

## Responses to email survey about CYT interventions and implementation with multicultural groups

| Contact  | Site   | Population   | Intervention  | Other CYT                    | Level of Care                    | Adaptations   |
|--|--|--|---|------------------------------|----------------------------------|---|
| Shannon Mulcahy<br>Clinical Director<br>smulcahy@ahinc.org   | Arapahoe House Inc.,<br>Denver, CO, EATS   | White 32.5%<br>Hispanic 22.5%<br>N. Amer. 2.5%<br>Biracial 12.5 %<br>Missing 27.5%<br>American 2.5 %   | MET/CBT5 plus case<br>management and family sessions.<br>See comments   | No.                          | Level I OP                       | No specific changes. See<br>comments  |
| <p><i>Comments: Intervention</i> For us, it is a 9-week intervention with the MET/CBT5 being the first five sessions, then during the next two weeks the case mgr has a family appt, preferably in the home, the third week after MET/CBT5 the clients come back together to do a "booster" group and then there is another family/case mgmt session. <b>Adaptations</b> One of our MET counselors is African American; we also have the ability to connect clients with our cultural services department if there are issues with Spanish-speaking only clients or other cultural issues; all of our staff are well trained in diversity and cultural awareness, both as a requirement of the agency and due to their education. <b>Other Comments</b> We had originally planned on doing some gender specific groups and potentially a monolingual (Spanish) group, but are finding that, unfortunately, staffing issues and in some ways clientele may prevent this.</p>  |  |  |   |                              |                                  |   |
| Kathy Davis<br>Clinical Director<br>kathy@childandfamily.org   | New Focus<br>Adolescent<br>Treatment Project,<br>Child & Family<br>Services (Capital<br>Area), Lansing, MI<br>EATS | AA 53%<br>Hispanic 21%<br>Asian Amer. 5%<br>Caucasian 21%<br>NOTE: Youth are<br>split equally<br>between urban and<br>suburban; few<br>rural youth | The primary modification is that<br>therapists are not sticking as<br>closely as suggested to the<br>materials and activities as<br>described in the manual.<br>Therapists have found that some<br>kids don't respond well to the<br>change from the motivational<br>approach of the first two sessions<br>to the more regimented CBT<br>group sessions. See comments | MET/CBT plus<br>CBT7 and FSN | OP                               | Using alternate settings<br>(e.g., alternative school,<br>day program for<br>adjudicated youth); also<br>providing individual<br>MET/CBT5 as some youth<br>responded poorly to the<br>group modality. See<br>comments |
| <p><i>Comments: Intervention</i> Our best observation at present seems to be that males and adolescents who have known one another prior to their involvement in the MET/CBT group have the most difficulty with the group format. The female only group we have at present is doing well with the group structure and format, fully engaging with the materials. We will be looking to see if this is true in future groups. <b>Other CYT</b> We are just planning a parent group, which will pull from the Family Support Network Curriculum for use with parents of kids in treatment. This intervention is just starting this month. <b>Adaptations</b> These kids know one another from classrooms and other group settings. They also know the therapist and have not responded well to the structure of the groups. <b>Other Comments</b> I'm very curious about other sites providing MET/CBT5. The challenge for all of the therapists working on the project here is that the transition from the MET sessions to the CBT sessions is too abrupt. The structure doesn't allow for group formation and kids aren't ready to engage with one another without some initial trust and relationship building. Therapists are finding that kids are not participating or responding to the material if they move too quickly. They are moving away from the material in order to draw kids into the process. Kids may have shared reasons for quitting in the GAIN and reviewed them in the individual session but are not willing to admit to that in a group setting with other kids that they have just met. Their resistance increases during the first couple of group sessions. We are very curious to know if others are having the same experience. If not, what are they doing differently?</p> |  |  |   |                              |                                  |   |
| Nancy Conine<br>Clinical Director<br>NConine@OperPar.org   | Operation PAR,<br>Pinellas Park, FL  | Primarily JJ<br>diversion<br>programs, reentry<br>from JJ<br>commitment<br>program   | MET/CBT5  | No; see<br>comments.         | Intervention &<br>outpatient LOC | No major differences<br>between cultural groups,<br>the issues are general<br>adolescent<br>issues/behaviors.   |
| <p><i>Comments: Other CYT</i> Academy (another PAR site) has a Targeted Expansion Project using Family Support Network (MET/CBT12) with additional services.</p>   |  |  |   |                              |                                  |   |

## Responses to email survey about CYT interventions and implementation with multicultural groups

| Contact  | Site  | Population   | Intervention   | Other CYT   | Level of Care   | Adaptations |
|--|---|--|--|---|---|-------------|
| Michael Collier<br>Clinical Manager<br>mcollier@cfdfll.com   | BEST Adolescent Initiative, Orlando, FL<br>EATS       | Serving a population of 30 clients, consisting of AA, Hispanic, Caucasian, and one American Indian | MET/CBT5   | No.   | Outpatient; see comments.   | None.       |
| <i>Comments:</i> <b>Level of Care</b> Expect to use the CBT6-CBT12 as part of our aftercare component. <b>Other Comments</b> This modality as instructed appears to be working well with adolescents who come from different races and ethnic backgrounds.   |   |  |  |   |   |             |
| David Friedentag<br>Clinical Director<br>david.friedentag@judicial.state.co.us   | Denver Juvenile TASC, Denver, CO, EATS                | Hispanic 51-52%, AA 27%, Rest is mix of Anglo, Asian, biracial, and other                          | MET/CBT5; see comments.  | Minimum of 12 sessions; use all the sessions in volume 2; see comments. | In-house OP tx program for kids involved in the juvenile justice system | None.       |
| <i>Comments:</i> <b>Intervention</b> I had a tough time finding the "Guide to Quitting Marijuana" as Chestnut no longer has it available; I found a copy on the internet but it was a little out of date so I downloaded it and revamped it to better meet our needs. I also slightly changed the Welcome sheet but find that very helpful in explaining to clients what they can expect and what we expect. We are not yet trained on the GAIN so we used our assessment summary in place of the Personalized Feedback Report and found no problems with that change. We found that the Personal Goal Worksheet was hard for our kids to understand. They have little experience setting goals and putting thing into action. The functional analysis is very helpful with our kids to get them to see what they perceive as a benefit from using and understand why their use is harming their lives. The Knowledge Is Power worksheet was a complete loss on our kids few filled it our or understood the concept. I found we needed to go through this with them one step at a time and really explain the concepts. We found I could do two whole groups on triggers and how your thoughts and feelings impact your behaviors. We all had good feedback on the Enhancing Social Support Networks. It appears that our kids found it very helpful to understand how to get support from anyone around sometimes even their using friends or extended family. I personally found it very helpful for my group to do a Sculpt with the kids in group and act out what a support group looks like. In this live demonstration of a group member's support system they can see what it might look like to have support around them. Our kids did poorly on the Social Circle Diagram but as I stated above they did the same thing by sculpting it out. The in session exercise is a good tool allowing interaction with the group members. Again the Real Live Practice was seldom turned in or completed. Planning for emergencies and coping with relapse is a topic we found needed more than one session. I found it appropriate to revisit this session several times during a client's treatment episode. It is relevant and needs to be discussed many times for our clients to grasp the idea that you can go to a family function or a concert and not use. A therapist skill at using terminology that is understandable to their population is most effective in brining the session to the clients level. We found it necessary to use different lingo or examples that were more relevant to our kids. The Personal Emergency Plan was helpful as a group activity and usually lead to good group discussion about what relapse is, and what to do after you relapse. It is important to note that we also did weekly random urinalysis on our kids to ensure abstinence. <b>Other CYT</b> We use the sessions and activities on an as needed basis rather than in the order presented. We find the most relevant session to where our group is at on that day or to expand on what was presented in the prior session. We felt this was very useful but again had to augment some of the activities. Our kids did poor. The key concepts are an excellent outline for any treatment program but we found the key is to augment the sessions and use your personal counseling skills in making the sessions work. It is important to let attendees know that we all struggle at first but the more comfortable you become with the concepts and the sessions the more real and relevant the sessions become to clients. <b>Other Comments</b> It is most important to have clinically sound staff that are Hispanic acculturated and Non-Hispanic acculturated, knowledgeable of AA culture, the differences in the many Anglo cultures as well as the different Asian populations we see. Staff are trained and culturally competent in order to deal with our very diverse population. We also identified the Teen Culture, Gang Culture, Gender Specific issues, Gay, Lesbian, and transgender, and the Drug culture as important issues to be aware of for our clients. We also felt that it was important enough to state that just because a counselor is of Hispanic or African American background does not mean they are culturally competent to work with that population. Training is most important. |   |  |  |   |   |             |
| Ann Brown<br>Program Director<br>Brownvirginiaa@uams.edu   | UAMS Programs for Young Adults, Little Rock, AR, EATS | Serving white and AA participants  | MET/CBT5 plus family, which runs concurrently with the first 2 CBT sections. | No.   | Outpatient  | None.       |
| <i>Comments:</i> <b>Intervention</b> This is a support/education group for parents of program participants. <b>Other Comments</b> the individual sessions and the groups have been going very smoothly so far, and the manual has been very helpful in assuring efficiency and consistency.  |   |  |  |   |   |             |

## Responses to email survey about CYT interventions and implementation with multicultural groups

| Contact  | Site   | Population   | Intervention  | Other CYT | Level of Care      | Adaptations  |
|--|--|--|---|-----------|--------------------|--|
| John Curry<br>Principal Investigator<br>curry005@mc.duke.edu   | Duke University,<br>Durham, NC, EATS                                   | Minority 14% (Hispanic & AA)                           | MET/CBT5 plus two parent education sessions   | No.       | Outpatient         | None.  |
| <i>Comments: Intervention</i> These are done in a group that meets twice per month. Education about the treatment, about monitoring adolescent substance use and consequences for use, and about parent-adolescent communication.  |  |  |   |           |                    |  |
| Tanya Iacono<br>Project Manager<br>TanyaI@ctrenaissance.com  | Project TEMPO<br>Connecticut<br>Renaissance Inc.,<br>Norwalk, CT, EATS | Urban youth with a number of AA and Hispanic referrals | MET/CBT5 plus family sessions when needed.  | No.       | Outpatient         | None; see comments.  |
| <i>Comments: Intervention</i> This is based upon the individual needs of each client, but has not happened in most cases. <i>Adaptations</i> We have not made any changes in regard to the clients' cultural, ethnic, and economic backgrounds because we are accustomed to working with this particular population. We have taken into account environmental factors that often lessen the likelihood that the clients we serve attend sessions regularly (i.e. socioeconomic status). In order to increase treatment participation, we have made every effort to bring the services to the client, rather than relying on the client to find transportation to our facility. <i>Other Comments</i> We haven't been doing home visits, we have partnered with the school-based health centers in the area that we serve so that we could see the clients at school. We have struggled with CBT group sessions, because school schedules do not always permit all of the students to be out of class at the same time. We have done the majority of our CBT sessions individually (both inside and outside of the facility) because we haven't had a really good mix of youths to have a group. We do not have much phone contact with our clients, but they have the option of calling us at the office, even though we meet with them at school. Family sessions are incorporated into treatment only when we have client willingness and consent. Since we do not need parent consent when we go into the schools (a blanket consent form was signed by parents for services through the SBHC at the beginning of the school year) parent involvement is minimal, therefore, family sessions are rare. Contact with the family is minimal, because we have run into a bit of resistance when getting families involved in treatment. A number of the families that we have come into contact with seem to view their child's substance use as a personal problem and not reflecting poor family functioning. We have struggled to get a lot of our referrals in for the intake sessions, because we have met so much resistance from the child's guardian(s). This is one of the reasons why we have found other ways of getting these youths in treatment. I would say that family interaction between Hispanic and African-American clients has been fairly consistent. The issue that seems to stick out in my mind most is that we are confronting macro problems such as poverty and the urban culture, before encountering cultural differences between these two groups. We have met resistance from Hispanic and African-American families, even though we have done our best to explain the services that are being provided and the potential benefits of participation. In the cases where there is a language barrier with Hispanic clients, we have brought along a translator in the hopes of stimulating interest in our programs. In a way, we have also addressed parent concerns regarding getting their child to treatment by bringing the services to the client. |  |  |   |           |                    |  |
| Kathleen Dunn<br>EI Specialist<br>kdunn@chestnut.org   | Bloomington HS,<br>Chestnut Health<br>Systems,<br>Bloomington, IL, SCY |  | I think the intervention is general enough to allow for normal variances in our approach taken with individual students; see comments | No.       | Early Intervention | Any changes or modifications made are minor and usually have more to do with the individual student than cultural differences. |
| <i>Comments: Intervention</i> The biggest differences I see don't have to do with ethnicity or socio-economic issues. Instead, the support environment and motivation, both internal and external, appear to be the keys. For example, a Caucasian female student with using parents did not do as well when the intervention was complete as did an African-American male with an extremely supportive (meaning supporting his goal to remain abstinent) mother. As far as internal and external motivation, the two African-American males I had did well in the intervention. One did not think using fit with his self-image and the other was on probation and being tested.  |  |  |   |           |                    |  |

## Responses to email survey about CYT interventions and implementation with multicultural groups

| Contact  | Site                                    | Population  | Intervention  | Other CYT | Level of Care          | Adaptations   |
|--|---|---|---|-----------|------------------------|---|
| Mary Beck<br>Project Manager<br>mbeck@<br>council-houston.org  | Take Five Program,<br>Houston, TX, EATS | GAINs have been conducted with youth who are: 2 AA, 9 Caucasian and 9 Hispanic. Of those 9 Hispanic, 6 Caucasian and 1 AA were appropriate for our program; see comments. | MET/CBT5 plus case management (which starts at the same time their first MET session does); see comments. | No.       | Brief Intervention, OP | The case management is the specific component we added so the program could work better across cultures. By visiting the clients, case managers can better identify not only the ethnic culture, but other cultural issues as well that may impact the success of the intervention. It also meets the needs of many families who are not able to travel across such a large county. |
| <p><i>Comments:</i> <b>Population</b> We noticed when writing the original grant that the African American youth tended to be on probation for possession and intent to sell, while Caucasian, Hispanic and Other youth were possession and use. The high Caucasian rate is unexpected. It also could be based on how the youth identifies himself. In the proposal, we used the traditional means for identifying race - by the birth certificate or father. <b>Intervention</b> The clients are designated to one of two groups: (1) in-home case management every week for 2 months and 2x the third month. For the rest of the year they receive phone case management; and (2) 2 in-home sessions and then phone for the rest of the year. The designation is based on GAIN results in relation to ASAM criteria. <b>Other Comments</b> TAKE FROM PROPOSAL: (1) case management services will be offered as an adjunct to the 5-session treatment program, (2) case managers and counselors will conduct scheduled meetings with adult caregivers to offer assistance in implementing a parent-driven behavioral management plan for adolescents and in resolving structural issues in the family that may be reinforcing adolescent substance use, and (3) case managers will meet with counselors weekly for "staffing" to discuss the progress of individual clients. These adaptations are made in order to address specific characteristics of the target population, specifically (1) juvenile justice involvement and (2) indications of parent-child cultural discrepancies. Case management plans will be incorporated into treatment plans, and these plans will serve as contracts between substance abuse counselors, case managers, and parents. Parents will be encouraged to ask case managers to coordinate services to meet specific family needs, whether or not these needs are directly related to adolescent treatment, in order to remove barriers to parental participation in treatment. All clients will receive referrals to self-help recovery groups in their area. For adolescents whose ASAM level is higher than Level I, case managers will continue to make home visits for up to one and a half months after the conclusion of the MET/CBT5 treatment. Time during these home visits will be divided between parent, child, and family counseling; and needs identification and services referrals. After the close of the three-month period, case managers will continue to contact client families via telephone at least once per month to monitor client progress and to offer appropriate assistance when necessary. Level I clients will not receive regular case management home visits (unless staffing decisions raise their level), but will receive monthly telephone follow-up. To engage and retain clients whose parents are unacculturated immigrants, case managers will assist these parents in acquiring enough bicultural competence to reduce their reliance on their children as cultural "guides" and restore their authoritative parental role; at the same time, case managers will assist their acculturated adolescent children to understand the valuable protective cultural assets available to them through their parents' connection to the family's culture of origin. This strategy has been repeatedly shown to be successful for engaging and retaining Hispanic youth in treatment (Szapocznik &amp; Williams, 2000). Once parents are engaged, their involvement will include interaction with case managers to ensure that needs are fulfilled and they are following their treatment plan. For the Take Five Program, the clinical supervisor will provide 24 hours of training in motivational interviewing. The use of motivational interviewing by case managers in interaction with youth and their parents will reinforce the MET component of MET/CBT5, and will build on the therapeutic alliance that the latter builds with youth. Throughout the case management phase of aftercare, case managers will regularly remind parents and adolescents of their progress in meeting the goals originally developed together in the treatment plan, emphasizing those goals that clients and parents initiated. Case managers will work with a comprehensive listing of social services that has been maintained by The Council since it began conducting case management over 10 years ago, is shared by each of The Council's case management programs, and which has been updated annually.</p> |   |   |   |           |                        |   |

## Responses to email survey about CYT interventions and implementation with multicultural groups

| Contact   | Site                                      | Population   | Intervention  | Other CYT | Level of Care   | Adaptations  |
|---|---|--|---|-----------|---|--|
| Dr. Howard Liddle<br>h.liddle@miami.edu   | University of Miami<br>School of Medicine |  | MDFT  |           |   |  |
| <p><b>Comments: Diverse Client Populations Targeted:</b> Inner-city minority (African-American and Hispanic) youth and families with few resources and serious and pervasive problems - Urban and rural Caucasian drug abusing teens and families - Young adolescents at high risk for drug abuse problems - Adolescent drug abusers with co-morbid psychiatric disorders - Adolescent drug abusing and delinquent females. <b>Research Developed Knowledge about how Multidimensional Family Therapy Works:</b> MDFT researchers have outlined the within-treatment process of improving family interactions (Diamond &amp; Liddle, 1999) - MDFT researchers have empirically demonstrated how therapists successfully build therapeutic relationships with teens (Diamond &amp; Liddle, 1996) - MDFT studies have shown that parents' skills and practices are systematically improved during therapy and that these changes are linked to reductions in adolescents' symptoms (Schmidt, Liddle, &amp; Dakof, 1996) - MDFT experts have studied the links between exploring important cultural themes and increasing teens' participation in treatment (Jackson-Gilfort, Liddle, Tejada, &amp; Dakof, 2001) - MDFT treatment developers have empirically adapted the model to the needs and issues of adolescent girls (Dakof, 2000). <b>Reference:</b> Jackson-Gilfort, A., Liddle, H.A., Tejada, M.J., &amp; Dakof, G.A. (2001). Facilitating engagement of African-American male adolescents in family therapy: A cultural theme process study. <i>Journal of Black Psychology</i>, 27 (3), 321-340.</p> |   |  |   |           |   |  |
| Amy Chapman<br>Project Manager<br>SOJABT1@fuse.net  | Butler County, OH<br>EATS                 | The majority of clients we serve are of Appalachian descent. We serve a few AA and Hispanic clients as well. | MET/CBT5 plus a family component that includes two family sessions and a parent workshop. | No.       | Outpatient  | A few of our staff members are fluent in Spanish. Our agency also coordinated with a local university to provide Spanish classes to staff members. We have a staff member that can interpret and is available to give us insight whenever needed. In our ABT program, we have an African American primary counselor that provides direct service and is able to give us insight as well. |
| <p><b>Comments:</b> We have found the MET/CBT model to be very effective with our clients and their families. They have responded to the intervention in a positive manner.</p>   |   |  |   |           |   |  |
| Victor Delgado<br>Director of<br>Community Court<br>Programs<br>Vdelgado@<br>phoenixhouse.org   | Phoenix House,<br>New York, NY            | Primarily Latino and AA, inner-city youth, ages 12-17  | MET/CBT5 plus FSN; see comments.  |           | We are a "Prevention Program" but will address low-level experimentation. | None yet; see comments.  |
| <p><b>Comments: Intervention</b> Intend to use a "Hip Hop" version, developed in Hartford, CT, at some point within the next 3 months. <b>Adaptations</b> Intend to implement "Substance Abuse Rap" which is a Hip Hop version of MET/CBT. With the increasing influence of rap music on our children, we feel that we may better deliver the information by using a format that they trust and relate to. <b>Other Comments</b> This service is in great demand for children within the NYC area. We have experienced interest from the Bronx, Brooklyn, and Queens boroughs of NYC, as well as Yonkers. However, East and Central Harlem are our catchment area.</p>  |   |  |   |           |   |  |

## Responses to email survey about CYT interventions and implementation with multicultural groups

| Contact   | Site  | Population   | Intervention                         | Other CYT | Level of Care   | Adaptations  |
|---|---|--|--------------------------------------|-----------|---|--|
| Judy Ramos Jordan<br>Associate Evaluator<br>judy@scan-inc.org   | SCAN Laredo,<br>ACC/ACRA  | Primarily a Mexican-American background;<br>Over 95% of clients are Hispanic and bilingual;<br>see comments. | ACRA and ACC plus FSN; see comments. |           | Level IV OP for clients coming out of residential treatment | More assertive approach in engaging parents/caregivers in the treatment process by adding the FSN parenting groups to ACC and ACRA; see comments   |
| <p><i>Comments:</i> <b>Population</b> Many of our clients speak what one may call “Tex-Mex,” which is a blend of both English and Spanish. However, a large percentage of counseling sessions are conducted primarily in Spanish. The majority of our clients in Webb County (Laredo) live in an urban environment, although some of them live in what are called “colonias”. Colonias are located on the outskirts of Webb county and do not have most conveniences of urban living. We have served an average of about 10-20 adolescents who live in the colonias over the past 3 years. In addition, our satellite offices in Zapata and Starr counties are rural locations (they are located about 40 and 150 miles, respectively, from Webb County). Therefore, about half of our clients come from a rural environment and half from a more urban environment. The majority of the clients we serve come from low-income families who have very limited resources available to them. <b>Intervention</b> We provide the ACRA and ACC procedures as primary outpatient treatment and as a continuing care model for those clients who are “stepping-down” from residential treatment to a lower level of care. In our community, there are no intensive outpatient services offered – either outpatient (level IV – 2-9 hrs. of counseling available per week as per Texas Commission of Alcohol and Drug Abuse standards) or residential treatment are the options. <b>Adaptations</b> This decision was made based on the fact that the majority of our parents have been observed to have poor parenting skills and limited resources to help them. We also feel that having a sense of community and belonging is inherent to our cultural values. As a result, we have begun to offer a “family night” to our clients and families as well as to those families who are on the waiting list for outpatient treatment services (as a type of interim service). “Family nights” are facilitated by an outpatient counselor and the content consists of the FSN parenting groups. Family members are provided with snacks and all family members are welcome to attend the meeting. Family nights have turned out to be very successful and both clients and their parents are invited to attend. All outpatient counselors reported good attendance and many of the clients do also participate in this activity along with their parents. Finally, we feel that by having both clients and parents participating in at an activity focused on helping the family, that this will strengthen the relationship between parent and child and further enhance the treatment process. <b>Translated Materials</b> Two of our outpatient counselors translated the Happiness Scale and the Caregiver-Adolescent Relationship Skills Scale into Spanish. These tools have been used with clients and parents/caregivers; counselors report that they have worked well with the Spanish translation. <b>Other Comments</b> I think that it is very important to recognize that we have put a lot of effort in trying to adhere to the content of the ACRA curriculum with a population that is sometimes at a lower educational level than would be expected. Some of our clients really need a lot of time spent on explaining the ACRA procedures and what each one is about. This creates a challenge for the counselor who is trying to adhere to a curriculum and maintain fidelity while having to adapt to the developmental level of the client. Another issue that was brought up by the counselors was that they felt that the curriculum was very easily adaptable to our client population and easy to relate to their life experiences. Counselors also feel that the procedures are very practical and applicable to the client’ lives. I did receive some mixed feelings about the functional analysis of substance use behavior, which was described as sometimes being somewhat redundant and timely (without client gaining much insight). However, other counselors liked this procedure because it gave <i>them</i> good insight about their client.</p> |   |  |                                      |           |   |  |
| Dr. Olga Tuller<br>Project Director<br>drotuller@yahoo.com  | PROTYPES,<br>Center for Innovation in Health, Mental Health, & Social Services,<br>Pomona (Culver City), CA, EATS | At this time, we have 54 clients in our program. We are serving 40-50% Latino and 40% AA clients.            | MET/CBT5                             | No.       | Outpatient  | Taking into consideration the value of family that Latino and AA clients hold, we are trying to involve families in treatment as much as possible. |
| <p><i>Comments:</i> <b>Adaptations</b> In addition, we are providing family psychotherapy sessions.</p>   |   |  |                                      |           |   |  |