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Guidelines for Implementing and Adapting Evidence-Based Interventions With Marginalized Youth in Schools

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With growing diversity within the U.S. population and notable barriers to accessing behavioral health care, marginalized youth are placed at risk for developing psychosocial and mental health problems. Promoting evidence-based interventions (EBIs) through school-based mental health services may improve accessibility and quality of care for marginalized youth facing mental health disparities. Culturally sensitive interventions (CSIs) may further improve engagement with and effectiveness of EBIs with marginalized youth. In this article, we provide guidelines for advancing CSIs when implementing and adapting EBIs with marginalized youth in schools. First, we emphasize inclusive strategies for advancing CSIs with marginalized youth in schools, focusing on antiracist adaptations to interventions and using a community-based participatory research approach when implementing EBIs. Following, we discuss techniques for tailoring CSIs to more effectively support marginalized youth and their families with school-based prevention and treatment. Specifically, we recommend using the Adapting Strategies for Promoting Implementation Reach and Equity framework as a guide to promote equitable implementation as well as key strategies for engaging marginalized youth and their families with school-based EBIs. Ultimately, we offer these guidelines to address disparities and inform more equitable practice in youth mental health care—and to motivate future studies advancing culturally responsive services with marginalized youth in schools.

Public Policy Relevance Statement
Promoting evidence-based interventions (EBIs) through school-based mental health services may improve accessibility and quality of care for marginalized youth facing mental health disparities. Inclusive and culturally sensitive EBIs may be especially useful for addressing inequities in marginalized youths' mental health outcomes. We provide guidelines and practical recommendations for implementing and adapting inclusive and culturally sensitive EBIs with marginalized youth in schools.

Mental health issues are rising among adolescents aged 12–17 years, with a 52% increase in significant internalizing symptoms since 2005 (Twenge et al., 2019). Furthermore, a substantial increase in depression and anxiety symptoms was seen in youth during the COVID-19 lockdown (in March 2020) compared to rates observed before the lockdown (Panchal et al., 2021). Mental health challenges are compounded for youths from low-income families, those within the juvenile justice and child welfare systems, those identifying with racial/ethnic minoritized communities, and those with substance abuse problems (Hodgkinson et al., 2017; Masi & Cooper, 2006). Populations that may be especially vulnerable to lower rates of mental health service access include marginalized youth and the uninsured (Kataoka et al., 2002; Larson & Halfon, 2010).

Marginalized youth—who experience racism, discrimination, and exclusion because of unequal power relationships across economic, social, racial, and cultural conditions—represent a considerable proportion of the U.S. population, yet they often have less access to mental health care compared to their White peers (Maura & Weisman de Mamani, 2017). Marginalized youth is therefore a broad and diverse category, representing children and adolescents

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with varying backgrounds, identities, and characteristics. In this article, we define marginalized youth as those who are 10–19 years old, who are excluded from social, economic, and/or educational opportunities enjoyed by other youth in their community due to numerous factors beyond their control (Auerswald et al., 2017). The care available to marginalized youth is frequently of poorer quality compared to care provided to the White population (Maura & Weisman de Mamani, 2017). Reasons for this disparity include lack of availability of community-based interventions, unequal access to evidence-based practices, and lack of resources to fund mental health services within communities (Mongelli et al., 2020). Furthermore, research shows that marginalized youth are 20%–50% less likely to seek mental health services and 40%–80% more likely to dropout of treatment prematurely compared to their White peers (Aggarwal et al., 2016).

School-Based Mental Health Interventions

School-based mental health interventions have played an important role in efforts to overcome service access barriers for children and adolescents. Given that children and adolescents spend a major part of their lives in schools and families spend a good amount of time addressing school-related concerns, schools have become a central system for addressing children's needs beyond academics (Kratochwill, 2007; Moon et al., 2017). With the availability of school-based mental health services, these interventions can potentially improve access to care and outcomes, especially for marginalized youth (Britto et al., 2001; Solomon et al., 2012). School-based interventions are especially key to improving access to quality mental health care for marginalized youth given that low-income and racially/ethnically diverse students are more likely to seek and receive school-based support compared to clinic-based treatment (Jaycox et al., 2010). Likewise, schools are an ideal setting for prevention and well-being promotion that can be supported by regular school–home communication. Compared to services provided in other settings, school-based mental health interventions may be more timely, accessible, and efficient—and they can reach larger numbers of children in need (Fazel et al., 2014).

To improve access to quality mental health care, schools often use a *multitiered systems of support* (MTSS) approach, which refers to the application of prevention systems in the school environment (Loftus-Rattan et al., 2023). MTSS has the potential to reduce disparities in mental health problems and increase access to mental health care for marginalized youth by providing early and targeted prevention that is embedded within the school context (Castro-Olivo, 2017). Malone et al. (2022) suggest an MTSS framework for culturally responsive mental health promotion and intervention should focus on creating school climates conducive to marginalized students' well-being and success in Tier 1 (universal prevention) and integrating culturally responsive practices in Tier 2 (targeted prevention) and Tier 3 (intensive prevention) to improve marginalized youths' mental health outcomes. Leveraging an MTSS approach allows schools to provide immediate and continuing mental health resources to students without requiring families to search for sources of care that are already limited (O'Connell et al., 2009; Short et al., 2018).

Many interventions for prevention and treatment of common mental health problems in school settings have been developed and validated, yet few evidence-based interventions (EBIs) have been successfully implemented and sustained in schools over time (Kutash et al., 2006; Langley et al., 2010). *School-based EBIs* are defined as practices that have been shown in controlled research studies to be efficacious in improving student outcomes on a continuum of low to high evidence (Sanetti et al., 2014). Unfortunately, research shows that EBIs are not often adopted, implemented, and maintained in schools and other community settings the way they were designed to be (Dingfelder & Mandell, 2011; Ennett et al., 2003). The field of *implementation science*—defined as the study of methods to promote the uptake and sustainment of evidence-based practices (Eccles & Mittman, 2006)—has grown up explicitly to address these concerns across service settings, including schools (Forman et al., 2013).

Much research in school-based implementation science has focused around identifying and understanding factors contributing to the *implementation gap in education* (i.e., the discrepancy between availability and actual use of EBIs schools; Sanetti & Collier-Meek, 2019). For example, Langley et al. (2010) found that lack of parent engagement, competing responsibilities, logistical barriers, and lack of support from school administrators and teachers are the main reasons why EBIs are not implemented in schools as designed. As another example, Forman et al. (2009) found five factors were most likely to influence implementation success: (a) effectiveness of school organizational structures, (b) usability of program characteristics, (c) fit with school goals, (d) availability of training and technical assistance, and (e) administrator support. Considering the literature in this area, the American Psychological Association: Division 16 Working Group on Translating Science to Practice proposed that much work is needed to develop practice guidelines for effectively addressing implementation factors specifically with racially/ethnically diverse students within diverse school contexts (Forman et al., 2013). Our article takes up this recommendation by honing in on how *culturally sensitive interventions* (CSIs) can be employed to improve implementation and adaptation of EBIs with marginalized youth in schools. To move on this, we must first operationalize the concept of *culture* as it relates to informing intervention. Culture may be defined by factors such as familial roles, communication patterns, beliefs relating to personal control, individualism, collectivism, spirituality, and other characteristics defining a given group with shared norms (Kreuter et al., 2003).

Culturally Sensitive Interventions

CSIs are defined as the systematic modification of an EBI or intervention protocol to consider language, culture, and context in a way that is compatible with a client's cultural patterns, meanings, and values (Castro et al., 2010). CSI modifications can range on a continuum of low to high cultural adaptation, characterized by awareness of culture, acquisition of knowledge about cultural aspects, and capacity to distinguish between culture and pathology. When applied to school-based interventions, CSIs could attend to both school culture (e.g., adaption for "fitting" within the school environment, alignment with an educational mission, ability to be implemented within a school's existing workflow) and student/family culture. CSIs have been shown to reduce stigma, increase treatment seeking among underserved populations, increase treatment duration, and improve outcomes for individuals from marginalized groups (Bernal & Sáez-Santiago, 2006; Rathod et al., 2018). Given marginalized youth are placed at risk of developing psychosocial and mental health problems, including substance use,

delinquency, low academic achievement, and poor self-esteem (Jackson, 2009), we suggest CSIs are crucial for addressing inequities in youth mental health outcomes.

CSIs have been shown to be more effective compared to traditional EBIs. For example, in a treatment study conducted by Cabiya et al. (2008), a culturally tailored cognitive behavioral intervention was evaluated with Puerto Rican children ($N = 608$) with disruptive behavior disorders and depressed mood. This study found significant reductions in depressed mood and disruptive behaviors for the culturally tailored group compared to the control group. Similarly, a randomized control trial examining a culturally tailored social skills training for Korean teens ($N = 447$) with autism spectrum disorder (ASD) found that, compared to the control group, teens who had a culturally tailored intervention showed significant improvements in social skills knowledge, interpersonal skills, and play/leisure skills, as well as significant decrease in depressive symptoms and ASD symptoms (Yoo et al., 2014).

A few meta-analyses have shown that CSIs produce superior outcomes for marginalized clients compared with conventional interventions. Rathod et al. (2018) found effect sizes ranging from small to large ($d = 0.23$–0.75) with 12 studies; Hall et al. (2016) demonstrated a medium effect size ($g = 0.52$) with 78 studies, and Benish et al. (2011) showed a small effect size ($d = 0.32$) with 21 studies. Furthermore, a recent meta-analysis with nine randomized trials found that Latinx participants had higher EBI success rates (15%–30%), with the effects maintained at 6–12 months, when cultural adaptations were implemented compared to traditional treatment (Escobar & Gorey, 2018). Additionally, a systematic review of 22 studies regarding substance abuse interventions for Latinx adolescents found more positive outcomes on substance use when interventions were culturally adapted compared to traditional treatment (Robles et al., 2018). Relatedly, a meta-analysis examining culturally adapted parent training programs for ethnic minority families showed CSIs are more effective in improving parenting behavior than programs that did not use cultural adaptations (van Mourik et al., 2017). Taken together, the several reviews on this topic suggest that CSIs are consistently more effective than interventions that ignore or otherwise fail to account for cultural considerations.

Purpose of Our Article

Given the importance of both school-based interventions and culturally adapted EBIs to enhance equity in youth mental health care, the purpose of our article is to provide guidelines for advancing CSIs when implementing and adapting EBIs with marginalized youth in schools. Recently, the Bipartisan Safer Communities Act was passed in June 2022, providing an additional $1 billion dollars to protect America's children, keep schools safe, and reduce the threat of violence across the country (Everytown for Gun Safety, 2021). Part of the funding for this legislation invests in programs to expand mental health and supportive services in schools, including early identification and intervention programs, school-based mental health and wraparound services, improvements to school-wide learning conditions, and school safety (Bipartisan Safer Communities Act, 2022). With this landmark legislation and associated funding, there is an opportunity to better student outcomes by considering and strengthening the guidelines we provide for implementing and adapting EBIs with marginalized youth in schools. We hope this article may be useful toward this end.

Prior to embarking on these guidelines, however, we acknowledge the foundational role of earlier work focusing on implementation science in schools (e.g., Forman et al., 2009, 2013; Sanetti & Collier-Meek, 2019). More specifically, we also acknolwedge studies examining culturally relevant EBIs in schools, including work focusing on implementation considerations, barriers, and supports toward advancing CSIs in schools (e.g., Aston & Graves, 2016; Beeks & Graves, 2016; McGoey et al., 2016; Ryan et al., 2016; Schaffner et al., 2016). These works have tested EBIs under less-than-optimal conditions while providing examples of culturally informed adaptations to intervention planning or procedures. Themes from these studies involve unique considerations and barriers to implementing interventions within school-based behavioral support systems across culturally diverse settings. We hope to continue and build upon this conversation in this article by providing additional guidelines for implementers of EBIs to provide CSIs with marginalized youth in schools. Throughout this article, when referring to *implementers of EBIs*, we mean anyone who is using EBIs in a school setting, including (but not limited to) teachers, counselors, researchers, and school-based clinicians.

Our guidelines for advancing CSIs for implementing and adapting EBIs with marginalized youth in schools center around two core themes. First, we emphasize inclusive strategies for improving and sustaining EBIs with marginalized youth in schools. Specifically, we focus on the importance of antiracist adaptations and using a community-based participatory research (CBPR) approach for enhancing implementation and sustainment of EBIs. Second, we discuss techniques for tailoring CSIs and more effectively supporting marginalized youth and their families with school-based prevention and treatment. These tailoring techniques include leveraging the Adapting Strategies for Promoting Implementation Reach and Equity (ASPIRE) framework to promote equitable implementation as well as employing key engagement strategies that focus around centering communication styles, emphasizing family values, considering how sociopolitical history can impact youth and their families, and relying on routine outcome monitoring to evaluate the effectiveness of CSIs (see Table 1 for a summary of our guidelines and associated recommendations). Ultimately, we offer these guidelines and recommendations to inform more equitable practice in youth mental health care and motivate future studies to advance culturally responsive services with marginalized youth in schools.

Inclusive Strategies for Advancing CSIs in Schools

Antiracist Adaptations

Given that antiracist efforts in schools are crucial for addressing educational disparities (Diem & Welton, 2020), our first recommendation related to inclusive strategies is to employ antiracist adaptations at the individual level, team level, and macrolevel within educational settings. To incorporate antiracist adaptations at the *individual level*, Welton et al. (2018) highlight the importance of both improving the relationships of implementers of EBIs with marginalized students and families as well as changing how implementers of EBIs talk about marginalized students with one another. Welton et al. (2018) propose implementers can examine and change district-wide institutional scripts, stereotypes, and deficit beliefs about marginalized students and how they learn. Furthermore, there should

Table 1
Summary of Guidelines and Recommendations

Guidelines	Recommendations
Use inclusive strategies for advancing CSIs	Use antiracist adaptions • Examine and change institutional scripts, stereotypes, and deficit beliefs about marginalized students • Take responsibility and ownership for the inequities students experience • Access belief systems about marginalized students learning and behavior • Host implicit bias trainings • Provide district and school-level training on restorative practices Use a community-based participatory research approach • Engage key stakeholders in collaborative planning throughout EBI implementation • Establish regular meeting times to work together • Conduct in-depth qualitative interventions and focus groups with key stakeholders to identify target problems and develop strategies
Use tailoring techniques for improving CSIs	Use the ASPIRE framework as a guide to promote equitable implementation • Step 1: Identify the underlying assumptions • Step 2: Identify potential sources of disparities • Step 3: Adapt the implementation strategy to ensure equity Use strategies for engaging marginalized youth and their families • Adapt communication styles to increase engagement and treatment outcomes • Understand family values to support the identification and development of services • Consider the sociopolitical history's impact on marginalized youths' engagement with EBIs and their treatment outcomes • Rely on routine outcome monitoring to evaluate the effectiveness of CSIs

Note. CSI = culturally sensitive intervention; EBI = evidence-based intervention; ASPIRE = Adapting Strategies for Promoting Implementation Reach and Equity.

be a shift from a language of deficit and despair to a language of hope, promise, and success when implementers of EBIs talk about marginalized students with one another (Welton et al., 2018). For example, instead of saying there is an "achievement gap" between Black and White students, we suggest adopting a more descriptive phrase that identifies malleable sources of the problem, such as "educational inequities that are a function of resource allocation disparities." By focusing narrowly on individuals' performance (e.g., "achievement gap"), deficit language obscures the persistent inequalities in educational outcomes that stem from unjust educational systems (e.g., "function of resource allocation disparities") and broader social and economic structures (Valencia, 2010). At the individual level, it is also necessary to help implementers of EBIs take responsibility and ownership for the inequities that marginalized students experience and to be responsive to feedback regarding how they might academically support and develop positive relationships with marginalized students. Welton et al. (2018) suggest this can be done by hosting district and school-level meetings to discuss vision and goals—emphasizing the goal for positive change is nonnegotiable.

Antiracist adaptations at the *team level* may require accessing implementers' belief systems about marginalized students learning and behavior as well as hosting ongoing implicit bias trainings and other professional development regarding how to implement more culturally responsive instruction and relationship building with students (Welton et al., 2018). To access implementers' belief systems about marginalized students learning and behavior, Welton et al. (2018) suggest examining current disciplinary data. Depending on the findings, we suggest it may be beneficial to have a district and/or school-wide discussion about the disciplinary data and what it means for marginalized students' experiences and learning outcomes. When conducting ongoing implicit bias trainings and implementing more culturally responsive instruction, it is crucial to consider an equity audit and walk-through of the school to determine what structures and processes impact the overall school climate and negative schooling experiences of marginalized students (Welton et al., 2018). We recommend using results from these formative assessments to drive the focus and topics of future professional development opportunities for implementers of EBIs.

Likewise, suggestions on antiracist adaptations at the *macrolevel* include providing district and school-level training on how to implement restorative practices (Welton et al., 2018). This entails eliminating ineffective zero-tolerance discipline policies (American Psychological Association Zero Tolerance Task Force, 2008) district-wide, and instead implementing effective restorative justice practices (Darling-Hammond et al., 2020) district wide (Welton et al., 2018). Furthermore, we suggest that it is important to have continuous critical examination and recalibration of district- and school-wide disciplinary policies and procedures. This can be implemented by gathering information from students via formative feedback assessments to examine the strengths and weaknesses of the restorative justice process and the overall culture and climate of the schools and district (Welton et al., 2018). Moreover, we recommend that advocating for diversifying the workplace to include implementers of EBIs from diverse racial/ethnic backgrounds may be beneficial to marginalized students, as evidence suggests the presence of more inclusive and representative school staff has desirable associations with students' test scores, attendance, course grades, disciplinary outcomes, and expectations in educational settings (Holt & Gershenson, 2019). Taken together, antiracist adaptations at the individual, team, and whole-school levels contribute to an inclusive school climate that sets the stage for implementers to promote and advance CSIs with marginalized youth.

CBPR Approach

Our second recommendation for actualizing inclusive strategies is to employ a CBPR approach. In addition to antiracist adaptations, employing a CBPR approach is a complementary strategy for improving the implementation and sustainability of EBIs with marginalized youth in schools. Barriers to implementing EBIs in school districts are often a result of proliferating new initiatives that become fragmented because people are working with different goals or purposes (Ahram et al., 2011). This fragmentation can impact implementation and sustainment of evidence-based practices and contribute to negative attitudes toward the implementation of new

initiatives. Other common barriers to effectively implementing interventions in schools include problems with care coordination (Weist et al., 2014), logistics related to confidentiality rules and regulations (Weist et al., 2012), and lack of participation and high dropout rates (Gross et al., 2011). Using a CBPR approach, which entails partnering with key stakeholders in schools early on, may help address many of these common barriers (Chambers & Azrin, 2013).

CBPR is a widely accepted collaborative approach to research that works to understand and protect public health by involving all partners in the research process (Israel et al., 1998). In the case of school-based mental health services, key stakeholders from local schools and their surrounding community may include school personnel, parents, community organizations, faith-based groups, clinicians, and researchers (Ngo et al., 2008). Engaging key stakeholders in collaborative planning of EBI implementation can ensure that the appropriate resources, incentives, and supports are in place to promote implementation success from the very beginning. In addition, buy-in from the larger system may be important in justifying the multisystem collaboration and cultivating a culture that supports EBIs and facilitates their use (Bryson et al., 2006). The CBPR approach can also be beneficial throughout all phases of intervention dissemination, from program development to implementation planning to EBI delivery and sustainment.

To ensure that an EBI is sustainable and accessible, partnerships with key stakeholders are crucial to developing intervention strategies that are consistent with the community's priorities, culture, and values. For example, it is critical that school partners identify the key issues they believe may be impacting students' mental health, well-being, and academic performance (Wong, 2006). Likewise, we suggest soliciting student voice and perspective—especially from diverse and representative groups of youth—is imperative (Yamaguchi et al., 2023). With this information visible and clear, the intervention can then be tailored in response to formal and informal feedback from parents, educators, community members, and youth themselves. These focus groups can then discuss existing engagement strategies, specific cultural, school, and community issues, as well as potential barriers to implementation (Ngo et al., 2008). We suggest engaging with key stakeholders during preimplementation planning is also beneficial to improve ongoing local community engagement. For example, Ngo et al. (2008) found that having multistakeholder planning committees allowed for ideal methods of local service delivery to be identified. Moreover, Ngo et al. found that conducting this planning phase before actual program delivery was crucial for tailoring how their intervention is introduced to a community and for identifying necessary contextual issues specific to the population receiving the intervention.

Based on the available literature on this topic, we recommend the following steps when using a CBPR approach to develop and implement CSIs in schools for addressing identified student needs. First, it is essential for implementers of EBIs to reach out and collaborate with key stakeholders such as school personnel, parents, community organizations, faith-based groups, clinicians, researchers, and the youth themselves. Once regular meeting times have been established, the team should work together to identify the target problem and develop a strategy for addressing this problem at a systems level. We suggest using in-depth qualitative interviews and focus groups with school personnel from multiple backgrounds, such as teachers, school counselors, and administrators, to help clarify the nature of the problems presenting within the school context. Depending on the problems identified, implementers could then ask specific questions to gain a better understanding of how the EBI could be adapted for implementation. For example, if the school wanted to target system-level issues, the following questions could be asked: *Do you perceive any structural barriers to our attempts at meeting students' needs? Can you please describe these barriers? Do you have any ideas about how we could address or eliminate some of these barriers?* Based upon these findings, a process of shared problem solving can occur, wherein potential interventions to address identified barriers can be identified and discussed. After the problem is defined collectively by the team, the intervention could be developed to help address the identified target area. During this step, the roles and responsibilities of all involved parties should be delineated, including a plan for how to evaluate the effectiveness of the intervention (see Merrell et al., 2022, for elaboration on conducting problem solving processes with and in schools). We strongly recommend that implementers move to implement the school-based EBI—now turned CSI—only after accomplishing these foundational steps.

Before discussing the advantages of the CBPR approach, we acknowledge the challenges that may be encountered by implementers when using this approach. The overarching challenge is that the CBPR approach requires significant resources—in terms of time, staff, expertise, and financial compensation—to carry out effectively. For example, implementers of EBIs may not have the resources to reach out to all key stakeholders, including a research or evaluation team. In addition, the availability of researchers or evaluators in schools and districts may also be limited, which may place a significant burden on community partners to perform these specialized functions. Therefore, we emphasize that open communication and careful planning with shared decision-making are crucial before engaging in CBPR. For more on the challenges experienced on this front, we recommend readers consider the guidelines by Ross et al. (2010) for addressing the limitations of CBPR to ensure a successful partnership.

The advantages of a CBPR approach are several. It allows for the adaptation of existing resources, explores local knowledge and perceptions, and empowers community members by considering them agents who can investigate and improve their own situations (Israel et al., 2001; Stevens & Hall, 1998). Furthermore, the community input derived from a CBPR approach makes the intervention credible, enhances the intervention impact by aligning with the local community's social and health goals, provides resources for the involved communities through its collaborative nature, proactively bridges cultural differences among participants, and helps to dismantle the lack of trust communities may experience related to involvement with research (Israel et al., 2001; Stevens & Hall, 1998; Webb, 1990).

Additional benefits to engaging the CBPR approach include: (a) community stakeholders and implementers of EBIs can strengthen their relationship through long-term collaboration regarding mutual interests, shared community involvement, and/or long-standing research engagements; (b) community stakeholders have an official status on community advisory boards and can potentially serve as coinvestigators; (c) research ideas are identified by or in collaboration with the impacted community and are driven by their expressed needs and values; (d) community stakeholders and implementers of EBIs can codesign interventions with their participation on community advisory boards, on steering committees, and in consultant roles; (e) community stakeholders and implementers of EBIs have

the opportunity to be coauthors/co-owners of research products; (f) opportunity for community-wide adoption of the developed intervention, training, policy recommendations, and actions; and (g) data/findings are available to the community for future funding requests regardless of researcher involvement (Collins et al., 2018). In sum, we propose using a CBPR approach cultivates an inclusive and collaborative context that both produces CSIs and prevents against many of the common barriers to implementing EBIs with marginalized youth in schools.

Tailoring Techniques for Improving CSIs in Schools

ASPIRE Framework

Our first recommendation for tailoring EBIs with marginalized youth is to apply the three-step process of the ASPIRE framework for evaluating and adapting implementation strategies (Gaias et al., 2022). The first step in the ASPIRE framework is to identify the underlying assumptions by considering how and why the implementation strategy is supposed to work and for whom (Gaias et al., 2022). As such, it is important to consider what would need to be true about the implementation strategy to promote equitable outcomes. Incorporating CBPR principles by including key stakeholders to codesign interventions and including community input to identify underlying assumptions are especially critical at this stage (Collins et al., 2018). When we include key stakeholders to codesign interventions, the underlying assumption is that the school and stakeholders have similar goals, norms, and language for engaging in implementation efforts. This step is especially beneficial when implementers of school-based EBIs are not naturally embedded within the school setting (e.g., consulting mental health professionals working primarily in other community settings), as educational and mental health (medical) service systems are grounded in different philosophical models and therefore often have differing values, priorities, and procedures (Gutkin, 2012; Weisz et al., 2013).

The second step in the ASPIRE framework is to identify potential sources of disparities that could appear if the implementation strategy is used without explicit attention to equity. Strategies include the individuals involved in the implementation strategy, the resources necessary to engage in the implementation strategy, the process required to validate the implementation strategy, the causal mechanisms that underlie the strategy, and the outcomes that may result from using the implementation strategy (Gaias et al., 2022). Integrating CBPR principles in this step is especially important since key stakeholders may provide an EBI that is more flexible, which would accommodate the iterative research process (Collins et al., 2018). Likewise, key stakeholders' input on the selection of strategies and measures, as well as giving community members an option to assist in recruitment and data collection, may further aid in addressing potential sources of disparities (Collins et al., 2018). Identifying potential sources of disparities may be especially beneficial when there are competing values or power dynamics between researchers and key stakeholders, which can sometimes lead to academic priorities dominating community needs or even the needs of the youth being served (Yamaguchi et al., 2023). Being able to identify sources of disparities during the planning phase of the intervention could prevent these disparities from occurring and optimize the benefits received by community partners and students themselves.

The third and final step of the ASPIRE framework is to adapt the implementation strategy to ensure that equity is considered in the underlying assumptions and has the potential to reduce disparities (Gaias et al., 2022). Therefore, it is crucial to identify changes that could improve equitable implementation and equitable student outcomes as a result of using a newly adopted implementation strategy. This includes the consideration of the participants involved, the process or steps that need to be executed, and the outcomes that need to be considered. Again, incorporating the CBPR principle of using key stakeholders' expertise and perspectives for adapting equitable implementation may be particularly helpful in maintaining the sustainability of the intervention (Collins et al., 2018). For example, when working together with key stakeholders, it is important to have clearly outlined and mutually reinforcing goals and expectations. With these elements in place, all partners can then share their skills and knowledge to enhance the intervention. While considering the underlying assumptions to reduce potential disparities within the ASPIRE framework, plans for sustaining the intervention would be proactively built into the research timeline and funding when following CBPR principles (Collins et al., 2018). This may also help researchers to work with key stakeholders beyond a single funding cycle. Consequently, we strongly recommend using the ASPIRE framework along with CBPR principles to intentionally promote more equitable implementation and student outcomes. We refer readers to Gaias et al. (2022) for additional guidance around navigating challenges that arise when using the ASPIRE framework.

Engagement Strategies

Our second recommendation for tailoring CSIs with marginalized youth is to use culturally responsive engagement strategies. The literature on CSIs suggests that it is essential to find a balance between EBI fidelity and culturally informed care, so that youth and their families have a better chance of staying engaged with services and improving outcomes (Bernal & Sáez-Santiago, 2006). Therefore, it is crucial that implementers of EBIs include culturally relevant people, materials, and concepts throughout treatment and address language needs to increase engagement and treatment outcomes. A review conducted by Park et al. (2022) highlights cultural tailoring strategies used in efficacious psychosocial interventions for youth of color, such as conceptualization, message, procedures, style, communication, and change agent. The most common CSIs include the use of procedures for addressing cultural context and involvement of providers with awareness and knowledge of the youth's culture. In addition to the strategies covered in the review by Park et al. (2022), the engagement strategies we highlight for CSIs include adapting communication styles, emphasizing family values, considering how sociopolitical history can impact youth and their families, and relying on routine outcome monitoring to evaluate the effectiveness of CSIs (Bernal, 2006; Hwang, 2006; Pumariega et al., 2005). Given these techniques aid the implementer's understanding of the experience of specific populations, we recommend that each be integrated throughout the intervention planning and full implementation, not only at intervention outset.

Adapt Communication Styles. Adapting communication styles is key for increasing engagement and treatment outcomes for marginalized youth. For instance, it is important for

implementers of EBIs to use simple gestures that are culturally appropriate (e.g., handshakes, facial expressions, greetings, and small talk) to help establish a positive first impression and begin building rapport with students. Keep in mind that students are typically new to intervention language or jargon, so it is necessary to educate them about expectations for sessions and meetings before starting. Sue and Sue (2008) outline several factors of communication style that may affect intervention usability. Differences in counselor and client proxemics, kinesics, and paralanguage may contribute to miscommunication during the intervention process. *Proxemics* describe individuals' culturally influenced sense of personal space, whereas *kinesics* refers to the use of bodily movements, such as facial expressions, posture, gestures, and eye contact, to communicate. *Paralanguage* describes the use of voice characteristics, including loudness, pauses, silences, speech rate, and inflection, to express differences in meaning. Implementers of EBIs should be mindful of these communication styles while also considering whether the student or family's cultural communication style is low context or high context. *Low-context* communication relies primarily on the message relayed by verbal communication, whereas *high-context* communication relies less on verbal communication and more on additional shared understanding, nonverbal cues, and paralanguage to convey the full meaning of the message.

Emphasize Family Values. Understanding family values is also essential to increase engagement and improve treatment outcomes for marginalized youth. To do so, implementers of EBIs should acquire knowledge of the cultural beliefs and practices valued by the families they serve (Lynch & Hanson, 2011). Previous research shows that family involvement in schools leads to improved educational success with marginalized youth (Benner et al., 2016; Dearing et al., 2006; Jeynes, 2012; Miedel & Reynolds, 1999). This knowledge may support the identification and development of services that are in line with the beliefs and values of families (Bradshaw, 2013). However, it is imperative to realize that cultural beliefs should not be assumed based on membership in a single cultural category (Harry, 2002). Each family has a different context influenced by factors that contribute to their unique family culture (e.g., ethnicity, race, social class, nationality, geographical location, language, age, profession, and personal interests; Harry, 2002). Gathering knowledge about family values can enhance the ability of implementers to match EBIs based on family needs and desires. Given there are multiple influences that contribute to the cultural beliefs and values of individual families, it is helpful to have open communication with families about what they expect from their children at different ages or stages of development (Durand, 2010). For example, when conducting assessments that ask about children's developmental milestones, implementers of EBIs could evaluate caregiver responses to determine if a milestone may not have been reached because it is not developmentally appropriate according to the family culture (Spodek & Saracho, 2006). That said, we acknowledge family involvement with EBIs in the school context may be met with resistance due to logistical and cultural barriers (e.g., lack of time, negative beliefs about EBIs, competing family priorities, taxing demands related to supporting EBIs). Implementers could therefore benefit from built-in school resources to help address these barriers, including teacher support, administrator support, good training and technical assistance, integrating the intervention with other school programs or academic curriculum, and engaging school personnel in planning for implementation (Forman et al., 2009).

Consider Sociopolitical History. It is imperative to consider how sociopolitical history can impact marginalized youths' engagement with EBIs and their treatment outcomes. Although progress has been made toward racial equality and equity, there is evidence to support the continued negative impact of racism on youths' health and well-being through implicit and explicit biases and discriminatory institutional structures (Bonnie et al., 2015; Gitterman et al., 2016). Relatedly, research shows that discriminatory encounters are still more prevalent among socially marginalized groups, which places them at greater risk for negative stereotypes and subjects them to historical, collective trauma resulting in intergenerational physical and mental health disparities (Bombay et al., 2009). As such, it is beneficial to consider how these salient factors impact marginalized youths' engagement with EBIs. One way to mitigate the effects of institutional racism in school settings is for marginalized youth to have exposure to a role model with a similar racial/ethnic background early in their educational experience. For example, research shows that African American students who have one African American teacher in elementary school are more likely to graduate from high school and enroll in college than their peers who did not have an African American teacher (Gershenson et al., 2018).

For implementers of EBIs, we recommend the following strategies to increase engagement when considering the impact of sociopolitical history on marginalized youth. First, it is crucial to get training in culturally competent care according to national standards for culturally and linguistically appropriate services (Barksdale et al., 2017; U.S. Department of Health & Human Services, 2001). When intervening with students in individual sessions, it may be beneficial to integrate positive youth development approaches with more traditional EBIs (e.g., Eichas et al., 2017). This includes racial socialization to identify strengths and assess youth for protective factors (e.g., supportive extended family network), which could help mitigate exposure to racist behaviors (Anderson et al., 2015; Ward, 2002). Furthermore, intentional antioppression programming strategies, such as Raising Resisters, could provide support to youth in the classroom, small group, or individual sessions to: (a) recognize racism in all forms, from subversive to blatant manifestations; (b) differentiate racism from other forms of unfair treatment and/or routine developmental stressors; (c) safely oppose the negative messages and/or behavior of others; and (d) counter or replace those messages and experiences with positives (Ward, 2000, 2002). Finally, when implementing EBIs in a classroom setting, it may be valuable to use culturally diverse materials to ensure that there is a representation of authors, images, stories, and life experiences that reflect the cultural diversity of the marginalized youth in the school setting (e.g., Positive Action, 2021; Trent et al., 2019).

Rely on Routine Outcome Monitoring. Finally, to evaluate the effectiveness of culturally tailored interventions and iterate appropriately, we recommend using routine outcome monitoring to guide data-based decision-making. Prior to culturally tailoring interventions, we suggest the use of routine outcome monitoring to help inform the needs of the students, school, and district. These assessments should be done before, during, and after the EBI is

implemented to help provide feedback regarding the fit of culturally tailored interventions (Boswell et al., 2015). Throughout routine outcome monitoring, it is important to assure the CSI remains evidence-based so that the core components are not changed or lost. Culturally adapting an EBI preserves the essential components of an intervention while tailoring or including cultural references to increase relevance and engagement for marginalized youth. Core components of EBIs include *content* (i.e., what is being taught), *pedagogy* (i.e., how the content is taught), and *implementation* (i.e., logistics responsible for a conducive learning environment; Office of the Assistant Secretary for Planning and Evaluation, 2013).

To help guide data-based decision-making, the first step is using routine outcome monitoring data to determine if CSIs are needed (Marsiglia & Booth, 2015). CSIs are recommended when: (a) a client's engagement in services fall below what is expected, (b) expected outcomes are not achieved, and (c) identified culturally specific risks and/or protective factors need to be incorporated into the intervention (Barrera & Castro, 2006). Using routine outcome monitoring to inform whether CSIs will meet the needs of the student is crucial during this step. Once there is determination to use CSIs, the second step in preserving EBIs is to use models that consider content and process (Ferrer-Wreder et al., 2012). In line with routine outcome monitoring, CSIs should be pilot tested and based on the outcomes in which the adaptations were made. Across all theories of adaptation, the process is repetitious, with changes made to the intervention at every stage based on the evidence of routine outcome monitoring generated in the previous stage (Domenech-Rodríguez & Wieling, 2005). Thus, we propose that maintaining the core components of EBIs while relying on routine outcome monitoring will guide implementers in effective data-based decision-making around CSIs.

Potential Challenges to CSI Implementation and Future Directions

Prior to closing, we want to acknowledge potential issues that may pose challenges to effectively implementing our recommendations. For example, practical concerns related to teacher unions and shortages, as well as contemporary barriers in social issues that influence what can be taught, read, shared, or addressed with students (e.g., Critical Race Theory debates at the school board and legislative levels or "Don't Say Gay" laws in some states) may undermine the ability to implement antiracist adaptions and CSIs in schools. We also acknowledge that our recommendations may not be applicable to some youths with significant mental health needs. Specifically, our recommendations may be largely irrelevant for youth who are placed at risk for mental health problems yet would not be reached—or are hard to reach—with school-based services, including those with poor attendance, those involved with juvenile justice systems, and unhoused populations (National Center for Homeless Education, 2020; The Council of State Governments Justice Center, 2020). Furthermore, we acknowledge our guidelines may be challenging to apply for those working in schools within MTSS frameworks (Loftus-Rattan et al., 2023), as our recommendations do not include instructions for applications at each potential level of service delivery (i.e., Tier 1, Tier 2, and Tier 3). We hope, however, that the substantive descriptions provided for each guideline are good enough for inspiring generalizations toward this end. We also suggest future work could build from the base we have established by operationalizing how school-based implementers could incorporate strategies to promote safe and affirming school climates for marginalized youth using the MTSS framework outlined by Malone et al. (2022).

Moreover, status quo methods for developing EBIs in schools may pose potential challenges to building an evidence base around our guidelines. Although, as we have argued above, schools are in a unique position to address mental health disparities among marginalized youth, modifications to our current research systems and treatment development practices are needed to engage youth in need of care (DeFosset et al., 2017). We recommend future work on EBIs evaluate which interventions are well-established for marginalized youth in real-world schools beyond efficacy trials. Efficacy trials usually adhere to strict inclusion/exclusion criteria (Pina et al., 2019). In addition, many efficacy trials have barriers to the inclusion and retention of marginalized youth, as studies take place at university laboratories or other highly controlled settings, which may be difficult to access (Abe-Kim et al., 2007; Freedenthal & Stiffman, 2007; Suite et al., 2007). Efficacy trials also tend to rely on interventionists such as graduate students, having high levels of fidelity to manuals with low levels of culturally responsive training or supervision (Pina et al., 2019). These factors may also affect the development of rapport building with marginalized youth, which results in nonengagement and eventual dropout (Valenzuela & Smith, 2016). For this reason, we recommend instead different types of hybrid effectiveness–implementation trials that are well suited to implementation and adaption: (a) testing effects of a clinical intervention on relevant outcomes while observing and gathering information on implementation; (b) dual testing of clinical and implementation interventions; and (c) testing of an implementation strategy while observing and gathering information on the clinical intervention's impact on relevant outcomes (Curran et al., 2012). Using hybrid effectiveness–implementation trials could reduce the time lag between research discovery and routine uptake in community settings such as schools (Glasgow et al., 2003). Faster intervention uptake and more effective implementation strategies may help improve outcomes more efficiently and effectively.

Beyond the general need for research in this area, we acknowledge that intentional empirical work is needed to further validate both the structure and content of our guidelines for supporting implementation and adaptation of EBIs with marginalized youth in schools. Our guidelines and associated recommendations are grounded in previous research and strong theory around culturally responsive services, yet our choice to prioritize these—and our conceptual scheme for organizing them (see Table 1)—were based largely around our values and intuitions on the topic. Thus, future research may seek to validate or reorganize our guidelines through empirical means, such as qualitative or quantitative evaluations of themes, factors, components, and so on. We imagine that studies investigating the usefulness of our recommendations for guiding implementation of CSIs (e.g., investigating the value-added of emphasizing family values for improving outcomes, above and beyond adapting communication styles) as well as the social validity of our guidelines for implementers of CSIs (e.g., the relative perceived importance of inclusive strategies compared with tailoring techniques) may both be fruitful toward this end. Specific aspects of our recommendations may also be tested independently to better understand their impact on improving student outcomes. For example, future studies exploring outcomes from use of the ASPIRE

framework could add credibility to its adoption and our recommendations. We therefore wish our guidelines remain open to revision as research and theory advances, as they surely will. We also hope our guidelines may be applied flexibly and responsively as the state of the world, as well as regional and local conditions (e.g., pandemic challenges, educational and mental health care legislation, availability of community resources), evolve over time.

Conclusion

Given the need to inform more equitable practice in youth mental health care, the purpose of this article was to provide guidelines for advancing CSIs when implementing and adapting EBIs with marginalized youth in schools. We first emphasized inclusive strategies—including antiracist adaptions and using a CBPR approach—to improve implementation and sustainment of EBIs toward CSIs in schools. Following, we reviewed techniques for tailoring CSIs by employing the ASPIRE framework and culturally responsive engagement strategies to more effectively support marginalized youth and their families with school-based prevention and treatment. Toward this end, we highlighted adapting communication styles, emphasizing family values, considering sociopolitical history, and relying on routine outcome monitoring to guide and iterate culturally tailored EBIs. We are optimistic that heeding our guidelines related to inclusive and culturally tailored interventions will go a long way toward helping implementers improve the accessibility and quality of EBIs available to marginalized youth in schools. Moreover, we hope putting these guidelines and recommendations into practice might make a positive contribution toward ameliorating mental health care disparities—and outcome inequities—experienced by marginalized youth and their families.

In closing, we acknowledge the inequities and disparities that marginalized youth experience in education and mental health care are complicated by systemic political, social, economic, and cultural barriers. By advocating for using EBIs—and specifically for advancing and improving CSIs—with marginalized youth in schools, educators and mental health professionals alike can collaborate to provide more accessible and higher-quality mental health care for the youth, families, and communities who need it most. To best address the mental health inequities experienced by marginalized youth over the long run, however, we encourage school-based researchers interested in adapting EBIs with this population to move away from efficacy studies and toward hybrid studies that intentionally adopt, implement, and evaluate EBIs in real-world schools. We suggest this methodological shift will produce a more accessible, pragmatic, and usable evidence base, which can be integrated more quickly into practice and used more straightforwardly to guide effective interventions with youth in schools. Finally, we hope the guidelines and recommendations we provided herein might immediately benefit implementers while also, over time, helping fuel future applied research toward addressing disparities and promoting mental health equity with marginalized youth in schools. It is both an understatement and a truism to end by saying *much work remains to be done toward this end.*

Keywords: evidence-based interventions, culturally sensitive interventions, youth mental health, school mental health, mental health disparities

References

Abe-Kim, J., Takeuchi, D. T., Hong, S., Zane, N., Sue, S., Spencer, M. S., Appel, H., Nicdao, E., & Alegría, M. (2007). Use of mental health–related services among immigrant and US-born Asian Americans: Results from the national Latino and Asian American study. *American Journal of Public Health*, *97*(1), 91–98. https://doi.org/10.2105/AJPH.2006.098541

Aggarwal, N. K., Pieh, M. C., Dixon, L., Guarnaccia, P., Alegría, M., & Lewis-Fernández, R. (2016). Clinician descriptions of communication strategies to improve treatment engagement by racial/ethnic minorities in mental health services: A systematic review. *Patient Education and Counseling*, *99*(2), 198–209. https://doi.org/10.1016/j.pec.2015.09.002

Ahram, R., Stembridge, A., Fergus, E., & Noguera, P. (2011). *Framing urban school challenges: The problems to examine when implementing Response to Intervention*. RTI Action Network. http://rtinetwork.org/component/content/article/12/465-framing-urban-school

American Psychological Association Zero Tolerance Task Force. (2008). Are zero tolerance policies effective in the schools? An evidentiary review and recommendations. *American Psychologist*, *63*(9), 852–862. https://doi.org/10.1037/0003-066X.63.9.852

Anderson, A. T., Jackson, A., Jones, L., Kennedy, D. P., Wells, K., & Chung, P. J. (2015). Minority parents' perspectives on racial socialization and school readiness in the early childhood period. *Academic Pediatrics*, *15*(4), 405–411. https://doi.org/10.1016/j.acap.2014.11.002

Aston, C., & Graves, S. (2016). Challenges and barriers to implementing a school-based afrocentric intervention in urban schools: A pilot study of the sisters of Nia cultural program. *School Psychology Forum*, *10*, 165–176.

Auerswald, C. L., Piatt, A. A., Mirzazadeh, A., & Unicef. (2017). *Research with disadvantaged, vulnerable and/or marginalized adolescents* (Issue Brief No. 6). United Nations Children's Fund. https://www.unicef-irc.org/publications/878-research-with-disadvantaged-vulnerable-and-or-marginalized-adolescents.html

Barksdale, C. L., Rodick, W. H., III, Hopson, R., Kenyon, J., Green, K., & Jacobs, C. G. (2017). Literature review of the national CLAS standards: Policy and practical implications in reducing health disparities. *Journal of Racial and Ethnic Health Disparities*, *4*(4), 632–647. https://doi.org/10.1007/s40615-016-0267-3

Barrera, M., Jr., & Castro, F. G. (2006). A heuristic framework for the cultural adaptation of interventions. *Clinical Psychology: Science and Practice*, *13*(4), 311–316. https://doi.org/10.1111/j.1468-2850.2006.00043.x

Beeks, A., & Graves, S., Jr. (2016). The effects of the mystery motivator intervention in an urban classroom. *School Psychology Forum*, *10*, 142–156.

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal of Counseling Psychology*, *58*(3), 279–289. https://doi.org/10.1037/a0023626

Benner, A. D., Boyle, A. E., & Sadler, S. (2016). Parental involvement and adolescents' educational success: The roles of prior achievement and socioeconomic status. *Journal of Youth and Adolescence*, *45*(6), 1053–1064. https://doi.org/10.1007/s10964-016-0431-4

Bernal, G. (2006). Intervention development and cultural adaptation research with diverse families. *Family Process*, *45*(2), 143–151. https://doi.org/10.1111/j.1545-5300.2006.00087.x

Bernal, G., & Sáez-Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology*, *34*(2), 121–132. https://doi.org/10.1002/jcop.20096

Bipartisan Safer Communities Act. (2022). *Increased funding for schools*. https://www.murphy.senate.gov/imo/media/doc/bipartisan_safer_communities_act_one_pager.pdf

Bombay, A., Matheson, K., & Anisman, H. (2009). Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. *International Journal of Indigenous Health*, *5*(3), 6–47. https://jps.library.utoronto.ca/index.php/ijih/article/view/28987

Bonnie, R. J., Stroud, C., Breiner, H., Committee on Improving the Health, Safety, and Well-Being of Young Adults, Board on Children, Youth, and Families, & Institute of Medicine; National Research Council. (2015). Diversity and the effects of bias and discrimination on young adults' health and well-being. In R. J. Bonnie, C. Stroud, & H. Breiner (Eds.), *Investing in the health and well-being of young adults* (pp. 127–129). National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK284777/

Boswell, J. F., Kraus, D. R., Miller, S. D., & Lambert, M. J. (2015). Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. *Psychotherapy Research*, *25*(1), 6–19. https://doi.org/10.1080/10503307.2013.817696

Bradshaw, W. (2013). A framework for providing culturally responsive early intervention services. *Young Exceptional Children*, *16*(1), 3–15. https://doi.org/10.1177/1096250612451757

Britto, M. T., Klostermann, B. K., Bonny, A. E., Altum, S. A., & Hornung, R. W. (2001). Impact of a school-based intervention on access to healthcare for underserved youth. *The Journal of Adolescent Health*, *29*(2), 116–124. https://doi.org/10.1016/S1054-139X(01)00196-3

Bryson, J. M., Crosby, B. C., & Stone, M. M. (2006). The design and implementation of cross-sector collaborations: Propositions from the literature. *Public Administration Review*, *66*(s1), 44–55. https://doi.org/10.1111/j.1540-6210.2006.00665.x

Cabiya, J. J., Padilla-Cotto, L., González, K., Sanchez-Cestero, J., Martínez-Taboas, A., & Sayers, S. (2008). Effectiveness of a cognitive-behavioral intervention for Puerto Rican children. *Interamerican Journal of Psychology*, *42*(2), 195–202.

Castro, F. G., Barrera, M., Jr., & Holleran Steiker, L. K. (2010). Issues and challenges in the design of culturally adapted evidence-based interventions. *Annual Review of Clinical Psychology*, *6*(1), 213–239. https://doi.org/10.1146/annurev-clinpsy-033109-132032

Castro-Olivo, S. M. (2017). Introduction to special issue: Culturally responsive school-based mental health interventions. *Contemporary School Psychology*, *21*(3), 177–180. https://doi.org/10.1007/s40688-017-0137-y

Chambers, D. A., & Azrin, S. T. (2013). Research and services partnerships: Partnership: A fundamental component of dissemination and implementation research. *Psychiatric Services*, *64*(6), 509–511. https://doi.org/10.1176/appi.ps.201300032

Collins, S. E., Clifasefi, S. L., Stanton, J., Straits, K. J. E., Gil-Kashiwabara, E., Rodriguez Espinosa, P., Nicasio, A. V., Andrasik, M. P., Hawes, S. M., Miller, K. A., Nelson, L. A., Orfaly, V. E., Duran, B. M., Wallerstein, N., & the The LEAP Advisory Board. (2018). Community-based participatory research (CBPR): Towards equitable involvement of community in psychology research. *American Psychologist*, *73*(7), 884–898. https://doi.org/10.1037/amp0000167

Curran, G. M., Bauer, M., Mittman, B., Pyne, J. M., & Stetler, C. (2012). Effectiveness-implementation hybrid designs: Combining elements of clinical effectiveness and implementation research to enhance public health impact. *Medical Care*, *50*(3), 217–226. https://doi.org/10.1097/MLR.0b013e3182408812

Darling-Hammond, S., Fronius, T. A., Sutherland, H., Guckenburg, S., Petrosino, A., & Hurley, N. (2020). Effectiveness of restorative justice in US K-12 schools: A review of quantitative research. *Contemporary School Psychology*, *24*(3), 295–308. https://doi.org/10.1007/s40688-020-00290-0

Dearing, E., Kreider, H., Simpkins, S., & Weiss, H. B. (2006). Family involvement in school and low-income children's literacy: Longitudinal associations between and within families. *Journal of Educational Psychology*, *98*(4), 653–664. https://doi.org/10.1037/0022-0663.98.4.653

DeFosset, A. R., Gase, L. N., Ijadi-Maghsoodi, R., & Kuo, T. (2017). Youth descriptions of mental health needs and experiences with school-based services: Identifying ways to meet the needs of underserved adolescents. *Journal of Health Care for the Poor and Underserved*, *28*(3), 1191–1207. https://doi.org/10.1353/hpu.2017.0105

Diem, S., & Welton, A. D. (2020). *Anti-racist educational leadership and policy: Addressing racism in public education* (1st ed.). Routledge. https://doi.org/10.4324/9780429487224

Dingfelder, H. E., & Mandell, D. S. (2011). Bridging the research-to-practice gap in autism intervention: An application of diffusion of innovation theory. *Journal of Autism and Developmental Disorders*, *41*(5), 597–609. https://doi.org/10.1007/s10803-010-1081-0

Domenech-Rodríguez, M., & Wieling, E. (2005). Developing culturally appropriate, evidence-based treatments for interventions with ethnic minority populations. In M. Rastogi & E. Wieling (Eds.), *Voices of color: First-person accounts of ethnic minority therapists* (pp. 313–334). Sage Publications. https://doi.org/10.4135/9781452231662.n18

Durand, T. M. (2010). Celebrating diversity in early care and education settings: Moving beyond the margins. *Early Child Development and Care*, *180*(7), 835–848. https://doi.org/10.1080/03004430802466226

Eccles, M. P., & Mittman, B. S. (2006). Welcome to implementation science. *Implementation Science*, *1*(1), Article 1. https://doi.org/10.1186/1748-5908-1-1

Eichas, K., Montgomery, M. J., Meca, A., & Kurtines, W. M. (2017). Empowering marginalized youth: A self-transformative intervention for promoting positive youth development. *Child Development*, *88*(4), 1115–1124. https://doi.org/10.1111/cdev.12866

Ennett, S. T., Ringwalt, C. L., Thorne, J., Rohrbach, L. A., Vincus, A., Simons-Rudolph, A., & Jones, S. (2003). A comparison of current practice in school-based substance use prevention programs with meta-analysis findings. *Prevention Science*, *4*(1), 1–14. https://doi.org/10.1023/A:1021777109369

Escobar, K. M., & Gorey, K. M. (2018). Cognitive behavioral interventions for depression among Hispanic people: Promising meta-analytic evidence for deep cultural adaptations. *Social Work in Mental Health*, *16*(6), 746–758. https://doi.org/10.1080/15332985.2018.1476284

Everytown for Gun Safety. (2021). *What is the Bipartisan Safer Communities Act?* https://www.everytown.org/what-is-the-bipartisan-safer-communities-act/

Fazel, M., Hoagwood, K., Stephan, S., & Ford, T. (2014). Mental health interventions in schools 1: Mental health interventions in high-income countries. *The Lancet Psychiatry*, *1*(5), 377–387. https://doi.org/10.1016/S2215-0366(14)70312-8

Ferrer-Wreder, L., Sundell, K., & Mansoory, S. (2012). Tinkering with perfection: Theory development in the intervention cultural adaptation field. *Child and Youth Care Forum*, *41*(2), 149–171. https://doi.org/10.1007/s10566-011-9162-6

Forman, S. G., Olin, S., Hoagwood, K., Crowe, M., & Saka, N. (2009). Evidence-based intervention in schools: Developers' views of implementation barriers and facilitators. *School Mental Health*, *1*(1), 26–36. https://doi.org/10.1007/s12310-008-9002-5

Forman, S. G., Shapiro, E. S., Codding, R. S., Gonzales, J. E., Reddy, L. A., Rosenfield, S. A., Sanetti, L. M. H., & Stoiber, K. C. (2013). Implementation science and school psychology. *School Psychology Quarterly*, *28*(2), 77–100. https://doi.org/10.1037/spq0000019

Freedenthal, S., & Stiffman, A. R. (2007). "They might think I was crazy": Young American Indians' reasons for not seeking help when suicidal. *Journal of Adolescent Research*, *22*(1), 58–77. https://doi.org/10.1177/0743558406295969

Gaias, L. M., Arnold, K. T., Liu, F. F., Pullmann, M. D., Duong, M. T., & Lyon, A. R. (2022). Adapting strategies to promote implementation reach and equity (ASPIRE) in school mental health services. *Psychology in the Schools*, *59*(12), 2471–2485. https://doi.org/10.1002/pits.22515

Gershenson, S., Hart, C. M., Hyman, J., Lindsay, C., & Papageorge, N. (2018). *The long-run impacts of same-race teachers*. National Bureau of Economic Research. https://doi.org/10.3386/w25254

Gitterman, B. A., Flanagan, P. J., Cotton, W. H., Dilley, K. J., Duffee, J. H., Green, A. E., Keane, V. A., Krugman, S. D., Linton, J. M., McKelvey, C. D., Nelson, J. L., & the Council on Community Pediatrics. (2016).

Poverty and child health in the United States. *Pediatrics*, *137*(4), Article e20160339. https://doi.org/10.1542/peds.2016-0339

Glasgow, R. E., Lichtenstein, E., & Marcus, A. C. (2003). Why don't we see more translation of health promotion research to practice? Rethinking the efficacy-to-effectiveness transition. *American Journal of Public Health*, *93*(8), 1261–1267. https://doi.org/10.2105/ajph.93.8.1261

Gross, D., Johnson, T., Ridge, A., Garvey, C., Julion, W., Treysman, A. B., Breitenstein, S., & Fogg, L. (2011). Cost-Effectiveness of childcare discounts on parent participation in preventive parent training in low-income communities. *The Journal of Primary Prevention*, *32*(5–6), 283–298. https://doi.org/10.1007/s10935-011-0255-7

Gutkin, T. B. (2012). Ecological psychology: Replacing the medical model paradigm for school-based psychological and psychoeducational services. *Journal of Educational & Psychological Consultation*, *22*(1–2), 1–20. https://doi.org/10.1080/10474412.2011.649652

Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behavior Therapy*, *47*(6), 993–1014. https://doi.org/10.1016/j.beth.2016.09.005

Harry, B. (2002). Trends and issues in serving culturally diverse families of children with disabilities. *The Journal of Special Education*, *36*(3), 132–140. https://doi.org/10.1177/00224669020360030301

Hodgkinson, S., Godoy, L., Beers, L. S., & Lewin, A. (2017). Improving mental health access for low-income children and families in the primary care setting. *Pediatrics*, *139*(1), Article e20151175. https://doi.org/10.1542/peds.2015-1175

Holt, S. B., & Gershenson, S. (2019). The impact of demographic representation on absences and suspensions. *Policy Studies Journal: The Journal of the Policy Studies Organization*, *47*(4), 1069–1099. https://doi.org/10.1111/psj.12229

Hwang, W.-C. (2006). The psychotherapy adaptation and modification framework: Application to Asian Americans. *American Psychologist*, *61*(7), 702–715. https://doi.org/10.1037/0003-066X.61.7.702

Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*, *19*(1), 173–202. https://doi.org/10.1146/annurev.publhealth.19.1.173

Israel, B. A., Schulz, A. J., Parker, E. A., Becker, A. B., & Community-Campus Partnerships for Health. (2001). Community-based participatory research: Policy recommendations for promoting a partnership approach in health research. *Education for Health*, *14*(2), 182–197. https://doi.org/10.1080/13576280110051055

Jackson, K. F. (2009). Building cultural competence: A systematic evaluation of the effectiveness of culturally sensitive interventions with ethnic minority youth. *Children and Youth Services Review*, *31*(11), 1192–1198. https://doi.org/10.1016/j.childyouth.2009.08.001

Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K. L., Scott, M., & Schonlau, M. (2010). Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. *Journal of Traumatic Stress*, *23*(2), 223–231. https://doi.org/10.1002/jts.20518

Jeynes, W. (2012). A meta-analysis of the efficacy of different types of parental involvement programs for urban students. *Urban Education*, *47*(4), 706–742. https://doi.org/10.1177/0042085912445643

Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *The American Journal of Psychiatry*, *159*(9), 1548–1555. https://doi.org/10.1176/appi.ajp.159.9.1548

Kratochwill, T. R. (2007). Preparing psychologists for evidence-based school practice: Lessons learned and challenges ahead. *American Psychologist*, *62*(8), 829–843. https://doi.org/10.1037/0003-066X.62.8.829

Kreuter, M. W., Lukwago, S. N., Bucholtz, D. C., Clark, E. M., & Sanders-Thompson, V. (2003). Achieving cultural appropriateness in health promotion programs: Targeted and tailored approaches. *Health Education & Behavior*, *30*(2), 133–146. https://doi.org/10.1177/1090198102251021

Kutash, K., Duchnowski, A. J., & Lynn, N. (2006). *School-based mental health: An empirical guide for decision-makers*. University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies, Research and Training Center for Children's Mental Health.

Langley, A. K., Nadeem, E., Kataoka, S. H., Stein, B. D., & Jaycox, L. H. (2010). Evidence-based mental health programs in schools: Barriers and facilitators of successful implementation. *School Mental Health*, *2*(3), 105–113. https://doi.org/10.1007/s12310-010-9038-1

Larson, K., & Halfon, N. (2010). Family income gradients in the health and health care access of US children. *Maternal and Child Health Journal*, *14*(3), 332–342. https://doi.org/10.1007/s10995-009-0477-y

Loftus-Rattan, S. M., Wrightington, M., Furey, J., & Case, J. (2023). Multi-Tiered System of Supports: An ecological approach to school psychology service delivery. *Teaching of Psychology*, *50*(1), 77–85. https://doi.org/10.1177/00986283211024262

Lynch, E. W., & Hanson, M. J. (2011). *Developing cross-cultural competence: A guide for working with children and their families* (4th ed.). Brookes Publishing Company.

Malone, C. M., Wycoff, K., & Turner, E. A. (2022). Applying a MTSS framework to address racism and promote mental health for racial/ethnic minoritized youth. *Psychology in the Schools*, *59*(12), 2438–2452. https://doi.org/10.1002/pits.22606

Marsiglia, F. F., & Booth, J. M. (2015). Cultural adaptation of interventions in real practice settings. *Research on Social Work Practice*, *25*(4), 423–432. https://doi.org/10.1177/1049731514535989

Masi, R., & Cooper, J. L. (2006). *Children's mental health: Facts for policymakers*. Columbia University, Mailman School of Public Health, National Center for Children in Poverty. https://academiccommons.columbia.edu/doi/10.7916/d8-4fcj-jq55/download

Maura, J., & Weisman de Mamani, A. (2017). Mental health disparities, treatment engagement, and attrition among racial/ethnic minorities with severe mental illness: A review. *Journal of Clinical Psychology in Medical Settings*, *24*(3–4), 187–210. https://doi.org/10.1007/s10880-017-9510-2

McGoey, K. E., Munro, A. B., McCobin, A., & Miller, A. (2016). Implementation of culturally relevant school-wide positive behavior support. *School Psychology Forum*, *10*(2), 134–141.

Merrell, K. W., Ervin, R. A., Gimpel Peacock, G., & Renshaw, T. L. (2022). *School psychology for the 21st century: Foundations and practices* (3rd ed.). Guilford Press.

Miedel, W. T., & Reynolds, A. J. (1999). Parent involvement in early intervention for disadvantaged children: Does it matter? *Journal of School Psychology*, *37*(4), 379–402. https://doi.org/10.1016/S0022-4405(99)00023-0

Mongelli, F., Georgakopoulos, P., & Pato, M. T. (2020). Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. *Focus—American Psychiatric Publishing*, *18*(1), 16–24. https://doi.org/10.1176/appi.focus.20190028

Moon, J., Williford, A., & Mendenhall, A. (2017). Educators' perceptions of youth mental health: Implications for training and the promotion of mental health services in schools. *Children and Youth Services Review*, *73*, 384–391. https://doi.org/10.1016/j.childyouth.2017.01.006

National Center for Homeless Education. (2020). *Data and statistics on homelessness*. https://nche.ed.gov/data-and-stats/

Ngo, V., Langley, A., Kataoka, S. H., Nadeem, E., Escudero, P., & Stein, B. D. (2008). Providing evidence based practice to ethnically diverse youth: Examples from the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) Program. *Journal of the American Academy of Child*

& Adolescent Psychiatry, *47*(8), 858–862. https://doi.org/10.1097/CHI.0b013e3181799f19

O'Connell, M. E., Boat, T., & Warner, K. E. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. National Academies Press.

Office of the Assistant Secretary for Planning and Evaluation. (2013). *Rate review annual report*. U.S. Department of Health and Human Services. https://aspe.hhs.gov/reports/us-department-health-human-services-rate-review-annual-report-september-2013

Panchal, U., Salazar de Pablo, G., Franco, M., Moreno, C., Parellada, M., Arango, C., & Fusar-Poli, P. (2021). The impact of COVID-19 lockdown on child and adolescent mental health: Systematic review. *European Child & Adolescent Psychiatry*. Advance online publication. https://doi.org/10.1007/s00787-021-01856-w

Park, A. L., Rith-Najarian, L. R., Saifan, D., Gellatly, R., Huey, S. J., & Chorpita, B. F. (2022). Strategies for incorporating culture into psychosocial interventions for youth of color. *Evidence-Based Practice in Child and Adolescent Mental Health*. Advance online publication. https://doi.org/10.1080/23794925.2022.2025629

Pina, A. A., Polo, A. J., & Huey, S. J. (2019). Evidence-based psychosocial interventions for ethnic minority youth: The 10-year update. *Journal of Clinical Child and Adolescent Psychology*, *48*(2), 179–202. https://doi.org/10.1080/15374416.2019.1567350

Positive Action. (2021). *Evidence-based multicultural education curriculum & programs*. https://www.positiveaction.net/multicultural-curriculum

Pumariega, A. J., Rothe, E., & Pumariega, J. B. (2005). Mental health of immigrants and refugees. *Community Mental Health Journal*, *41*(5), 581–597. https://doi.org/10.1007/s10597-005-6363-1

Rathod, S., Gega, L., Degnan, A., Pikard, J., Khan, T., Husain, N., Munshi, T., & Naeem, F. (2018). The current status of culturally adapted mental health interventions: A practice-focused review of meta-analyses. *Neuropsychiatric Disease and Treatment*, *14*, 165–178. https://doi.org/10.2147/NDT.S138430

Robles, E. H., Maynard, B. R., Salas-Wright, C. P., & Todic, J. (2018). Culturally adapted substance use interventions for Latino adolescents: A systematic review and meta-analysis. *Research on Social Work Practice*, *28*(7), 789–801. https://doi.org/10.1177/1049731516676601

Ross, L. F., Loup, A., Nelson, R. M., Botkin, J. R., Kost, R., Smith, G. R., Jr., & Gehlert, S. (2010). The challenges of collaboration for academic and community partners in a research partnership: Points to consider. *Journal of Empirical Research on Human Research Ethics; JERHRE*, *5*(1), 19–31. https://doi.org/10.1525/jer.2010.5.1.19

Ryan, A., Graves, S., Sobalvarro, A., Nichols, K., Schutte, K., Aston, C., & Griffin, A. (2016). An evaluation of strong kids in an urban African American female sample: The need for gender-specific and culturally focused interventions. *School Psychology Forum*, *10*, 157–164.

Sanetti, L. M. H., & Collier-Meek, M. A. (2019). Increasing implementation science literacy to address the research-to-practice gap in school psychology. *Journal of School Psychology*, *76*, 33–47. https://doi.org/10.1016/j.jsp.2019.07.008

Sanetti, L. M. H., Kratochwill, T. R., Collier-Meek, M. A., & Long, A. C. J. (2014). *PRIME: Planning realistic implementation and maintenance by educators*. Institute of Education Sciences.

Schaffner, K. F., McGoey, K. E., & Venesky, L. (2016). Teacher-child interaction training with an urban clinical preschool population. *School Psychology Forum*, *10*(2), 177–190.

Short, K. H., Bullock, H., Jaouich, A., & Manion, I. (2018). Beyond Silos: Optimizing the promise of school-based mental health promotion within integrated systems of care. In A. Leschied, D. Saklofske, & G. Flett (Eds.), *Handbook of school-based mental health promotion* (pp. 65–81). Springer. https://doi.org/10.1007/978-3-319-89842-1_5

Solomon, B. G., Klein, S. A., Hintze, J. M., Cressey, J. M., & Peller, S. L. (2012). A meta-analysis of school-wide positive behavior support: An exploratory study using single-case synthesis. *Psychology in the Schools*, *49*(2), 105–121. https://doi.org/10.1002/pits.20625

Spodek, B., & Saracho, O. N. (2006). *Handbook of research on the education of young children* (2nd ed.). Lawrence Erlbaum.

Stevens, P. E., & Hall, J. M. (1998). Participatory action research for sustaining individual and community change: A model of HIV prevention education. *Aids Education and Prevention*, *10*(5), 387–402. https://pubmed.ncbi.nlm.nih.gov/9799936/

Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice*. Wiley.

Suite, D. H., La Bril, R., Primm, A., & Harrison-Ross, P. (2007). Beyond misdiagnosis, misunderstanding and mistrust: Relevance of the historical perspective in the medical and mental health treatment of people of color. *Journal of the National Medical Association*, *99*(8), 879–885. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2574307/

The Council of State Governments Justice Center. (2020). *Rethinking the role of the juvenile justice system: Improving youth's school attendance and educational outcomes*. https://csgjusticecenter.org/publications/rethinking-the-role-of-the-juvenile-justice-system-improving-youths-school-attendance-and-educational-outcomes/

Trent, M., Dooley, D. G., Dougé, J., & Health, S. (2019). The impact of racism on child and adolescent health. *Pediatrics*, *144*(2), Article e20191765. https://doi.org/10.1542/peds.2019-1765

Twenge, J. M., Cooper, A. B., Joiner, T. E., Duffy, M. E., & Binau, S. G. (2019). Age, period, and cohort trends in mood disorder indicators and suicide-related outcomes in a nationally representative dataset, 2005–2017. *Journal of Abnormal Psychology*, *128*(3), 185–199. https://doi.org/10.1037/abn0000410

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity: A supplement to mental health: A report of the Surgeon General*. Department of Health and Human Services, U. S. Public Health Service. https://www.ncbi.nlm.nih.gov/books/NBK44243/

Valencia, R. R. (2010). *Dismantling contemporary deficit thinking: Educational thought and practice*. Routledge. https://doi.org/10.4324/9780203853214

Valenzuela, J. M., & Smith, L. (2016). Provider–patient interactions: An important consideration for racial/ethnic health disparities in youth. *Journal of Pediatric Psychology*, *41*(4), 473–480. https://doi.org/10.1093/jpepsy/jsv086

van Mourik, K., Crone, M. R., de Wolff, M. S., & Reis, R. (2017). Parent training programs for ethnic minorities: A meta-analysis of adaptations and effect. *Prevention Science*, *18*(1), 95–105. https://doi.org/10.1007/s11121-016-0733-5

Ward, J. V. (2000). Raising resisters: The role of truth telling in the psychological development of African American girls. In L. Weis & M. Fine (Eds.), *Construction sites: Excavating race, class and gender among urban youth* (pp. 50–64). Teachers College Press.

Ward, J. V. (2002). *The skin we're in: Teaching our teens to be emotional strong, socially smart, and spiritually connected*. Free Press.

Webb, C. (1990). Partners in research. *Nursing Times*, *86*(32), 40–44.

Weist, M. D., Lever, N. A., Bradshaw, C. P., & Owens, J. S. (Eds.). (2014). *Handbook of school mental health: Research, training, practice, and policy* (2nd ed.). Springer. https://doi.org/10.1007/978-1-4614-7624-5

Weist, M. D., Mellin, E. A., Chambers, K. L., Lever, N. A., Haber, D., & Blaber, C. (2012). Challenges to collaboration in school mental health and strategies for overcoming them. *The Journal of School Health*, *82*(2), 97–105. https://doi.org/10.1111/j.1746-1561.2011.00672.x

Weisz, J. R., Ugueto, A. M., Cheron, D. M., & Herren, J. (2013). Evidence-based youth psychotherapy in the mental health ecosystem. *Journal of Clinical Child and Adolescent Psychology*, *42*(2), 274–286. https://doi.org/10.1080/15374416.2013.764824

Welton, A. D., Owens, D. R., & Zamani-Gallaher, E. M. (2018). Anti-racist change: A conceptual framework for educational institutions to take

systemic action. *Teachers College Record*, *120*(14), 1–22. https://doi.org/10.1177/016146811812001402

Wong, M. (2006). Building partnerships between schools and academic partners to achieve a health-related research agenda. *Ethnicity & Disease*, *16*(S1), S149–S153. https://pubmed.ncbi.nlm.nih.gov/16681138/

Yamaguchi, S., Bentayeb, N., Holtom, A., Molnar, P., Constantinescu, T., Tisdall, E. K. M., Tuong, J., Iyer, S. N., & Ruiz-Casares, M. (2023). Participation of children and youth in mental health policymaking: A scoping review [Part I]. *Administration and Policy in Mental Health*, *50*(1), 58–83. https://doi.org/10.1007/s10488-022-01223-0

Yoo, H. J., Bahn, G., Cho, I. H., Kim, E. K., Kim, J. H., Min, J. W., Lee, W. H., Seo, J. S., Jun, S. S., Bong, G., Cho, S., Shin, M. S., Kim, B. N., Kim, J. W., Park, S., & Laugeson, E. A. (2014). A randomized controlled trial of the Korean version of the PEERS(®) parent-assisted social skills training program for teens with ASD. *Autism Research*, *7*(1), 145–161. https://doi.org/10.1002/aur.1354