Coordination Using High Fidelity Wraparound* (Wraparound)				X				
Intercept ®*** (formerly Youth Villages Intercept)				X				
Interpersonal Psychotherapy (Weissman et al. Manual)**				X			X	
Interpersonal Psychotherapy for Depressed Adolescents*					X			
Iowa Parent Partner Approach*					X			
Methadone Maintenance Therapy**				X	X			
Motivational Interviewing***	X		X	X	X			X
Multidimensional Family Therapy (MDFT)**				X	X		X	
Multisystemic Therapy (MST)**		X		X	X			
Narrative Exposure Therapy*		X					X	
Nurse-Family Partnership (NFP)***				X	X			
Ohio's Kinship Supports Intervention/ProtectOHIO				X	X			
Parent-Child Care				X	X			
Parent-Child Interaction Therapy (PCIT)***		X		X	X[8]		X	
Parenting with Love and Limits®**				X				
Parents Anonymous®**				X	X			
Parents as Teachers***				X	X			
Prolonged Exposure Therapy for Adolescents for PTSD*				X			X	
Prolonged Exposure Therapy for PTSD (Adults)*				X				
Promoting First Relationships**	X		X	X	X			

[8] With Guiando a Ninos Activos – Guiding Active Children -- a culturally adjusted version of PCIT)

*Promising, ** Supported, ***Well-Supported								
Intervention and Rating	**American Indian or Alaskan Native**	**Asian/ Pacific Islander**	**Bi-Racial or Multi-Racial**	**African American**	**Latinx/ Hispanic**	**Native Hawaiian or Pacific Islander**	**Other**	**LGBTQ2SI+**
SafeCare**	X			X	X			
Screening Brief Intervention and Referral to Treatment (SBIRT)*		X		X				
Smart Beginnings*				X	X			
Sobriety Treatment and Recovery Teams*				X				
Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14)				X				
Strong African American Families (SAAF)***				X				
Trust-Based Relational Interview (TBRI® 101)*				X				
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)*	X	X	X	X	X			P (N=24)
Triple P – Positive Parenting Program – Group (Level 4)*		X		X	X		X	
Triple P – Positive Parenting Program – Online (Level 4)**				X	X			
Trust-Based Relational Intervention-Caregiver Training*				X				
Video Interaction Project*				X	X			

LGBTQ2SI+: Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Undecided, Intersex, and Asexual.

A sample list of additional interventions that have been recognized as very helpful for various cultural groups but that have not yet been rated by the Prevention Services Clearinghouse are below:[9]

- American Indian Life Skills (Alaskan Natives, American Indian)
- Canoe Journey (Alaskan Natives, American Indian)

[9] Special thanks to Angelina Callis of the Colorado Office of Children, Youth and Families and the Research, Analytics, and Data team of the Colorado Department of Human Services for their identification of some of these American Indian interventions.

- Criando con Amor, Promoviendo Armonía y Superación (CAPAS; Raising Children with Love, Promoting Harmony, and Self-Improvement)
- Drumming Ceremonies (Alaskan Natives, American Indian)
- Family Connections (Alaskan Natives, American Indian)
- Honoring Fatherhood Program (Alaskan Natives, American Indian)
- Native H.O.P.E. (Alaskan Natives, American Indian)
- Native STAND (Alaskan Natives, American Indian)
- Nurturing Families 5-19 (African American, American Indian, Haitian, Latinx)
- Nurturing Parenting Program (NPP) including the American Indian supplement (African American, American Indian, Haitian, Latinx)
- Ohana Program (Hawaiian/Pacific Islander)
- Positive Indian Parenting Program (Alaskan Natives, American Indian)
- Project Venture (Alaskan Natives, American Indian)
- Red Road Approach to Wellness and Healing (White Bison) (Alaskan Natives, American Indian)
- Sweat Lodge Ceremonies (Alaskan Natives, American Indian)
- Talking Circles (Alaskan Natives, American Indian)
- The Model Adolescent Suicide Prevention Program (Alaskan Natives, American Indian)
- Trauma-Systems Therapy for Refugees (TST- R) (Somali, Somali Bantu, and Bhutanese refugee youth)

Conclusions

The Prevention Services Clearinghouse has evaluated and rated as *Promising* or higher 81 interventions as of November 20, 2023. Our review finds that 61 of the 81 interventions currently rated as *Promising*, *Supported,* or *Well-Supporte*d are effective with at least one ethnic group. This might be due to one or more of their intervention model components (e.g., being family-centered, carefully listening to family perspectives, building upon family social support networks, incorporating a strengths-oriented assessment). However, we found very little evidence that any of these interventions are effective with LGBTQ2SI+ persons (only five interventions had evidence for this group). While many of the developers said their interventions are effective with this population these interventions need additional evaluation to provide specific evidence.

As we mentioned earlier, modifying a program with new examples to help it be more culturally relevant or competent is allowed by the Prevention Services Clearinghouse. But more significant changes mean that the modified program is viewed as a “new” intervention that must be evaluated separately. This requires a new line of evaluation research for each culturally modified intervention. ***Because of this requirement, we need more focused support for Indian tribal nations and other communities of***

color to document and evaluate those interventions that have been culturally adapted. This is important because there has historically been significant emphasis in funding research on interventions developed by white people.[17] This includes initial funding to develop interventions as well as funding to evaluate the interventions. Thus, many advocates are calling for equity and funding evaluations for interventions developed for and by BIPOC developers and researchers.

It is important to note that some American Indian tribal nations have an alternate pathway to have an intervention certified for FFPSA funding. These tribal nations can use culturally appropriate practice-based evidence. This is related to a broader movement: advocates of *practice-based evidence* (PBE) emphasize the value of cultural knowledge as a cornerstone of healing and recovery.[18] Fundamental to PBE is the following:[19]

- Knowledge of the function of cultural help-seeking patterns.
- Understanding the cultural context of problem identification.
- Use of culturally informed therapeutic intervention(s).
- Provision of therapeutic interventions and support in a manner that consistently recognizes the value of the cultural self to wellness and recovery.
- Engaging the local community and/or cultural resources to achieve and sustain the long-term positive effects from the intervention.

Outcome studies using rigorous PBE evaluation designs and economic analyses would not only better establish the effectiveness of these interventions, but they would also measure whether these inventions produce any cost-savings.[20] As jurisdictions optimize their array of interventions and consider innovative funding approaches such as increased use of Medicaid funding, pay-for-success and social impact bonds,[21] studies of culturally and LGBTQ2SI+ relevant interventions that use PBE, comparison groups, and Return On Investment components will be needed.

Endnotes

[1] The FFPSA law can be found here: https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf The recent request for comments is located here and contains additional criteria about how the intervention studies will be reviewed and rated: https://www.federalregister.gov/d/2018-13420.

[2] The FFPSA Clearinghouse handbook can be found here: https://preventionservices.abtsites.com/review-process

[3] Casey Family Programs. (2014). *Annual report*. Seattle, WA: Author. Retrieved from www.casey.org.

[4] See for example:

- Pecora, P. J., Sanders, D., Wilson, D., English, D., Puckett, A., & Rudlang-Perman, K. (2012). Addressing common forms of child maltreatment: Intervention strategies and gaps in our knowledge base. *Child and Family Social Work, 19*(3) 1-12, doi: 10.1111/cfs.12021.
- Rogg, C. S., Davis, C. W., & O'Brien, K. (2011). *Permanency roundtable project: 12-month outcome evaluation report*. Seattle, WA: Casey Family Programs.
- Townsend, S., Hignight, A., & Rubovits, D. (2008). Factors affecting permanency outcomes for foster children before and after passage of the Adoption and Safe Families Act of 1997. *Illinois Child Welfare, 4*(1), 59-73.

[5] Casey Family Programs. (2012). *Shifting resources in child welfare to achieve better outcomes for children and families.* Seattle, WA: Author. Retrieved from http://www.casey.org/Resources/Publications/pdf/ShiftingResources.pdf U.S. Department of Health and Human Services, Administration for Children and Families, Administration for Children and Families, Children's Bureau. (2012). *Promoting the social and emotional well-being of children and youth receiving child welfare services.* Memorandum No. ACYF-CB-IM-12-04. Washington, DC: Author. Retrieved from http://www.acf.hhs.gov/programs/cb/resource/im1204.

[6] LGBTQ2SI+: Lesbian, Gay, Bisexual, Transgender, Queer, Two-Spirit, Intersex +

[7] See for example:

- New York City Administration for Children's Services (ACS). 2020. *Experiences and well-being of sexual and gender diverse youth in foster care in New York City: Disproportionality and disparities.* Author.
- Wilson, B. D., & Kastanis, A. A. (2015). Sexual and gender minority disproportionality and disparities in child welfare: A population-based study. *Children and Youth Services Review*, *58,* 11-17
- Wulczyn, F. (2023). On causal inference and the limits of disproportionality as a construct: The case of foster care placement. *Social Service Review, 97(2),* 362-397. https://www.journals.uchicago.edu/doi/epdf/10.1086/724657
- Wulczyn, F. & Halloran, J. (2017). Foster care dynamics and system science: Implications for research and policy. *International Journal of Environmental Research and Public Health*. 14. 1181, 1-12. DOI: 10.3390/ijerph14101181

[8] Dee Bigfoot, personal communication, December 14, 2020.

[9] Maryland Department of Human Services; (2023). *Comments on Title IV-E Clearinghouse Handbook of Standards and Procedures, Draft Version 2.0.* Annapolis, MD: Author, pp. 4-5.

[10] Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

[11] See, for example:

- American Psychological Association (APA). (2006). *APA presidential task force on evidence-based practice* (APA EBP). Author.

- Austin, A., & Craig, S. L. (2015). Empirically supported interventions for sexual and gender minority youth. Journal of Evidence-Informed Social Work, 12(6), 567–578. https://doi.org/10.1080/15433714.2014.884958
- Bochicchio L., Reeder, K., Ivanoff, A., Pope, H. & Stefancic, A. (2022) Psychotherapeutic interventions for LGBTQ + youth: A systematic review, *Journal of LGBT Youth*, 19:2, 152-179, DOI: 10.1080/19361653.2020.1766393

[12] See for example, Austin et al. (2018) and Bochicchio et al. (2022), pp. 162-163 and 168-169 and Expósito-Campos (2023). Also see Briana McGeough & Adrian Aguilera (2020) Clinical interventions with sexual minority clients: Review, critique, and future directions, *Journal of Gay & Lesbian Social Services*, 32:4, 421-439, DOI: 10.1080/10538720.2020.1764895 In addition, "although the efficacy of cognitive–behavioral therapy (CBT) for SM adults is beginning to be established (e.g., Hart, Tulloch, & O'Cleirigh, 2014; Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015; Ross, Doctor, Dimito, Kuehl, & Armstrong, 2007), empirical research exploring the efficacy of CBT with SMY [sexual minority youth] is almost nonexistent. Case studies and conceptual literature have suggested CBT as an acceptable approach with SMY (Craig, Austin, & Alessi, 2013; Duarte-Velez, Bernal, & Bonilla, 2010) because CBT encourages youth to modify maladaptive thoughts and behaviors, develop and maintain healthy coping strategies, and create social support systems" (Hobaica, Alman, Jackowich, & Kwon, 2018, p.2). References for the above:

- Austin, A., Craig, S. L., & D'Souza, S. A. (2018). An AFFIRMative cognitive behavioral intervention for transgender youth: Preliminary effectiveness. *Professional Psychology: Research and Practice, 49*(1), 1–8. https://doi.org/10.1037/pro0000154
- Craig, S. L., Austin, A., & Alessi, E. (2013). Gay affirmative cognitive behavioral therapy for sexual minority youth: A clinical adaptation. *Clinical Social Work Journal, 41,* 258–266. http://dx.doi.org/10.1007/s10615-012-0427-9
- Duarté-Vélez, Y., Bernal, G., & Bonilla, K. (2010). Culturally adapted cognitive-behavior therapy: Integrating sexual, spiritual, and family identities in an evidence-based treatment of a depressed Latino adolescent. *Journal of Clinical Psychology, 66,* 895–906. http://dx.doi.org/10.1002/jclp.20710
- Expósito-Campos, P., Pérez-Fernández, J. I., & Salaberria, K. (2023). Empirically supported affirmative psychological interventions for transgender and non-binary youth and adults: A systematic review. *Clinical Psychology Review*, *100*, 102229. https://doi.org/10.1016/j.cpr.2022.102229
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- Hobaica, S., Alman, A., Jackowich, S., & Kwon, P. (2018, March 15). Empirically Based Psychological Interventions with Sexual Minority Youth: A Systematic Review. *Psychology of Sexual Orientation and Gender Diversity*. Advance online publication. http://dx.doi.org/10.1037/sgd0000275
- Pachankis, J. E., Hatzenbuehler, M. L., Rendina, H. J., Safren, S. A., & Parsons, J. T. (2015). LGB-affirmative cognitive-behavioral therapy for young adult gay and bisexual men: A randomized controlled trial of a transdiagnostic minority stress approach. *Journal of Consulting and Clinical Psychology, 83,* 875– 889. http://dx.doi.org/10.1037/ccp0000037
- Ross, L. E., Doctor, F., Dimito, A., Kuehl, D., & Armstrong, M. S. (2007). Can talking about oppression reduce depression? Modified CBT group treatment for LGBT people with depression. *Journal of Gay & Lesbian Social Services, 19,* 1–15. http://dx.doi.org/10.1300/J041v19n01_01

[13] See, for example:

- Huey, S. J. & Polo, A. (2008). Evidence-based psychosocial treatments for ethnic minority youth. *Journal of Clinical Child & Adolescent Psychology*, *37*(1), 262-301.
- Hutchful, E. (2024). *Culture is healing: Removing the barriers facing providers of culturally responsive services*. Center for the Study of Social Policy. https://cssp.org/resource/culture-is-healing/

- Smith, A. C. (2020). Cultural sensitivity in mental health care: Getting to know your audience. *Psychology Today Blog*, Retrieved from https://www.psychologytoday.com/us/blog/and-running/202009/cultural-sensitivity-in-mental-health-care
- Substance Abuse and Mental Health Administration (SAMHSA) (2020*). CCBHCs and Cultural Competence.* Washington, DC: Author. Retrieved from https://www.samhsa.gov/section-223/cultural-competency

[14] Interventions that were rated by the CEBC according to its established criteria using the three highest levels of effectiveness for the CEBC classification system as follows:

1. ***Well-Supported by Research Evidence***: Sample criteria include multiple-site replication and at least two randomized control trials (RCTs) in different usual care or practice settings that have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published peer-reviewed literature.
2. ***Supported by Research Evidence***: Sample criteria include at least one RCT in usual care or a practice setting that has found the practice to be superior to an appropriate comparison practice. The RCT has been reported in published peer-reviewed literature. In at least one RCT, the practice has shown to have a sustained effect for at least one year beyond the end of treatment.
3. ***Promising Research Evidence***: Sample criteria include at least one study using some form of comparison (e.g., untreated group, placebo group, matched wait list) that has established the practice's benefit over the comparison or found it to be equal to or better than an appropriate comparison practice. In at least one RCT, the practice had a sustained effect for at least six months beyond the end of treatment. (See http://www.cebc4cw.org/ratings/scientific-rating-scale/ for more complete definitions.)

[15] For examples of meta-analyses reporting intervention effect sizes, see: Lee, B. R., Bright, C. L., Svoboda, D. V., Fakunmoju, S., & Barth, R. P. (2011). Outcomes of group care for youth: A review of comparative studies. *Research on Social Work Practice, 21*(2), 177-189. doi:10.1177/1049731510386243; Leenarts, L. E. W., Diehle, J., Doreleijers, T. A. H., Jansma, E. P., & Lindauer, R. J. L., (2012). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: systematic review. *European Child & Adolescent Psychiatry* 22:269-283.

[16] See:

- Hyland, S. T., & O'Brien, J. (2023). *Evidence-based programs desk guide 2023.* Chapin Hall at the University of Chicago. Retrieved from https://www.chapinhall.org/wp-content/uploads/Chapin-Hall_EBP-Desk-Guide_December-2023.pdf
- O'Brien, J., Evans, J., Heaton, L., Hyland, S., & Weiner, D. (2021). *Elevating culturally specific evidence-based practices*. Chicago: Chapin Hall at the University of Chicago. Retrieved from https://www.chapinhall.org/wp-content/uploads/Elevating-Culturally-Specific-EBPs.pdf

[17] For example, see:

- https://www.ascb.org/science-policy/ending-racial-disparities-in-nih-funding/
- https://advances.sciencemag.org/content/5/10/eaaw7238
- https://www.npr.org/sections/health-shots/2019/10/18/768690216/whats-behind-the-research-funding-gap-for-black-scientists

[18] Practice-based evidence is also referred to as *community-defined evidence* (CDE).

[19] Echo-Hawk, Holly (2018). *Family First Prevention Services Act of 2018 Background: Culturally Based and Emerging Evidence-Based Practice*. Paper prepared for Casey Family Programs. Seattle, WA. E-mail: echohawk@pacifier.com, Page 2.

[20] For articles discussing the need for more economic analyses, see:

- Karoly, L. A., Kilburn, M. R., Bigelow, J. H., Caulkins, J. P., & Cannon, J. S. (2001). *Assessing costs and benefits of early childhood intervention programs: Overview and applications to the Starting Early, Starting Smart Program*. Santa Monica, CA: RAND.

- Lee, S., & Aos, S. (2011). Using cost-benefit analysis to understand the value of social interventions. *Research on Social Work Practice*, *21*(6), 682-688.
- Mullen, E. J., & Shuluk, J. (2010). Outcomes of social work intervention in the context of evidence-based practice. *Journal of Social Work*, *11*(1), 49-63.
- Pecora, P. J., Sanders, D., Wilson, D., English, D., Puckett, A., & Rudlang-Perman, K. (2012). Addressing common forms of child maltreatment: Intervention strategies and gaps in our knowledge base. *Child and Family Social Work, 19*(3) 1-12, doi: 10.1111/cfs.12021.

[21] Rudd, T., Nicoleletti, E., Misner, K., & Bonsu, J. (2013). *Financing promising evidence-based programs: Early lessons from the New York City Social Impact Bond*. New York, NY: MDRC. Retrieved from http://www.mdrc.org/sites/default/files/Financing_Promising_evidence-Based_Programs_FR.pdf. Also see: https://www.whitehouse.gov/omb/factsheet/paying-for-success

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