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Shared Decision Making Following a Large-Scale EBP Implementation Effort in Publicly-Funded Children's Mental Health Services: A Focus on Latinx Caregivers

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Shared Decision Making Following a Large-Scale EBP Implementation Effort in Publicly-Funded Children's Mental Health Services: A Focus on Latinx Caregivers

by

A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy in Psychology

by

Blanche M. Wright

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ABSTRACT OF THE DISSERTATION

Shared Decision Making Following a Large-Scale EBP Implementation Effort in Publicly-Funded Children's Mental Health Services: A Focus on Latinx Caregivers

by

Blanche M. Wright

Doctor of Philosophy in Psychology

University of California, Los Angeles, 2022

Professor Anna Shan-Lai Chung, Chair

Previous research suggests that caregiver treatment engagement is critical to achieving improved child clinical outcomes with many evidence-based practices (EBPs) requiring caregiving participation (Boggs et al., 2005; Kaminski & Claussen, 2017) . Unfortunately, there is evidence of disparities in caregiver engagement that disfavor low-income Latinx families (Elster et al., 2003; Kapke & Gerdes, 2016). In order to maximize the public health impact of EBPs for Latinx children, strategies are needed to strengthen Latinx caregiver engagement. The current dissertation used observational methods to examine shared-decision making (SDM) as a potential engagement strategy for caregivers of Latinx youth within the context of multiple EBP delivery. The dissertation had three central aims: (1) Characterize community therapist use of SDM within EBP delivery; (2) Identify therapist- and session- level factors associated with increased SDM; and (3) Examine the association between SDM and therapist-caregiver bond, a

dimension of alliance. The OPTION instrument was used to measure SDM in 210 audio-recorded therapy sessions with 62 community therapists and 109 Latinx caregivers. The TPOCS-A was used to measure alliance. Multilevel linear regressions were conducted to examine aims. Results revealed that community therapists used SDM in most sessions (N=192; 91.43%) about varied types of decisions, but only at modest levels. SDM was higher within sessions in which therapists were targeting conduct problems and in English-language sessions. We did not find an association between global measurements of SDM and therapeutic bond elements. However, the specific SDM process of identifying alternate options appeared to be protective against negative therapist-caregiver bond. Practice implications and future directions for SDM research within the context of youth mental health treatment will be discussed.

The dissertation of Blanche M. Wright is approved.

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2022

DEDICATION

I dedicate this dissertation to every single Latinx parent who has provided any level of support to their child's mental health. I am extremely thankful for the Latinx families and community therapists who participated in the research studies represented in this dissertation. This research would not be possible without the immense effort and generosity of Drs. Anna Lau and Lauren Brookman-Frazee; they have built strong community-academic partnerships to incite real-world change via science, and I hope to do the same in my career. I am eternally thankful to my 19 undergraduate research assistants, who invested their time and effort to supporting a project that had personal significance to us all. Your patience and persistence with coding made this project happen! I also thank key mentors who have guided me throughout this dissertation process: Drs. Margarita Alegría, David Langer and Bryce McLeod.

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Yu, S.H., Brookman-Frazee, L., Kim, J. J., Barnett, M.L., Wright, B. & Lau, A. S. (2021). Therapist adaptations to evidence-based practices and associations with implementation outcomes in child therapy sessions. *Journal of Consulting and Clinical Psychology*.

Wright, B., Lau, A. S., & Brookman-Frazee, L. (2019). Factors Associated with Caregiver Attendance in Implementation of Multiple Evidence-Based Practices in Youth Mental Health Services. *Psychiatric Services*, appi.ps.2018004.

Chlebowski, C., Hurwich-Reiss, E., Wright, B., & Brookman-Frazee, L. (2019). Using stakeholder perspectives to guide systematic adaptation of an autism mental health intervention for Latinx families: A qualitative study. *Journal of Community Psychology*.

Barnett, M. L., Lau, A. S., Lind, T., Wright, B., Stadnick, N., Innes-Gomberg, D., Pesanti, K., & Brookman-Frazee (2019). Caregiver attendance as a quality indicator in the implementation of multiple evidence-based practices for children. *Journal of Clinical Child & Adolescent Psychology*, 1-15.

Chlebowski, C., Magaña, S., Wright, B., & Brookman-Frazee, L. (2018). Implementing an intervention to address challenging behaviors for autism spectrum disorder in publicly-funded mental health services: Therapist and parent perceptions of delivery with Latinx families. *Cultural Diversity and Ethnic Minority Psychology*, *24*(4), 552.

Rodriguez, A., Lau, A. S., Wright, B., Regan, J., & Brookman-Frazee, L. (2018). Mixed-method analysis of program leader perspectives on the sustainment of multiple child evidence-based practices in a system-driven implementation. *Implementation Science*, *13*(1), 44.

Dyson, M. W., Chlebowski, C., Wright, B., & Brookman-Frazee, L. (2017). How do certified and uncertified therapists differ in their perceptions of a mental health intervention for ASD? *Evidence-Based Practice in Child and Adolescent Mental Health*, 1-16.

Introduction

Nationally, tax dollars are invested into the community-implementation of evidence-based practices (EBPs) to reduce child clinical symptoms and improve the overall quality of mental health care for youth (Rubin et al., 2016). Meta-analyses have indicated that EBP efficacy trials demonstrate strong, medium-to-large effects on improved youth mental health outcomes across a variety of target problems (e.g., Comer, Chow, Chan, Cooper-Vince, & Wilson, 2013; Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). Meta-analyses also reveal that EBPs outperform usual clinical care in the community, but with attenuated effects compared to those observed in efficacy trials (Eckshtain et al., 2020; Weisz et al., 2006, 2017; Weisz, Kuppens, et al., 2013). When implemented in the community, EBPs produce small effects (d=.29; Weisz, Kuppens, et al., 2013). Explanations for this apparent "voltage drop" in EBP effects are likely found at multiple levels of the mental health ecosystem - system, organization, provider, and client/family (Chambers et al., 2013; Weisz, Ugueto, et al., 2013). Diluted effects are troubling as public policy has catalyzed the scale-up of EBPs into county- and state- wide public mental health systems with few answers about how to optimize implementation outcomes (Brookman-Frazee et al., 2016; Walker et al., 2019).

Key differences in the patient populations served in community routine care settings compared to those treated in the clinical research settings of randomized controlled trials are likely strong contributors to this "voltage drop" (Weisz et al., 2014). In terms of clinical presentation, clients served in the community tend to have more severe symptomatology and comorbidity than those in samples of research trials subject to stringent inclusion and exclusion criteria (Southam-Gerow et al., 2008). The influence of these clinical presentation factors have been neglected in trials of EBPs, but some data suggest that higher severity of symptoms seems

to contribute to reduced effectiveness (Weisz, Kuppens, et al., 2013). Furthermore, youth served in the community are more likely to be from low-income and racial/ethnic minoritized backgrounds compared to samples in controlled trials (Quetsch et al., 2020; Sibley et al., 2020; Southam-Gerow et al., 2008). These key demographic differences have motivated discourse on the appropriateness of EBPs with diverse groups and the need for cultural adaptation of EBPs for community implementation with ethnic minority youth (Bernal et al., 2009; Huey & Polo, 2008).

Not surprisingly, most attention about EBP implementation with diverse groups has been dedicated to Latinx youth given that Latinx is the second largest racial/ethnic group in the U.S. (Pina et al., 2019; United States Census Bureau, 2019). Latinx individuals are more concentrated in some U.S. regions such as California (Flores et al., 2019). Moreover, a large percentage of the population living below the federal poverty line in California's three largest counties are Latinx – Los Angeles County (37.2%), San Diego County (31.3%) and Orange County (33.5%) (Data USA, 2019). Moreover, 51% of youth served in California's public mental health care and insured by Medi-Cal (i..e., California's Medicaid system) are Latinx (California Health Care Foundation, 2018). Samples within EBP efficacy trials have generally not represented Latinx youth to the degree they are accessing community treatment in the California region. A research focus on Latinx samples can reveal ways to optimize EBP success for this important stakeholder group.

Importance of Engagement in EBP Delivery

The National Institute of Health (2001) has cited engagement as a critical threat to EBP implementation success with research showing that engagement is a pronounced challenge for Latinx families. Prior to summarizing literature on the engagement of Latinx families, we will review engagement broadly. Theoretical models of engagement (e.g., Berkel, Mauricio,

Schoenfelder, & Sandler, 2011) and previous research demonstrate that client engagement (e.g., attendance, participation in activities, attitudinal buy-in) is critical to achieving clinical improvements within EBP delivery (Chu & Kendall, 2004; Haine-Schlagel & Walsh, 2015; Ruiz, Korchmaros, Greene, & Hedges, 2011). Within youth mental health care, the engagement of both youth and their primary caregivers (e.g., biological parent, foster parent) is essential for outcomes, as caregivers are key agents of behavioral change (Fawley-King et al., 2013; Wright et al., 2019). Unfortunately, client engagement has been a well-documented challenge in community settings for decades (Gopalan et al., 2010; Nock & Ferriter, 2005). Attrition rates, one common metric of client engagement, are higher in community care compared to randomized controlled trials. In fact, efficacy trials of Parent-Child Interaction Therapy, a parent-mediated EBP, show attrition rates up to 47% compared to 77% in community-based implementation (Budd & Lyon, 2010). A meta-analysis revealed that dropout rates are higher in effectiveness trials in the community (mean = 50%; range: 17-72%) versus efficacy trials in clinical research settings (mean = 28.4%; range: 16-50%) (de Haan et al., 2013). As EBPs are transported from clinical research to community contexts, variation in client engagement may also account for some of the "voltage drop" in effectiveness.

The term "engagement" refers to a range of client behaviors and attitudes and has been commonly operationalized by metrics including treatment initiation, participation, attendance, and adherence. Despite variable measurement of engagement in the literature, most scholars agree that client engagement includes both attitudinal (e.g., "buy-in") and behavioral components (e.g., in-session participation, attendance, compliance), which are inter-related and necessary for clients to receive the benefits of an intervention (Staudt, 2007). Engagement is not easily

captured by any static measure of client's receptivity toward an intervention, but rather is a multidimensional and complex, dynamic process that unfolds over time (Bamberger et al., 2014).

As defined by the Staudt (2007) conceptual framework, engagement may be hindered by multiple factors such as access barriers, client skepticism about the intervention, daily life stressors and competing demands, and perceptions of the relevance or fit of the intervention for their situation. Further, community therapists commonly report concerns about intervention fit with clients' background, and research supports engagement as a key reason for adapting EBPs (Jensen-Doss et al., 2009; Wiltsey Stirman et al., 2019). Research has consistently shown that client circumstances of social disadvantage and poverty are associated with poorer engagement in the form of lower rates of attendance, early termination, and homework compliance. (Chacko et al., 2016; Coatsworth et al., 2018). Suboptimal engagement observed in community-based services relative to controlled trials may be due in part to the aforementioned differences in the client characteristics that may also impact perceptions of the relevance and acceptability of treatment (Weisz et al., 2014).

Poor Engagement of Latinx Caregivers in Children's Mental Health Treatment

Extant literature highlights pronounced engagement problems amongst some demographic groups, but especially Latinx families. For instance, having financial problems has predicted dropout rates in youth community outpatient settings generally (Garcia & Weisz, 2002) and within EBP delivery specifically (Fernandez & Eyberg, 2009). Studies of racial/ethnic disparities within publicly funded mental health services show that Latinx families are particularly vulnerable to poor engagement. Compared to other racial/ethnic groups, Latinx youth have been found to have lower mental health service utilization (Mennies et al., 2020; Whitaker et al., 2018). Following treatment entry, Latinx youth show increased risk of missed

appointments, lower treatment dosage and higher dropout rates compared to White and other racial/ethnic minority youth (Bacio et al., 2017; Flicker et al., 2008; Warnick et al., 2012). In qualitative studies conducted in Southern California, community therapists have cited promotion of client engagement as a reason for making EBP adaptations during delivery to Latinx youth and caregivers (Barnett, Brookman-Frazee, et al., 2019; Chlebowski et al., 2019).

In addition to youth, there is evidence of disparities in caregiver engagement in children's mental health treatment that disfavor low-income Latinx families (Elster et al., 2003; Kapke & Gerdes, 2016). Research showing poor engagement of Latinx caregivers is troubling as the American Academy of Pediatrics (2012) has declared that every child has a right to high-quality care that is family-centered. Caregiver refers to the primary adult who cares for the youth and is involved in the youth's mental health care. Caregiver may refer to a biological parent, foster parent, grandparent, etc.; henceforth, caregiver and parent may be used interchangeably.

Suboptimal engagement of Latinx caregivers is problematic for several reasons. First, caregivers are gatekeepers of care access, as they execute logistics such as providing consent to services for their child, scheduling appointments and facilitating transportation (Haine-Schlagel & Walsh, 2015). Second, caregivers are often the primary agents of behavior change for young children, children with externalizing problems and/or youth being treated with an EBP that prescribes parent participation. Many EBP protocols are explicitly designed to include caregivers to drive therapeutic change or improve caregiver-child relationships. Examples include, attachment-based treatments for trauma with young children and parent training for youth presenting with externalizing problems (Dowell & Ogles, 2010; Evans et al., 2017; Kaminski & Claussen, 2017; Lieberman, 2004; McCart & Sheidow, 2016). For externalizing problems, such as conduct and ADHD, caregivers are essential to facilitate symptom improvement by

implementing behavioral strategies (e.g., positive reinforcement) in the home that were previously learned in therapy sessions (Chamay Weber et al., 2016; Eyberg et al., 2008). Third, caregiver engagement in child psychotherapy is linked to improved child outcomes (Boggs et al., 2005; Karver et al., 2006) and delivery of higher doses of EBP content by therapists (Chaffin et al., 2011; Dorsey et al., 2014; Nock & Kazdin, 2005). Based on these points, when caregivers are actively participating in treatment, they can be considered clients alongside the youth.

Studies show that Latinx caregivers have low levels of involvement in their child's psychotherapy sessions within community mental health settings (Dickson et al., 2017; Fawley-King et al., 2013; Guan et al., 2019; McCabe, 2002; Stadnick et al., 2016). Following a system-driven implementation of multiple EBPs for children in Los Angeles County, low levels of caregiver attendance were found in a sample of predominantly Latinx caregivers (Wright et al., 2019); in the same context, administrative claims data found lower caregiver attendance for Latinx families compared to White families based on billing procedure codes (Barnett, Lau, et al., 2019). These findings were particularly concerning because low rates of caregiver attendance were observed when active parent participation was indicated – in sessions for preadolescent youth presenting with externalizing problems and/or being treated with an EBP that prescribed caregiver directed intervention. Low levels of caregiver attendance in child therapy presents a barrier to delivering high quality and evidence-based care to youth, particularly for presenting problems and treatment models that necessitate caregivers to be a key driver of therapeutic change.

Beyond attendance, observational studies in publicly-funded service systems in Southern California demonstrate low Latinx caregiver participation in psychotherapy sessions. For instance, in a small community study (n=18), an observational coding system was used to

measure parent participation behaviors (e.g., asking questions, sharing perspective about homework); results showed that Latinx caregivers had lower session participation than White caregivers (Dickson et al., 2017). Another study examining caregiver participation within the delivery of an evidence-based intervention for autism spectrum disorder also found reduced participation in Latinx caregivers compared to White parents even when controlling for income (Guan et al., 2019). Notably, differences were exacerbated for Spanish-speaking parents. In short, emerging data suggests Latinx caregivers may evince suboptimal levels of treatment engagement based on multiple behavioral indices.

Thus, to maximize the public health impact of EBPs in service systems caring for the rapidly growing population of Latinx children with mental health need, strategies are needed to improve caregiver engagement. Latinx families accessing community care through public insurance are particularly vulnerable to engagement issues and relatedly, reduced opportunity of optimal EBP delivery. Logistic and perceptual barriers are exacerbated among low-income, Latinx families (Alegría et al., 2015). Compared to other racial/ethnic groups, Latinx caregivers reported having more access barriers (e.g., transportation, insurance coverage, language) to their child's mental health treatment (Young & Rabiner, 2015). Limited caregiver mental health literacy and educational attainment also negatively affect treatment engagement among Latinx families (Chavira et al., 2017; Lawton & Gerdes, 2014; McCabe, 2002; Umpierre et al., 2015). Moreover, low service utilization is exacerbated among families with immigrant status, especially those with limited or without English proficiency (Georgiades et al., 2018; Yun et al., 2019). An estimated 50% of Latinx youth have at least one parent who is an immigrant; with approximately one in four having a parent who is undocumented (Clarke et al., 2017).

Cultural determinants of Latinx caregiver's knowledge about, attitudes towards and engagement in children mental health treatment have also not been well studied. The extant literature, albeit limited, suggests that the interplay between culture and treatment process is complex. For instance, Latinx caregivers are less likely than non-Hispanic White caregivers to believe that child mental health problems are caused by factors that are readily addressable in child therapy (Yeh et al., 2004, 2005). Perspectives about child problems may influence whether to begin treatment. Compared to other racial/ethnic groups, Latinx parents report higher levels of mental health stigma over child emotional and behavioral problems (Turner et al., 2015; Young & Rabiner, 2015) that appear to deter service utilization (Heflinger & Hinshaw, 2010; Mukolo et al., 2010).

Relatively little research has directly examined Latinx caregivers' preferences for and expectations of treatment involvement. One qualitative study with community therapists and Latinx caregivers participating in a parent-mediated intervention for autism spectrum disorder revealed potential misunderstandings about Latinx caregivers' preferences about their treatment involvement (Chlebowski et al., 2018). Results indicated that most therapists reported wanting caregivers to be involved in treatment but perceived that parents often did not expect to have an active role in their child's therapy. Incongruously, 90% of Latinx caregivers said they expected and wanted to be highly involved in treatment. These disparate perceptions may be related to the Latinx cultural value *respeto* and its influence on caregiver-therapist communication (Barker et al., 2010). Latinx parents may not be vocal about their views in therapy out of *respeto* or deference to the therapist as an expert authority figure (Calzada et al., 2010; Santilli et al., 2017) whereas therapists may interpret deference as a lack of motivation to participate (Añez et al., 2008; Foxen, 2016). Interestingly, in this sample 35% of therapists self-identified as Latinx. The

study implications are that therapists (regardless of racial/ethnic match with Latinx parents) may need to make more explicit efforts to solicit the perspectives of Latinx caregivers in order to promote involvement and strengthen the therapeutic relationship.

Engagement Dimension: Caregiver-Therapist Alliance

Recently, Becker and colleagues (2018) conducted a systematic review on engagement interventions and highlighted the therapeutic "relationship" as a key domain within their multidimensional measurement framework of engagement called REACH (Relationship, Expectancy, Attendance, Clarity, and Homework). "Relationship" represents the quality of the client-provider relationship and therapeutic alliance. Alliance, a key engagement factor, is comprised of (a) a positive, supportive bond between client and therapist and (b) agreement on the valued tasks and goals of treatment (Becker et al., 2018; Elvins & Green, 2008; Shirk & Karver, 2003). Within youth psychotherapy, therapists must establish and develop alliance with all clients, which typically includes youth and their parents (Karver et al., 2018). Evidence consistently demonstrates a small, positive effect of youth-therapist and caregiver-therapist alliance on child mental health treatment outcomes (Bickman et al., 2012; de Greef et al., 2017; Garland et al., 2010; Karver et al., 2006, 2018; Kazdin et al., 2006). Caregiver-therapist alliance is of critical importance, as a meta-analysis has shown that it has stronger associations with treatment outcomes than youth-alliance (McLeod, 2011). Additionally, some research suggests that youth reference their caregiver's approval of treatment to inform their own opinion of and engagement in treatment, especially when therapy is a novel experience (Jensen et al., 2010; Ormhaug & Jensen, 2018). In a community study, where 75% of treatment cases lacked consensus between the caregiver, youth and therapist on a target problem focus, therapists tended to agree more with caregivers than youth (Hawley & Weisz, 2003). For outcomes, the

relationship between alliance and youth symptom improvement is greatest for caregivers involved in the treatment of young children with externalizing problems (Green, 2006; Hawley & Garland, 2008; Karver et al., 2018; McLeod, 2011; Murphy & Hutton, 2018; Shirk & Karver, 2003), and when alliance is measured in later stages of treatment (Welmers-Van de Poll et al., 2018). Moreover, caregiver-therapist alliance has also been found to predict satisfaction with care (Hawley & Weisz, 2005) and appears to have important positive implications for other engagement indices (Karver et al., 2018; Robbins et al., 2008). For instance, caregiver-reported alliance was positively associated with parent session attendance in a routine care setting (Hawley & Weisz, 2005).

Despite these benefits, there is a dearth of literature on caregiver-therapist alliance within Latinx families. Therapist-youth alliance has been explored within samples with a large proportion of Latinx children and adolescents (Cordaro et al., 2012; Levin et al., 2012; Mattos et al., 2017), but there has been limited targeted study of Latinx caregiver-therapist alliance. A few studies have explored alliance with Latinx families involved in youth substance abuse treatments. For instance, in a trial of Brief Strategic Family Therapy, family alliance, an aggregated score of caregiver-therapist and adolescent-therapist alliance, was positively associated with treatment completion; importantly, caregiver-reported alliance was higher than adolescent-reported alliance (Robbins et al., 2008). A racial/ethnic disparity was observed in Multisystemic Therapy for adolescent substance abuse such that caregiver-therapist emotional bond was weaker for Latinx caregivers than White caregivers when youth presented with elevated externalizing problems (Ryan et al., 2013). In family therapy specifically, therapeutic alliance building is complex in that therapists must form a bond with multiple family members, who may have distinct perceptions about desired tasks and may require different approaches

(Thompson et al., 2007). Within family therapy paradigms, differences in alliance emerging amongst family members are described as an "alliance imbalance," which appears to inhibit treatment retention and progress among Latinx families to a greater extent than White families (Flicker et al., 2008). Although studies are limited, findings thus far suggest the central importance of caregiver-therapist alliance for Latinx youth treatment progress.

Despite its apparent value, questions remain about how to develop a strong therapeutic alliance. In the review by Becker and colleagues (2018), only two studies were found with engagement strategies that successfully strengthened the relationship quality and/or therapeutic alliance. Strategies included cultural acknowledgement and assessment of family's strengths and needs. One engagement intervention that appears relevant to strengthening the Relationship engagement domain is the Parent and Child Active Participation Toolkit (PACT), which aims to broadly increase parent participation within the treatment of child disruptive problems (Haine-Schlagel et al., 2016). PACT included therapist training in skills hypothesized to strengthen alliance (e.g., actively listen; convey partnership; communicate positive regard), collaborate with parents (e.g., offer suggestions; seek/incorporate input; review home actions) and empower parents (e.g., recognize parent effort). PACT trials did demonstrate increased parent participation in treatment (Haine-Schlagel et al., 2016, 2020), but alliance or other relationship outcomes were not reported on.

Overall, questions remain about to enhance the Relationship domain of engagement with caregivers involved in their child's therapy. As previously described, caregivers play several critical roles at both initiation of services and in ongoing care. Additionally, when considering Latinx cultural values of prioritizing families alongside caregiver involvement that is clinically indicated, the family or caregiver-youth dyad is a more appropriate unit of analysis in treatment.

Caregivers should be included as clients alongside their child in order to help optimize the delivery of EBPs that necessitate active caregiver involvement to achieve targeted outcomes (Hawley & Weisz, 2003; Tompson et al., 2017).

Engagement Strategy: Shared Decision Making

One potential strategy to bolster Latinx caregiver engagement is shared decision-making (SDM). SDM is a structured care process that can be integrated into EBP implementation, provide explicit action steps for providers to increase engagement and has some evidence of strengthening therapeutic alliance with adult patients (Alegria et al., 2010; Langer & Jensen-Doss, 2018). SDM is intended to cultivate a partnership between the healthcare provider and client to jointly and collaboratively make treatment decisions (Elwyn et al., 2013). Touted as a linchpin of recovery-oriented and patient-centered care (Barry & Edgman-Levitan, 2012), SDM was born out of the medical literature in the 1980s and has become influential as a model of treatment decision making. In a landmark report, the Institute of Medicine defined patient-centered care as, "providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions" (Institute of Medicine & Committee on Quality of Health Care in America, 2001, p. 6). The Substance Abuse and Mental Health Services Administration (SAMSHA) describes recovery-oriented care, as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (Substance Abuse and Mental Health Services Administration, 2012, p. 3). In essence, SDM as an exemplar of patient-centered, recovery-oriented care prioritizes patient autonomy, empowerment and respect and is thought to drive superior patient outcomes by increasing treatment engagement (Dixon et al., 2016).

SDM is defined in direct opposition to paternalistic care in which the provider uses their clinical expertise and judgement to prescribe interventions with limited or no patient input (Emanuel & Emanuel, 1992). Indeed, ethical principles emphasize the need for providers to respect patient autonomy and encourage their participation in the decision-making process (Deber, 1994). Integration of SDM into healthcare services has garnered immense support from the U.S. Department of Health and Human Services, the Agency for Healthcare Quality and Research and the Affordable Care Act (Section 3506) as a key component of quality care (Hawley & Morris, 2017).

SDM operates under the premise of "mutual participation and respect" such that both the provider and client have valuable information to inform treatment decisions (United States, 1982). More specifically, the healthcare provider contributes knowledge and expertise about diagnosis and options for treatment to remedy or manage symptoms while the patient contributes knowledge of their values and their subjective experiences which are considered essential for treatment planning (Brock, 1991; Emanuel & Emanuel, 1992; Morant et al., 2016). Together, they exchange information and discuss treatment options to ultimately arrive at a consensus on healthcare decisions (Adams & Drake, 2006). In medical settings, treatment decisions for mental health concerns may include initiating a behavioral intervention, prescribing medication, and making lifestyle changes (Cheng et al., 2017).

Based on existing conceptual frameworks, Elwyn and colleagues (2013) developed a practical three-step model to guide health care providers to implement the dynamic practice of SDM into routine clinical care. As shown in Figure 1, Elwyn's widely cited three-talk model includes (1) Choice talk: clinician informs patient that options are available (2) Option talk: clinician provides patient with more detailed information about alternatives and (3) Decision

talk: clinician considers patient's preferences to decide together what is best. Importantly, the model steps are not intended to represent a linear process, as "clinical interactions are by necessity fluid" (Elwyn et al., 2013, p. 1363). For instance, a clinician may share information about options, elicit patient preferences and realize that a patient has misunderstood some aspect of an option and so must revert to providing clarifying information. Additionally, for conditions that are chronic in nature and that necessitate more than one clinical encounter for treatment, decisions may not be contained in a single visit. Patients may require out-of-session deliberation to consider options or seek consultation from family members, friends, or other health care providers.

In simple terms, SDM involves both the provider and client sharing information, deliberating about preferred treatment options and coming to agreement about which treatment to implement (Charles et al., 1997). Within youth mental health care, caregivers are ideally in close communication with providers given their roles as a key or the sole decision maker in care (Wyatt et al., 2015). When considering the patient-centered and recovery-oriented tenets, parents, compared to children, may be more developmentally equipped to formulate and express opinions regarding values and preferences in relation to treatment. Moreover, parents are necessary facilitators for youth to become self-directed and improve their health.

Shared Decision Making in Adult Mental Health Care

Given that research on SDM within youth mental health care is scarce, especially in regard to Latinx caregivers, the adult literature will first be reviewed. To date, research on SDM has been largely conducted with adults in primary and specialty health care settings (Stiggelbout et al., 2015) with studies showing benefits in patient satisfaction, adherence, and health outcomes (Durand et al., 2014; Shay & Lafata, 2015). Theorized model pathways identify patient

activation as the mechanism by which SDM leads to improved treatment outcomes (Street, 2013). Patient activation is defined as a patient's ability and willingness to manage their health and care, which includes making treatment decisions and/or lifestyle changes (Coulter & Collins, 2011; Hibbard & Cunningham, 2008). Activated patients are considered to be better informed about their condition and more committed to adhering to clinical recommendations. SDM is a care process that supports activated patients and can also increase activation among more passive consumers.

To align with principles of patient-centered care, the Institute of Medicine and SAMSHA have advocated for the infusion of SDM in mental health services (Center for Mental Health Services, 2010; Institute of Medicine, 2006). Within mental health care, systematic reviews reveal SDM benefits for adults in treatment satisfaction, treatment engagement, therapeutic relationship and mental health symptoms/functioning (James & Quirk, 2017; Zisman-Ilani et al., 2017). However, SDM research in mental health treatment is in its infancy and thus, the robustness of its benefits has not yet been fully established (James & Quirk, 2017; Shay & Lafata, 2015; Thompson & McCabe, 2012).

Given its origins in medical settings, much focus has been dedicated to examining the integration of SDM in psychotropic medication management (e.g., Deegan & Drake, 2006; Ludman et al., 2003). SDM is viewed as a way to engage patients with mental health problems, who may feel disempowered in treatment decision-making, and who may have significant concerns about adverse effects of medication (Morant et al., 2016). Specifically, SDM interventions for adults have shown improvements in their engagement in medication decision-making and also in improved symptoms (Guille et al., 2019; Hamann et al., 2006; Harris et al., 2009; Salyers et al., 2017). For example, a SDM intervention implemented in a rehabilitation

program within a community mental health center resulted in decreased conflict with providers about medication decisions (Paudel et al., 2018). Another randomized controlled trial of a SDM intervention with depressed adults in primary care showed that better symptom improvement was mediated by superior adherence to antidepressants in the SDM versus control condition (Loh, Leonhart, et al., 2007; Loh, Simon, et al., 2007).

Beyond medication decision making, SDM is postulated as a means to increase and improve client engagement in mental health care (Dixon et al., 2016). Although SDM research in mental health is nascent, there is some limited evidence in support of this claim, especially for the relational facet of engagement - therapeutic alliance (Matthias et al., 2014; Pinto et al., 2012). Researchers posit that SDM has the ultimate goal of coming to an agreement on treatment decision, which could be considered part of the task dimension of alliance (e.g., Joosten et al., 2008). Although the mechanisms by which SDM can strengthen alliance have not yet been empirically tested nor theoretically conceptualized, the association between SDM and alliance has been examined. For instance, in the Netherlands, social workers and nurses trained in a SDM intervention rated their alliance with adult patients with substance use disorders stronger than providers in the control group (Joosten et al., 2008). However, providers were not masked to condition and other research has found no relationship between alliance and SDM in observational studies (Yanos et al., 2019) and trials of SDM interventions (Metz et al., 2018, 2019). More data are needed to establish whether SDM indeed strengthens the therapeutic relationship by promoting patient-provider collaboration in coming to joint decisions about the course of treatment (James & Quirk, 2017).

Given that clinicians are typically the initiators of SDM with their clients, it seems important to understand how clinician background factors may be associated with SDM use.

Research on healthcare provider characteristics associated with use of SDM is sparse, especially within the mental health service sector. One study of adult psychiatric care found that provider gender and type of provider (i.e., nurse practitioner versus physician) did not predict observationally measured SDM (Fukui et al., 2014). Another study of primary care for depressed adults found that older physicians were observed to use SDM less frequently (Young et al., 2008). The authors speculated a generational cohort effect in which providers trained earlier held a more paternalistic view of the physician as the expert and thus, sole decision maker in care. With such limited data, however, more research is needed to substantiate any claims about the relationship between provider factors and SDM usage.

Shared Decision Making within EBP Delivery

Commentaries on the need to integrate SDM into mental health care are plentiful (Curtis et al., 2010; Drake et al., 2010; Duncan et al., 2008; Huffman, 2018; O'Brien et al., 2011), yet, notable gaps exists in examining SDM processes within the community implementation of EBPs. EBPs are generally disseminated as standardized protocols with psychotherapy content and techniques manualized to promote provider fidelity to treatments (Chorpita et al., 2011). Initially, manualized protocols arose as tools to permit the conduct and replicability of controlled trials, but it is unclear whether these tools interfere with the personalization of treatment for individual children or family contexts (Beidas, 2010; Chu, 2009; Kendall et al., 2008). Interestingly, EBP implementation has been discussed as a strategy to improved quality of care rather than the overarching goal being to deliver EBPs with strict fidelity; supporting this idea is some evidence showing therapist will use EBPs that were designed to treat a problem that is not indicated in the youth (Park, Tsai, et al., 2018). As mental health systems scale up specific EBPs, the extent to which therapists collaborate with consumers on decisions about target problems, goals, and

treatment selection is unknown. Delineating the extent to which therapists make EBP-related decisions independently or collaboratively will help clarify which supports are needed to better integrate SDM in large-scale EBP implementation.

As SDM has been theorized to increase client treatment engagement, SDM could potentially act as a facilitator of EBP uptake, adherence and completion by patients. Based on this premise, Mott and colleagues (2014) conducted a pilot study (N=27) of a SDM intervention for doctoral-level providers and adults presenting with post-traumatic stress disorder (PTSD) in the Veterans Administration (VA) care system. The trial was in response to challenges with client engagement and penetration of evidence-based care following a 2012 mandate to offer two EBPs, Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT), to veterans with a primary diagnosis of PTSD in the VA (Veterans Health Administration, 2012). In the trial, SDM centered on decisions about what treatment model to use – EBPs (CPT or PE) or other treatment approaches (e.g., education about PTSD, supportive psychotherapy). Trial results showed that compared to the control group, a higher proportion of patients in the SDM group selected an EBP among available treatment options and had subsequent increased engagement indexed by a higher session dosage (Mott et al., 2014). This is notable because CPT and PE are exposure-based interventions often considered more challenging and more difficult to tolerate.

In terms of youth-focused studies of SDM in the context of EBP delivery, two studies were identified. A trial of a SDM intervention for mostly White depressed youth and their caregivers revealed that after engaging in a collaborative process to choose treatment (i.e., medication, cognitive-behavioral therapy, or combination), the SDM intervention group had better clinical outcomes and rates of treatment completion than the control group (Richardson et al., 2014). In the United Kingdom, one qualitative study with depressed adolescents in Cognitive Behavioral

Therapy reported that therapist use of SDM practices strengthened their bond with therapists (Wilmots et al., 2019). These preliminary studies suggest that SDM may facilitate the implementation success of EBPs via fortifying behavioral and relational aspects of client engagement in both adult and youth mental health care. With the popularization of large-scale implementation of EBPs, practical engagement strategies, such as SDM, that can transcend multiple EBPs would be particularly valuable for youth mental health care. SDM can thus broaden the reach of community EBP implementation efforts to families at risk of poor treatment engagement.

Shared Decision Making: Reducing Disparities in Care

Racial/ethnic minority groups, in particular, stand to significantly benefit from SDM based on documented racial/ethnic disparities in access to care, engagement in care and quality of care. Although considerations of race/ethnicity and cultural factors have been advocated for since the inception of SDM research in mental health (Whitley, 2009), significant gaps remain in understanding the benefits for racial/ethnic minority clients. A recent meta-analysis examining outcomes of 19 SDM interventions with disadvantaged groups (e.g., racial/ethnic minority, low education, low-income) found higher patient knowledge about healthcare, self-efficacy, activation and SDM with providers; however, there was less evidence supporting improvements in adherence and clinical outcomes (Durand et al., 2014). Important limitations were that most studies were focused on healthcare and were rated as having low methodological rigor. Nevertheless, some results were promising and warrant further investigation about how SDM may improve care for diverse patients and mitigate disparities in mental health care (Hawley & Morris, 2017).

Some promising research on SDM has been conducted with Latinx and Hispanic adults (Perez Jolles et al., 2019). For example, the Right Question Project–Mental Health (RQP-MH) was a SDM intervention that was employed with a sample comprised of 82% Latinx adult clients to increase patient activation in decision-making in community-based outpatient clinics (Alegría et al., 2008). To counteract the passive consumer role which has been observed with Latinx groups, RQP-MH emphasizes patient empowerment and encourages patients to engage in question formulation to seek information and engage in SDM with providers. The intervention was tailored to the Latinx, Spanish-speaking and immigrant backgrounds of participants during intervention development and implementation. For instance, interventionists made increased efforts to motivate Latinx participants who were hesitant to formulate questions for fear of violating expectations of *respeto*, or who were intimidated by providers because of their educational status and limited understanding of the mental health care system (Polo et al., 2012). Patients in the RQP-MH arm had greater engagement indexed by attendance and retention.

Relatedly, SDM has been described as a strategy to bridge cultural factors in clinical encounters that may stand in the way of producing a strong therapeutic alliance with Latinx patients (Trinh et al., 2019). In a randomized controlled trial of an SDM intervention directed toward both adult patients and community mental health providers, adult patients from predominantly racial/ethnic minority backgrounds participating in the intervention arm reported better quality mental health care, which was partially mediated by improved alliance (Alegria et al., 2018). In an observational study in Spain, Hispanic adults with schizophrenia showed a positive association between their self-reported participation in SDM and therapeutic alliance with psychiatrists and psychiatric nurses (Pérez-Revuelta et al., 2018).

In short, SDM has been proposed as an avenue to diminish engagement barriers in the care of racial/ethnic minority groups. However, the potential of SDM to reduce racial/ethnic disparities in engagement is not well tested, and there is a need for research exploring SDM with diverse patient populations and in the context of family/caregiver involvement in care (Charles et al., 2006; Hamann & Heres, 2019).

SDM with Caregivers & Treatment Decisions

Beyond adult mental health care, SAMHSA (2010) and the American Academy of Pediatrics (2012) have advocated for use of SDM as a quality improvement strategy in children's mental health services. To date, SDM research has focused primarily on adults, leaving a significant gap on its utility within youth mental health treatment (Zisman-Ilani et al., 2017). Youth psychotherapy presents many opportunities for SDM and can help therapists tailor their delivery of EBPs to youth and caregiver characteristics, culture, and preferences (APA Presidential Task Force on Evidence-Based Practice, 2006). Interest in incorporating SDM into youth mental health care is certainly growing with both youth and their caregivers as targets. Though understanding how to best involve youth as they age and mature is still underway (Wyatt et al., 2015), there is also a call for more investigations of caregiver involvement in decision-making (O'Brien et al., 2011).

Examination of SDM with caregivers involved in youth mental health treatment has begun in the past few years. A recent systematic review on tools, techniques and interventions that promote and support the use of SDM in youth mental health settings found 22 studies, where the majority of interventions were aimed at parents (n=14) (Cheng et al., 2017). SDM interventions with parents generated lower treatment dropout (He, Gewirtz, Lee, Morrell, & August, 2016), less conflict with mental health providers about treatment decisions and greater satisfaction with

care (Westermann, Verheij, Winkens, Verhulst, & Van Oort, 2013). As previously mentioned, in a SDM intervention trial in which mostly White depressed youth and their caregivers collaboratively chose between treatment options with their provider (i.e., medication, Cognitive-Behavioral therapy, or Combination), the intervention group had better clinical outcomes and rates of treatment completion than the control group (Richardson et al., 2014). Similar trials of SDM interventions for caregivers are underway (e.g., Liverpool, Webber, Matthews, Wolpert, & Edbrooke-Childs, 2019). Still, other studies have found no changes in outcomes of interest. It is also important to note that most trials of SDM interventions have focused on medication decision making in small samples (e.g., Samalin et al., 2018).

Some attention has been dedicated to child clinical presentations and diagnosis when exploring the potential benefits of caregiver-provider SDM. Across both internalizing and externalizing disorders, qualitative studies reveal positive attitudes toward SDM practices among caregivers and healthcare providers alike (Barnett et al., 2016, 2018; Coletti et al., 2012; Mak et al., 2014; Simmons et al., 2011, 2013). Research also suggests that type of mental health disorder may be an important determinant of therapist SDM use. A national survey demonstrated that parents of children with autism spectrum disorder report lower caregiver-provider SDM compared to children with developmental disorders, ADHD, and depression (Hubner et al., 2016; Vohra et al., 2014). Treatment of externalizing problems, like ADHD, may lend themselves to more collaboration with caregivers as front-line treatments require parent enforcement of structure and behavioral strategies within the home setting. Nonetheless, the national survey findings are concerning because SDM has been shown to have a positive association with satisfaction in mental health care for parents of children with autism spectrum disorder (Golnik et al., 2012).

Characterizations of caregiver-provider SDM within youth psychotherapy sessions are lacking as most studies have focused on pharmacotherapy and relied on survey methods. (Hetrick et al., 2008; Murphy et al., 2010). Parent-reported data from national surveys of children with special healthcare needs indicate benefits of caregiver-therapist SDM in improving youth functional impairment (Butler et al., 2015; Fiks et al., 2012). For instance, one national survey showed that parent-reported SDM in child mental health treatment was associated with decreased symptom severity and lower unmet need (Butler et al., 2015). Prospective survey studies of parent experience of SDM found associations with improvements in child psychosocial outcomes (Edbrooke-Childs et al., 2015; Jager et al., 2017).

Despite positive results, survey data greatly limits understanding of SDM in the youth psychotherapy context. Specifically, much is left unknown about the quality of SDM with caregivers. Additionally, there is little existing data bearing on the naturalistic use of SDM with caregivers in ongoing community-based child psychotherapy. One longitudinal survey study in the United Kingdom sampling youth receiving psychotherapy found that parent-reported SDM was associated with greater reductions in youth's psychosocial difficulties (Edbrooke-Childs et al., 2015). Another limitation of past research is that most quantitative studies of SDM in the mental health context assess SDM at a single time point, often only at the outset of care (Mott et al., 2014; Richardson et al., 2014). Further research is needed to characterize therapists' of SDM process across multiple encounters in the treatment episode. Within the delivery of an EBP, the range of potential therapy content and techniques is defined; however, a number of ongoing decisions about treatment remain possible throughout care. Despite extensive rhetoric about the promise and potential of caregiver-therapist SDM, clearly, much foundational work is still in need.

Specifically, empirical data about the types of decisions that child mental health therapists engage caregivers in SDM is limited and there exists some ambivalence about the types of decisions that warrant SDM. For example, there is some rhetoric that SDM should be reserved for when there are multiple treatment options (e.g., choosing between two different manualized treatments) (Langer & Jensen-Doss, 2018). While another empirical SDM study with Latinx youth and caregivers in therapy broadened eligibility of decisions; for example, in addition to traditional treatment planning decision points, they included decisions about child's school functioning (e.g., bullying), interpersonal communication with the family, and sociopolitical concerns (e.g., deportation of a family member) (Hale et al., 2019). Despite the lack of consensus about what types of decisions that coincide with SDM, examples of decisions that may benefit from collaboration with caregivers in child therapy include choosing a treatment target, selecting an intervention strategy to practice outside of session, and determining whether and when treatment termination is appropriate.

Additionally, significant critiques point to potential boundary conditions on the impact of SDM in youth mental health treatment. Systematic reviews discuss three major criticisms of SDM that seem most pertinent to clinical interactions within youth mental healthcare, where caregivers involvement is prevalent (Boland et al., 2019). First, a major challenge cited by healthcare providers is that youth and caregivers' emotional distress may pose challenges to engaging in the SDM process if they feel "overwhelmed, anxious, in denial, or defensive" (Boland et al., 2019). Second, some critiques indicate that caregivers do not want to be involved in treatment decisions, and they instead want their providers to make decisions. As a rebuttal, SDM advocates argue that even when the caregiver does not want to be responsible for the final decision, the mechanisms of SDM are achieved through participating in the decision-making

process rather than by impacting who makes the decision (Edwards & Elwyn, 2006). Pertinent to the critiques above, qualitative research indicates that although preferences for decision making involvement vary, the majority of caregivers indicate that they do want to be involved in treatment decisions (Davis et al., 2012; Gondek et al., 2017; Lipstein et al., 2012). Additionally, SDM has been championed as a strategy to minimize power differentials by expecting mental health professionals to provide information about treatment options tailored to the caregiver's literacy levels (Boland et al., 2019; Gondek et al., 2017). In routine care, providers often present only one treatment option or may present biased information based on their own preference (Boland et al., 2019). As previously described, such power differentials in mental health and health care may be a particular concern for low-income, Latinx families.

Shared Decision Making with Latinx Caregivers Involved in Youth Psychotherapy

SDM research on racial/ethnic minority caregivers generally and Latinx caregivers specifically is sparse and existing scholarship points to some alarming disparities (Perez Jolles et al., 2019). National surveys, in particular, have illuminated disparities in SDM practices with Latinx caregivers. For example, one national survey revealed that fewer Latinx caregivers of children with mental health needs had experiences with SDM compared to their White counterparts; this is problematic because results also showed that higher SDM resulted in greater patient satisfaction (Jolles et al., 2018). Another survey study showed that Latinx caregivers (versus White), caregivers with less education, and families who rely on public insurance are less likely to report SDM in care (Smalley et al., 2014). A study focusing on ADHD using national survey data found that SDM was a facilitator for accessing treatment among White families, but not among Latinx families (Hinojosa et al., 2019). Disparities seem consistent and unfortunately, not surprising given the longstanding documentation of poor quality of patient-provider

interactions among minority groups (Alegria et al., 2010). Clearly, further investigation is needed to carefully examine provider-caregiver interactions to help identify targets for SDM integration.

A comprehensive literature review revealed only two studies using observational methods to characterize SDM with mental health providers and ethnic minority caregivers. One exploratory study found that pediatricians treating children (n=26) with ADHD using pharmacotherapy demonstrated less SDM with ethnic minority, lower-income and less educated caregivers; moreover, observer-ratings of SDM were low overall suggesting that SDM was not commonplace in usual psychiatric care (Brinkman et al., 2011). In the second study, Hale and colleagues (2019) characterized SDM using data collected from a patient activation intervention trial for Latina mothers of children being served in community mental health clinics. Their session sample (N=100) was mostly psychotherapy sessions (81%) and medication management appointments (17%) and 96% of sessions were in Spanish. After applying OPTION^5, a validated observational-coding system based on Elwyn's three-talk model, to English- and Spanish-language therapy sessions (Elwyn et al., 2013), results revealed only modest levels of SDM. Moreover, there were no differences in SDM implementation found between the intervention and control groups. Observational studies that characterize SDM in routine psychotherapy settings are lacking, but needed, to establish baseline rates of SDM with Latinx caregivers of youth served in the public mental health sector.

Summary of Gaps in SDM Literature

Overall, policy recommendations to incorporate SDM as a quality improvement strategy in children's mental health care have outpaced the research in this area, as SDM has been largely examined with adult patients in healthcare (Hetrick et al., 2008; Morant et al., 2016). In terms of our understanding of the quality of caregiver-therapist SDM within youth psychotherapy

sessions, crater-sized scientific gaps exist. For instance, recommendations to focus on SDM in the early phases of treatment (Barnett et al., 2018; Hawley & Morris, 2017; Langer & Jensen-Doss, 2018; Simmons et al., 2013) have reduced attention to how caregiver-therapist SDM may represent an ongoing process with decisions that occur throughout care as emergent needs and clinical developments arise (Guan, Levy, et al., 2017; Park, Moskowitz, et al., 2018; Regan et al., 2016). More rigorous research in SDM is needed for Latinx caregivers actively involved in their child's EBP treatment within community settings (Cheng et al., 2017; Morant et al., 2016). This line of work would benefit from exploration of factors such as racial/ethnic match with therapist, and language of treatment; these considerations are likely salient for mental health systems that serve predominantly Latinx youth such as Los Angeles County. Additionally, no study to date has examined community therapist factors that predict use of SDM with caregivers of youth with mental health problems. Based on limited previous findings within adult SDM literature, therapist background characteristics such as years of experience may be negatively associated with SDM. Provider variance in relation to SDM has been largely overlooked but should be accounted for in research examining use of SDM within EBP delivery.

Lastly, despite widely disseminated guidance to use SDM as a strategy to engage ethnic minority consumers and reduce disparities in care, research examining this premise among Latinx caregivers in mental health services are lacking (Perez Jolles et al., 2019). Based on studies showing a positive link between SDM and therapeutic alliance with Latinx adult patients (Alegria et al., 2018; Joosten et al., 2008; Matthias et al., 2014; Pérez-Revuelta et al., 2018), the examination of SDM effects on caregiver-therapist alliance is warranted. In summary, direct study is needed to characterize caregiver-therapist SDM in ongoing youth psychotherapy,

examine the role of factors salient in Latinx families, and test whether SDM can bolster caregiver-therapist alliance and care outcomes.

The Current Dissertation

This dissertation is the first investigation of therapist use of SDM and its association with therapeutic alliance with caregivers of Latinx children receiving community mental health settings following a system-driven multiple EBP implementation effort. The dissertation capitalized on audio recorded psychotherapy sessions in which community therapists delivered specific EBPs with caregivers of Latinx youth to achieve three aims. Aim 1 was to characterize SDM as it occurred naturalistically within community EBP implementation-as-usual and among therapist with no specific training in SDM who were providing therapy to Latinx youth. Aim 1 had two components as we reported on specific SDM processes and also the types of decisions that were the focus of SDM dialogue.

For Aim 2, we identified therapist- and session- level factors that predicted increased SDM use. SDM was examined across a diverse set of EBPs that target different presenting problems and have distinct practice components. This context allowed for examination of SDM within a broad range evidence-based care to potentially strengthen the generalizability of findings. It is important to consider that in previous studies community therapists have expressed concern that the prescriptive components of EBPs may restrict their ability to tailor to meet the needs of clients (Burgess et al., 2017; Jensen-Doss et al., 2009). In contrast, other community therapists have reported the benefits of structured EBP protocols such as reduced anxiety related to treatment planning (Barnett et al., 2017). Based on these previous studies, we hypothesized that more structured EBPs would be negatively associated with therapist use of SDM. Additionally, as caregivers are key agents of behavioral change for the treatment of externalizing problems

(e.g., Fawley-King et al., 2013), we anticipated that SDM would be higher in sessions targeting externalizing problems compared to internalizing problems and trauma. In essence, presenting problem was used a proxy of the expected level of involvement of caregivers such that externalizing problems would have higher expected participation than mood problems or trauma.

Lastly, in Aim 3, we examined the association between SDM and therapeutic alliance between community therapists and Latinx caregivers. We hypothesized that SDM would be positively associated with caregiver-therapist bond, a component of alliance. In sum, the current dissertation aimed to understand the use of SDM with low-income, high-need, Latinx families receiving care in children's mental health services following a large-scale multiple EBP implementation initiative.

Method

Dissertation Context

The current dissertation utilized data from two NIMH-funded studies. The system context for both studies was children's community mental health services within Los Angeles County Department of Mental Health (LACDMH). In 2009, LACDMH enacted the Prevention and Early Intervention (PEI) transformation which utilized a state revenue stream funded by a voter-approved ballot initiative to support the implementation of multiple EBPs for common child mental health targets. LACDMH offered community agencies reimbursement for the delivery of EBPs from an approved list and facilitated the rapid scale-up of six EBPs (Regan et al., 2017). The EBP training requirements established by LACDMH in collaboration with EBP developers are briefly described in the PEI Implementation Handbook (Los Angeles County Department of Mental Health, 2016).

The first study is the Knowledge Exchange on Evidence-based Practice Sustainment (4KEEPS study) and the second study is a follow-up to 4KEEPS, the EBP Concordant Care Assessment (ECCA Study). 4KEEPS aimed to examine determinants of EBP sustainment following the PEI initiative in LACDMH (Lau & Brookman-Frazee, 2015). The 4KEEPS In-Depth study involved the collection of EBP session recordings within the validation of therapist-reported delivery of EBP strategies using the EBP Concordant Care Assessment (ECCA). The 4KEEPS eligibility criteria were therapists who provide services in a LACDMH-contracted community mental health centers and deliver at least one EBP for anxiety, conduct, depression or trauma-related problems. The full 4KEEPS In-Depth sample included 101 therapists delivering EBP care to 267 youth clients across 685 sessions. The ECCA study is ongoing and focuses on the refinement of the ECCA therapist-self report tool first developed in 4KEEPS with the goal of developing a pragmatic quality assessment tool in the community delivery of EBPs for youth. ECCA study eligibility were therapists who provide services in a LACDMH-contracted community mental health centers and were trained in at least one EBP for anxiety, conduct, depression or trauma-related problems. Within both the 4KEEPS and ECCA studies, all youth accessed care from agencies serving Medicaid-eligible families, indicating they came from low-income backgrounds.

Data drawn for the dissertation included therapy session audio recordings in which therapists delivered the following EBPs: Child-Parent Psychotherapy (CPP), Positive Parenting Program (Triple P), Trauma Focused Cognitive Behavior Therapy (TF-CBT), Managing and Adapting Practices (MAP) and Parent-Child Interaction Therapy (PCIT). CPP addresses trauma in children under 6 years old in primarily conjoint child-caregiver sessions with some caregiver-focused sessions (Lieberman, 2004). Triple P also requires caregiver attendance in all sessions; it

targets conduct problems in youth under 18 years old (Sanders, 1999). PCIT is a parent training program that targets child disruptive behaviors; PCIT requires caregiver attendance in every session (Eyberg & Funderburk, 2011). TF-CBT addresses trauma in youth 3-18 years old. Optimal implementation prescribes caregiver participation in every session; however, TF-CBT can be delivered and effective for youth without a caregiver participant (Cohen & Mannarino, 2015). Not considered a standalone EBP, MAP is a system of decision support tools that guide evidence-based treatment planning and delivery; therapists can select practice elements for anxiety, depression, conduct problems and trauma for individuals 0-21 years old (Chorpita, Daleiden, et al., 2014). Although most MAP practice elements targeting conduct problems are caregiver-directed, some strategies may be exclusively youth-directed (e.g., problem solving skills training).

Sample

Inclusion criteria for the current dissertation was determined at the session level. Inclusion criteria for sessions were: (1) session participants included a caregiver of a child client who is Latinx; (2) only one caregiver is present; and the (3) caregiver is present for at least ten minutes. These inclusion criteria resulted in a sample comprised of 62 therapists who delivered psychotherapy to 109 youth clients with observations from 210 sessions. Table 1 summarizes therapist, client and session characteristics.

Of the 62 therapists, the average age was 35.20 (SD=9.17; range: 25-62) and 91.94% (n=57) self-identified as female. Additionally, the majority self-identified as Latinx (n=45; 69.35%). Most therapists were unlicensed (n=47; 75.18%) and held a Master's Level degree (n=55; 88.71%). There was a diverse representation of therapists' primary theoretical orientations with cognitive behavioral (n=32; 51.61%) being the most common. The client

sample included 109 Latinx youth with a relatively even gender distribution (male n=58; 53.21%) and an average age of 8.26 years old (SD=3.59; range: 1-18).

Characteristics of the 201 sessions are presented in Table 2. Most sessions (n=164) were sourced from the 4KEEPS study, with fewer from the ECCA Study (n=46). Caregiver demographics are reported at the session level as it was possible, but uncommon, for different caregivers to attend sessions for the same child. The majority of session had caregivers who were female (n=192; 91.43%). Most sessions (n=192; 91.43%) were attended by the child's parent. Caregiver participants in 82.86% of sessions (n=174) were mothers, 8.57% (n=18) were other female caregivers (e.g., aunts, older sisters and grandmothers), and 8.57% (n=18) were fathers. Sessions participants varied with 81.43% (N=171) sessions being conjoint caregiver and youth sessions and 18.57% (n=39) being caregiver only sessions. Just over half of eligible sessions were conducted in Spanish (n=112; 53.33%). The primary presenting problem that was the focus of the session were conduct problems (n=94; 44.76%), trauma (n=68; 32.38%) and internalizing problems (n=48; 22.86%). Table 2 show the frequencies of specific internalizing problems (i.e. anxiety and depression). The EBPs being delivered in session included TF-CBT (n=38; 18.10%), Triple P (n=29; 13.81%), PCIT (n=9; 4.29%), MAP (n=95; 45.24%) and CPP (n=39; 18.57%).

Procedure

All procedures for the 4KEEPS and ECCA studies were approved by the Institutional Review Boards at the University of California, San Diego, University of California, Los Angeles and LACDMH. The 4KEEPS In-Depth study data used was collected between 2015 and 2017. Informed consent of therapists was obtained at recruitment meetings held at agency staff meetings. Therapists completed a baseline survey about their background and perspectives on EBP(s) and submitted questionnaires describing their delivery of EBPs for three sessions for up

to three clients. Therapists obtained permission from caregivers for session recordings, but no identifying information was collected about clients or caregivers beyond basic demographics and presenting problem. Therapists received $20 for the survey and $5 for each session questionnaire as well as $5 for each session recording.

Sessions from the ongoing ECCA study were sourced from data collected between August 2018 and October 2020. In the ECCA study, therapists completed a baseline survey and reported on up to eight sessions for up to four child clients. Therapists were compensated with $30 in a gift card for the baseline survey and $40 for the baseline interview and $10 for each session recording and session survey. Consistent with LACDMH data security procedures, research staff visited program sites weekly to download session recordings from study issued iPods. Caregivers also complete a baseline phone interview to report on background characteristics as well as their child's mental health care history. Caregivers are compensated with a $40 gift card for the baseline interview.

Measures

Therapist Background Characteristics

Therapists reported their personal (i.e., age, gender, race/ethnicity) and professional background (i.e., licensure status, highest degree obtained, years of experience and mental health discipline) on the Therapist Background Questionnaire (Brookman-Frazee et al., 2012).

Youth Characteristics

Therapists reported on client demographics: gender, race/ethnicity, and age.

Session Characteristics

Therapists reported session information: session problem focus (i.e., targeted presenting problem in the session), and the name of the EBP delivered.

EBP Prescribed Session Content and Order

Based on the LACDMH PEI Implementation Handbook (LACDMH 2010a–e) and practice manuals, the EBPs were classified according to whether they had prescribed session content and order (Barnett et al., 2017). Prescribed session content and order was defined as an EBP treatment manual that had explicit guidance as to what content should be covered in session (e.g., didactics scripts, specified skills training, discussion guides, activities) and had a suggested order for when specified treatment content should be delivered. Five child clinical psychologists with expertise in EBPs participated in a group consensus process to determine how to characterize each EBP under investigation. TF-CBT, Triple P and PCIT were categorized as having prescribed session content and order, whereas CPP and MAP were categorized as not.

Observed Shared Decision Making: OPTION Instrument

To assess the extent to which a therapist engaged in SDM processes with caregivers, an adapted version of Observing Patient Involvement in Decision-Making (OPTION^5) was used (Elwyn et al., 2013). OPTION^5 is a validated observational coding system that assesses healthcare providers use of SDM processes with adult patients (e.g., Barr et al., 2015; Geessink et al., 2018; Vortel et al., 2016). It has been proposed as a single construct measure comprised of five items that characterize specific SDM provider behaviors: (1) *Alternate Options*: Draws attention to or confirms that alternate treatment option(s) exist or that the need for a decision exists; (2) *Support Deliberation*: reassures or re-affirms that they will support patient to become informed and/or deliberate about the options; (3) *Option Information*: gives information or checks understanding about options; (4) *Elicit Preferences*: elicits client preferences about options; and (5) *Integrate Preferences*: integrates client's preferences into decision as decisions made. Coders rated each item on a 5-point scale ranging from 0 (behavior not observed) to 4

(behavior is observed with exemplary effort). In the published OPTION[5] system, the five item scores are summed and re-scaled to a composite value between 0 and 100.

OPTION Adaptations. Given that OPTION[5] was not developed for the youth mental health context and has been typically been applied to single sessions within beginning stages of healthcare, adaptations were made to apply the measure to the context of ongoing youth focused psychotherapy sessions. In developing the adapted coding manual, codes were applied to nine gold standard session recordings, and e-mail consultation was sought from the measure developer, Dr. Glyn Elwyn, to confirm the appropriateness of code application and scale ratings. The adaptation process also involved a literature review and numerous consultations with experts in SDM within both adult and youth mental health care, Drs. Margarita Alegría and David Langer, respectively. In addition, in-person and phone consultation was received from Drs. Margarita Alegría and Anna Lau. The adapted observational system was finalized through an iterative process of applying the original coding system to sample 4KEEPS session recordings and subsequently, applying the adapted version of OPTION[5].

Two main adaptations were made. First, exemplars from 4KEEPS sessions recordings were included in the coding manual to help provide clarity and exemplars of eligible content for each code in the context of child mental health treatment. Secondly, when a coder observed at least one SDM behavior as defined by the OPTION[5] system, they were asked to provide a concise description (up to 30 words) about the decision being deliberated. Based on a literature review and expert consultation, a categorical system was established to classify the types of decisions within a priori categories. Five a priori categories were defined as decisions that related to the: 1) Focus of session/treatment (e.g., target child behavior problem), 2) EBP strategy to implement (e.g., active ignoring), 3) participants to include in treatment, 4) treatment termination

or length/dosage, or 5) need for referral/supplemental services. Coders could also categorize decisions into an "other" category. Coders are instructed to designate the time-stamp denoting when a decision was first being discussed in session, write a brief description of the decision and categorize it in one of the treatment decision categories. There could be multiple decisions being discussed in one session, but coders provided global ratings of OPTION[5] codes based on the entire session (i.e., not for each decision being deliberated).

OPTION Coding Procedure. Coders listened to the complete session audio recording and took detailed notes on therapist behaviors that aligned with OPTION[5] codes. For each session recording, the coder assigned global ratings for each of the five OPTION[5] codes using the 5-point scale ranging from 0 (behavior not observed) to 4 (behavior is observed with exemplary effort). When assigning ratings, coders considered the duration, frequency, and extensiveness (detail and depth) for each SDM behavior that the therapist engaged in.

OPTION Coder Training. The Master Coder (Blanche Wright) trained coders using eight gold standard sessions, in which she applied the adapted OPTION[5] manual. Coders included 10 undergraduate students. Seven identified as Latinx and one was mixed-race (Latinx and Middle Eastern); these eight students were native Spanish speakers and bilingual in English and Spanish. Two undergraduate coders were Asian-American.

First, coders attended a group didactic training led by the Master Coder to review and discuss the coding process including code definitions, rating scale application, and exemplars of codes. During trainings, coders were trained to exclude therapists' directives and to ensure that decisions were clearly intended to be made collaboratively with caregivers. Coders then practiced applying OPTION[5] to the eight gold standard sessions rated by the Master Coder. After coding each practice session, the Master Coder met individually with coders to discuss their

discrepancies from gold standard ratings. Coders then re-listened to the session to compare their ratings and notes to those of the gold standard. Once coders reached agreement within 1-point on at least of 80% of the global ratings for eight gold standard sessions, the coders were allowed to independently code a minimum of three sessions weekly. To prevent coder drift, the Master Coder held weekly meetings and offered consultation about eligibility of session content for OPTION[5] coding. Additionally, the Master Coder conducted booster training whenever a coder exceeded two weeks without coding. Booster training consisted of manual review and reestablishing reliability on at least two additional gold standard sessions before resuming independent coding.

OPTION Coder Reliability. To assess inter-rater reliability, approximately 40% of sessions (N=84) were randomly selected to be coded by a second coder. To examine reliability between ratings at the item-level and composite score, reliability was iteratively indexed using the single-item intraclass correlation coefficient (ICC). When item-level ICCs were observed to be below .40, the Master Coder held booster trainings for all coders to promote adherence to the coding system.

We attempted to reliably code all five original OPTION[5] items. For inclusion in the study analyses, we planned to retain codes that had acceptable interrater reliability based on double-coded sessions (ICC ≥ .40) (Cicchetti, 1994) and an occurrence rate of at least 20% in our session sample. We calculated single-score ICC, given that each rating represents a single measurement (i.e., not the average of two measurements). *Support Deliberation* was the only item that occurred in less than 20% of session, observed in 19.34% (n=41) of sessions. As presented in Table 3, all five items had adequate interrater reliability (Mean ICC = .53; range =

.41 - .56); the composite had an ICC of .73. Based on adequate ICC and *Support Deliberation* occurring in almost 20% of sessions, we retained all five OPTION[5] items for factor analyses.

Factor Analyses. To our knowledge, this is the first study assessing a factor solution to OPTION[5] in its application to caregiver-involved youth psychotherapy sessions. Due to the multilevel structure of the data, we first examined the proportion of variance attributed to each level of data. We conducted a null model with the OPTION[5] 5-item composite set as the outcome and then computed the ICC. We used conventional ICC guidelines to detect notable clustering as indexed by an ICC > .05 (Hayes, 2006). The model revealed ICCs > .05 at the client and therapist levels.

Based on prior work establishing OPTION[5] as a single-construct measure (Barr et al., 2015), we initially examined a one-factor solution using confirmatory factor analysis (CFA) for the 5 items: (1) *Alternate Options*, (2) *Support Deliberation*, (3) *Option Information*, (4) *Elicit Preferences*, and (5) *Integrate Preferences*. Using Mplus (Muthén & Muthén, 2005), we sought to run a 3-level CFA but we could not obtain standardized loadings for all items (i.e. one loading is fixed at 1.0). To fully explore item loadings and bypass this limitation of the 3-level CFA, we opted to run a 2-level CFA with session nested within clients. Our threshold for acceptable factor loadings was ≥ .40. Factor loadings are reported in Table 3. The only code that did not meet the factor loading criterion was Item 2 *Support Deliberation*. The CFA using all five items for a one-factor solution had poor model fit (RMSEA=.15; CFI=.86; TLI=.72). Prior research has discussed difficulties with coding Item 2, including a low occurrence rate and difficulties with establishing interrater reliability (Barr et al., 2015; Kölker et al., 2018).

Thus, another 2-level CFA was conducted to examine a one factor solution dropping Item 2 *Support Deliberation* (i.e., using the remaining 4 items). All four items had factor loadings

above .40 (range: .60-.71) and fit indices revealed a strong model fit for a one-factor solution (RMSEA=.00; CFI=1.00; TLI=1.00). The reliability appeared strong as indexed by Omega, which was .81. Thus, this four-item version of the measure was used in analyses and is referred to hereafter as OPTION.

Therapy Process Observational Coding System for Child Psychotherapy-Alliance scale (TPOCS-A).

The TPOCS-A was applied to characterize caregiver-therapist alliance in audio recorded session recordings. The TPOCS-A has a one-factor solution and aims to measure therapeutic bond (i.e., affective aspects of the client-therapist relationship) and task (i.e., client-therapist collaboration on treatment activities), two components of alliance (McLeod et al., 2017). When establishing the gold standard sessions, the Master Coder regularly consulted via email and video meetings with the TPOCS-A developer, Dr. Bryce McLeod, to confirm the appropriateness of code application and scale ratings.

Coding Procedures. Coders listened to the entire session audio recording and made detailed notes on the behaviors of caregivers and therapists. Then, coders assigned a rating on a 6-point Likert scale designed to assess of the degree to which each TPOCS-A item was observed over the course of a session (0 = Not at all to 5 = A great deal). When assigning ratings, coders considered the extensiveness, duration, and frequency with each TPOCS-A item observed.

TPOCS-A Coder Training. An independent group of nine coders (who did not engage in OPTION coding) were trained in the TPOCS-A. All coders were undergraduates, identified as Latina and were bilingual in English and Spanish. Coder training included manual review, didactic training sessions, and practice coding. Coders were considered reliable and ready to start independent coding when they reached at least 80% agreement with “gold standard” item ratings

across at least six training sessions. To prevent coder drift, the Master Coder hosted weekly meetings and offered consultation concerning eligibility of session content for TPOCS-A coding. Additionally, the Master Coder hosted booster training any time a coder exceeded two weeks without coding. Booster training consisted of manual review and reestablishing reliability on at least two additional gold standards before resuming independent coding.

TPOCS-A Coder Reliability. To assess inter-rater reliability, approximately 30% of sessions (N=62) were randomly selected to be coded by a second coder. We attempted to code all nine TPOCS-A items. For inclusion in the current study analyses, codes were required to have acceptable interrater reliability based on double-coded sessions (ICC ≥ .40) (Cicchetti, 1994) and an occurrence of at least 20% of sessions. We calculated single-score ICC, given that each rating represents a single measurement (i.e., not the average of two measurements). Due to low interrater reliability and observed occurrence in less than 20% of sessions, we were not able to include Parent Noncompliance. All other 8 items were retained for factor analyses based on adequate interrater reliability (Mean ICC = .57; range = .42 - .67) and occurrence in more than 20% of sessions. Table 4 includes item-level ICCs.

Factor Analyses. Factor analyses are summarized in Table 4. Due to the multilevel structure of the data, we first examined the proportion of variance attributed to each level of data. We conducted a null model with the TPOCS-A composite set as the outcome and then computed the ICC. We used conventional ICC guidelines to detect notable clustering as indexed by an ICC > .05 (Hayes, 2006). The model revealed ICCs > .05 at the client and therapist levels. However, as we wanted to fully explore factor loadings for every item, we opted for a 2-level CFA. Based on prior work establishing the a single factor solution in the measurement of Therapist-Youth Alliance (McLeod et al., 2021), we initially used a CFA to examine a one-factor solution for

Therapist-Caregiver Alliance using the following 8 items: (1) Feeling Understood, (2) Hostile Manner, (3) Positive Affect, (4) Shares Experiences, (5) Parent Discomfort, (6) Parent/Therapist Discomfort, (7) Changes Outside and (8) Working Equally. However, factor loadings for 5 items were poor and only Feeling Understood, Shares Experiences and Working Equally had factor loadings above .40. Additionally, model fit indices revealed poor fit to the data (RMSEA=.10; CFI=.60; TLI=.44).

To our knowledge, this is the first study using TPOCS-A to assess caregiver-therapist alliance with Latinx caregivers for youth psychotherapy and most extant studies applying TPOCS-A assessed youth-therapist alliance (McLeod et al., 2021). Because the factor structure of alliance measures may vary depending on the study sample (Hatcher & Gillaspy, 2006), we conducted an exploratory factor analysis (EFA) to determine the appropriate factor structure of the 8 reliably coded TPOCS-A items. An EFA with oblique rotation was employed which allowed factors to correlate.

A two-factor structure best fit the data with the first factor *Positive Bond/Mutual Work* including three items: Feeling Understood, Shares Experiences, and Working Equally. A second factor *Negative Affective Bond* also included three items: Hostile Manner, Parent Discomfort and Parent/Therapist Discomfort. Two items with standardized loadings lower than .40 (Positive Affect and Changes Outside) were dropped as they did not evince fit with the broader construct in the current sample (Tabachnick et al., 2007). The correlation between *Positive Bond/Mutual Work* and *Negative Affective Bond* was -.06 and nonsignificant ($p>.05$). Given that most all items retained in these two factors pertained to the affective bond in the therapeutic relationship (rather than to the agreement on tasks component of therapeutic alliance), we will hereafter refer to these as indices of Alliance - Bond. The reliability each factor was calculated using Omega;

Positive Bond/Mutual Work had an ω = .71and *Negative Affective Bond* had an ω = .64. Given that each factor only had 3 items, we believe the factors emerging from the EFA are defensible.

Analytic Plan

Quantitative analyses were conducted in Stata version 15.1 (StataCorp, 2017). Due to the multilevel structure of the data, we first examined the proportion of variance attributed to each level of data. We conducted three null models with the OPTION 4-item composite, *Positive Bond/Mutual Work*, and *Negative Affective Bond* set as the outcomes and then computed the intraclass correlation (ICC) for each model. We used conventional ICC guidelines to detect notable clustering as indexed by an ICC > .05 (Hayes, 2006). The models for the OPTION 4-item composite and *Positive Bond/Mutual Work* revealed ICCs > .05 at the client and therapist levels. The model for *Negative Affective Bond* only revealed notable clustering at the client level, but the ICC at the therapist level was <.05. Given that at least one dependent variable necessitated a three-level structure, we opted for consistency and employed a three-level structure for all aims with sessions (Level 1), nested within clients (Level 2), nested within therapists (Level 3).

Aim 1a: Characterize Community Therapist Use of Specific SDM Steps within EBP Delivery

For Aim 1, basic descriptive statistics were presented including the frequency, means, standard deviations and ranges of the four items retained from the OPTION measure and the rescaled composite. The original five-item OPTION system suggests rescaling the composite score to from a 0-20 to 0-100 scale to help with interpretability. Given that the *Support Deliberation* item was dropped due to CFA results, we rescaled the composite score to 0-80 by multiplying the raw composite by 5.

Aim 1b: Characterize Types of Decisions that were the Focus of SDM dialogue

In addition, we conducted a qualitative analysis of the concise text descriptions (up to 30 words) about the decision being deliberated. The text descriptions were analyzed via a consensus coding process between the OPTION Master Coder and an undergraduate OPTION coder (herein referred to as Assistant Master Coder). Notably, the Master and lead coding team members reviewed coding sheets to ensure that no decision eligibility was based solely on a *Support Deliberation* rating. Initially, we identified five a priori categories to code the types of decisions. However, a review of the text descriptions revealed that these a priori categories were insufficient to fully capture the variety of decisions in which therapists used at least one element of SDM as defined by OPTION. Thus, we applied the grounded theory method, an inductive process in which themes were generated from review of the data through an iterative process of data review and analysis (Glaser et al., 1968).

We took a stepwise approach to developing the treatment decision coding book beginning with the five a priori themes: (1) Focus of session/treatment (e.g., target problem), (2) EBP strategy to implement (e.g., active ignoring), (3) participants to include in treatment, (4) treatment termination or length/dosage, or (5) need for referral/supplemental services. The codebook contained definitions of codes, and examples of decision topics that would be deemed eligible for inclusion in the specific treatment decision category. For the second category of "EBP strategy to implement," we specifically sought to code decisions that were about evidence-based parenting strategies as outlined in the EBP Concordance Care Assessment (ECCA) (Brookman-Frazee et al., 2021). Items in the ECCA were derived from a practice expert survey and previous measurement systems, including the Practice and Research: Advancing Collaboration version of the Therapy Process Observational Coding System (PRAC-TPOCS; Garland et al., 2010; Garland, Brookman-Frazee, & McLeod, 2008) and the Monthly Treatment

and Progress Summary (MTPS; Child and Adolescent Mental Health Division, 2003). The ECCA captures strategies from six EBPs of interest: CPP, CBITS, TF-CBT, SS, MAP, and Triple P. Items assess both EBP Content (24 items) and EBP Technique (8 items) strategies. Content items were defined as, "the substance or issue being addressed in the therapeutic intervention" and included several evidence-based parenting strategies: Identifying/Altering Antecedents to Prevent Problem Behavior, Following the Child's Lead, Praise, Tangible Rewards, Ignoring/Differential Reinforcement of Other Behaviors, Distracting & Redirecting Parent/Child Quality Time, Natural & Logical Consequences, Timeout, Effective Commands, Behavioral Contracting and Accepting and Tolerating Child Distress.

NVivo (QSR International Pty Ltd, 2020) qualitative analysis software program was used to analyze text descriptions of decisions. All text descriptions were coded by both the Master Coder and Assistant Master Coder, and they refined the codebook to capture emergent themes throughout the coding process. NVivo allowed for the aggregation of codes and systematic analysis of text units (Seale & Silverman, 1997). Through the process of review and comparison emergent sub- and super- ordinate themes were identified. Both coders also debriefed on disagreements to obtain consensus on finalized coding of text descriptions. Our approach allowed for multiple codes to be applied to the same text description; that is, coding themes were not mutually exclusive.

Aim 2: Examine Therapist- and Session- Level Predictors of Increased SDM

For Aim 2, multilevel linear regression models were run to identify session-, and therapist-level predictors of SDM. We ran five models in total; the main model indicated the overall OPTION composite as a dependent variable and the four other models used the individual OPTION items as dependent variables, *Alternate Options*, *Option Information*, *Elicit*

Preferences and *Integrate Preferences*. Therapist-level predictors included therapist racial/ethnic background, licensure status, mental health discipline and theoretical orientation. For therapist racial/ethnic background, we created a dichotomous variable indicated whether the therapist was Latinx or not to examine whether racial/ethnic match to caregiver was a predictor of SDM. We also dichotomized discipline establishing whether therapists were trained as Marriage and Family therapists or not. Dichotomization of discipline allowed us to explore whether specialized training in family therapy facilitated SDM with parents within individual child therapy. Given the low sample sizes of several theoretical orientations (e.g., eclectic, humanistic), we opted to compare therapists who had a Cognitive Behavioral or Behavioral orientation to those who had a different orientation.

We initially intended to treat the following variables as session-level predictors: the problem focus of session, whether the EBP was structured with prescribed order and content, and the language of session. Upon further inspection of the raw data, we found that only 6-7 clients had any variation across sessions within these variables. Although there was technically some variation at the session-level, we opted to treat these variables as homogeneous within clients. We employed a decision rule to assign the value represented in the majority of sessions. When there was a tie, the value was recoded to the less common category in the overall sample. For when there was a tie for session language, the value was recoded to English based on the reasoning that the client's family was able to receive services in English to some extent. In addition, for problem focus of the session, we combined anxiety and depression to form an internalizing problems category due to the low sample size of depression; we used conduct problems as the referent. We also covaried for the number of minutes that therapists attended to the caregiver. In caregiver and youth attended sessions, coders estimated the number of minutes

attended to the caregiver versus child. In caregiver-only sessions, the total number of minutes of the session recording was used.

Below is one example of a three-level linear mixed structural model (Raudenbush & Bryk, 2002) for Aim 2. $OPTION_{ijk}$ represents therapist SDM (composite or item rating) within session i for client j of therapist k.

Level 1:

$$OPTION_{ijk} = \pi_{0jk} + \pi_{1jk}(\text{minutes attended to caregiver})_{ijk} + e_{ijk}$$

Level 2:

$$\pi_{0jk} = b_{00k} + b_{01k}(\text{session problem focus})_{ijk} + b_{02k}(\text{EBP prescribed order \& content})_{ijk} + b_{03k}(\text{language of session})_{ijk} + r_{0jk}$$

$$\pi_{1jk} = b_{10k} + b_{11k}(\text{session problem focus})_{ijk} + b_{12k}(\text{EBP prescribed order \& content})_{ijk} + b_{13k}(\text{language of session})_{ijk} + r_{0jk}$$

Level 3:

$$b_{00k} = \gamma_{000} + \gamma_{001}(\text{therapist race/ethnicity})_k + \gamma_{002}(\text{licensure status})_k + \gamma_{003}(\text{mental health discipline})_k + \gamma_{004}(\text{theoretical orientation})_k + u_{00k}$$

$$b_{01k} = \gamma_{010} + \gamma_{011}(\text{therapist race/ethnicity})_k + \gamma_{012}(\text{licensure status})_k + \gamma_{013}(\text{mental health discipline})_k + \gamma_{014}(\text{theoretical orientation})_k + u_{01k}$$

$$b_{02k} = \gamma_{020} + \gamma_{021}(\text{therapist race/ethnicity})_k + \gamma_{022}(\text{licensure status})_k + \gamma_{023}(\text{mental health discipline})_k + \gamma_{024}(\text{theoretical orientation})_k + u_{02k}$$

$$b_{03k} = \gamma_{030} + \gamma_{031}(\text{therapist race/ethnicity})_k + \gamma_{032}(\text{licensure status})_k + \gamma_{033}(\text{mental health discipline})_k + \gamma_{034}(\text{theoretical orientation})_k + u_{03k}$$

$$b_{10k} = \gamma_{100} + \gamma_{101}(\text{therapist race/ethnicity})_k + \gamma_{102}(\text{licensure status})_k + \gamma_{103}(\text{mental health discipline})_k + \gamma_{104}(\text{theoretical orientation})_k + u_{10k}$$

$$b_{11k} = \gamma_{110} + \gamma_{111}(\text{therapist race/ethnicity})_k + \gamma_{112}(\text{licensure status})_k + \gamma_{113}(\text{mental health discipline})_k + \gamma_{114}(\text{theoretical orientation})_k + u_{11k}$$

$$b_{12k} = \gamma_{120} + \gamma_{102}(\text{therapist race/ethnicity})_k + \gamma_{122}(\text{licensure status})_k + \gamma_{123}(\text{mental health discipline})_k + \gamma_{124}(\text{theoretical orientation})_k + u_{12k}$$

$$b_{13k} = \gamma_{130} + \gamma_{131}(\text{therapist race/ethnicity})_k + \gamma_{132}(\text{licensure status})_k + \gamma_{133}(\text{mental health discipline})_k + \gamma_{134}(\text{theoretical orientation})_k + u_{13k}$$

Aim 3: Examine the Association Between SDM and Therapist-Caregiver Alliance-Bond

Lastly, for Aim 3, we conducted five models to examine how SDM, as indexed by OPTION measurement, was associated with *Positive Bond/Mutual Work* and *Negative Affective Bond*. We ran five models in total; the main model used the overall OPTION composite as the

independent variable of interest and the four other models used the individual OPTION items as the independent variable of interest, *Alternate Options*, *Option Information*, *Elicit Preferences* and *Integrate Preferences*. We retained predictors from Aim 2 models as covariates. We grand mean centered OPTION items and the composite. Below is one example of a three-level linear mixed structural model (Raudenbush & Bryk, 2002) for Aim 3. Bond represents either *Positive Bond/Mutual Work* and *Negative Affective Bond* within session i for client j of therapist k. OPTION represents therapist SDM (composite or item rating).

Level 1:

$$\text{Bond}_{ijk} = \pi_{0jk} + \pi_{1jk}(\overline{OPTION})_{ijk} + \pi_{2jk}(\text{minutes attended to caregiver})_{ijk} + e_{ijk}$$

Level 2:

$$\pi_{0jk} = b_{00k} + b_{01k}(\text{session problem focus})_{ijk} + b_{02k}(\text{EBP prescribed order \& content})_{ijk} + b_{03k}(\text{language of session})_{ijk} + r_{0jk}$$

$$\pi_{1jk} = b_{10k} + b_{11k}(\text{session problem focus})_{ijk} + b_{12k}(\text{EBP prescribed order \& content})_{ijk} + b_{13k}(\text{language of session})_{ijk} + r_{0jk}$$

$$\pi_{2jk} = b_{20k} + b_{21k}(\text{session problem focus})_{ijk} + b_{22k}(\text{EBP prescribed order \& content})_{ijk} + b_{23k}(\text{language of session})_{ijk} + r_{0jk}$$

Level 3:

$$b_{00k} = \gamma_{000} + \gamma_{001}(\text{therapist race/ethnicity})_k + \gamma_{002}(\text{licensure status})_k + \gamma_{003}(\text{mental health discipline})_k + \gamma_{004}(\text{theoretical orientation})_k + u_{00k}$$

$$b_{01k} = \gamma_{010} + \gamma_{011}(\text{therapist race/ethnicity})_k + \gamma_{012}(\text{licensure status})_k + \gamma_{013}(\text{mental health discipline})_k + \gamma_{014}(\text{theoretical orientation})_k + u_{01k}$$

$$b_{02k} = \gamma_{020} + \gamma_{021}(\text{therapist race/ethnicity})_k + \gamma_{022}(\text{licensure status})_k + \gamma_{023}(\text{mental health discipline})_k + \gamma_{024}(\text{theoretical orientation})_k + u_{02k}$$

$$b_{03k} = \gamma_{030} + \gamma_{031}(\text{therapist race/ethnicity})_k + \gamma_{032}(\text{licensure status})_k + \gamma_{033}(\text{mental health discipline})_k + \gamma_{034}(\text{theoretical orientation})_k + u_{03k}$$

$$b_{10k} = \gamma_{100} + \gamma_{101}(\text{therapist race/ethnicity})_k + \gamma_{102}(\text{licensure status})_k + \gamma_{103}(\text{mental health discipline})_k + \gamma_{104}(\text{theoretical orientation})_k + u_{10k}$$

$$b_{11k} = \gamma_{110} + \gamma_{111}(\text{therapist race/ethnicity})_k + \gamma_{112}(\text{licensure status})_k + \gamma_{113}(\text{mental health discipline})_k + \gamma_{114}(\text{theoretical orientation})_k + u_{11k}$$

$$b_{12k} = \gamma_{120} + \gamma_{121}(\text{therapist race/ethnicity})_k + \gamma_{122}(\text{licensure status})_k + \gamma_{123}(\text{mental health discipline})_k + \gamma_{124}(\text{theoretical orientation})_k + u_{12k}$$

$$b_{13k} = \gamma_{130} + \gamma_{131}(\text{therapist race/ethnicity})_k + \gamma_{132}(\text{licensure status})_k + \gamma_{133}(\text{mental health discipline})_k + \gamma_{134}(\text{theoretical orientation})_k + u_{13k}$$

$$b_{20k} = \gamma_{200} + \gamma_{201}(\text{therapist race/ethnicity})_k + \gamma_{202}(\text{licensure status})_k + \gamma_{203}(\text{mental health discipline})_k + \gamma_{204}(\text{theoretical orientation})_k + u_{20k}$$

$$b_{21k} = \gamma_{210} + \gamma_{211}(\text{therapist race/ethnicity})_k + \gamma_{212}(\text{licensure status})_k + \gamma_{213}(\text{mental health discipline})_k + \gamma_{214}(\text{theoretical orientation})_k + u_{21k}$$

$$b_{22k} = \gamma_{220} + \gamma_{221}(\text{therapist race/ethnicity})_k + \gamma_{222}(\text{licensure status})_k + \gamma_{223}(\text{mental health discipline})_k + \gamma_{224}(\text{theoretical orientation})_k + u_{22k}$$

$b_{23k} = \gamma_{230} + \gamma_{231}(\text{therapist race/ethnicity})_k + \gamma_{232}(\text{licensure status})_k + \gamma_{233}(\text{mental health discipline})_k + \gamma_{234}(\text{theoretical orientation})_k + u_{23k}$

Results

Aim 1a and 1b: Therapist use of SDM processes with Latinx caregivers

Across all sessions, at least one of the four OPTION items occurred in 91.43% (n = 192) of sessions. In sessions where at least one of the four OPTION items was observed, the mean rescaled composite score was 26.22 (SD=14.22; range: 5-65) with a maximum possible composite score of 80. *Alternate Options* occurred in 75.71% (N=159) of sessions with mean score of 1.61 (SD=.79; range:1-4). *Information About Options* was observed in 70.00% (N=147) of sessions with mean rating of 1.66 (SD=.82; range:1-4). *Eliciting Preferences* occurred in 80.66% (N=171) of sessions with a mean rating of 1.65 (SD=.85; range: 1-4). Lastly, *Integrating Preferences* occurred in 80.47% (N=169) of sessions with a mean rating of 1.65 (SD=.25; range: 1-4). Figure 2 depicts the OPTION item mean ratings and frequency within the session sample.

SDM as indexed by the four OPTION items occurred in relation to a variety of types of treatment decisions. The average number of treatment decisions that encompassed SDM dialogue was 2.67 (SD=1.61; range: 1-9). Qualitative analyses revealed four superordinate themes in the decisions raised in sessions where SDM occurred: (1) Treatment planning, (2) Evidence-based Parenting Strategies, (3) Youth Functioning and (4) Family Psychosocial Needs. There were two decisions that did not align with the four superordinate categories; one decision was about the language of treatment delivery (i.e., English or Spanish) and one decision about was about teaching the child how to become responsible with managing money (i.e., caregiver raised concern and therapist problem solved with caregiver). A summary of the decision categories is

presented in Table 5 and visual depiction of the frequency of the superordinate categories represented at the session level is in Figure 3.

The most commonly coded decision category was Treatment Planning, which occurred in 53.81% of sessions (N=113) and encompassed a variety of subthemes. The most common subtheme was about deciding what to focus on in the current session. Practical treatment decisions were also characterized under Treatment Planning and included deciding who should participate in future sessions (e.g., a sibling; child's other caregiver) and planning treatment termination. There was much diversity in the decisions included in the case management subcode, which required the therapist to "coordinate care across multiple sectors, such as education, financial, medical/dental, social connections, and advocacy" (O'Neal et al., 2022, p. 2). Case management decisions included referrals for mental health treatment for family members, facilitating donations for family (e.g., clothes for child) and linking child to supplemental services (e.g., regional center evaluation; academic tutoring). The least common Treatment Planning subtheme was about the child's medication, such as ensuring adherence.

In about half of sessions (50.48%; n=106), at least one decision was raised about Evidence-based Parenting Strategies. Common parenting strategies included praise, behavioral contracting, natural/logical consequences and parent/child quality time. There were many instances in which the therapist provided information about multiple parenting strategies at once and elicited the caregiver's preference for using the strategies. For example, one coder's concise description of the decision being deliberated was, "Therapist asks mom to pick which strategy to use this week (e.g., rewards/consequences, planned ignoring, time-out, clear/calm instructions, quiet time, etc.)." More than half (55.66%; n=59/106) of the Evidence-based Parenting Strategies

decisions were about planning or reviewing implementation of an evidence-based parenting strategy.

Approximately half of sessions (45.71%; n=96) included decisions about Youth Functioning. Youth Functioning often included decisions about strategies used to support child's mental health needs, but could not be discerned as one of the vetted evidence-based parenting strategies per se. The most common subcategory being about facilitating the child's emotional regulation; most of these decisions were about the caregiver helping the child generalize their coping skills outside of session and prompting the child to express their emotions when in distress. School functioning represented a variety of decisions within the school context, including problem solving with caregiver about how to manage child's peer conflict or bullying. School functioning also included decisions that were dually coded within Case Management, such as requesting an Individualized Education Plan and the caregiver following-up on special school accommodations for child's homework. Therapists were observed to engage the caregiver in SDM when devising daily and specialty routines (e.g., bedtime routine) based on the caregiver's preferences and feasibility of implementation within the broader family context. Child's use of technology was a concern that caregivers initiated and sought the therapist's support in deciding how to limit screen time; many of such decisions also focused on child-sibling conflict about sharing a device. Only five decisions had decisions about keeping the child safe, such as restricting access to knives.

The final superordinate theme identified was broadly about addressing Family Psychosocial Needs (n=35; 16.67%). Caregiver Well-Being was the most prominent subcategory, with therapists helping caregivers identify coping skills and self-care practices. Caregiver referrals for individual adult therapy or parenting groups were also decisions

deliberated. Therapists also used SDM to address caregiver's challenges with co-parenting or navigating child's visits and relationship with other family members. Some co-parenting decisions had the family context of shared legal custody between the mother and father; the decision often encompassed the mother gaining therapist suggestions about how to effectively communicate to child's father about differing parenting practices. The least common subcategory was about Family Financial Strain and included unique decisions, such as problem-solving about housing insecurity.

Aim 2: Multilevel factors associations with increased SDM

Models examining predictors of the OPTION composite and item-level OPTION scores are summarized in Table 6. Most of the therapist- or session-level variables examined were not significantly associated with the OPTION composite score. Exceptions were session problem focus and language of session. Compared to sessions targeting conduct problems, sessions in which trauma was the problem focus had lower overall SDM (B = -8.79, 95% CI[-14.09, -3.49], p=.001). In Spanish-language sessions, therapists were observed to have lower OPTION composite scores compared to English-language sessions (B = -4.57, 95% CI[-8.97, -.17], p=.04).

When examining therapist- and session- level predictors of item-level OPTION scores, session problem focus was associated with *Option Information*, *Elicit Preferences* and *Integrate Preferences*. In all three models, item-level OPTION scores were consistently lower for sessions in which therapists were targeting trauma compared to conduct. Session problem focus was marginally associated with *Alternate Options* (B = -.33, 95% CI[-.69, .03], p=.07) for the same conduct versus trauma comparisons. Session language was also associated with *Elicit Preferences* such that Spanish-language sessions had lower *Elicit Preferences* ratings compared

to English-language sessions (*B* = -.34, 95% CI[-.64, -.04], *p*=.03). Therapist licensure status was associated with *Integrate Preferences*; sessions led by licensed therapists had a higher ratings compared to unlicensed therapists (*B* = .24, 95% CI[.003, .48], *p*=.047).

Aim 3: Associations between SDM and Alliance – Bond

Across all sessions, behaviors aligned with *Positive Bond/Mutual Work* occurred in all 210 sessions with a mean score of 8.72 (SD=2.88; range: 1-15). Behaviors aligned with *Negative Affective Bond* occurred in 67.62% of sessions (N=142). In sessions where *Negative Affective Bond* occurred, the mean score was -2.78 (SD=2.05; range: -1 - (-13)).

Models examining the association between the OPTION scores and *Positive Bond/Mutual Work* and *Negative Affective Bond* are summarized in Table 7. The OPTION composite score was not associated with *Positive Bond/Mutual Work* (*B* = .02, 95% CI[-.01, .05], *p*=.14) or *Negative Affective Bond* (*B* = -.02, 95% CI[-.04, .01], *p*=.14). When examining item-level OPTION scores and their associations with *Positive Bond/Mutual Work* and *Negative Affective Bond*, only *Alternate Options* was significantly negatively associated with *Negative Affective Bond* (*B* = -.32, 95% CI[-.64, -.01], *p*=.04).

Discussion

The current dissertation used observational methods to characterize community therapist's use of SDM with Latinx caregivers during the delivery of child-focused EBPs, examine potential determinants of SDM, and to determine whether SDM processes strengthen caregiver engagement as indexed by measures of the bond aspect of therapeutic alliance. There was little systematic association between therapist and session characteristics, and observed therapist SDM behaviors. Only Spanish language use in sessions and session problem focus were

consistently associated with SDM use. Lastly, overall SDM was not associated with either index of therapeutic alliance observed in sessions.

Yet, there was much learned about the naturalistic occurrence of SDM in the current context of a community-based implementation of EBPs serving Latinx youth. Aim 1 results revealed that SDM, as measured by an adapted version of the OPTION observational measure, occurred in most sessions (91.43%; N=192). However, composite scores indicated that SDM processes were observed at low levels of extensiveness with an average rating of 26.2 out of a possible scaled score of 80. These results were highly aligned with a previous study examining SDM using the OPTION instrument within child mental health appointments (81% were psychotherapy sessions) with Latina mothers, in which at least one instance of SDM was observed in 90% of sessions (Hale et al., 2019). Although all five OPTION items were retained in that study, average levels of SDM were comparable as they found a mean of 33.20 on a 0-100 scale and in the current study (i.e. the observed mean of 26.2 rescaled to a 0-100 scale would be a composite score of 32.78). Notably, Hale et al. (2019) drew their data from a RCT of patient activation, where caregivers were empowered and taught to gather information about their child's care. In studies with families from other racial/ethnic groups and clinical populations, SDM has also been observed to be implemented with modest levels of extensiveness. In one RCT of a SDM intervention implemented with physicians working with parents of children newly diagnosed with ADHD, they found an OPTION score of 31.2 in the control group, which was significantly lower than the intervention group's composite of 43.8 (Brinkman et al., 2013). Another study within a developmental behavioral pediatric clinic measured physicians' and nurses' use of SDM with parents of children with autism spectrum disorder (Anixt et al., 2018). Within 45 routine visits, they found a mean OPTION[5] composite score of 24.5 on the 0-100

scale. The small sample of studies using observational methods to examine SDM with caregivers involved in their child's mental health treatment vary from routine care studies (Anixt et al., 2018) to RCTs implementing an intervention to increase provider-initiated SDM (Brinkman et al., 2013) or to increase parent participation in care (Hale et al., 2019). The current dissertation and prior studies suggest that SDM occurs naturalistically but at low levels without focal training efforts for providers. This can be likened to EBP strategies that are observed at only modest levels within usual child mental health care (Garland et al., 2010).

A novel contribution of this study was an in-depth qualitative examination of the types of decisions to which SDM processes were applied in child psychotherapy sessions with caregivers. Most studies either do not track the specific decisions being discussed (e.g., Butler et al., 2014) or focus on one particular decision, typically decisions about psychotropic medication within mental health care (e.g., Richardson et al., 2014). Most sessions included decisions about treatment planning (N=113) with large representation (66/113; 58.40%) of practical decisions about what to focus on in the current session or who to include. It is possible that SDM may be most likely to be related to important therapeutic process outcomes (e.g., alliance) when the focal decisions are more substantive and related to meaningful dimensions of caregiver preferences, values, and understandings of their child's problem (i.e. explanatory models of illness, c.f. Yeh et al., 2019).

Although there were treatment planning decisions directly linked to presenting problems, such as identifying the treatment target, there were many decisions that did not narrowly focus on the child and/or their presenting problem but rather addressed challenges within the broader family system. For example, Case Management represented more than a quarter of the treatment planning decisions and about supplementing outpatient care (36/113; 31.86%). Case

management decisions included auxiliary services such as referrals for individual treatment for other family members and easing financial strain by finding donations for families. Within the total session sample, Family Psychosocial Needs (35/210; 16.67%) was another decision category that was not narrowly focused on child presenting problems and required therapists to hone in on caregiver needs. The major subcategory was about Caregiver Well-Being, which typically included decisions about developing coping skills or inquiring whether the caregiver had interest in individual therapy.

The notable presence of Case Management and Family Psychosocial Needs decisions highlights the common scope of responsibility that community therapists are tasked with, and the multiple competing needs for session time and attention. Indeed, qualitative results from a study in the same system context highlighted that Latinx therapists often engage in care coordination with their clients to address holistic needs of families beyond individual psychotherapy (Ramos et al., 2021). Research on emergent life events within EBP delivery has also shed light on unexpected stressors that have significant impact on families that are often not the central focus of planned treatment session content (Chorpita, Korathu-Larson, et al., 2014). Previous studies report that common emergent life events include marital/family conflicts, problems at school and housing/financial issues (Guan, Levy, et al., 2017; Guan, Park, et al., 2017). Community providers' responses to emergent life events commonly include "informal problem solving" and "informal advice giving" (Guan et al., 2018). The current findings suggest that therapists and parents can take on these discussions about how to navigate emergent stressors collaboratively.

The second most frequent decision type represented at the session-level were decisions about Evidence-Based Parenting Strategies (106/210; 50.48%). This is not surprising based on the study context of community-EBP delivery within caregiver-involved sessions. Moreover,

over 50% of these decisions were about the out-of-session implementation of the evidence-based parenting strategies, which included either planning for implementation or reviewing previous implementation. Implementation of parenting strategies presents an opportune environment for therapists to engage parents in SDM as there are micro decisions (e.g., problem solving potential barriers; sharing pros/cons about strategy) within the macro decision of whether to use the strategy with the child. To our knowledge, this is the first study examining SDM using observational methods within a multiple EBP delivery context in youth outpatient community care. These findings present preliminary evidence that sharing power and control with parent stakeholders is achievable within EBP decisions.

In addition, within the broad category of Youth Functioning, SDM most occurred with decisions about caregivers supporting child emotional regulation (63/96; 65.62%). Frequent decisions included helping their children identify emotions and also use their coping skills when they become dysregulated outside of session. Unfortunately, we did not specifically track whether emotional regulation techniques were evidence-based, but through our qualitative analyses, we noticed common child coping strategies such as progressive muscle relaxation and diaphragmatic breathing. It appears that therapists take a collaborative approach when helping the caregiver reinforce child-focused communication and coping strategies as a means to generalize outside of session use.

In the second aim, we examined the relationships between therapist- and session- level factors with overall SDM, as indexed by the OPTION composite, and specific SDM processes, as indexed by individual OPTION item ratings. For therapist factors, there was only one significant association such that in sessions led by licensed therapists, therapists were observed to integrate caregivers' preferences into decisions more. Research on relationships between

provider characteristics and their use of SDM is scarce, and no known study has assessed licensure as a determinant of SDM use. Being licensed connotes having greater clinical practice experience, which ostensibly is associated with knowledge and competence for independent clinical practice. Licensed professionals may have garnered sufficient experience to develop the skills necessary to work effectively with parents (not just the child client) including strengthening their collaboration skills to not only listen to parent perspectives but to incorporate them into the treatment (Kon, 2010). However, continued research is needed to understand the explanations for why licensed professionals may engage in SDM at higher levels.

For client factors, we found that session problem focus was consistently associated with overall SDM and most specific SDM processes. When compared to trauma-focused sessions, it appears that sessions in which conduct problems was the targeted problems, therapists engaged Latinx caregivers in higher levels of SDM overall and specifically the SDM processes of sharing information about options, eliciting preferences and integrating their preferences. This is aligned with our hypothesis that externalizing problems would be linked to higher SDM, with the understanding that problem focus is a likely a proxy of treatment types delivered. Specifically, evidence-based treatment for behavioral problems conceptualize caregivers as key agents of changes and most interventions target alterations in parenting strategies (Fawley-King et al., 2013). In contrast, a systematic review of EBP for child trauma revealed much variability in the nature of caregiver involvement in treatment (e.g., psychoeducation only; learning behavioral a management skills; just session attendance) suggesting that the benefits of caregiver treatment participation are not yet clear (Leenarts et al., 2013). Recent work has begun to identify the core elements of caregiver participation in trauma treatment, but the advantage of these elements with regard to improved child clinical outcomes remains an unanswered and important empirical

question (Kiser et al., 2020). This lack of consensus in the evidence-base may translate as therapist ambivalence about the extent to include caregivers in child trauma treatment and thus, reduced levels of SDM. To date, findings related to presenting problem and SDM have been inconsistent with research showing that externalizing problems, including conduct, are associated with both higher (Hubner et al., 2016; Vohra et al., 2014) and lower (Liverpool et al., 2021) caregiver-reported SDM. This adds to the small but growing literature examining diagnosis or presenting problem as a determinant of SDM in youth mental health care and provided further evidence that treatment of externalizing problems facilitates SDM more than other psychopathology.

Contrary to our hypothesis, we did not find that structured EBPs (i.e., those with prescribed order and content) were associated with therapist SDM use. This might be conceived as a positive as it implies that therapists are finding opportunities to collaborate with caregivers and make shared decisions regardless of if there are certain components they must deliver. Previous studies have found that that community EBP delivery effectively is flexible delivery of practices that does not align with strict fidelity (Lau et al., 2017; Park, Tsai, et al., 2018) and this flexible context may allow for more SDM. To further explore the relationship between SDM and EBP delivery, future work will examine whether SDM use is associated with more or less extensive delivery of common EBP strategies as measured in the ECCA tool. This line of inquiry can shed light on the extent to which SDM represents a collaborative approach that could potentially facilitate or complement or impede EBP content and technique delivery in community implementation.

In addition, session language was associated with overall SDM with Spanish-language sessions having lower OPTION composite scores than English-language sessions. Upon further

inspection using models with specific OPTION items as independent variables and controlling for racial/ethnic match, providers were observed to elicit caregiver preferences at lower levels in Spanish sessions than English sessions. Importantly, sessions conducted in Spanish involve either monolingual Spanish-speaking parents or parents who preferred to speak Spanish; language preference has been used as a proxy for acculturation in previous studies and Spanish preference may suggest lower acculturation to the U.S. context and closer alignment to the native culture (Kim et al., 2016). Moreover, Spanish service delivery requires provider bilingualism but not necessarily racial/ethnic match. In our sample, therapists providing care in Spanish came from predominantly Latinx backgrounds but there were some that identified as White. The observed lower observed elicitation of Spanish-speaking caregivers preferences is troubling as the engagement of all caregivers can make treatment more effective (Ingoldsby, 2010). Several factors may be interacting to explain this association and therapists may be overlooking the critical importance of practicing cultural sensitivity when working with less acculturated caregivers. Specifically, they may be overlooking the Latinx cultural value of *familismo*, which emphasizes cohesion, obligation, support and obedience amongst one's nuclear and extended family members (Falicov, 1998; Stein et al., 2014). A hierarchical family structure exists such that parents have clear authority, which underlines the importance of seeking parent input in decisions (Kapke & Gerdes, 2016). Relatedly, previous research in community mental health settings suggests that Latinx parents may defer to community therapists because they highly value *respeto*, which can include respect to professionals, and this may be interpreted by providers as Latinx parents not wanting to actively participate in their child's treatment (Chlebowski et al., 2018). Latinx parents may not be proactive about sharing their thoughts and opinions, which further emphasizes that therapist should be taking more initiative in explicitly

asking for their input and not assume that the caregiver does not have a preference. Future studies on SDM within Latinx populations would benefit from examining the role of acculturation and therapist implicit bias in their use of SDM; measuring such concepts could illuminate whether SDM use is equitable across families.

Lastly, within Aim 3, we conducted the first examination of SDM and the therapeutic relationship between child mental health therapists and Latinx caregivers. Contrary to our hypothesis, we did not find an association between overall SDM use and therapeutic alliance in either the positive or negative bond dimensions measured. There could be many reasons for this null funding. First, SDM could, in fact, have no benefits for the therapy bond with caregivers. A recent trial of an SDM intervention for youth mental health treatment found no differences in self-reported alliance score between the intervention and control groups (Langer et al., 2021). Researchers postulated that rapport-building over time is essential to building therapeutic alliance, and in the SDM intervention sessions, providers had limited time to engage clients in rapport-focused activities. To date, the mechanisms by which SDM influences alliance have not been established in the literature. Establishing the mechanisms by which SDM may promote positive outcomes in treatment (e.g., adherence) is essential. Second, this dissertation encompassed the first application of TPOCS-A to a sample of Latinx caregivers, and the psychometric results did not support the measurement of the task dimension of alliance. It is very plausible that SDM may have greater implications for the perception that therapist and the caregiver agree on the goals and activities of therapy than it has on the affective bond between them. Although the TPOCS-A has been used in other countries/cultures (e.g., Netherlands; Liber et al., 2010), our data indicate that adaptations to assess working alliance in therapy with Latinx caregivers may be needed.

Nonetheless, to further explore the relationship between SDM and bond, we also assessed specific SDM processes' associations with *Positive Bond/Mutual Work* and *Negative Affective Bond*. The only item-level OPTION association that was significant was a negative relationship between *Alternate Options* and *Negative Affective Bond*; that is, identifying that there is a decision and/or options to deliberate was associated with reduced parent/therapist discomfort and parent hostility towards therapist. Given the scarcity of research on this topic, we are unable to draw upon prior SDM literature to help explain this finding. However, at the heart of the *Alternate Options* item is clear communication in which the therapist is delineating that choices are to be made. Clear communication about decisions can quickly help the therapist and caregiver align in the goal at hand (i.e., make a decision) and prevent confusion or discomfort about what is to come in session and establishing that caregiver's views matter. Indeed, one Delphi study with clinicians, caregivers, and youth found that lack of clear communication hinders a "good" therapeutic relationship (Ryan et al., 2021). In sum, our finding presents initial evidence of the potential of SDM steps to prevent ruptures in the therapeutic relationship between community child therapists and Latinx caregivers involved in EBP delivery.

Limitations

Though the dissertation makes novel contributions to the literature on SDM within youth mental health care, several limitations must be considered. First, the behaviors measured and retained in the analyses do not represent a comprehensive catalogue of SDM behaviors or alliance indices. Some therapist and caregiver behaviors intended to be measured were not observed with sufficient frequency and/or reliably rated by coders and were omitted from the analyses. For alliance measurement specifically, factor analysis results only permitted retaining items that aligned with the bond component of alliance as almost all items intended to index the

task dimension were dropped. Thus, we effectively were not able to examine the relationship between SDM and a comprehensive measurement of alliance. Second, the phase of treatment during which sessions occurred was unknown and the same clients could have had sessions from any time in treatment. Alliance takes time to strengthen and the therapeutic relationship is likely fragile in early stages. As we were unable to control stage of treatment, this may have hindered our ability to detect an association with alliance over and above time of treatment (e.g., if most sessions in early stages). Lastly, our sample was comprised of racially and ethnically diverse community therapists that were mostly unlicensed, Master's level clinicians serving Latinx clients and their caregivers from low-income and mostly Latinx backgrounds. These background characteristics should be considered when generalizing findings.

Conclusion

This dissertation was the first study to examine community therapists use of SDM with caregivers during multiple EBP delivery to Latinx youth. The study also adds to the small body of research examining the relationship between SDM and alliance within mental health care broadly and within youth mental health care specifically. Main findings suggest that therapists are engaging in steps of SDM during most EBP sessions, but only at modest levels. Moreover, therapists seem to be tasked with engaging caregivers in decision-making about topics beyond the narrow scope of child outpatient psychotherapy, as many decisions encompassed concerns that impact the larger ecosystem of the child. Other findings suggest that the SDM behavior of bringing attention to options and that there is decision to be made could potentially prevent negative interactions between caregivers and therapist and thus, prevent the formation of a rupture in their bond. Based on the modest positive finding and the limitation of this dissertation's inability to examine the task dimension of alliance, further investigation about the

relationship between SDM and alliance is warranted. Research should include multi-informant alliance measures that have been well validated for caregiver use. Such analyses could generate empirical data about the potential benefits of SDM and whether investment in therapist training is merited. In summary, though SDM research in youth mental health care is in infancy, this study provides preliminary evidence that community therapists are to some extent sharing power and control with Latinx caregivers in treatment decisions. However, the specific benefits of strengthening the quality of their collaboration skills within care decisions, especially in regards to alliance, have not yet been identified.

Figure 1

Three Talk Model of Shared Decision Making (Elwyn et al., 2017)

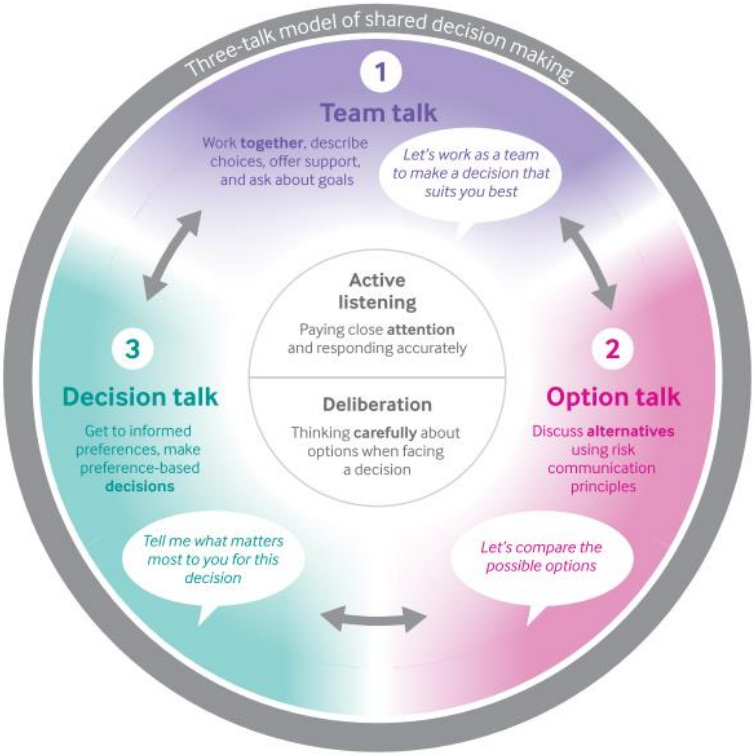
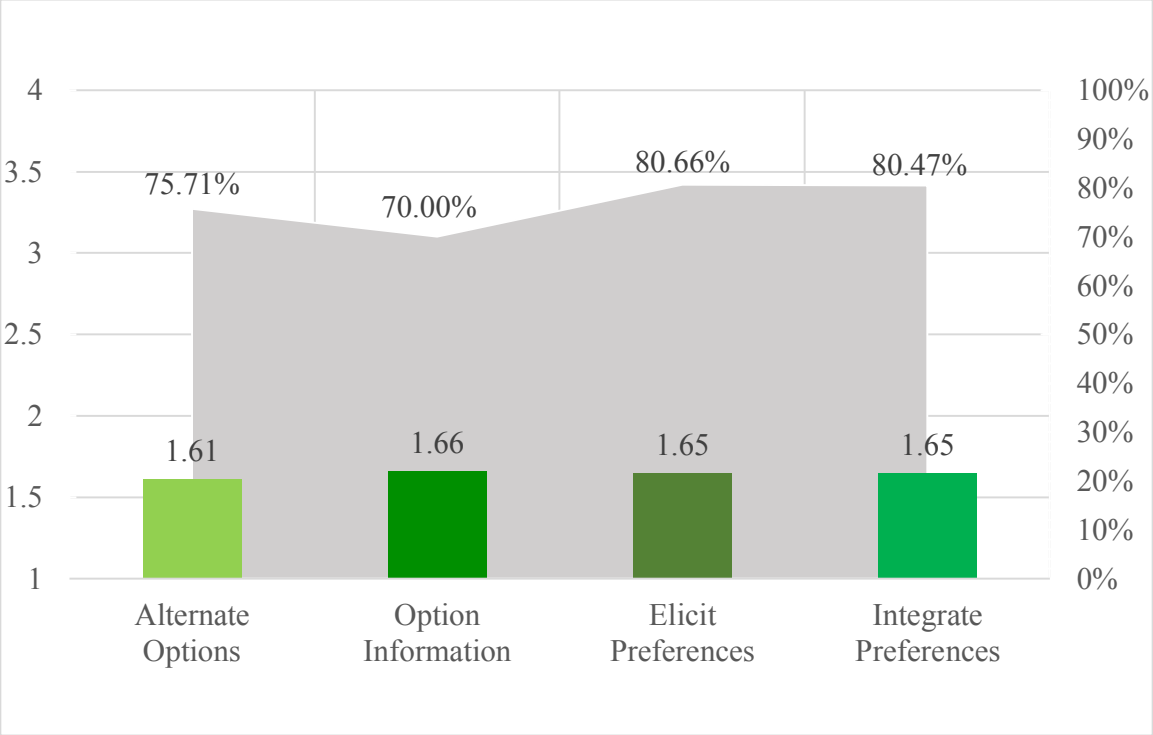


Figure 2

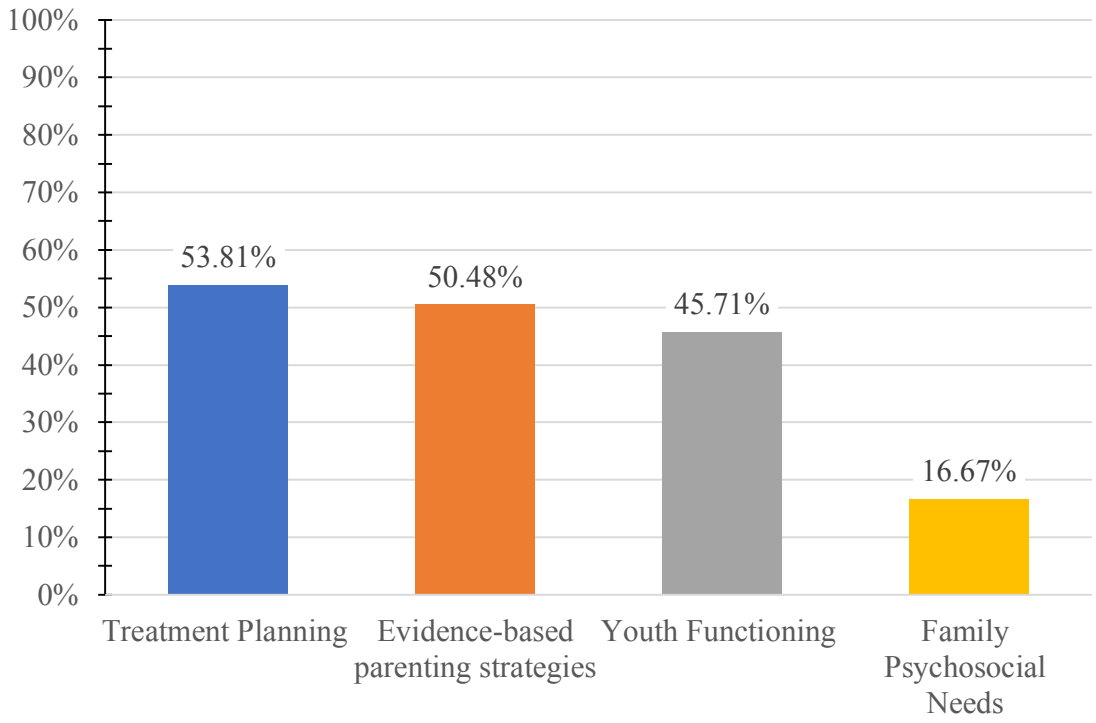
OPTION Items: Mean Ratings & Frequency



Note. This figure demonstrates both the mean rating of OPTION items and their frequency within the total session sample (N=210). Bars represent the mean ratings of each item among sessions where the code was observed. The grey background represents the frequency in the form of percentage that each code was observed in the total sample of sessions.

Figure 3

Session-level Frequency of Decision Categories in Total Session Sample



Note. This figure represents the frequency in the form of percentage of the types of decisions that were the focus of SDM dialogue within the total session sample (N=210).

Tables

Table 1

Characteristics of Therapists

Therapist Characteristics	
Total *N*	62
Gender, *N* (%)	
Female	57 (91.94)
Male	5 (8.06)
Race-ethnicity, *N* (%)	
Latinx	43 (69.35)
White	13 (20.97)
Other racial-ethnic group	6 (9.68)
Education, *N* (%)	
Master's	55 (88.71)
Below Master's	4 (6.45)
Doctoral	3 (4.84)
Age, *M*(SD)	35.20 (9.17)
Years of experience, *M*(SD)	5.48 (5.89)
Licensure, *N* (%)	
No	47 (75.18)
Yes	15 (24.19)
Discipline, *N* (%)	
Marriage and family therapist	30 (48.39)
Social worker	24 (38.71)
Psychologist	5 (8.06)
Other	3 (4.84)
Theoretical Orientation, *N* (%)	
Cognitive Behavioral	32 (51.61)
Family systems	11 (17.74)
Eclectic	6 (9.68)
Humanistic	4 (6.45)
Behavioral	4 (6.45)
Psychodynamic	3 (4.84)
Other	2 (3.23)

Table 2

Characteristics of Youth Clients & Sessions

Youth Characteristics	
Total *N*	109
Age, *M*(SD)	8.26 (3.59)
Gender, *N* (%)	
Male	58 (53.21)
Female	51 (46.79)
Language of Session	
Spanish	59 (54.13)
English	50 (45.87
Problem Focus of Session, *N* (%)	
Conduct	44 (40.37)
Trauma	40 (36.70)
Anxiety/Depression	25 (22.94)
Evidence-Based Practice delivered	
Trauma Focused-Cognitive Behavioral Therapy[a]	25 (22.94)
Positive Parenting Program[a]	12 (11.01
Parent Child Interaction Therapy[a]	3 (2.75)
Managing and Adaptive Practice[b]	54 (49.54)
Child Parent Psychotherapy[b]	15 (13.76)
Session Characteristics	
Total *N*	210
Session type by participant(s), *N* (%)	
Caregiver & Youth	171 (81.43)
Caregiver only	39 (18.57)
Caregiver gender, *N* (%)	
Female	192 (91.43%)
Male	18 (8.57%)

[a]Practice has prescribed session content and order

[b]Practice does not have prescribed session content and order

Table 3

OPTION Reliability and Factor Loadings

		CFA Loadings	
	ICC	5-item CFA	4-item CFA
Item 1. Alternate Options	.54	**.60**	**.60**
Item 2. Support Deliberation	.41	.36	-
Item 3. Option Information	.56	**.61**	**.63**
Item 4. Elicit Preferences	.45	**.72**	**.71**
Item 5. Integrate Preferences	.46	**.66**	**.63**
OPTION Composite	.73	-	-

Table 4

TPOCS-A Reliability and Factor Loadings

			EFA for Final Factor Solution	
	ICC	CFA Loadings	Positive Bond/Mutual Work Loadings	Negative Affective Bond Loadings
Feeling Understood	0.56	**0.98**	**0.68**	-.04
Hostile Manner	0.52	-0.09	.08	**0.61**
Positive Affect	0.67	0.26	.30	.03
Shares Experiences	0.67	**0.90**	**0.68**	-.12
Parent Discomfort	0.58	-0.01	.12	**0.53**
Parent/Therapist Discomfort	0.51	-0.23	-.08	**0.59**
Changes Outside	0.66	0.12	.19	.10
Parent Noncompliance	0.18	-	-	-
Working Equally	0.42	**0.51**	**.54**	.17
Eigenvalue	-	-	1.40	1.00
% of Variance	-	-	72.27%	51.66%

Table 5

Treatment Decisions Raised in Sessions

Decision Categories	Examples of topics	Number of sessions decision raised (% out of total 210 sessions)
Treatment Planning		**113 (53.81%)**
Session Focus	– Agenda setting – Selecting session activities/topics	46 (21.90%)
Case management	– Therapy referral for other family members – Linkage to recreational activities – Facilitating donations for family	36 (17.14%)
Treatment Targets	– Identifying the target problem – How to measure target problem	36 (17.14%)
Treatment Participants	– Selecting family members to include in sessions – Planning collaterals	20 (9.52%)
Termination	– Ending treatment	10 (4.76%)
Medication Regimen	– Caregiver concerns about medication – Medication adherence	5 (2.38%)
Evidence-based parenting strategies		**106 (50.48%)**
Evidence-based parenting strategies	– Praise – Parent/Child Quality Time – Natural & Logical Consequences	106 (50.48%)
Out-of-Session Strategy Implementation	– Planning out-of-session strategy implementation – Reviewing out-of-session strategy implementation	59 (28.10%)
Youth Functioning		**96 (45.71%)**
Child Emotional Regulation	– Facilitating child's use of coping skills – Facilitating child's emotional expression	63 (30.00%)
School Functioning	– Improving academic performance – School accommodations – Bullying	43 (20.48%)
Child routine	– Daily schedules – Balancing tasks & breaks – Specialty routines (e.g., sleep; screen time)	19 (9.05%)
Child Technology Use	– Limiting screen time – Using device use as a consequence	15 (7.24%)
Child Safety	– Making plan to keep knife out of reach of child	5 (2.38%)

	– Problem solving to prevent child from running into street	
Family Psychosocial Needs		**35 (16.67%)**
Caregiver Well-Being	– Caregiver coping – Caregiver's own mental health care (e.g., individual therapy)	34 (16.19%)
Challenges with co-parenting/family visits	– Navigating visitations with child's father – Inconsistent disciplinary practices across caregivers	18 (8.57%)
Family Financial Strain	– Problem solving sleeping arrangements in overcrowded housing – Finding free activities to support family bonding	6 (2.86%)
Other		**46 (21.91%)**
Other	– Language of treatment – Scheduling time/location	46 (21.91%)

Note. This table demonstrates treatment decisions that encompassed at least one element of SDM as defined by the four items retained from the OPTION measure. Most sessions had more than one decision and decision categories were not mutually exclusive; thus, the total does not equate to the number of sessions in sample.

Table 6

Aim 2 Results: Therapist- and Session- Level Determinants of OPTION Composite and Items

	OPTION Composite			Alternate Options			Option Information			Elicit Preferences			Integrate Preferences		
		95% CI			95% CI			95% CI			95% CI			95% CI	
Predictors	*B (SE)*	LL	UL	*B (SE)*	LL	UL	*B (SE)*	LL	UL	*B (SE)*	LL	UL	*B (SE)*	LL	UL
Intercept	26.64** (3.34)	20.09	33.19	1.31** (.23)	.86	1.75	1.25** (.22)	.94	1.65	1.52** (.23)	1.08	1.97	1.29** (.16)	.98	1.61
Therapist-level															
Race/ethnicity (Not Latinx)															
Latinx	.15 (2.78)	-5.31	5.60	.21 (.19)	-16	.58	-.07 (.17)	-.40	.26	.02 (.19)	-.35	.40	-.10 (.13)	-.35	.14
Licensure status (Not licensed)															
Licensed	1.01 (2.81)	-4.49	6.51	-.11 (.19)	-.48	.27	-.07 (.16)	-.40	.25	-.01 (.19)	-.39	.37	.24* (.12)	.003	.48
Discipline (Not MFT)															
Marriage & Family Therapy	1.82 (2.50)	-2.80	6.99	.14 (.17)	-.20	.47	.10 (.15)	-.19	.39	.18 (.17)	-.15	.53	-.02 (.11)	-.24	.19
Theoretical Orientation (Not CBB)															
Cognitive Behavioral/Behavioral	.76 (2.44)	-4.02	5.55	-.12 (.17)	-.45	.20	.15 (.14)	-.13	.44	.03 (.17)	-.30	.36	-.04 (.11)	-.25	.17
Client-level															
Session Problem Focus (Conduct)															
Trauma	-8.79** (2.70)	-14.09	-3.49	-.33† (.18)	-.69	.03	-.49** (.17)	-.82	-.16	-.55** (.18)	-.91	.19	-.47** (13)	-.72	-.22
Internalizing	3.15 (2.71)	-2.17	8.47	.07 (.19)	-.29	.43	.22 (.19)	-.15	.59	.12 (.17)	-.24	.48	.13 (.15)	-.15	.42
EBP with prescribed content/order	1.11 (2.62)	-4.02	6.24	.05 (.18)	-.30	.41	-.26 (.16)	-.05	.57	-.05 (.18)	-.30	.41	-.10 (.12)	-.13	.33
Session Language (English)															
Spanish	-4.57* (2.24)	-8.97	-.17	-.19 (.15)	-.49	.11	-.22 (.15)	-.51	.07	-.34* (.15)	-.64	-.04	-.13 (.11)	-.35	.09
Session-level															
Minutes attended to caregiver	.27** (.06)	.15	.40	.02** (.004)	.01	.03	.01** (004)	.004	.02	.01* (.004)	.001	.02	.02** (.004)	.01	.02

Note. CI = confidence interval; LL = lower limit; UL = upper limit.

*$p < .05$, **$p < .01$.

Table 7

Aim 3 Results: Associations between OPTION Composite and OPTION Items with Positive Bond/Mutual Work and Negative Affective Bond

	Positive Bond/Mutual Work			Negative Affective Bond		
		95% CI			95% CI	
Model: Predictor	*B (SE)*	LL	UL	*B (SE)*	LL	UL
Model 1 & 2: OPTION Composite	.02 (.01)	-.001	.05	-.02 (.01)	-.04	.01
Model 3 & 4: Alternate Options	.31 (.21)	-.11	.73	-.32* (.16)	-.64	-.01
Model 5 & 6: Option Information	.16 (.19)	-.21	.53	-.14 (.14)	-.42	.15
Model 7 & 8: Elicit Preferences	.20 (.20)	-.19	.60	-.05 (.15)	-.35	.25
Model 9 & 10: Integrate Preferences	.33 (.23)	-.13	.78	-.22 (.18)	-.57	.14

Note. All models run with covariates: therapist race/ethnicity, licensure status, discipline, theoretical orientation, session problem focused, EBP prescribed content/order, session language and minutes attended to caregiver

*$p < .05$, **$p < .01$.

Appendix A: Therapist Background Questionnaire

Instructions: Please answer the following questions about yourself (check appropriate boxes and fill in responses as needed). Please answer all questions as completely as you can.

Therapist Demographics

1. **Gender:**

☐ Male ☐ Female

2. **Date of Birth**:_____

3. **Are you Hispanic?**
   1. No,
   2. Yes,

4. **What is your race? (select one)**
   1. White
   2. Black, African Am.
   3. American Indian or Alaska Native
   4. Asian American/Pacific Islander
   5. Multiracial
   6. Other, specify: _____

5. **In which language(s) other than English can you deliver clinical services? (select all that apply)**

   ☐ Spanish -→ For what percentage of your clients do you deliver in this language?

   ☐ Other, specify → For what percentage of your clients do you deliver care in this language?

   ☐ Other 2, specify → For what percentage of your clients do you deliver care in this language?

6. **Please select your primary mental health discipline (choose one only):**

   ☐ Marriage Family Therapy
   ☐ Counseling
   ☐ Clinical Psychology
   ☐ School Psychology
   ☐ Psychiatry
   ☐ Social Work
   ☐ Other, please specify_____

7. **What is your highest level of education?**

   ☐ High School/GED
   ☐ Associates Degree/Some College
   ☐ Bachelor's Degree
   ☐ Master's Degree
   ☐ Doctoral Degree

☐ Other: _____

8. Are you licensed? ☐ Y☐ No

9. For how many years have you practiced as a therapist? ____ years

10. How long have you worked at your present agency? _____ years

11. Are you considered (select one):

☐ Trainee
☐ Staff
☐ Independent contractor

12. Please select the primary theoretical orientation that you incorporate in your practice (choose one only)

☐ Behavioral
☐ Cognitive Behavioral
☐ Humanistic
☐ Family systems
☐ Psychodynamic
☐ Eclectic-please specify if possible_____
☐ Other-please specify if possible_____

13. Please select the <u>primary setting</u> in which you work (select one):

☐ Outpatient
☐ Inpatient
☐ Residential Treatment Center
☐ Day Treatment Center
☐ Case Management
☐ Group Home
☐ Assessment/Evaluation Clinic
☐ Other, please specify_____

Current Caseload Characteristics

14. How many clients do you have on your current caseload? _____

Force items with percentages to add to 100% in Survey Gizmo

15. What is the ethnic composition of your current caseload?

____% Hispanic or Latino
____% White
____% Black or African American
____% American Indian or Alaska Native

____% Asian American/ Pacific Islander
____% Other

16. How often are delivering services in a language other than your child client's primary language?

- Never
- Occasionally
- Sometimes
- Often
- Usually
- Always

17. How often are delivering services in a language other than your client's caregivers' primary language?

- Never
- Occasionally
- Sometimes
- Often
- Usually
- Always

18. H**ow many hours per week do you typically work at your agency**?_____ hours

19. How many hours per week do you typically spend on the following activities:

- Direct Service (e.g. psychotherapy, case management, assessment, collateral, other client contact): ____
- Clinical Documentation (e.g., case notes, report writing): ____
- Outcomes Monitoring (e.g., administration, scoring, data entry) ____
- Billing/Claiming: _____
- Receiving Supervision/Consultation: ____
- Providing Supervision/Consultation: ____
- Other EBP-related Activities (e.g., preparing certification materials, reviewing EBP materials): _____
- Administrative Meetings (e.g., staff meetings, DMH meetings): _____
- Travel time for client contact: ____
- Other: ____ (please specify):_____

Appendix B: Youth Characteristics

About which child client are you responding? Please enter this child client's initials in the space provided: _____

Client Child's gender:

- ○ Male
- ○ Female
- ○ Other

Is the identified client Hispanic?

- ☐ Yes
- ☐ No

Client/Child's Race:

- ○ White
- ○ Black/African American
- ○ American Indian or Alaska Native
- ○ Asian American
- ○ Pacific Islander
- ○ Multiracial
- ○ Other

Client Child's Age: _____ (1-18)

Appendix C: Session Characteristics

Please answer the following questions regarding the session you had with *client*.

Date of session (mm/dd/yyyy): _____

Session time (e.g., 9:00am, 4:00pm): _____

(Only display if session occurred over 1 week ago) Thank you for your time. Unfortunately, this session report has expired. Please select another client or session on which to report. As a reminder, please complete this questionnaire within one day of the session.
Did you see another 4KEEPS client today?

- ○ Yes *(redirect to beginning of survey)*
- ○ No *(end survey)*

Length of session:

- ○ 0-30 minutes
- ○ 31-60 minutes
- ○ 61-90 minutes
- ○ x > 91 minutes

Please select the primary language in which the session was conducted:

- ○ English
- ○ Spanish
- ○ Both Spanish and English about equally
- ○ Other, please specify: _____

Was there an interpreter present during this session?

- ○ Yes
- ○ No

Where did the session take place?

- ○ Office
- ○ Home
- ○ School
- ○ Other, please specify: _____

Which PEI practice was used during this session?

- ○ Child-Parent Psychotherapy (CPP)
- ○ Interpersonal Psychotherapy for Depression (IPT)
- ○ Incredible Years (IY)
- ○ Managing and Adapting Practices (MAP)
- ○ Parent-Child Interaction Therapy (PCIT)
- ○ Trauma Focused Cognitive Behavior Therapy (TF-CBT)
- ○ Triple-P Positive Parenting Program (Triple-P)

(Only display if MAP selected) Please specify the predominant MAP problem focus:

- ○ Anxiety
- ○ Conduct
- ○ Depression
- ○ Trauma
- ○ Other, please specify: _____

Who was present for any portion of this session?

- ○ Child client
- ○ Any caregiver
- ○ Sibling(s)/other child(ren)

(Only display if both caregiver and child selected) Did you direct your therapeutic strategies to the caregiver?

- ○ Yes
- ○ No

(only display if both caregiver and child selected) Did you direct your therapeutic strategies to the child client?

- ○ Yes
- ○ No

What is the primary presenting problem for the youth who is the identified child client?

- ○ Anxiety
- ○ Mood
- ○ Trauma
- ○ Disruptive Behavior or Conduct Problems
- ○ Attention or Hyperactivity Problems
- ○ Autism Spectrum

- ○ Substance Use
- ○ Other, please specify:

_____

What is the secondary presenting problem for the youth who is the identified child client?

- ○ Anxiety
- ○ Mood
- ○ Trauma
- ○ Disruptive Behavior or Conduct Problems
- ○ Attention or Hyperactivity Problems
- ○ Autism Spectrum
- ○ Substance Use
- ○ Other, please specify:

_____

- ○ There is no secondary presenting problem

Was this a group session?

- ○ Yes
- ○ No

(Only display blurb if group session)
Please answer the following question about what occurred in the group session generally.

Appendix D: OPTION^5 Manual

OPTION^5 – General Guidelines
Codes for OPTION^5 for Youth Psychotherapy are primarily focused on the therapist behaviors. They could be behaviors initiated by the therapist, or therapist response to the caregiver. Codes are ONLY for therapist behaviors when interacting with caregiver NOT youth clients.

Purpose of Guiding Examples & Exemplars:
"To assist raters to assess conversations and ultimately score sessions we have provided some example phrases. These phrases are suggestions not prescriptions for scoring. We urge researchers to take detailed notes of conversations and examples of language used to differentiate between a score of 1 versus 2 and so on."

Give credit when decision-making processes from past sessions are mentioned
"Items in Observer OPTION^5 are framed to provide raters the opportunity to give credit where there is evidence for deliberation that extends across multiple sessions.

Where a caregiver has been asked to review information prior to attending the session to inform a decision, or where a clinician at a prior session has made an effort to provide information to the caregiver, it is acceptable to take that work into account, provided that the clinician re-affirms their support of a deliberative process."

Timestamps
Opportunities for SDM between the caregiver and therapist vary greatly within youth psychotherapy. It is very important that you take detailed notes with timestamps, so that we can review audio recordings when needed.

Note Taking: Not counting content
It is natural to take notes of therapist behaviors that may not actually be eligible for coding. If you take notes, but aren't counting those behaviors when applying your ratings, then please follow this notation process:

(X) TIME STAMP - Notes that I am not counting .... stuff that therapists says.....

- Provide rationale about why therapist behaviors are not eligible for coding

This notation is critical for measuring reliability.

Note Taking: No occurrence of specific Item
If therapist behaviors for specific items do not occur in session, please write, "Not observed" in the notes box. This will help the Master Coder understand when items are coded "0."

OPTION[5] – Rating Scale

Rating	Description
0	No effort; Zero effort observed.
1	Minimal effort; brief/perfunctory; short phrases
2	Moderate effort; Basic phrases or sentences used.
3	Skilled effort; Substantive phrases or sentences used.
4	Exemplary effort; Clear, accurate communication methods used.

When rating therapist behaviors, coders must consider two dimensions:

Thoroughness/Intensity is determined by: (1) the concentration of effort or commitment the therapist demonstrates; (2) the detail/depth in which the therapist verbally speaks; and (3) the extent to which the therapist follows-through with the shared-decision making processes reflected in the codes.

Frequency/Time Duration is whether it occurred at all and the number of instances a therapist demonstrated behavior for the specific code. It relates to the number of times and/or the amount of time a therapist demonstrates behaviors described in the codes during a session.

Item 0: Describe Identified Problem/Issue/Topic
Determine whether a problem/issue/topic that requires an action or decision-making process between the therapist/caregiver occurs in session. Either the parent or provider can raise a problem/issue/topic that requires action/advice about the child. It is possible that several problems/issues/topics that require a decision-making process occur in session, and it's important that you make note of all of them.

There are five categories that identified problems/issues/topics could be put into; however, these categories are not representative of all possible problems/issues/topics, and thus, if a problem/issue/topic does not fit in the five provided categories, describe it in the appropriate "other" categories.

All therapist behaviors coded in Items 1-5 must be linked to an Item 0.

For each identified problem/issue/topic that requires a decision-making process:

(i.)***Item 0, Category:*** Write the appropriate 1a-1g *and* the category name of the identified problem/issue/topic.

For example: 1a. Focus of Session

(ii.)***Timestamp****:* provide the first timestamp of Items 1-5 related to the identified problem/issue/topic (e.g.; 1:20 is one minute and 20 seconds).

(iii.)***Item 0, Description****:* describe the identified problem/issue/topic that motivates the decision-making process (*max 20 words*).

	Item 0, Category	***Time Stamp***	***Item 0, Description*** (max 20 words)

Description of Item 0 categories:

1a. Focus of session/treatment: Therapist asks for input about what should be the focus of session or what symptoms should be targeted in treatment.

Exemplars:

What happens in session:

Therapist: What do you think we should work on today?

Description provided by Coder: Therapist asks what they should focus on in session (9 words).

What happens in session:

Therapist: Should we go over interrupting adults or sharing with other kids?

Description provided by Coder: Therapist gives options about the topic to focus on in session (11 words).

1b. Strategy to implement: Therapist proposes strategies/interventions that caregiver could use with child to help improve symptoms in some way.

Exemplar:

What happens in session:

Therapist: Strategies to promote positive relationships. And basically, obviously quality time, affection, and talk with child. I want to talk about which one you can do this week.

Description provided by Coder: Therapist wants caregiver to decide which strategy she can use to promote a positive relationship with her child (18 words).

** For examples, see Evidence-based parenting strategies **

1c. Treatment participants: Therapist inquires about who should attend session (e.g., child's father should attend, sibling should attend) or be involved in treatment.

Exemplar:

What happens in session:

Therapist: I was thinking it would be good for his dad to come next week. What do you think?

Description provided by Coder: Therapist asks about father attending session (6 words).

1d. Termination/Treatment dosage: Therapist discusses whether treatment should end (i.e., termination) or how much longer treatment should go for (i.e., treatment dosage).

Exemplar:

What happens in session:

Therapist: I am going to be ending my position here soon. I wanted to talk about whether you want him to get a new therapist or end treatment now?

Description provided by Coder: Therapist discusses whether treatment should end or get a new therapist because she is leaving job. (16 words).

1e. Services/Referral needed: Therapist discusses other services for caregiver/family/child that could help with quality of life and/or treatment/symptoms. Services can include additional assessment, respite care, medication, etc. Other services can be new or ongoing services.

Exemplar:

What happens in session:

Therapist discusses potentially talking to teacher so that child can get an IEP (individualized education plan) assessment done for child. Makes it clear that she wants caregiver's input.

Description provided by Coder: Therapist getting an IEP assessment done for child. (8 words).

Categories 1a-1e are not comprehensive and thus do not intend to cover all of the possible problems/issues/topics that would require decision making within the context of youth mental health treatment.

1f. Other - Treatment Decision. (*Max 20 words)* If you believe that a decision-making process emerges that is <u>explicitly about treatment</u> but does not fall within one of the five aforementioned categories, please describe what the identified problem/issue/topic was.

1g. Other - Non-treatment Decision. (*Max 20 words)* If you believe that a decision-making process emerges that is <u>NOT explicitly about treatment</u> but does not fall within one of the five aforementioned categories, please describe what the identified problem/issue/topic was**.**

Exemplar:

What happens in session:

Therapist discusses ending visits with extended family members by 7pm to not disrupt client's routine when the theme of session was about client getting ready for school on time

Description provided by Coder: Ending family visits by 7pm to not disrupt client's morning school routine. (12 words).

THE FOLLOWING EXEMPLARS DO NOT COUNT AS ITEM 0s:

- Decision about whose turn it is in a game
- Any decisions related to rules in a game (e.g., need 4 coins for connect-4; options in game if one rolls a particular # on dice)

Item 1. Option talk: Alternate Options:
For the identified problem/issue/topic being discussed, the clinician:

- draws attention to or confirms that alternate treatment/management/skills-training options exist or
- that the need for a decision exists. Includes clinician making efforts to justify that the identified problem/issue/topic requires decision making (e.g. caregiver preferences will vary and need to be considered).

If the caregiver rather than the clinician draws attention to the availability of options, the clinician responds by agreeing that the options need deliberation.

0	1	2	3	4
The clinician **makes no effort to convey or confirm** that there alternate treatment/management/skills training options or to state that there is a need for a decision. Or The caregiver initiates the possibility that options need to be considered but the clinician **makes no effort to convey or confirm** that there are alternate treatment/management/skills training options or to state that there is a need for a decision	The clinician **makes a minimal effort to convey or confirm** the existence of alternate treatment/management/skills training options or states that there is a need for a decision. Or If the caregiver initiates the possibility that options need to be considered, the clinician **makes a minimal effort to convey or confirm** the existence of alternate treatment/management/skills training options or states that there is a need for a decision.	The clinician **makes a moderate effort to convey or confirm** the existence of alternate treatment or management options or explains the need for a decision. Or If the caregiver initiates the possibility that options need to be considered, the clinician	The clinician **makes a skilled effort to convey or confirm** the existence of options or explains the need for a decision. Skilled effort could include checking that the caregiver understands this issue or could provide justification for the need to take the time to make a decision.	The clinician **makes an exemplary effort to convey or confirm** the existence of options or explains the need for a decision. Exemplary effort could include <u>checking that the caregiver understands the</u> identified problem/issue/topic, or could provide justification for the need to take time to make a decision. Or: If the caregiver initiates the possibility that options need to be considered, the clinician **makes an exemplary**

		makes a moderate effort to convey or confirm the existence of alternate treatment or management options or explains the need for a decision.	Or: If the caregiver initiates the possibility that options need to be considered, the clinician **makes a skilled effort to convey or confirm** the existence of options or explains the need for a decision.	**effort to convey or confirm** the existence of alternate options or explains the need for a decision. Exemplary effort could include checking that the caregiver understands this issue or could provide justification for the need to take the time to make a decision.
	Guiding Examples: *There are a couple of ways...; a range of options...; many different choices exist ...*	*Guiding Examples:* *Alternative options exist; we need to consider what to do for the best and choose between a range of options.*	*Guiding Examples:* *These different options are offered because it is reasonable to consider them - they have different pros and cons ...*	*Guiding Examples:* *Now that we have agreed on the problem, let's consider how to take the next steps (manage/treat/investigate).* *As in many situations, there are alternative possibilities, and each of these possibilities will differ. Shall I*

			Different people will react differently to them - so this is why it is important to compare them so that you help decide what fits your circumstances.	*explain these alternatives to you?* *My goal is for you to understand more about these options, and then hear from you as to what matters most to you.*

<u>*Code Tips:*</u>

Consider whether the therapist has been explicit about the fact that these are options that caregiver can choose from.

- Exemplary effort would likely require that a therapist is explicit that these are options that the caregiver can choose from

Note that "4=exemplary effort" could include checking that the caregiver understands the issue.

<u>*Exemplars*</u>

Intention isn't to change what works for you, it's to offer a different option in situations where what's working with you won't work.

With this one, the sound is soothing and hopefully you feel relax. With this one, I see what you're saying - it is more like. working your body to release that physical stress

- Caregiver rather than the clinician drew attention to options, and the clinician responds by agreeing.

You quickly get overwhelmed when you take responsibility for her forgetfulness. At what point can you be a guide instead?

- An alternate is identified – to guide instead of doing for child. Low intensity, fleeting.

Out of all the ones listed like interrupting and sharing, I want you to choose 1 behavior that we can try to make better.

- Would also count in **Item 4. Eliciting preferences/exploring concerns.**

Item 2. Team Talk: Support deliberation / forming a partnership.
The clinician reassures the caregiver or re-affirms that they will support him/her to:

- become informed
- deliberate about the options
  - If the caregiver states that they have sought or obtained information prior to the session, the clinician supports such a deliberation process (e.g., reassures caregiver that their role is to work together to decide).

Includes when clinician explains to caregivers that by working together as a team, including with family members where appropriate, they will be supported to consider the choice that needs to be made, to ensure that the caregiver is not at risk of feeling abandoned to face a difficult decision alone.

Includes provider reassuring the caregiver that they will help make the best decision for the identified problem/issue/topic.

0	1	2	3	4
The clinician **makes no effort to reassure** the caregiver that they will be supported during the process of being given information or being asked to deliberate about options. Or: If information has been provided or obtained by the caregiver before session, the clinician	The clinician **makes a minimal effort to reassure** the caregiver that they will be supported during the process of being given information or asked to deliberate about options. Or: If information has been provided or obtained by the caregiver before session, the clinician	The clinician **makes a moderate effort to reassure** the caregiver that they will be supported during the process of being given information or asked to deliberate about options. Or: If information has been provided or obtained by the caregiver before session, the clinician	The clinician **makes a skilled effort to reassure** the caregiver that they will be supported during the process of being given information or asked to deliberate about options. Or: If information has been provided or obtained by the caregiver before session, the clinician **makes a skilled effort**	The clinician **makes an exemplary effort to reassure** the caregiver that they will be supported during the process of being given information or asked to deliberate about options. Or: If information has been provided or obtained by the

makes no effort to reassure the caregiver that they will be supported during the process of being given information or asked to deliberate about options.	**makes a minimal effort to reassure** the caregiver that they will be supported during the process of being given information or asked to deliberate about options.	**makes a moderate effort to reassure** the caregiver that they will be supported during the process of being given information or asked to deliberate about options	**to reassure** the caregiver that they will be supported during the process of being given information or asked to deliberate about options.	caregiver before session, the clinician **makes an exemplary effort to reassure** the caregiver that they will be supported during the process of being given information or asked to deliberate about options.
	Guiding Examples: *Let's work together to ... ; I will help you to think about...; my role is to work with you ...*	*Guiding Examples:* *This might be new for you; therefore, we will ... ; considering options is hard, therefore we will ...*	*Guiding Examples:* *I'm going to make sure that you have more information about the relevant options, and then we'll work together to consider those options.* *This might feel like a lot of work, but don't worry, I'm here to help you consider these options and work out what might be best for you.*	*Guiding Examples:* *I'm going to make sure that you have more information about the relevant options. Some caregivers sometimes feel overwhelmed by this kind of information, but I'll do my best to make it clear and easy to follow.* *I will describe how the options*

				are different, where they lead to benefits and where they lead to harm, and how often these happen. *My job is to make sure I support you in getting to an understanding of these options so that we can compare them and work out what is best for you. Do you have any questions?*

Code Tips:
Consider whether content can be coded here as well as other items.

Exemplars

I want to stop here and see if you had any questions about all the information I just said – I know it was a lot.

- Therapist is reaffirming that they are supporting caregiver in getting information about options.
- This would also count in **Item 3. Information about options/checks understanding**

Does that sound good? Choose 1-2 that you want to practice, and we'll talk about it

Item 3. Option Talk: Information about options/checks understanding.
Regarding the options that are considered reasonable (this can include taking 'no action'), the clinician engages in the following to support the caregiver in **comparing** alternatives:

- **gives information or**
  - Includes describing the pros/cons of the options.
- **checks understanding**
  - Includes teach-back, which is when the therapist asks the caregiver to describe the options in their own words.
  - Includes if the caregiver requests clarification, the clinician does so.

0	1	2	3	4
The clinician **makes no effort to provide information** about options or **to check the accuracy/ appropriateness** of the **caregiver's understanding of** the options.	The clinician **makes a minimal effort to provide information** about options or **to check the accuracy/ appropriateness** of the **caregiver's understanding of** the options.	The clinician **makes a moderate effort to provide information** about options or **to check the accuracy/ appropriateness** of the **caregiver's understanding of** the options.	The clinician **makes a skilled effort to provide information** about options or **to check the accuracy/ appropriateness** of the **caregiver's understanding of** the options.	The clinician **makes an exemplary effort provide information** about options or **to check the accuracy/ appropriateness** of the **caregiver's understanding of** the options.

	Guiding Examples: *There are the following options available: A and B. Let me describe them to you.*	*Guiding Examples:* *There are the following options available: A and B. Let me describe them to you so that you can understand both the benefits of each option and the harms and how likely these are to take place.*	*Guiding Examples:* *There are the following options available: A and B. Let me describe them to you so that you can understand both the benefits of each option and the harms and how likely these are to take place. Did you understand? Do you have questions? Can I explain something again?*	*Guiding Examples:* *There are the following options available: A and B. Let me describe them to you so that you can understand both the benefits of each option and the harms and how likely these are to take place.* *Did you understand? Do you have questions? Can I explain something again?* Teach-back example: *"In your own words, tell me what you have heard or understood."*
Code Tips:				

In youth psychotherapy, therapists tend to teach strategies. It is critical that we are capturing descriptions of option that have been provided to caregiver ***not*** just information sharing by the therapist.

Consider whether the therapist discusses pro/con of each option

- Exemplary effort would likely require that a therapist discusses risks and benefits of options

Exemplars

So this is supposed to be the right cycle. So there's a tantrum, clear calm instructions to stop, child continues, quiet time, logical consequences of implementing, stops and learns. So if you follow this obviously there's potentially no cycle coming about. Because what happens is that, when you, when a kid tantrums, obviously if you follow these footsteps, it gives you the ability to be on top of his behavior, then and there. It recognizes that, "Hey I know what you're doing. I'm on to you. And obviously this needs to stop."

- Therapist explains steps to intervene upon a tantrum and also highlights the pros of this intervention

Let's say you hired a guide…the guide isn't just going to carry you there. You have to tell the guide where you want to go…the guide might say well we can go this way or this way…the guide leaves that decision to you…when we just take on the responsibilities ourselves…that becomes a much longer-term challenge I think where…mom takes care of everything, then when some challenge comes up, it will be 'mom will take care of this'…and she won't necessarily have all the decision making ability

- Therapist discusses with caregiver pros and cons of being a guide

Item 4. Decision Talk: Eliciting preferences/exploring concerns.
The clinician **elicits the caregiver's preferences** in response to the options that have been described.

- If the caregiver declares his or her preference(s), the clinician is ***supportive***.

Clinician acknowledges and/or explores **caregiver's concerns/fears/worries** or related negative feelings about specific options.

It is acceptable to code these behaviors, even if the therapist is reviewing a decision that has already been made.

0	1	2	3	4
The clinician makes no effort to **elicit the caregiver's preferences.** Or: If the caregiver declares their preferences, the clinician makes no effort to be supportive**.**	The clinician makes **a minimal effort to elicit the caregiver's preferences** in response to the options that have been described. Or: If the caregiver declares their preferences, the clinician **makes a minimal effort** to be supportive.	The clinician makes a **moderate effort to elicit the caregiver's preferences** in response to the options that have been described. Or: If the caregiver declares their preferences, the clinician makes a **moderate effort to be supportive.**	The clinician makes a **skilled effort to elicit or confirm the caregiver's preferences** in response to the options that have been described. Or: If the caregiver declares their preferences, the clinician **makes a skilled effort to be supportive**.	The clinician makes an **exemplary effort to elicit or confirm the caregiver's preferences** in response to the options that have been described. Or: If the caregiver declares their preferences, the clinician **makes an**

				exemplary effort to be supportive.
	Guiding Examples: *What did you think?*	*Guiding Examples:* *Now that I have described the options, did you think that one of them seemed to fit in with your wishes or views?*	*Guiding Examples:* *What did you think of the options?* *Were you able to form an opinion about them? Did some aspect of them worry you or appeal to you?* *I'm curious to know your reactions or priorities now that you know a bit more.*	*Guiding Examples:* *Did you have any questions or concerns about the options I described?* *Maybe you heard some things that you liked? Or were worried about? That is normal, and my work is to try to understand your views about the options.* *What did you think of the options?*

				Were you able to form an opinion about them? Did some aspect of them worry you or appeal to you? *I'm curious to know your reactions or priorities now that you know a bit more.*
Code Tips: Sometimes caregivers ***quickly*** agree with one of the options posed by the therapist - this is still counted if the therapist expresses support.				
Exemplars *Anything else you would either add or change to that approach of managing his tantrum?* *What coping skill can you practice with child this week?* *I'm wondering about whether guilt would be factor if we used this strategy?* *Out of all the ones listed like interrupting and sharing, I want you to choose 1 behavior that we can try to make better.* • Would also count in **Item 1. Alternate Options.**				

Item 5. Decision Talk: Making, Deferring or Reviewing with Preferences. The clinician **integrates the caregiver's elicited preferences** as options are narrowed and decisions are made. The clinician takes caregiver's preferences into account as decisions are made. It is acceptable for **decision to be deferred** to a later time, to allow for more deliberation. Includes when clinician **reviews a decision that has already been made** and integrates caregiver's preferences.				
0	**1**	**2**	**3**	**4**
The clinician makes **no effort to integrate** the caregiver's informed preferences as decisions are made, reviewed or deferred.	The clinician makes **a minimal effort to integrate** the caregiver's informed preferences as decisions are made, reviewed or deferred.	The clinician makes **a moderate effort to integrate** the caregiver's informed preferences as decisions are made, reviewed or deferred.	The clinician makes **a skilled effort to integrate** the caregiver's informed preferences as *decisions are made*, reviewed *or deferred.*	The clinician makes an **exemplary effort to integrate** the caregiver's informed preferences as decisions are made, reviewed or deferred.
	Guiding Examples: *I think you are happy with option A; let's do that.*	*Guiding Examples:* *I think you are happy with option A. Did I get that right?*	*Guiding Examples:* *So if I can summarize, you think that both options are possibilities. But you*	*Guiding Examples:* *So, if I can summarize, you think*

			think option A is better for you because you think X. Is that right?	*that both options are possibilities. But you think option A is better for you because you think X. Is that right? I want to be sure that I've understood your preferences or priorities, so please let me know if you want to say more about this. My job is to make sure that the choice is based on the things that matter most to you and that have the*

				best chance of working for you in your situation.

Code Tips:

Youth psychotherapy can span weeks, months even years. It is possible that a decision has been made in a previous session and the therapist reviews it to see how it went. This context is acceptable for coding if the therapist behaviors in the manual occur and thus, if the therapist is integrating caregiver's preferences for Item 5

Exemplars

Okay, I'll give you this one since you said [the child] would do better with it

I want you to think about which one of her behaviors is the biggest obstacle. You can think about it and choose one and tell me next week.

- Deferring decision to mom for next session. Would also count for **Item 4. Eliciting Preferences**.

OPTION[5]: Evidence-based parenting strategies

To assist in coding **Item 0, 1b. Strategy to Implement,** below are common strategies that are discussed in youth psychotherapy that involves parents/caregivers.

1	**Identifying/Altering Antecedents to Prevent Problem Behavior.**
	Identifying and developing a plan for altering antecedents (i.e., triggers, events) to youth problem behaviors. For example, this may include identifying antecedents through an ABC worksheet, removing distractions, or providing a warning. "ABC" = Antecedent, behavior, consequence.
2	**Following the Child's Lead.**
	Follow the youth's lead using behavior and feelings description, imitation, reflection, or expressing enjoyment. This may include avoiding criticism, commands, or questions.
3	**Praise**
	Provide social rewards in response to desired behaviors (e.g., verbal praise, encouragement, affection, or physical proximity).
4	**Tangible Rewards**
	Deliver tangible rewards in response to desired behaviors. This can involve tokens, charts, or record keeping.
5	**Ignoring/Differential Reinforcement of Other Behaviors.**
	Remove attention to problem behaviors and to increase attention to positive alternative behaviors.
6	**Distracting & Redirecting.**
	Distract or redirect the youth to a positive activity when they become upset.
4	**Tangible Rewards**
	Deliver tangible rewards in response to desired behaviors. This can involve tokens, charts, or record keeping.
5	**Ignoring/Differential Reinforcement of Other Behaviors.**
	Remove attention to problem behaviors and to increase attention to positive alternative behaviors.
6	**Distracting & Redirecting.**
	Distract or redirect the youth to a positive activity when they become upset.
7	**Parent/Child Quality Time**

	Increasing youth and caregiver positive/quality one-on-one time. Examples: Planning of specific times, activities, and monitoring of one-on-one time, or caregiver practicing quality one-on-one time in session.
8	**Natural & Logical Consequences.**
	Allow the youth to experience the negative consequences of problem behaviors, or delivering consequences that are linked to the youth's problem behaviors.
9	**Timeout.**
	Remove the youth from all reinforcement for a specified period of time in response to a problem behavior.
10	**Effective Commands**
	Give clear and specific directions to increase youth compliance. Principles that are frequently included in giving commands include differentiating between direct and indirect commands (e.g. telling a child to do something vs. asking them to do something), telling children what "to do" as opposed to "what not to do," how to state commands in a manner that children will listen, giving developmentally appropriate commands or instructions, and how and when to give explanations for the commands that are given.
11	**Behavioral Contracting.**
	Develop a formal agreement with child specifying rules or expected behaviors and consequences, and commitment from both youth and caregiver. A token economy is a behavioral contract if made with input from both the youth and caregiver. This could be as part of a step towards developing a final contract where both youth and caregiver would discuss the issue at home and agree to a commitment. This would include coming up with consequences or a plan around specific behaviors of concern.
12	**Caregiver Coping.**
	Facilitating caregiver learning or practicing strategies to more effectively handle stressful situations (e.g., self-care, problem-solving about respite, coping skills). Importance of caregiver's wellbeing and coping, works with the caregiver to identify specific strategies or activities to assist the caregiver, and develops a plan for their implementation.
13	**Accepting and Tolerating Child Distress.**
	Caregiver to accept and tolerate child distress and to respond in soothing or nurturing ways. Caregiver may label the child's emotions and provide nurturance, through physical affection, comforting words, or with facial expression.

14	**Patterns of Parent-Child Interaction.**
	Changing the quality of parent-child relationship, and the way the parent and child typically play and interact.

Appendix E TPOCS-A

SCORING MANUAL

FOR THE

THERAPY PROCESS OBSERVATIONAL

CODING SYSTEM FOR CHILD

PSYCHOTHERAPY

ALLIANCE SCALE

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Table of Contents

I. INTRODUCTION

The scoring manual is designed to provide coders with a comprehensive guide for scoring recordings of psychotherapy sessions using the Therapy Process Observational Coding System for Child Psychotherapy Alliance Scale (TPOCS-A). The scoring manual serves as a companion document for training new coders to use the TPOCS-A as well as a reference document for trained coders to use while scoring sessions. As such, this scoring manual contains a thorough description of each item and provides additional information to help the coder make scoring decisions in an informed and reliable manner.

This scoring manual is organized in accordance with the presentation of items on the TPOCS-A. The *General Instructions* section provides an overview of scoring strategies and coder caveats to help coders acquire and maintain coding reliability. Then, the *Alliance Scale* section provides detailed item descriptions. These sections are presented in the following format:

(a) The item as it appears on the TPOCS-A.
(b) Brief description of the item.
(c) Exemplars
(d) Item Distinctions

II. GENERAL INSTRUCTIONS

This section provides an overview of scoring guidelines intended to help coders score sessions in an efficient, standardized, and reliable manner. Coders should read this section carefully. It is important to become thoroughly familiar with the coding guidelines before scoring sessions.

A. PROCEDURAL GUIDELINES:

1. **Importance of Reliability**: The goal of the coding process is to obtain valid and reliable descriptive data about the quality of the child- and parent-therapist alliance in sessions. The potential validity of the codes is based, in part, on the extent to which the codes are used reliably by multiple coders. Reliability refers to the degree to which independent observers provide the same (or similar) ratings of the events that they observe. If two different coders were to use very different codes to describe the same session, the coding system would be unreliable and have little meaning. It is critical to maximize the degree to which independent coders rate sessions similarly. To achieve that objective, a number of different elements have been put in place to maintain the reliability of the TPOCS-A, including: (a) clear definitions of codes, (b) a structured coding process, (c) training and ongoing practice, and (d) continuous reliability review. Reliability is absolutely critical to the scientific process and most of the instructions in this scoring manual are designed to help you code as efficiently and reliably as possible. If recordings are not coded reliably, the scientific objectives of the study will be seriously compromised.

2. **Focus of Coding**: The TPOCS-A is designed to provide comprehensive descriptive data on the quality of the child- and parent-therapist alliance in sessions. It is not designed to address client involvement (i.e., degree to which a client is involved in therapeutic activities). Nor is it designed to assess why therapists do what they do, or how well they do it. These limitations are important to remember in order to focus on the goal of characterizing the alliance.

3. **Structure of Coding**: You will be coding an entire session that will usually be 45-50 minutes long. Ratings will be made on each item at the end of the session. The main body of this manual includes descriptions of the 16 codes you will be looking for.

4. **Definitions of Key Terms**:

   (a) ***"Client"*** – the TPOCS-A is designed to assess the quality of the child- and parent-therapist alliance. We use the term "client" to refer the target of coding, which could be the child or parent.

   (b) ***"Target Child"*** – the child who is the target of treatment and therefore the focus of the alliance ratings. For the purposes of this scoring manual, "child" will be used to refer to both children and adolescents. If multiple children are present within a session, be sure to identify the target child before starting to watch the session.

   (c) ***"Functional Parent"*** – the primary caretaker (i.e., biological parent, foster parent, grandmother, aunt, or other caretaker). If multiple adults are present within a session, be sure to identify the functional parent before starting to watch the session (e.g., identify the caretaker that comes to the majority of sessions).

(d) *"**Therapist"*** – the person who delivers therapeutic interventions and is the focus of alliance ratings.

B. SCORING THE ALLIANCE:

1. **Rating the Alliance**: Coders need to consider the following factors when scoring the child- and/or parent-therapist alliance.

   (a) **Focus on Child and Parent**: Prior to scoring sessions, coders must identify the target child and functional parent. When coding multiple sessions from the same client it is vital that coders generate ratings for the same target child and functional parent. This might, for example, require coders to review the sessions that will be coded from a case to identify the functional parent (i.e., the caretaker that participates in a majority of the sessions). If there is any question about who the target child or functional parent is coders should not start coding a session.

   (b) **Rate Client and Therapist Behavior**: Coders are required to rate the alliance along two dimensions: (1) client behavior (e.g., child and/or parent actions and statements), and (2) client and therapist interactions (e.g., verbal and non-verbal exchanges between the client and the therapist).

   (c) **Ten Minute Rule**: Depending on the nature and focus of treatment, the target child and functional parents may or may not participate in large portions of a session. Alliance ratings should be made if a target child or functional parent participates in more than ten minutes of a session.

2. **Intensity and Frequency**: Most items require the coder to consider the frequency and/or intensity of particular behaviors when scoring the alliance.

   (a) **Intensity** is the amount of effort or force the client (and therapist) places in a behavior when it occurs. Intensity is determined by: (1) the concentration of effort or commitment the client (and therapist) puts into the behavior, and/or (2) the extent to which the client (and therapist) follows through with a behavior. For example, if a client only briefly smiles towards the therapist when asked questions, the concentration of effort is less than if the client consistently smiles and demonstrates positive affect towards the therapist .

   (b) **Frequency** is defined as the number of times and/or the amount of time the client (and therapist) spends demonstrating certain behaviors during a session. In other words, whereas thoroughness relates to how intensively a client (and therapist) engages in a specific behavior, frequency relates to the number of times and/or the amount of time a client (and therapist) emits a specific behavior during a session.

3. **Alliance Ratings**: Alliance is coded globally on a 6-point Likert scale ranging from "Not at all" to "Great deal". For example, a client might be scored highly for the alliance based on an intense demonstration of affect that occurs during a brief segment of the session. Conversely, a high score may be given when a client frequently demonstrate positive affect, but not intensely. The

highest mark ("5") is reserved for alliance that is both intense and frequent throughout a session.

0	1	2	3	4	5
Not at all		**Somewhat**		**Great deal**	

Each item description provides guidelines for weighing the relative importance of frequency and intensity. In order to determine how much weight to assign the two dimensions (i.e., frequency and intensity) for each item, coders will have to rely on their training, item descriptions, familiarity with the scale, and experience in coding recordings. See Table 1 for coding guidelines.

Table 1
Coding guidelines for coding the alliance.

	Anchors
0	**No presence.** • There is no evidence of the behavior
1	**Little to some presence.** • There is some indication of the behavior
2	
3	**Medium to large presence.** • There are clear indications of the behavior
4	
5	**A great deal.** • There are clear indications of frequent and intense behaviors.

4. **Exemplar Statements**: Examples are found throughout this scoring manual and are to be used as prototypes for categorizing in-session client behavior. *Exemplars* appear in two places, the *Item Descriptions* section (under the subheading *Exemplars)*, and the *Item Distinction* section. *Exemplars* are meant to help coders identify examples of alliance in a reliable manner by: (1) Providing coders with an idea of what a client behavior might look like, and (2) Helping coders differentiate between similar items. *Exemplars* are presented as a single sentence, or as a brief series of sentences to help cue the coder to a prototypical content.

5. **Item Distinctions**: Each TPOCS-A item is designed to represent a unique facet of the alliance. However, distinguishing between items can pose a challenge for coders. An *Item Distinction* subsection is included to help coders make these distinctions. This subsection contains information regarding how target items are to be distinguished from other items. Each entry describes how the target item differs in content and focus from other items.

C. CODER CAVEATS

1. **Scoring "Is" not "Ought"**: All scoring focuses on behavior. Thus, coders should only score what is actually done in session, not what might have been done or should have been done. Thus, an item should only receive a positive score if that item is somehow represented in the

client's (and therapist's) behavior (e.g., what the client does or says). Here is a brief summary of important guidelines for rating "is", not "ought":

(a) Code only behavior.

(b) Rate only what is done, not what you believe the client and/or therapist should have done, and not what you believe the client or therapist intended to do.

(c) Never assume or guess what a client or therapist might be thinking. If there is no behavioral evidence, in the form of something the client or therapist says or does, then do not give the corresponding item a positive score.

2. **Jumping the Gun**: Since TPOCS-A items are scored on a global level, items are not scored until the entire session has been viewed. Behavior that occurs later in the session may influence a coder's estimation of behavior that takes place earlier. For example, a client who does not initially demonstrate positive affect towards the therapist may show more as the session progresses. However, re-estimation can work in reverse. A client who demonstrates positive affect early on may show less later in the session, so an early inclination to give high ratings may be reevaluated as the session progresses. Coders may find it useful to keep notes as they code sessions, particularly during training.

3. **Being Thorough**: Carefully read each TPOCS-A item every time an item is scored so that the full content is considered in formulating a final decision. When coding, always have a scoring manual present and refer to it whenever there is any confusion about scoring an item.

   Periodically review the *General Instructions* and *Alliance Scale* sections after training. Review helps ensure reliable ratings and protects against coder drift (i.e., helps prevent coders from inadvertently imposing their own definitions and standards on items). Finally, because scoring recordings is a demanding and work-intensive process, do not do other tasks when scoring.

4. **Avoiding Halo Effects**: Coders should be careful to avoid instances of "halo" effects. Halo effects refer to situations where the scoring for one item is biased or influenced by the scoring awarded to another item, or by a global judgment about the whole session. Halo effects come in many forms; here are some relevant examples:

   (a) A coder decides s/he really likes the client and/or the therapist. As a result, the coder tends to give high scores on every item.

   (b) A coder is particularly impressed with a specific therapeutic segment. As a result, the coder gives high scores to too many items.

   (c) A coder observes early on that, if the session were stopped, the session would receive low scores. Having formed a negative opinion, the coder does not give sufficient weight to behavior that appears later in the session. The coder therefore gives low scores for most items.

   (d) A coder decides s/he really dislikes the client and/or the therapist. As a result, the coder tends to give low scores on every item.

(e) A coder intentionally decides or unintentionally acts as though two different items naturally go together.

To avoid halo effects coders have to follow the consistent criteria provided by this manual. Coders must score each item as a separate, independent entity that is not influenced by other items. Essentially, coders should treat each TPOCS-A item as if it is completely uncorrelated with every other item even if that item appears to have similar characteristics.

5. **Call'em Like you See'em**: Please remember that not every aspect of the alliance can be scored. The TPOCS-A is not an exhaustive list of all dimensions of the alliance. Coders should therefore not stretch the assessment of behavior just so it will fit into one of the items (even if it seems like a particularly potent therapeutic moment). When behavior is forced to fit certain items (or vice-versa), coder reliability is severely compromised.

III. ITEM DESCRIPTIONS

This section presents detailed descriptions and examples of each item contained in the TPOCS-A. Items are distributed across two different alliance components: (1) Bonds, and (2) Tasks. Item descriptions are designed to provide coders with the guidelines required to promote effective understanding and reliable scoring for each item. As such, descriptions are intended to provide both a detailed introduction to the content of that item and a practical reference for trained coders to aid in the scoring process.

Each of the 16 items that comprise the TPOCS-A is presented in this subsection according to the following format:

i. The item as it appears on the TPOCS-A
ii. Brief description of the item
iii. Exemplars
iv. Item Distinctions

PART I: BOND

Bond is defined as the extent to which the client and therapist develop a relationship characterized by: (1) Positive affect (e.g., liking, understanding, and caring), and (2) Trust. Scores should be based on the entire session.

B1. *FEELING UNDERSTOOD*: To what extent did the client indicate that s/he experiences the therapist as understanding and/or supporting?

This item captures the extent to which the client indicates that s/he feels understood and appreciated by the therapist. The client may explicitly refer to the therapist's understanding and support (e.g., "I really like talking to you, you really understand me"), or may implicitly indicate feeling understood or supported by taking risks in therapy (e.g., elaborate further on the therapist's remarks and/or disclose feelings - either verbally or in play).

RATING GUIDELINES

When scoring this item, coders must consider how frequently (e.g., how often does the client elaborate on therapist comments) and/or intensely (e.g., discloses that s/he has been contemplating suicide) the client indicates that s/he feels understood and appreciated in the session. The following guidelines are designed to provide general anchors for the ratings.

0 = No presence
- The client does not indicate that s/he experiences the therapist as understanding and/or supporting during the session.

1-2 = Little to Some Presence
- The client rarely indicates that s/he experiences the therapist as understanding and/or supporting during the session.

3-4 = Medium to Large Presence
- The client indicates that s/he experiences the therapist as understanding and/or supporting consistently throughout the session.

5 = A Great Deal
- The client frequently and intensely indicates that s/he experiences the therapist as understanding and/or supporting during the session.

EXEMPLARS

"I love coming here every week to talk to you. You always listen to me"

"My parents never understand me the way you do."

"There is something I really wanted to share with you today, and I haven't told anybody else."

ITEM DISTINCTIONS

Vs. *B3 Positive Affect*

For *B1 Feeling Understood* the client demonstrates that they feel understood or supported by the therapist and for *B3 Positive Affect* the client uses verbal or nonverbal behavior to show that they

like or care for the therapist.

Vs. *B4 Shares Experiences*

B1 Feeling Understood is coded when the client demonstrates that they feel understood or supported by the therapist whereas *B4 Shares Experience* concerns the degree to which the client expresses his/her viewpoint or experiences to the therapist but does not necessarily feel understood or supported.

B2. *HOSTILE MANNER:* To what extent did the client act in a hostile, critical, or defensive manner towards the therapist?

This item captures the extent to which the client interacts with the therapist in an angry or suspicious fashion. The client may be verbally hostile (e.g., "I hate you), critical (e.g., "Why do you always ask the same stupid questions"), or defensive (e.g., "Why do you keep asking me that"). The client may also be physically hostile (e.g., throws items at the therapist).

It is unusual for clients to be overtly hostile, aggressive, or critical of a therapist during a session. They are more likely to take a "defensive" stance. Therefore, the intensity of hostile, aggressive, or critical behavior will often be given more weight than the frequency of these behaviors when scoring this item. Oftentimes, clients may appear disengaged in therapeutic tasks due to inattentiveness, hyperactivity, depression, or other psychological symptoms; however, this item should only be coded if the client is demonstrating hostility, defensiveness, or a critical attitude towards the therapist.

RATING GUIDELINES

When scoring this item, coders must consider how frequently (e.g., frequently states that s/he does not like therapist) and/or intensely (e.g., intensely yells that s/he thinks the therapist is a "No good idiot") the client interacts with the therapist in a hostile, critical, or defensive manner. The following guidelines are designed to provide general anchors for the ratings.

0 = No presence
- The client does not demonstrate any hostility or defensiveness during the session.

1-2 = Little to Some Presence
- The client demonstrates a few non-intense instances (< 2-3) of hostility and/or defensiveness towards the therapist.

3-4 = Medium to Large Presence
- The client demonstrates a number of instances and/or a few intense instances of hostility or defensiveness towards the therapist during the session.

5 = A Great Deal
- A great deal of hostility or defensiveness is demonstrated by the client towards the therapist during the session.

EXEMPLARS

"You don't know what it's like to be me."

"If you ask me that question one more time, I'm going to scream."

"I wasn't doing anything! Why are you always on my case?"

"Why do I have to come here? This isn't helping."

"You aren't even a real doctor."

ITEM DISTINCTIONS

Vs. *B5 Client Discomfort*

B2 Hostile Manner is coded when the client is verbally or physically hostile, critical, or defensive towards the therapist whereas *B5 Client Discomfort* is coded when the client appears uncomfortable or awkward when interacting with the therapist. Generally, *B2 Hostile Manner* is coded when the client has a negative attitude towards the therapist and *B5 Client Discomfort* is coded when the client is shy or uncomfortable engaging with the therapist.

Vs. *B6 Client/Therapist Discomfort*

B2 Hostile Manner is coded when the client is verbally or physically hostile, critical, or defensive towards the therapist whereas *R6 Client/Therapist Discomfort* is coded when the client and therapist appear uncomfortable or awkward when interacting with one another. Generally, *B2 Hostile Manner* is coded when the client has a negative attitude towards the therapist and *B6 Client/Therapist Discomfort* is coded when the client and therapist demonstrate discomfort and/or awkward flow of interaction.

Vs. *T2 Client Noncompliance*

B2 Hostile Manner is coded when the client is verbally or physically hostile, critical, or defensive towards the therapist whereas *T2 Client Noncompliance* is coded when the client refuses to participate in the therapeutic tasks. A client may exhibit hostility or defensiveness towards the therapist when refusing to participate in therapeutic tasks and thus the two items may co-occur.

B3. POSITIVE AFFECT: To what extent did the client demonstrate positive affect toward the therapist?

This item captures the extent to which the client demonstrates that s/he likes and/or cares for the therapist. The client may verbally report that s/he likes the therapist (e.g., "I really like you), or non-verbally demonstrate that s/he likes the therapist by smiling, laughing, or being physically oriented towards the therapist. Please note that this item does not measure the extent to which the client enjoys or has fun engaging in therapeutic tasks. Rather, this item focuses on affect directed towards the therapist.

RATING GUIDELINES

When scoring this item, coders must consider how frequently (e.g., frequently smiles and laughs) and/or intensely (e.g., intensely states that s/he really likes the therapist) the client demonstrates that s/he likes the therapist. The following guidelines are designed to provide general anchors for the ratings.

0 = No presence
- The client does not demonstrate any positive affect toward the therapist during the session.

1-2 = Little to Some Presence
- The client only indicates a few instances of positive affect toward the therapist during the session.

3-4 = Medium to Large Presence
- The client frequently and/or intensely directs positive affect toward the therapist during the session.

5 = A Great Deal
- The client frequently intensely directs positive affect toward the therapist during the session.

EXEMPLARS

"I love coming here and playing with you."

(Client smiles and laughs while interacting with therapist)

(Client is physically oriented towards therapist and makes frequent eye contact)

"I made you this at school today because I love coming to see you."

ITEM DISTINCTIONS

Vs. *B1 Feeling Understood*

For *B3 Positive Affect*, the client uses verbal or nonverbal behavior to show that they like or care

for the therapist and for *B1 Feeling Understood* the client demonstrates that they feel understood or supported by the therapist.

Vs. *B4 Shares Experiences*

For *B3 Positive Affect* the client uses verbal or nonverbal behavior to show that they like or care for the therapist whereas *B4 Shares Experiences* concerns the degree to which the client expresses his/her viewpoint or experiences to the therapist but does not necessarily demonstrate positive affect while doing so.

B4. *SHARES EXPERIENCES:* To what extent did the client share his/her experience with the therapist?

This item concerns the degree to which the client expresses his/her viewpoint to the therapist. Client who like and trust a therapist will be more willing to share their experience and personal viewpoints with the therapist. The client may express his/her experience by freely, openly, and easily talking about hopes, dreams, and opinions. Sharing experiences is not confined to the client sharing his/her experience while engaged in therapeutic activities (e.g., giving elaborate answers to therapist questions). Rather, this item captures the extent to which the client shares his/her general experience with the therapist (e.g., personal achievements such as facing fears, or doing well on a math test).

RATING GUIDELINES

When scoring this item, coders must consider how frequently the client expresses his/her experience when presented the opportunity (e.g., how often the client shares his/her experience when asked by the therapist) and/or intensely the client shares his or her experience with the therapist by openly disclosing information (e.g., a traumatic experience). That is, no aspect of the client's experience is missing that would reasonably be expected. This item may be rated higher if a client initiates discussion of their experiences. The following guidelines are designed to provide general anchors for the ratings.

0 = No presence
- The client does not share his/her experience with the therapist.

1-2 = Little to Some Presence
- The client rarely shares his/her experience with the therapist during the session.

3-4 = Medium to Large Presence
- The client frequently and/or intensely shares his/her experience with the therapist during the session.

5 = A Great Deal
- The client frequently and intensely shares his/her experiences with the therapist during the session.

EXEMPLARS

"I really worry that something bad might happen to my parents."

"Oh yeah, last week when I was at school that happened. We had a math test, and I got nervous and thought I was going to fail no matter what."

"I tried to do relaxation like we learned last week, but I didn't like the one where I squeezed the lemons."

ITEM DISTINCTIONS

Vs. *B1 Feeling Understood*

B1 Feeling Understood is coded when the client demonstrates that they feel understood or supported by the therapist whereas *B4 Shares Experience* concerns the degree to which the client expresses his/her experiences with the therapist but does not necessarily feel understood or supported.

Vs. *B3 Positive Affect*

For *B3 Positive Affect* the client uses verbal or nonverbal behavior to show that they like or care for the therapist whereas *R4 Shares Experience* concerns the degree to which the client expresses his/her viewpoint or experiences to the therapist but does not necessarily demonstrate positive affect while doing so.

B5. *CLIENT DISCOMFORT*: To what extent did the client appear uncomfortable when interacting with the therapist?

This item concerns the degree to which the client appears anxious, uncomfortable, or awkward when interacting with the therapist. The client may explicitly state that s/he is uncomfortable interacting with the therapist (e.g., "I really don't feel comfortable talking with you"), or implicitly indicate that s/he is uncomfortable by not interacting freely, openly, and easily (e.g., turning away from the therapist, not talking, not playing). Please note that this item does not focus on the therapist's comfort level. Rather, this item focuses exclusively on the degree to which the client appears anxious, uncomfortable, or awkward when interacting with the therapist.

RATING GUIDELINES

When scoring this item, coders must consider how frequently and/or intensely the client appears uncomfortable when interacting with the therapist. Coders should only consider observable client behavior when scoring this item and not how uncomfortable the therapist appears or how uncomfortable the coder may feel when observing the session. The following guidelines are designed to provide general anchors for the ratings.

0 = No presence
- The client does not appear uncomfortable when interacting with the therapist during the session.

1-2 = Little to Some Presence
- In general, the client does not appear uncomfortable when interacting with the therapist, but the client does show 2-3 non-intense signs of feeling uncomfortable over the course of the session.

3-4 = Medium to Large Presence
- The client frequently appears to be uncomfortable during the session or appears intensely uncomfortable during 1-2 parts of the session.

5 = A Great Deal
- The client is frequently and intensely uncomfortable during the session.

EXEMPLARS

"I don't really want to talk about that right now. It makes me feel weird."

(Client turns away from therapist and does not answer therapist after being asked a question)

"I don't like it when you ask those types of questions, they are hard to answer."

(Client does not use eye contact when talking to therapist and stutters when completing a therapeutic task)

ITEM DISTINCTIONS

Vs. *B2 Hostile Manner*

B5 Client Discomfort is coded when the client appears uncomfortable or awkward when interacting with the therapist whereas *B2 Hostile Manner* is coded when the client is verbally or physically hostile, critical, or defensive towards the therapist. Generally, *B5 Client Discomfort* is coded when the client is shy or uncomfortable engaging with the therapist in treatment and *B2 Hostile Manner* is coded when the client has a negative attitude towards the therapist.

Vs. *B6 Client/Therapist Discomfort*

B5 Client Discomfort is coded when the client appears uncomfortable or awkward when interacting with the therapist whereas *B6 Client/Therapist Discomfort* is coded when the client and therapist appear uncomfortable or awkward when interacting with one another.

B6. *CLIENT/THERAPIST DISCOMFORT*: To what extent did the therapist and client appear uncomfortable interacting with one another?

This item concerns the degree to which the client and therapist have difficulty interacting because they are uncomfortable. The client and therapist may display discomfort through uncomfortable verbal exchanges (e.g., awkward silences or pauses in conversation), or uncomfortable non-verbal exchanges (e.g., difficulty playing). This item is intended to capture the ease of flow between the therapist and the client (e.g., the back and forth nature of conversation) and how the therapist responds to the client's discomfort (e.g., rolls with client's resistance; becomes nervous when client begins to cry).

RATING GUIDELINES

When scoring this item, coders must consider how frequently and/or intensely the client and therapist appear uncomfortable when interacting with one another. Coders should only consider observable client and therapist behavior when scoring this item and not how uncomfortable the coder may feel when observing the session. The following guidelines are designed to provide general anchors for the ratings.

0 = No presence
- The client and therapist do not appear uncomfortable when interacting with each other during the session.

1-2 = Little to Some Presence
- In general, the client and therapist do not appear uncomfortable when interacting with each other, but do show 2-3 non-intense signs of feeling uncomfortable interacting with one another over the course of the session.

3-4 = Medium to Large Presence
- The client and therapist frequently appear to be uncomfortable interacting with one another during the session or appear intensely uncomfortable during 1-2 segments of the session.

5 = A Great Deal
- The client and therapist are frequently and intensely uncomfortable interacting with one another during the session.

EXEMPLARS

Client: "I was very sad when the other kids began to tease me about my weight." Therapist: [Awkward Silence].

Client: [Tearful after completing an exposure].
Therapist: "Ummm, why don't we just play a game or we can end early today."

ITEM DISTINCTIONS

Vs. *B2 Hostile Manner*

B6 Client/Therapist Discomfort is coded when the client and therapist appear uncomfortable or awkward when interacting with one another whereas *B2 Hostile Manner* is coded when the client is verbally or physically hostile, critical, or defensive towards the therapist. Generally, *B6 Client/Therapist Discomfort* is coded when the client and/or therapist are shy or uncomfortable engaging with one another in session and *B2 Hostile Manner* is coded when the client has a negative attitude towards the therapist.

Vs. *B5 Client Discomfort*

B6 Client/Therapist Discomfort is coded when the client and therapist appear uncomfortable or awkward when interacting with one another *whereas B5 Client Discomfort* is coded when the client appears uncomfortable or awkward when interacting with the therapist.

PART II: THERAPEUTIC TASKS

Therapeutic tasks are defined as: (1) The therapeutic interventions employed by the therapist, and (2) The client's willingness to use or follow the therapeutic interventions. Scores should be based on the entire session.

T1. *CHANGES OUTSIDE:* To what extent did the client use therapeutic tasks to make changes outside the therapy session?

This item captures the extent to which the client uses therapeutic tasks to make changes or find solutions outside the session. To use therapeutic tasks to make changes outside of the session the client must demonstrate that s/he has acted upon something learned in therapy to understand and resolve problems (e.g., "I used the reward chart this week to get my son to pick up his room"). That is, the client must report that s/he used a therapeutic task outside the session. Oftentimes, this item focuses on homework completion/incompletion; however, it is not necessary that the therapeutic tasks be formally assigned homework.

When scoring this item, it is important to consider that it is rare to spend a lot of time talking about how therapeutic tasks are used outside of the session. So, this item will have a lower frequency than some other items. Therefore, coders will need to carefully consider frequency and intensity when scoring this item.

RATING GUIDELINES

When scoring this item, coders must first consider whether there is clear evidence that the client acted on something learned in therapy to make changes outside the session. If clear evidence exists, then coders must consider whether the client frequently and/or intensely (e.g., provides a detailed account of how s/he used therapeutic tasks to make changes) uses therapeutic tasks to make changes outside the session. The following guidelines are designed to provide general anchors for the ratings.

0 = No presence
- The client does not indicate that s/he used therapeutic tasks to make changes outside of the session.

1-2 = Little to Some Presence
- The client rarely indicates that s/he used therapeutic tasks to make changes outside of the session.

3-4 = Medium to Large Presence
- The client frequently and/or intensely indicates that s/he used therapeutic tasks to make changes outside of the session.

5 = A Great Deal
- The client frequently and intensely indicates that s/he used therapeutic tasks to make changes outside of the session.

EXEMPLARS

"I completed all my homework and went through all the steps of the coping plan this week!"

"I tried to use relaxation like we talked about a few weeks ago to calm myself."

Therapist: “Did you do any fun activities with your friends this week like we had planned for at last week’s session?”

Client: “Yes, we went to go see a new movie that just came out on Friday.”

T2. *CLIENT NONCOMPLIANCE:* To what extent did the client not comply with therapeutic tasks?

This item captures the extent to which the client refuses to participate in the therapeutic tasks. The client may explicitly refuse to use therapeutic tasks (e.g., "I don't want to play"; "I don't want to talk to my mother about this problem") or implicitly refuse to participate in therapeutic tasks by: (1) Not complying with therapist requests or directives (e.g., does not play with therapist, explore emotions), or (2) Disrupting therapeutic tasks (e.g., taps loudly on a table while the therapist asks him/her about feelings).

It is unusual for clients to outright refuse to participate in a therapeutic task. They are more likely to show noncompliance by not fully engaging or participating in a therapeutic task. Since it is unusual for clients to be noncompliant with therapeutic tasks a few instances of noncompliance are often enough to give higher ratings on this item.

RATING GUIDELINES

When scoring this item, coders must consider whether the client frequently and/or intensely (e.g., absolutely refuses to participate in a specific therapeutic task) refuses to use or participate in the therapeutic tasks. The following guidelines are designed to provide general anchors for the ratings.

0 = No presence
- The client does not refuse to participate in any therapeutic activity during a session.

1-2 = Little to Some Presence
- The client generally participates in therapeutic activities, but there are a few non-intense signs of noncompliance (e.g., acts in a distracting manner).

3-4 = Medium to Large Presence
- The client is noncompliant with therapeutic activities but typically will comply after some prompting.

5 = A Great Deal
- The client is consistently noncompliant with therapeutic tasks.

EXEMPLARS

"I don't want to talk about my dad today, it doesn't matter."

"I'm not doing the exposure today, it is way too scary!"

Therapist: "Let's play the Thinking, Feeling, Doing game"
Client: (Lies head on desk and does not participate)

ITEM DISTINCTIONS

Vs. *B2 Hostile Manner*

T2 Client Noncompliance is coded when the client refuses to participate in the therapeutic tasks *whereas B2 Hostile Manner* is coded when the client is verbally or physically hostile, critical, or defensive towards the therapist. A client may exhibit hostility towards the therapist when refusing to participate in therapeutic tasks and thus the two items may co-occur.

T3. *WORK EQUALLY:* To what extent did the therapist and client work together equally on therapeutic tasks?

This item measures the degree to which the client and therapist work as a team on the therapeutic tasks. When the client and therapist work together on the therapeutic tasks the interaction is characterized by equal effort (e.g., therapist and client both exert the same level of effort on the therapeutic tasks) and responsive exchanges (i.e., verbal or nonverbal). For example, the therapist and client may elaborate further on remarks, or help each one another complete the therapeutic tasks (e.g., suggest feelings, help build a house together out of Legos). This item is intended to capture the "give and take" between the client and therapist.

RATING GUIDELINES

When scoring this item, coders must consider how frequently and/or intensely the client and therapist work together on the therapeutic tasks. The following guidelines are designed to provide general anchors for the ratings.

0 = No presence
- The client and therapist do not work equally on therapeutic tasks.
- There is clear evidence that the client or therapist put forth more effort and/or that the client and therapist are not able to work together.

1-2 = Little to Some Presence
- The client and therapist have difficulty working equally on therapeutic tasks, though there are a few instances in which they do work equally.

3-4 = Medium to Large Presence
- The client and therapist work equally on therapeutic tasks throughout the session with only a few instances of the client and/or therapist putting forth more efforts.

5 = A Great Deal
- The client and therapist are able to work equally throughout the whole session.

EXEMPLARS

Therapist: "Okay, I'm going to act out the first emotion and you have to guess what it is and then you'll act out the second one and I'll guess what it is." (Therapist and client proceed to take turns acting out and guess emotions)

Therapist: "Let's make a list together of all the possible solutions. One thing you could do is ask your mother in advance if it is okay for your friend to come over."
Client: "Another thing I could do is set my watch alarm so I know when free time is up."
Therapist: "That's a great idea!"

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Target Client (Circle one): Parent OR Child

TPOCS ALLIANCE SCALE

INSTRUCTIONS: *Using the Likert scale provided below, please base all bond and therapeutic tasks scores on the entire session. Write the appropriate number from the scale in the space provided.*

0	1	2	3	4	5
Not at all		**Somewhat**			**Great deal**

PART I: BOND

For this scale, ***bond*** *is defined as the extent to which the client and therapist develop a relationship characterized by: (1) Positive affect (e.g., liking, understanding, and caring), and (2) Mutual trust.*

____ **B1**. ***FEELING UNDERSTOOD*: To what extent did the client indicate that s/he experiences the therapist as understanding and/or supporting?**

____ **B2**. ***HOSTILE MANNER:* To what extent did the client act in a hostile, critical, or defensive manner towards the therapist?**

____ **B3**. ***POSITIVE AFFECT*: To what extent did the client demonstrate positive affect toward the therapist?**

____ **B4**. ***SHARES EXPERIENCES:* To what extent did the client share his/her experience with the therapist?**

____ **B5**. ***CLIENT DISCOMFORT*: To what extent did the client appear uncomfortable when interacting with the therapist?**

____ **B6**. ***CLIENT/THERAPIST DISCOMFORT*: To what extent did the therapist and client appear uncomfortable interacting with one another?**

PART II: THERAPEUTIC TASKS

For this scale, ***therapeutic tasks*** *are defined as: (1) The therapeutic interventions employed by the therapist, and (2) The client's willingness to use or follow the therapeutic interventions*

____ **T1**. ***CHANGES OUTSIDE:* To what extent did the client use therapeutic tasks to make changes outside the therapy session?**

____ **T2**. ***CLIENT NONCOMPLIANCE:* To what extent did the client not comply with therapeutic tasks?**

____ **T3**. ***WORK EQUALLY:* To what extent did the therapist and client work together equally on therapeutic tasks?**

References

Adams, J. R., & Drake, R. E. (2006). Shared decision-making and evidence-based practice. *Community Mental Health Journal*, *42*(1), 87–105. https://doi.org/10.1007/s10597-005-9005-8

Alegría, Green, J. G., McLaughlin, K. A., & Loder, S. (2015). *Disparities in child and adolescent mental health and mental health services in the U.S.* 1–23.

Alegria, M., Atkins, M., Farmer, E., Slaton, E., & Stelk, W. (2010). *One Size Does Not Fit All : Taking Diversity , Culture and Context Seriously*. 48–60. https://doi.org/10.1007/s10488-010-0283-2

Alegria, M., Nakash, O., Johnson, K., Ault-Brutus, A., Carson, N., Fillbrunn, M., Wang, Y., Cheng, A., Harris, T., Polo, A., Lincoln, A., Freeman, E., Bostdorf, B., Rosenbaum, M., Epelbaum, C., LaRoche, M., Okpokwasili-Johnson, E., Carrasco, M. J., & Shrout, P. E. (2018). Effectiveness of the DECIDE Interventions on Shared Decision Making and Perceived Quality of Care in Behavioral Health With Multicultural Patients. *JAMA Psychiatry*, *75*(4), 325. https://doi.org/10.1001/jamapsychiatry.2017.4585

Alegría, M., Polo, a, Gao, S., & Santana, L. (2008). Evaluation of a patient activation and empowerment intervention in mental health care. *Medical Care*, *46*(3), 247–256. https://doi.org/10.1097/MLR.0b013e318158af52.Evaluation

American Academy of Pediatrics. (2012). Patient- and Family-Centered Care and the Pediatrician's Role. *Pediatrics*, *129*(2), 394–404. https://doi.org/10.1542/peds.2011-3084

Añez, L. M., Silva, M. A., Paris, M., & Bedregal, L. E. (2008). Engaging Latinos Through the Integration of Cultural Values and Motivational Interviewing Principles. *Professional*

Psychology: Research and Practice, *39*(2), 153–159. https://doi.org/10.1037/0735-7028.39.2.153

Anixt, J. S., Meinzen-Derr, J., Estridge, H., Smith, L., & Brinkman, W. B. (2018). Characteristics of Treatment Decisions to Address Challenging Behaviors in Children with Autism Spectrum Disorder. *Journal of Developmental & Behavioral Pediatrics*, 1. https://doi.org/10.1097/dbp.0000000000000561

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, *61*(4), 271–285. https://doi.org/10.1037/0003-066X.61.4.271

Bacio, G. A., Garcia, T. A., Anderson, K. G., Brown, S. A., & Myers, M. G. (2017). Engagement and Retention of Ethnically Diverse Adolescents to a Voluntary, School-Based Alcohol Use Intervention. *Journal of Behavioral Health Services and Research*, *44*(1), 52–62. https://doi.org/10.1007/s11414-016-9540-9

Bamberger, K. T., Coatsworth, J. D., Fosco, G. M., & Ram, N. (2014). Change in Participant Engagement During a Family-Based Preventive Intervention: Ups and Downs with Time and Tension. *Journal of Family Psychology*, *28*(6), 811–820. https://doi.org/10.1037/fam0000036

Barker, C. H., Cook, K. L., & Borrego, J. (2010). Addressing Cultural Variables in Parent Training Programs With Latino Families. *Cognitive and Behavioral Practice*, *17*(2), 157–166. https://doi.org/10.1016/j.cbpra.2010.01.002

Barnett, Brookman-Frazee, L., Gonzalez, J. C., Zhan, C., Rodriguez, A., Stadnick, N. A., & Lau, A. S. (2019). Qualitative Reports of How and When Therapists Adapt Children's Evidence-Based Practices during Community Implementation. *Journal of Clinical Child &*

Adolescent Psychology, *48*(6), 894–905. https://doi.org/10.1080/15374416.2018.1485107

Barnett, E. R., Boucher, E. A., Daviss, W. B., & Elwyn, G. (2018). Supporting Shared Decision-making for Children's Complex Behavioral Problems: Development and User Testing of an Option Grid™ Decision Aid. *Community Mental Health Journal*, *54*(1), 7–16. https://doi.org/10.1007/s10597-017-0136-5

Barnett, E. R., Boucher, E. A., Neubacher, K., & Carpenter-Song, E. A. (2016). Decision-making around psychotropic medications for children in foster care: Perspectives from foster parents. *Children and Youth Services Review*, *70*, 206–213. https://doi.org/10.1016/j.childyouth.2016.09.012

Barnett, Lau, A. S., Lind, T., Wright, B., Stadnick, N. A., Innes-gomberg, D., Pesanti, K., Brookman-frazee, L., Barnett, M. L., Lau, A. S., Lind, T., Wright, B., Stadnick, N. A., Innes-gomberg, D., Pesanti, K., Caregiver, L. B., Barnett, M. L., Lau, A. S., & Brookman-frazee, L. (2019). Caregiver Attendance as a Quality Indicator in the Implementation of Multiple Evidence-Based Practices for Children Caregiver Attendance as a Quality Indicator in the Implementation of Multiple Evidence-Based Practices for Children. *Journal of Clinical Child & Adolescent Psychology*, *00*(00), 1–15. https://doi.org/10.1080/15374416.2019.1683851

Barnett, M., Brookman-Frazee, L., Regan, J., Saifan, D., Stadnick, N., & Lau, A. (2017). How Intervention and Implementation Characteristics Relate to Community Therapists' Attitudes Toward Evidence-Based Practices: A Mixed Methods Study. *Administration and Policy in Mental Health and Mental Health Services Research*, *44*(6), 824–837. https://doi.org/10.1007/s10488-017-0795-0

Barr, P. J., O'Malley, A. J., Tsulukidze, M., Gionfriddo, M. R., Montori, V., & Elwyn, G.

(2015). The psychometric properties of Observer OPTION5, an observer measure of shared decision making. *Patient Education and Counseling*, *98*(8), 970–976. https://doi.org/10.1016/j.pec.2015.04.010

Barry, M. J., & Edgman-Levitan, S. (2012). Shared decision making - The pinnacle of patient-centered care. *New England Journal of Medicine*, *366*(9), 780–781. https://doi.org/10.1056/NEJMp1109283

Becker, K. D., Boustani, M., Gellatly, R., & Chorpita, B. F. (2018). Forty Years of Engagement Research in Children's Mental Health Services: Multidimensional Measurement and Practice Elements. *Journal of Clinical Child & Adolescent Psychology*, *47*(1), 1–23. https://doi.org/10.1080/15374416.2017.1326121

Beidas, R. (2010). Flexible Applications of the Coping Cat Program for Anxious Youth. *NIH Public Access*, *20*(2), 1–11. https://doi.org/10.1016/j.cbpra.2009.11.002.Beidas

Berkel, C., Mauricio, A. M., Schoenfelder, E., & Sandler, I. N. (2011). Putting the Pieces Together: An Integrated Model of Program Implementation. *Prevention Science*, *12*(1), 23–33. https://doi.org/10.1007/s11121-010-0186-1

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural Adaptation of Treatments: A Resource for Considering Culture in Evidence-Based Practice. *Professional Psychology: Research and Practice*, *40*(4), 361–368. https://doi.org/10.1037/a0016401

Bickman, L., De Andrade, A. R. V., Athay, M. M., Chen, J. I., De Nadai, A. S., Jordan-Arthur, B. L., & Karver, M. S. (2012). The relationship between change in therapeutic alliance ratings and improvement in youth symptom severity: Whose ratings matter the most? *Administration and Policy in Mental Health and Mental Health Services Research*, *39*(1–2),

78–89. https://doi.org/10.1007/s10488-011-0398-0

Boggs, S. R., Eyberg, S. M., Edwards, D. L., Rayfield, A., Jacobs, J., Bagner, D., & Hood, K. K. (2005). Outcomes of Parent-Child Interaction Therapy: A Comparison of Treatment Completers and Study Dropouts One to Three Years Later. *Child & Family Behavior Therapy*, *26*(4), 1–22. https://doi.org/10.1300/J019v26n04_01

Boland, L., Graham, I. D., Légaré, F., Lewis, K., Jull, J., Shephard, A., Lawson, M. L., Davis, A., Yameogo, A., & Stacey, D. (2019). *Barriers and facilitators of pediatric shared decision-making : a systematic review*.

Brinkman, W. B., Hartl, J., Rawe, L. M., Sucharew, H., Britto, M. T., & Epstein, J. N. (2011). Physicians' shared decision-making behaviors in attention-deficit/ hyperactivity disorder care. *Archives of Pediatrics and Adolescent Medicine*, *165*(11), 1013–1019. https://doi.org/10.1001/archpediatrics.2011.154

Brinkman, W. B., Hartl Majcher, J., Poling, L. M., Shi, G., Zender, M., Sucharew, H., Britto, M. T., & Epstein, J. N. (2013). Shared decision-making to improve attention-deficit hyperactivity disorder care. *Patient Education and Counseling*, *93*(1), 95–101. https://doi.org/10.1016/j.pec.2013.04.009

Brock, D. W. (1991). The ideal of shared decision making between physicians and patients. *Kennedy Institute of Ethics Journal*, *1*(1), 28–47. https://doi.org/10.1353/ken.0.0084

Brookman-Frazee, L., Drahota, A., & Stadnick, N. (2012). Training community mental health therapists to deliver a package of evidence based practice strategies for school-age children with Autism Spectrum Disorders: A pilot study. *Journal of Autism and Developmental Disorders*, *42*(8), 1651–1661. https://doi.org/10.1007/s10803-011-1406-7.Training

Brookman-Frazee, L., Stadnick, N. A., Lind, T., Roesch, S., Terrones, L., Barnett, M. L., Regan,

J., Kennedy, C. A., F. Garland, A., & Lau, A. S. (2021). Therapist-Observer Concordance in Ratings of EBP Strategy Delivery: Challenges and Targeted Directions in Pursuing Pragmatic Measurement in Children's Mental Health Services. *Administration and Policy in Mental Health and Mental Health Services Research*, *48*(1), 155–170. https://doi.org/10.1007/s10488-020-01054-x

Brookman-Frazee, L., Stadnick, N., Roesch, S., Regan, J., Barnett, M., Bando, L., Innes-Gomberg, D., & Lau, A. (2016). Measuring Sustainment of Multiple Practices Fiscally Mandated in Children's Mental Health Services. *Administration and Policy in Mental Health and Mental Health Services Research*, *43*(6), 1009–1022. https://doi.org/10.1007/s10488-016-0731-8

Budd, K. S., & Lyon, A. R. (2010). A Community Mental Health Implementation of Parent-Child Interaction Therapy (PCIT). *Journal of Child and Family Studies*, *19*(5), 654–668. https://doi.org/10.1007/s10826-010-9353-z

Burgess, A. M., Okamura, K. H., Izmirian, S. C., Higa-McMillan, C. K., Shimabukuro, S., & Nakamura, B. J. (2017). Therapist Attitudes Towards Evidence-Based Practice: A Joint Factor Analysis. *Journal of Behavioral Health Services and Research*, *44*(3), 414–427. https://doi.org/10.1007/s11414-016-9517-8

Butler, A. M., Elkins, S., Kowalkowski, M., & Raphael, J. L. (2014). Shared Decision Making Among Parents of Children with Mental Health Conditions Compared to Children with Chronic Physical Conditions. *Maternal and Child Health Journal*, *19*(2), 410–418. https://doi.org/10.1007/s10995-014-1523-y

Butler, A. M., Weller, B., & Titus, C. (2015). Relationships of Shared Decision Making with Parental Perceptions of Child Mental Health Functioning and Care. *Administration and*

Policy in Mental Health and Mental Health Services Research, *42*(6), 767–774. https://doi.org/10.1007/s10488-014-0612-y

California Health Care Foundation. (2018). *Mental Health in California: For Too Many, Care Not There*. *March*.

Calzada, E. J., Fernandez, Y., & Cortes, D. E. (2010). Incorporating the cultural value of respeto into a framework of Latino parenting. *Cultural Diversity and Ethnic Minority Psychology*, *16*(1), 77–86. https://doi.org/10.1037/a0016071

Center for Mental Health Services. (2010). Shared Decision-Making in Mental Healthcare: Practice, Research, and Future Directions. *Substance Abuse and Mental Health Services Administration: Rockville, MD, USA*.

Chacko, A., Jensen, S. A., Lowry, L. S., Cornwell, M., Chimklis, A., Chan, E., Lee, D., & Pulgarin, B. (2016). Engagement in Behavioral Parent Training: Review of the Literature and Implications for Practice. *Clinical Child and Family Psychology Review*, *19*(3), 204–215. https://doi.org/10.1007/s10567-016-0205-2

Chaffin, M., Funderburk, B., Bard, D., Valle, L. A., & Gurwitch, R. (2011). A combined motivation and parent-child interaction therapy package reduces child welfare recidivism in a randomized dismantling field trial. *Journal of Consulting and Clinical Psychology*, *79*(1), 84–95. https://doi.org/10.1037/a0021227

Chamay Weber, C., Camparini, N., Lanza, L., & Narring, F. (2016). Parents' integration in the treatment of adolescents with obesity: A qualitative study. *Families, Systems, & Health*, *34*(4), 396–403. https://doi.org/10.1037/fsh0000219

Chambers, D. A., Glasgow, R. E., & Stange, K. C. (2013). The dynamic sustainability framework: Addressing the paradox of sustainment amid ongoing change. *Implementation*

Science, *8*(1), 1–11. https://doi.org/10.1186/1748-5908-8-117

Charles, C., Gafni, A., Whelan, T., Gafnv, A., & Whelan, T. (1997). Shared decision-making in the medical encounter: What does it mean? (Or it takes, at least two to tango). *Social Science and Medicine*, *44*(5), 681–692. https://doi.org/10.1016/S0277-9536(96)00221-3

Charles, C., Gafni, A., Whelan, T., & O'Brien, M. A. (2006). Cultural influences on the physician-patient encounter: The case of shared treatment decision-making. *Patient Education and Counseling*, *63*(3 SPEC. ISS.), 262–267. https://doi.org/10.1016/j.pec.2006.06.018

Chavira, D. A., Bustos, C. E., Garcia, M. S., Ng, B., & Camacho, A. (2017). Delivering CBT to Rural Latino Children with Anxiety Disorders: A Qualitative Study. *Community Mental Health Journal*, *53*(1), 53–61. https://doi.org/10.1007/s10597-015-9903-3

Cheng, H., Hayes, D., Edbrooke-Childs, J., Martin, K., Chapman, L., & Wolpert, M. (2017). What approaches for promoting shared decision-making are used in child mental health? A scoping review. *Clinical Psychology and Psychotherapy*, *24*(6), O1495–O1511. https://doi.org/10.1002/cpp.2106

Child and Adolescent Mental Health Division. (2003). Service Provider Monthly Treatment and Progress Summary. In *Hawaii Department of Health Child and Adolescent Mental Health Division*.

Chlebowski, C., Hurwich-Reiss, E., Wright, B., Brookman-Frazee, L., & Frazee, L. B. (2019). Using stakeholder perspectives to guide systematic adaptation of an autism mental health intervention for Latinx families: A qualitative study. *Journal of Community Psychology*, *September*, jcop.22296. https://doi.org/10.1002/jcop.22296

Chlebowski, C., Magaña, S., Wright, B., & Brookman-Frazee, L. (2018). Implementing an

Intervention to Address Challenging Behaviors for Autism Spectrum Disorder in Publicly-Funded Mental Health Services: Therapist and Parent Perceptions of Delivery With Latinx Families. *Cultural Diversity and Ethnic Minority Psychology*, *24*(4), 552–563. https://doi.org/10.1037/cdp0000215s

Chorpita, B. F., Daleiden, E. L., & Collins, K. S. (2014). Managing and Adapting Practice: A System for Applying Evidence in Clinical Care with Youth and Families. *Clinical Social Work Journal*, *42*(2), 134–142. https://doi.org/10.1007/s10615-013-0460-3

Chorpita, B. F., Korathu-Larson, P., Knowles, L. M., & Guan, K. (2014). Emergent life events and their impact on service delivery: Should we expect the unexpected? *Professional Psychology: Research and Practice*, *45*(5), 387–393. https://doi.org/10.1037/a0037746

Chorpita, B. F., Rotheram-Borus, M. J., Daleiden, E. L., Bernstein, A., Cromley, T., Swendeman, D., & Regan, J. (2011). The old solutions are the new problem: How do we better use what we already know about reducing the Burden of mental illness? *Perspectives on Psychological Science*, *6*(5), 493–497. https://doi.org/10.1177/1745691611418240

Chu, B. C., & Kendall, P. C. (2004). Positive Association of Child Involvement and Treatment Outcome Within a Manual-Based Cognitive-Behavioral Treatment for Children With Anxiety. *Journal of Consulting and Clinical Psychology*, *72*(5), 821–829. https://doi.org/10.1037/0022-006X.72.5.821

Chu, B. C., & Kendall, P. C. (2009). Therapist responsiveness to child engagement: flexibility within manual-based CBT for anxious youth. *Journal of Clinical Psychology*, *65*(7), 736–754. https://doi.org/10.1002/jclp.20582

Cicchetti, D. V. (1994). Guidelines, Criteria, and Rules of Thumb for Evaluating Normed and Standardized Assessment Instruments in Psychology. *Psychological Assessment*, *6*(4), 284–

290. https://doi.org/10.1037/1040-3590.6.4.284

Clarke, W., Turner, K., & Guzman, L. (2017). *One Quarter of Hispanic Children in the United States Have an Unauthorized Immigrant Parent*.

Coatsworth, J. D., Hemady, K. T., & George, M. W. (2018). Predictors of Group Leaders' Perceptions of Parents' Initial and Dynamic Engagement in a Family Preventive Intervention. *Prevention Science*, *19*(5), 609–619. https://doi.org/10.1007/s11121-017-0781-5

Cohen, J. A., & Mannarino, A. P. (2015). Trauma-focused Cognitive Behavior Therapy for Traumatized Children and Families. *Child and Adolescent Psychiatric Clinics of North America*, *24*(3), 557–570. https://doi.org/10.1016/j.chc.2015.02.005

Coletti, D. J., Pappadopulos, E., Katsiotas, N. J., Berest, A., Jensen, P. S., & Kafantaris, V. (2012). Parent perspectives on the decision to initiate medication treatment of attention-deficit/hyperactivity disorder. *Journal of Child and Adolescent Psychopharmacology*, *22*(3), 226–237. https://doi.org/10.1089/cap.2011.0090

Comer, J. S., Chow, C., Chan, P. T., Cooper-Vince, C., & Wilson, L. A. S. (2013). Psychosocial treatment efficacy for disruptive behavior problems in very young children: A meta-analytic examination. *Journal of the American Academy of Child and Adolescent Psychiatry*, *52*(1), 26–36. https://doi.org/10.1016/j.jaac.2012.10.001

Cordaro, M., Tubman, J. G., Wagner, E. F., & Morris, S. L. (2012). Treatment Process Predictors of Program Completion or Dropout among Minority Adolescents Enrolled in a Brief Motivational Substance Abuse Intervention. *Journal of Child and Adolescent Substance Abuse*, *21*(1), 51–68. https://doi.org/10.1080/1067828X.2012.636697

Coulter, & Collins, P. A. (2011). Making shared decision making a reality. No decision about

me, without me. *The Kings Fund*, 1–56.

Curtis, L. C., Wells, S. M., Penney, D. J., Ghose, S. S., Mistler, L. A., Mahone, I. H., Delphin-Rittmon, M., del Vecchio, P., & Lesko, S. (2010). Pushing the envelope: Shared decision making in mental health. *Psychiatric Rehabilitation Journal*, *34*(1), 14–22. https://doi.org/10.2975/34.1.2010.14.22

Data USA. (2019). https://datausa.io

Davis, C. C., Claudius, M., Palinkas, L. A., Wong, J. B., & Leslie, L. K. (2012). Putting Families in the Center: Family Perspectives on Decision Making and ADHD and Implications for ADHD Care. *Journal of Attention Disorders*, *16*(8), 675–684. https://doi.org/10.1177/1087054711413077

de Greef, M., Pijnenburg, H. M., van Hattum, M. J. C., McLeod, B. D., & Scholte, R. H. J. (2017). Parent-Professional Alliance and Outcomes of Child, Parent, and Family Treatment: A Systematic Review. *Journal of Child and Family Studies*, *26*(4), 961–976. https://doi.org/10.1007/s10826-016-0620-5

de Haan, A. M., Boon, A. E., de Jong, J. T. V. M., Hoeve, M., & Vermeiren, R. R. J. M. (2013). A meta-analytic review on treatment dropout in child and adolescent outpatient mental health care. *Clinical Psychology Review*, *33*(5), 698–711. https://doi.org/10.1016/j.cpr.2013.04.005

Deber, R. B. (1994). Physicians in health care management: 7. The patient-physician partnership: changing roles and the desire for information. *CMAJ : Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, *151*(2), 171–176.

Deegan, P. E., & Drake, R. E. (2006). Shared Decision Making and Medication Management in the Recovery Process. *Psychiatric Services*, *57*(11), 1636–1639.

https://doi.org/10.1176/ps.2006.57.11.1636

Dickson, K. S., Zeedyk, S. M., Martinez, J., & Haine-Schlagel, R. (2017). Examining ethnic disparities in provider and parent in-session participation engagement. *Journal of Children's Services*, *12*(1), 47–58. https://doi.org/10.1108/JCS-12-2016-0022

Dixon, L. B., Holoshitz, Y., & Nossel, I. (2016). Treatment engagement of individuals experiencing mental illness: Review and update. *World Psychiatry*, *15*(1), 13–20. https://doi.org/10.1002/wps.20306

Dorsey, S., Conover, K. L., & Revillion Cox, J. (2014). Improving Foster Parent Engagement: Using Qualitative Methods to Guide Tailoring of Evidence-Based Engagement Strategies. *Journal of Clinical Child and Adolescent Psychology*, *43*(6), 877–889. https://doi.org/10.1080/15374416.2013.876643

Dowell, K. a, & Ogles, B. M. (2010). The Effects of Parent Participation on Child Psychotherapy Outcome: A Meta-Analytic Review. *Journal of Clinical Child & Adolescent Psychology*, *39*(2), 151–162. https://doi.org/10.1080/15374410903532585

Drake, R. E., Deegan, P. E., & Rapp, C. (2010). The promise of shared decision making in mental health. *Psychiatric Rehabilitation Journal*, *34*(1), 7–13. https://doi.org/10.2975/34.1.2010.7.13

Duncan, E., Best, C., & Hagen, S. (2008). Shared decision making interventions for people with mental health conditions. In E. Duncan (Ed.), *Cochrane Database of Systematic Reviews* (Issue 1, p. CD007297). John Wiley & Sons, Ltd. https://doi.org/10.1002/14651858.CD007297

Durand, M. A., Carpenter, L., Dolan, H., Bravo, P., Mann, M., Bunn, F., & Elwyn, G. (2014). Do interventions designed to support shared decision- making reduce health inequalities? A

systematic review and meta-analysis. *PLoS ONE*, *9*(4). https://doi.org/10.1371/journal.pone.0094670

Eckshtain, D., Kuppens, S., Ugueto, A., Ng, M. Y., Vaughn-Coaxum, R., Corteselli, K., & Weisz, J. R. (2020). Meta-Analysis: 13-Year Follow-up of Psychotherapy Effects on Youth Depression. *Journal of the American Academy of Child & Adolescent Psychiatry*, *59*(1), 45–63. https://doi.org/10.1016/j.jaac.2019.04.002

Edbrooke-Childs, J., Jacob, J., Argent, R., Patalay, P., Deighton, J., & Wolpert, M. (2015). The relationship between child- and parent-reported shared decision making and child-, parent-, and clinician-reported treatment outcome in routinely collected child mental health services data. *Clinical Child Psychology and Psychiatry*, *21*(2), 324–338. https://doi.org/10.1177/1359104515591226

Edwards, A., & Elwyn, G. (2006). Inside the black box of shared decision making: Distinguishing between the process of involvement and who makes the decision. *Health Expectations*, *9*(4), 307–320. https://doi.org/10.1111/j.1369-7625.2006.00401.x

Elster, A., Jarosik, J., VanGeest, J., & Fleming, M. (2003). Racial and ethnic disparities in health care for adolescents: a systematic review of the literature. *Archives of Pediatrics & Adolescent Medicine*, *157*(9), 867–874.

Elvins, R., & Green, J. (2008). The conceptualization and measurement of therapeutic alliance: An empirical review. *Clinical Psychology Review*, *28*(7), 1167–1187. https://doi.org/10.1016/j.cpr.2008.04.002

Elwyn, G., Durand, M. A., Song, J., Aarts, J., Barr, P. J., Berger, Z., Cochran, N., Frosch, D., Galasiski, D., Gulbrandsen, P., Han, P. K. J., Härter, M., Kinnersley, P., Lloyd, A., Mishra, M., Perestelo-Perez, L., Scholl, I., Tomori, K., Trevena, L., … Van Der Weijden, T. (2017).

A three-talk model for shared decision making: Multistage consultation process. *BMJ (Online)*, *359*, 1–7. https://doi.org/10.1136/bmj.j4891

Elwyn, G., Tsulukidze, M., Edwards, A., Légaré, F., & Newcombe, R. (2013). Using a "talk" model of shared decision making to propose an observation-based measure: Observer OPTION5 Item. *Patient Education and Counseling*, *93*(2), 265–271. https://doi.org/10.1016/j.pec.2013.08.005

Emanuel, E. J., & Emanuel, L. L. (1992). Four Models of the Physician-Patient Relationship. *JAMA: The Journal of the American Medical Association*, *267*(16), 2221–2226. https://doi.org/10.1001/jama.1992.03480160079038

Evans, S. W., Owens, J. S., Wymbs, B. T., & Ray, A. R. (2017). Evidence-Based Psychosocial Treatments for Children and Adolescents With Attention Deficit/Hyperactivity Disorder. *Journal of Clinical Child & Adolescent Psychology*, *47*(2), 1–42. https://doi.org/10.1080/15374416.2017.1390757

Eyberg, S. M., & Funderburk, B. (2011). *PCIT: Parent-child Interaction Therapy Protocol: 2011*. PCIT International, Incorporated.

Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. *Journal of Clinical Child and Adolescent Psychology*, *37*(1), 215–237. https://doi.org/10.1080/15374410701820117

Falicov, C. J. (1998). *Latino families in therapy: A guide to multicultural practice.* Guilford Press.

Fawley-King, K., Haine-Schlagel, R., Trask, E. V., Zhang, J., & Garland, A. F. (2013). Caregiver Participation in Community-Based Mental Health Services for Children Receiving Outpatient Care. *The Journal of Behavioral Health Services & Research*, *40*(2),

180–190. https://doi.org/10.1007/s11414-012-9311-1

Fernandez, M. A., & Eyberg, S. M. (2009). Predicting treatment and follow-up attrition in parent-child interaction therapy. *Journal of Abnormal Child Psychology*, *37*(3), 431–441. https://doi.org/10.1007/s10802-008-9281-1

Fiks, A. G., Mayne, S., Localio, A. R., Feudtner, C., Alessandrini, E. A., & Guevara, J. P. (2012). Shared decision making and behavioral impairment: a national study among children with special health care needs. *BMC Pediatrics*, *12*(1), 153. https://doi.org/10.1186/1471-2431-12-153

Flicker, S. M., Turner, C. W., Waldron, H. B., Brody, J. L., & Ozechowski, T. J. (2008). Ethnic Background, Therapeutic Alliance, and Treatment Retention in Functional Family Therapy With Adolescents Who Abuse Substances. *Journal of Family Psychology*, *22*(1), 167–170. https://doi.org/10.1037/0893-3200.22.1.167

Flores, A., Lopez, M. H., & Krogstad, J. M. (2019). US Hispanic population reached new high in 2018, but growth has slowed. *Pew Research Center. Retrieved July*, *22*, 2019.

Foxen, P. (2016). Mental Health Services for Latino Youth: Bridging Culture and Evidence. In *National Council of La Raza*.

Fukui, S., Salyers, M. P., Matthias, M. S., Collins, L., Thompson, J., Coffman, M., & Torrey, W. C. (2014). Predictors of shared decision making and level of agreement between consumers and providers in psychiatric care. *Community Mental Health Journal*, *50*(4), 375–382. https://doi.org/10.1007/s10597-012-9584-0

Garcia, J. A., & Weisz, J. R. (2002). When youth mental health care stops: Therapeutic relationship problems and other reasons for ending youth outpatient treatment. *Journal of Consulting and Clinical Psychology*, *70*(2), 439–443. https://doi.org/10.1037/0022-

006X.70.2.439

Garland, A., Brookman-Frazee, L., & McLeod, B. (2008). Scoring manual for the PRAC study therapy process observational coding system for child psychotherapy: strategies scale. *San Diego: Child and Adolescent Services Research Center*.

Garland, A. F., Bickman, L., & Chorpita, B. F. (2010). Change what? Identifying quality improvement targets by investigating usual mental health care. *Administration and Policy in Mental Health and Mental Health Services Research*, *37*(1–2), 15–26. https://doi.org/10.1007/s10488-010-0279-y

Garland, Ann, Brookman-Frazee, L., Hurlburt, M., Accurso, E., Zoffness, R., Haine-Schlagel, R., & Ganger, W. (2010). Mental Health Care for Children With Disruptive Behavior Problems: A View Inside Therapists' Offices. *Psychiatric Services*, *61*(8). https://doi.org/10.1176/appi.ps.61.8.788

Geessink, N. H., Ofstad, E. H., Olde Rikkert, M. G. M., van Goor, H., Kasper, J., & Schoon, Y. (2018). Shared decision-making in older patients with colorectal or pancreatic cancer: Determinants of patients' and observers' perceptions. *Patient Education and Counseling*, *101*(10), 1767–1774. https://doi.org/10.1016/j.pec.2018.06.005

Georgiades, K., Paksarian, D., Rudolph, K. E., & Merikangas, K. R. (2018). Prevalence of Mental Disorder and Service Use by Immigrant Generation and Race/Ethnicity Among U.S. Adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, *57*(4), 280-287.e2. https://doi.org/10.1016/j.jaac.2018.01.020

Glaser, B. G., Strauss, A. L., & Strutzel, E. (1968). The Discovery of Grounded Theory; Strategies for Qualitative Research. In *Nursing Research* (Vol. 17, Issue 4, p. 364). https://doi.org/10.1097/00006199-196807000-00014

Golnik, A., Maccabee-Ryaboy, N., Scal, P., Wey, A., & Gaillard, P. (2012). Shared decision making: Improving Care for children with Autism. *Intellectual and Developmental Disabilities*, *50*(4), 322–331. https://doi.org/10.1352/1934-9556-50.4.322

Gondek, D., Edbrooke-Childs, J., Velikonja, T., Chapman, L., Saunders, F., Hayes, D., & Wolpert, M. (2017). Facilitators and Barriers to Person-centred Care in Child and Young People Mental Health Services: A Systematic Review. *Clinical Psychology and Psychotherapy*, *24*(4), 870–886. https://doi.org/10.1002/cpp.2052

Gopalan, G., Goldstein, L., Klingenstein, K., Sicher, C., Blake, C., & McKay, M. M. (2010). Engaging Families into Child Mental Health Treatment: Updates and Special Considerations. *Journal of the Canadian Academy of Child and Adolescent Psychiatry = Journal de l'Academie Canadienne de Psychiatrie de l'enfant et de l'adolescent*, *19*(3), 182–196.

Green, J. (2006). Annotation: The therapeutic alliance - A significant but neglected variable in child mental health treatment studies. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *47*(5), 425–435. https://doi.org/10.1111/j.1469-7610.2005.01516.x

Guan, K., Kim, R. E., Rodas, N. V, Brown, T. E., Gamarra, J. M., Krull, J. L., & Chorpita, B. F. (2018). Emergent Life Events: An In-Depth Investigation of Characteristics and Provider Responses during Youth Evidence-Based Treatment. *Journal of Clinical Child & Adolescent Psychology*, *00*(00), 1–16. https://doi.org/10.1080/15374416.2018.1496441org/10.1080/15374416.2018.1496441

Guan, K., Lau, A. S., Zhang, A., Chlebowski, C., Haine-Schlagel, R., & Brookman-Frazee, L. (2019). In-Session Caregiver Behaviors during Evidence-Based Intervention Delivery for Children with ASD in Community Mental Health Services. *Evidence-Based Practice in*

Child and Adolescent Mental Health, *4*(1), 55–71. https://doi.org/10.1080/23794925.2019.1565500

Guan, K., Levy, M. C., Kim, R. E., Brown, T. E., Reding, M. E. J., Rith-Najarian, L., Sun, M., Lau, A. S., & Chorpita, B. F. (2017). Managing In-Session "Surprises:" Provider Responses to Emergent Life Events during Evidence-Based Treatment Implementation. *Administration and Policy in Mental Health and Mental Health Services Research*, *44*(2), 164–176. https://doi.org/10.1007/s10488-015-0692-3

Guan, K., Park, A. L., & Chorpita, B. F. (2017). Emergent Life Events During Youth Evidence-Based Treatment: Impact on Future Provider Adherence and Clinical Progress. *Journal of Clinical Child and Adolescent Psychology*, *0*(0), 1–13. https://doi.org/10.1080/15374416.2017.1295382

Guille, C., Jones, H. E., Abuhamad, A., & Brady, K. T. (2019). Shared Decision-Making Tool for Treatment of Perinatal Opioid Use Disorder. *Psychiatric Research and Clinical Practice*, *1*(1), 27–31. https://doi.org/10.1176/appi.prcp.20180004

Haine-Schlagel, R., Fettes, D. L., Finn, N., Hurlburt, M., & Aarons, G. A. (2020). Parent and Caregiver Active Participation Toolkit (PACT): Adaptation for a Home Visitation Program. *Journal of Child and Family Studies*, *29*(1), 29–43. https://doi.org/10.1007/s10826-019-01659-3

Haine-Schlagel, R., Martinez, J. I., Roesch, S. C., Bustos, C. E., & Janicki, C. (2016). Randomized Trial of the Parent And Caregiver Active Participation Toolkit for Child Mental Health Treatment. *Journal of Clinical Child and Adolescent Psychology*, *00*(00), 1–11. https://doi.org/10.1080/15374416.2016.1183497

Haine-Schlagel, R., & Walsh, N. E. (2015). A Review of Parent Participation Engagement in

Child and Family Mental Health Treatment. *Clinical Child and Family Psychology Review*, *18*(2), 133–150. https://doi.org/10.1007/s10567-015-0182-x

Hale, K. L., Wallace, D. D., Blanco-Durán, D., Annis, I. E., Guzman, L. E., García, S. J., Pérez Jolles, M., Sleath, B. L., Elwyn, G., Stein, G. L., & Thomas, K. C. (2019). Conversations between Latina mothers and their child's mental health provider: An observational study of shared decision-making regarding pediatric patient mental health needs. *Patient Education and Counseling*. https://doi.org/10.1016/j.pec.2019.08.013

Hamann, J., & Heres, S. (2019). Why and how family caregivers should participate in shared decision making in mental health. *Psychiatric Services*, *70*(5), 418–421. https://doi.org/10.1176/appi.ps.201800362

Hamann, Langer, B., Winkler, V., Busch, R., Cohen, R., Leucht, S., & Kissling, W. (2006). Shared decision making for in-patients with schizophrenia. *Acta Psychiatrica Scandinavica*, *114*(4), 265–273. https://doi.org/10.1111/j.1600-0447.2006.00798.x

Harris, N., Lovell, K., Day, J., & Roberts, C. (2009). An evaluation of a medication management training programme for community mental health professionals; service user level outcomes. A cluster randomised controlled trial. *International Journal of Nursing Studies*, *46*(5), 645–652. https://doi.org/10.1016/j.ijnurstu.2008.10.010

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research*, *16*(1), 12–25. https://doi.org/10.1080/10503300500352500

Hawley, K. M., & Garland, A. F. (2008). Working alliance in adolescent outpatient therapy: Youth, parent and therapist reports and associations with therapy outcomes. *Child and Youth Care Forum*, *37*(2), 59–74. https://doi.org/10.1007/s10566-008-9050-x

Hawley, K. M., & Weisz, J. R. (2003). Child, parent, and therapist (dis)agreement on target problems in outpatient therapy: The therapist's dilemma and its implications. *Journal of Consulting and Clinical Psychology*, *71*(1), 62–70. https://doi.org/10.1037/0022-006X.71.1.62

Hawley, K. M., & Weisz, J. R. (2005). Youth Versus Parent Working Alliance in Usual Clinical Care: Distinctive Associations With Retention, Satisfaction, and Treatment Outcome. *Journal of Clinical Child & Adolescent Psychology*, *34*(1), 117–128. https://doi.org/10.1207/s15374424jccp3401_11

Hawley, & Morris, A. M. (2017). Cultural challenges to engaging patients in shared decision making. *Patient Education and Counseling*, *100*(1), 18–24. https://doi.org/10.1016/j.pec.2016.07.008

Hayes, A. F. (2006). A Primer on Multilevel Modeling. *Human Communication Research*, *32*(4), 385–410. https://doi.org/10.1111/j.1468-2958.2006.00281.x

He, Y., Gewirtz, A., Lee, S., Morrell, N., & August, G. (2016). A randomized preference trial to inform personalization of a parent training program implemented in community mental health clinics. *Translational Behavioral Medicine*, *6*(1), 73–80. https://doi.org/10.1007/s13142-015-0366-4

Heflinger, C. A., & Hinshaw, S. P. (2010). Stigma in child and adolescent mental health services research: Understanding professional and institutional stigmatization of youth with mental health problems and their families. *Administration and Policy in Mental Health and Mental Health Services Research*, *37*(1–2), 61–70. https://doi.org/10.1007/s10488-010-0294-z

Hetrick, S., Simmons, M., & Merry, S. (2008). SSRIs and depression in children and adolescents: The imperative for shared decision-making. *Australasian Psychiatry*, *16*(5),

354–358. https://doi.org/10.1080/10398560802189888

Hibbard, J. H., & Cunningham, P. J. (2008). How engaged are consumers in their health and health care, and why does it matter? In *Center for Studying Health System Change* (Issue 8).

Hinojosa, M. S., Hinojosa, R., & Nguyen, J. (2019). Shared Decision Making and Treatment for Minority Children With ADHD. *Journal of Transcultural Nursing*. https://doi.org/10.1177/1043659619853021

Hofmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research*, *36*(5), 427–440. https://doi.org/10.1007/s10608-012-9476-1

Hubner, L. M., Feldman, H. M., & Huffman, L. C. (2016). Parent-reported shared decision making: Autism spectrum disorder and other neurodevelopmental disorders. *Journal of Developmental and Behavioral Pediatrics*, *37*(1), 20–32. https://doi.org/10.1097/DBP.0000000000000242

Huey, S. J., & Polo, A. J. (2008). Evidence-Based Psychosocial Treatments for Ethnic Minority Youth. *Journal of Clinical Child & Adolescent Psychology*, *257*(5), 2432–2437. https://doi.org/10.1016/j.immuni.2010.12.017.Two-stage

Huffman, L. C. (2018). Shared Decision Making in the Care of Children with Autism Spectrum Disorder. *Journal of Developmental & Behavioral Pediatrics*, *55*(5), 1. https://doi.org/10.1097/DBP.0000000000000582

Ingoldsby, E. M. (2010). Review of Interventions to Improve Family Engagement and Retention in Parent and Child Mental Health Programs. *Journal of Child and Family Studies*, *19*(5), 629–645. https://doi.org/10.1007/s10826-009-9350-2

Institute of Medicine. (2006). Improving the Quality of Health Care for Mental and Substance-

Use Conditions. In *Health Care* (Vol. 12, Issue 7). The National Academies Press. https://doi.org/10.17226/11470

Institute of Medicine & Committee on Quality of Health Care in America. (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. In *BMJ : British Medical Journal* (Vol. 323, Issue 7322). https://doi.org/10.1136/bmj.323.7322.1192

Jager, M., Reijneveld, S. A., Almansa, J., Metselaar, J., Knorth, E. J., & De Winter, A. F. (2017). Less reduction of psychosocial problems among adolescents with unmet communication needs. *European Child and Adolescent Psychiatry*, *26*(4), 403–412. https://doi.org/10.1007/s00787-016-0901-y

James, K., & Quirk, A. (2017). The rationale for shared decision making in mental health care: A systematic review of academic discourse. *Mental Health Review Journal*, *22*(3), 152–165. https://doi.org/10.1108/MHRJ-01-2017-0009

Jensen-Doss, A., Hawley, K. M., Lopez, M., & Osterberg, L. D. (2009). Using Evidence-Based Treatments: The Experiences of Youth Providers Working Under a Mandate. *Professional Psychology: Research and Practice*, *40*(4), 417–424. https://doi.org/10.1037/a0014690

Jensen, T. K., Haavind, H., Gulbrandsen, W., Mossige, S., Reichelt, S., & Tjersland, O. A. (2010). What constitutes a good working alliance in therapy with children that may have been sexually abused? *Qualitative Social Work*, *9*(4), 461–478. https://doi.org/10.1177/1473325010374146

Jolles, M. P., Lee, P. J., & Javier, J. (2018). Shared decision-making and parental experiences with health services to meet their child's special health care needs: Racial and ethnic disparities. *Patient Education and Counseling*, *101*(10), 1753–1760. https://doi.org/10.1016/j.pec.2018.05.022

Joosten, E. A. G., de Weert, G. H., Sensky, T., van der Staak, C. P. F., & de Jong, C. A. J. (2008). Effect of shared decision-making on therapeutic alliance in addiction health care. *Patient Preference and Adherence*, *2*, 277–285. https://doi.org/10.2147/PPA.S4149

Kaminski, J. W., & Claussen, A. H. (2017). Evidence Base Update for Psychosocial Treatments for Disruptive Behaviors in Children. *Journal of Clinical Child & Adolescent Psychology*, *46*(4), 477–499. https://doi.org/10.1080/15374416.2017.1310044

Kapke, T. L., & Gerdes, A. C. (2016). Latino Family Participation in Youth Mental Health Services: Treatment Retention, Engagement, and Response. *Clinical Child and Family Psychology Review*. https://doi.org/10.1007/s10567-016-0213-2

Karver, M. S., De Nadai, A. S., Monahan, M., & Shirk, S. R. (2018). Meta-analysis of the prospective relation between alliance and outcome in child and adolescent psychotherapy. *Psychotherapy*, *55*(4), 341–355. https://doi.org/10.1037/pst0000176

Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2006). Meta-analysis of therapeutic relationship variables in youth and family therapy: The evidence for different relationship variables in the child and adolescent treatment outcome literature. *Clinical Psychology Review*, *26*(1), 50–65. https://doi.org/10.1016/j.cpr.2005.09.001

Kazdin, A. E., Whitley, M., & Marciano, P. L. (2006). Child-therapist and parent-therapist alliance and therapeutic change in the treatment of children referred for oppositional, aggressive, and antisocial behavior. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *47*(5), 436–445. https://doi.org/10.1111/j.1469-7610.2005.01475.x

Kendall, P. C., Gosch, E., Furr, J. M., & Sood, E. (2008). Flexibility Within Fidelity. *Journal of the American Academy of Child & Adolescent Psychiatry*, *47*(9), 987–993. https://doi.org/10.1097/CHI.ObO13e31817eed2f

Kim, R. E., Lau, A. S., & Chorpita, B. F. (2016). The Impact of Latino Caregiver Acculturation on Treatment Engagement in Children's Community Mental Health Services. *Journal of Child and Family Studies*, *25*(3), 891–901. https://doi.org/10.1007/s10826-015-0259-7

Kiser, L. J., Miller, A. B., Mooney, M. A., Vivrette, R., & Davis, S. R. (2020). Integrating parents with trauma histories into child trauma treatment: Establishing core components. *Practice Innovations*, *5*(1), 65–80. https://doi.org/10.1037/pri0000109

Kölker, M., Topp, J., Elwyn, G., Härter, M., & Scholl, I. (2018). Psychometric properties of the German version of Observer OPTION 5. *BMC Health Services Research*, *18*(1), 1–8. https://doi.org/10.1186/s12913-018-2891-6

Kon, A. A. (2010). The Shared Decision-Making Continuum. *JAMA*, *304*(8), 903. https://doi.org/10.1001/jama.2010.1208

Langer, D. A., Holly, L. E., Wills, C. E., Tompson, M. C., & Chorpita, B. F. (2021). Shared Decision-Making for Youth Psychotherapy: A Preliminary Randomized Clinical Trial on Facilitating Personalized Treatment. *Journal of Consulting and Clinical Psychology*, *90*(1), 29–38. https://doi.org/10.1037/ccp0000702

Langer, D. A., & Jensen-Doss, A. (2018). Shared Decision-Making in Youth Mental Health Care: Using the Evidence to Plan Treatments Collaboratively. *Journal of Clinical Child & Adolescent Psychology*, 1–11. https://doi.org/10.1080/15374416.2016.1247358

Lau, A., Barnett, M., Stadnick, N., Saifan, D., Regan, J., Wiltsey Stirman, S., Roesch, S., & Brookman-Frazee, L. (2017). Therapist report of adaptations to delivery of evidence-based practices within a system-driven reform of publicly funded children's mental health services. *Journal of Consulting and Clinical Psychology*, *85*(7), 664–675. https://doi.org/10.1037/ccp0000215

Lau, A. S., & Brookman-Frazee, L. (2016). The 4KEEPS study: identifying predictors of sustainment of multiple practices fiscally mandated in children's mental health services. *Implementation Science*, *11*(1), 31. https://doi.org/10.1186/s13012-016-0388-4

Law, D. (2011). Goal Based Outcomes (GBOs): Some useful information. *Intenal CORC Publication, Avaliable at Http://Www. Corc. Uk. Net Google Scholar*.

Lawton, K. E., & Gerdes, A. C. (2014). Acculturation and Latino Adolescent Mental Health: Integration of Individual, Environmental, and Family Influences. *Clinical Child and Family Psychology Review*, *17*(4), 385–398. https://doi.org/10.1007/s10567-014-0168-0

Leenarts, L. E. W., Diehle, J., Doreleijers, T. A. H., Jansma, E. P., & Lindauer, R. J. L. (2013). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: A systematic review. *European Child and Adolescent Psychiatry*, *22*(5), 269–283. https://doi.org/10.1007/s00787-012-0367-5

Levin, L., Henderson, H. A., & Ehrenreich-May, J. (2012). Interpersonal predictors of early therapeutic alliance in a transdiagnostic cognitive-behavioral treatment for adolescents with anxiety and depression. *Psychotherapy*, *49*(2), 218–230. https://doi.org/10.1037/a0028265

Liber, J. M., McLeod, B. D., Van Widenfelt, B. M., Goedhart, A. W., van der Leeden, A. J. M., Utens, E. M. W. J., & Treffers, P. D. a. (2010). Examining the Relation Between the Therapeutic Alliance , Treatment Adherence , and Outcome of Cognitive Behavioral Therapy for Children With Anxiety Disorders. *Behavior Therapy*, *41*(2), 172–186. https://doi.org/10.1016/j.beth.2009.02.003

Lieberman, A. F. (2004). Child-Parent Psychotherapy: A Relationship-Based Approach to the Treatment of Mental Health Disorders in Infancy and Early Childhood. In *Treating parent-infant relationship problems: Strategies for intervention.* (pp. 97–122). Guilford Press.

Lipstein, E. A., Brinkman, W. B., & Britto, M. T. (2012). What is known about parents' treatment decisions? A narrative review of pediatric decision making. *Medical Decision Making*, *32*(2), 246–258. https://doi.org/10.1177/0272989X11421528

Liverpool, S., Hayes, D., & Edbrooke-Childs, J. (2021). Parent/Carer-Reported Experience of Shared Decision Making at Child and Adolescent Mental Health Services: A Multilevel Modelling Approach. *Frontiers in Psychiatry*, *12*(July). https://doi.org/10.3389/fpsyt.2021.676721

Liverpool, S., Webber, H., Matthews, R., Wolpert, M., & Edbrooke-Childs, J. (2019). A Mobile App to Support Parents Making Child Mental Health Decisions: Protocol for a Feasibility Cluster Randomized Controlled Trial. *JMIR Research Protocols*, *8*(8), e14571. https://doi.org/10.2196/14571

Loh, A., Leonhart, R., Wills, C. E., Simon, D., & Härter, M. (2007). The impact of patient participation on adherence and clinical outcome in primary care of depression. *Patient Education and Counseling*, *65*(1), 69–78. https://doi.org/10.1016/j.pec.2006.05.007

Loh, A., Simon, D., Wills, C. E., Kriston, L., Niebling, W., & Härter, M. (2007). The effects of a shared decision-making intervention in primary care of depression: A cluster-randomized controlled trial. *Patient Education and Counseling*, *67*(3 SPEC. ISS.), 324–332. https://doi.org/10.1016/j.pec.2007.03.023

Los Angeles County Department of Mental Health. (2016). *TRAINING PROTOCOLS FOR PREVENTION AND EARLY INTERVENTION PRACTICES*.

Ludman, E., Katon, W., Bush, T., Rutter, C., Lin, E., Simon, G., von Korff, M., & Walker, E. (2003). Behavioural factors associated with symptom outcomes in a primary care-based depression prevention intervention trial. *Psychological Medicine*, *33*(6), 1061–1070.

https://doi.org/10.1017/S003329170300816X

Mak, L., Hiebert-Murphy, D., Walker, J. R., & Altman, G. (2014). Parents' Decision Making and Their Information Needs Concerning Treatments for Child Anxiety: Implications for Family-Centered Practice. *Journal of Family Social Work*, *17*(1), 51–67. https://doi.org/10.1080/10522158.2013.809671

Matthias, M. S., Fukui, S., Kukla, M., Eliacin, J., Bonfils, K. A., Firmin, R. L., Oles, S. K., Adams, E. L., Collins, L. A., & Salyers, M. P. (2014). Consumer and Relationship Factors Associated With Shared Decision Making in Mental Health Consultations. *Psychiatric Services*, *65*(12), 1488–1491. https://doi.org/10.1176/appi.ps.201300563

Mattos, L. A., Schmidt, A. T., Henderson, C. E., & Hogue, A. (2017). Therapeutic alliance and treatment outcome in the outpatient treatment of urban adolescents: The role of callous–unemotional traits. *Psychotherapy*, *54*(2), 136–147. https://doi.org/10.1037/pst0000093

McCabe, K. M. (2002). Factors That Predict Premature Termination Among Mexican-American Children in Outpatient Psychotherapy. *Journal of Child and Family Studies*, *11*(3), 347–359. https://doi.org/10.1023/A:1016876224388

McCart, M. R., & Sheidow, A. J. (2016). Evidence-Based Psychosocial Treatments for Adolescents With Disruptive Behavior. *Journal of Clinical Child and Adolescent Psychology*, *45*(5), 529–563. https://doi.org/10.1080/15374416.2016.1146990

McLeod, B. D. (2011). Relation of the alliance with outcomes in youth psychotherapy: A meta-analysis. *Clinical Psychology Review*, *31*(4), 603–616. https://doi.org/10.1016/j.cpr.2011.02.001

McLeod, B. D., Cecilione, J., Jensen-Doss, A., Southam-Gerow, M. A., & Kendall, P. C. (2021). Reliability, factor structure, and validity of an observer-rated alliance scale with youth.

Psychological Assessment, *33*(10), 1013–1023. https://doi.org/10.1037/pas0001036

McLeod, B. D., Southam-Gerow, M. A., & Kendall, P. C. (2017). Observer, youth, and therapist perspectives on the alliance in cognitive behavioral treatment for youth anxiety. *Psychological Assessment*, *29*(12), 1550–1555. https://doi.org/10.1037/pas0000465

Mennies, R. J., Birk, S. L., Norris, L. A., & Olino, T. M. (2020). The Main and Interactive Associations between Demographic Factors and Psychopathology and Treatment Utilization in Youth: A Test of Intersectionality in the ABCD Study. *Journal of Abnormal Child Psychology*, 5–17. https://doi.org/10.1007/s10802-020-00687-8

Metz, Elfeddali, I., Veerbeek, M., De Beurs, E., Beekman, A., & Van der Feltz-Cornelis, C. (2018). Effectiveness of a multi-facetted blended eHealth intervention during intake supporting patients and clinicians in Shared Decision Making: A cluster randomised controlled trial in a specialist mental health outpatient setting. *PLoS ONE*, *13*(6), 1–18. https://doi.org/10.1371/journal.pone.0199795

Metz, Veerbeek, M. A., Twisk, J. W. R., van der Feltz-Cornelis, C. M., de Beurs, E., & Beekman, A. T. F. (2019). Shared decision-making in mental health care using routine outcome monitoring: results of a cluster randomised-controlled trial. *Social Psychiatry and Psychiatric Epidemiology*, *54*(2), 209–219. https://doi.org/10.1007/s00127-018-1589-8

Morant, N., Kaminskiy, E., & Ramon, S. (2016). Shared decision making for psychiatric medication management: beyond the micro-social. *Health Expectations*, *19*(5), 1002–1014. https://doi.org/10.1111/hex.12392

Mott, J. M., Stanley, M. A., Street, R. L., Grady, R. H., & Teng, E. J. (2014). Increasing Engagement in Evidence-Based PTSD Treatment Through Shared Decision-Making: A Pilot Study. *Military Medicine*, *179*(2), 143–149. https://doi.org/10.7205/MILMED-D-13-

00363

Mukolo, A., Heflinger, C. A., & Wallston, K. A. (2010). The Stigma of Childhood Mental Disorders: A Conceptual Framework. *Journal of the American Academy of Child and Adolescent Psychiatry*, *49*(2), 92–103. https://doi.org/10.1097/00004583-201002000-00003

Murphy, A., Gardner, D., Kutcher, S., Davidson, S., & Manion, I. (2010). Collaborating with youth to inform and develop tools for psychotropic decision making. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *19*(4), 256–263.

Murphy, & Hutton, P. (2018). Practitioner Review: Therapist variability, patient-reported therapeutic alliance, and clinical outcomes in adolescents undergoing mental health treatment – a systematic review and meta-analysis. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *59*(1), 5–19. https://doi.org/10.1111/jcpp.12767

Muthén, L. K., & Muthén, B. O. (2005). *Mplus: Statistical analysis with latent variables: User's guide*. Muthén & Muthén Los Angeles.

National Institute of Mental Health. (2001). *Blueprint for change: Research on Child and Adolescent Mental Health's Council's Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment*.

Nock, M. K., & Ferriter, C. (2005). Parent Management of Attendance and Adherence in Child and Adolescent Therapy: A Conceptual and Empirical Review. *Clinical Child and Family Psychology Review*, *8*(2), 149–166. https://doi.org/10.1007/s10567-005-4753-0

Nock, M. K., & Kazdin, A. E. (2005). Randomized controlled trial of a brief intervention for increasing participation in parent management training. *Journal of Consulting and Clinical Psychology*, *73*(5), 872–879. https://doi.org/10.1037/0022-006X.73.5.872

O'Brien, M. S., Crickard, E. L., Rapp, C. A., Holmes, C. L., & McDonald, T. P. (2011). Critical

issues for psychiatric medication shared decision making with youth and families. *Families in Society*, *92*(3), 310–316. https://doi.org/10.1606/1044-3894.4135

O'Neal, C. W., Quichocho, D., Burke, B., & Lucier-Greer, M. (2022). Case Management in Community Mental Health Centers: Staffing Considerations that Account for Client and Agency Context. *Children and Youth Services Review*, *135*(January 2021), 106387. https://doi.org/10.1016/j.childyouth.2022.106387

Ormhaug, S. M., & Jensen, T. K. (2018). Investigating treatment characteristics and first-session relationship variables as predictors of dropout in the treatment of traumatized youth. *Psychotherapy Research*, *28*(2), 235–249. https://doi.org/10.1080/10503307.2016.1189617

Park, A. L., Moskowitz, A. L., & Chorpita, B. F. (2018). Community-Based Providers' Selection of Practices for Children and Adolescents With Comorbid Mental Health Problems. *Journal of Clinical Child & Adolescent Psychology*, *47*(5), 796–807. https://doi.org/10.1080/15374416.2016.1188706

Park, A. L., Tsai, K. H., Guan, K., & Chorpita, B. F. (2018). Unintended Consequences of Evidence-Based Treatment Policy Reform: Is Implementation the Goal or the Strategy for Higher Quality Care? *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(4), 649–660. https://doi.org/10.1007/s10488-018-0853-2

Paudel, S., Sharma, N., Joshi, A., & Randall, M. (2018). Development of a Shared Decision Making Model in a Community Mental Health Center. *Community Mental Health Journal*, *54*(1), 1–6. https://doi.org/10.1007/s10597-017-0134-7

Pérez-Revuelta, J., Villagrán-Moreno, J. M., Moreno-Sánchez, L., Pascual-Paño, J. M., & González-Saiz, F. (2018). Patient perceived participation in decision making on their antipsychotic treatment: Evidence of validity and reliability of the COMRADE scale in a

sample of schizophrenia spectrum disorders. *Patient Education and Counseling*, *101*(8), 1477–1482. https://doi.org/10.1016/j.pec.2018.03.018

Perez Jolles, M., Richmond, J., & Thomas, K. C. (2019). Minority patient preferences, barriers, and facilitators for shared decision-making with health care providers in the USA: A systematic review. *Patient Education and Counseling*, *102*(7), 1251–1262. https://doi.org/10.1016/j.pec.2019.02.003

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 & Adolescent Psychology*, *00*(00), 1–24. https://doi.org/10.1080/15374416.2019.1567350

Pinto, R. Z., Ferreira, M. L., Oliveira, V. C., Franco, M. R., Adams, R., Maher, C. G., & Ferreira, P. H. (2012). Patient-centred communication is associated with positive therapeutic alliance: A systematic review. *Journal of Physiotherapy*, *58*(2), 77–87. https://doi.org/10.1016/S1836-9553(12)70087-5

Polo, A. J., Alegría, M., & Sirkin, J. T. (2012). Increasing the engagement of Latinos in services through community-derived programs: The right question project-mental health. *Professional Psychology: Research and Practice*, *43*(3), 208–216. https://doi.org/10.1037/a0027730

QSR International Pty Ltd. (2020). *NVivo*.

Quetsch, L. B., Girard, E. I., & McNeil, C. B. (2020). The impact of incentives on treatment adherence and attrition: A randomized controlled trial of Parent-Child Interaction Therapy with a primarily Latinx, low-income population. *Children and Youth Services Review*, *112*(October 2019), 104886. https://doi.org/10.1016/j.childyouth.2020.104886

Ramos, G., Brookman-Frazee, L., Kodish, T., Rodriguez, A., & Lau, A. S. (2021). Community

providers' experiences with evidence-based practices: The role of therapist race/ethnicity. *Cultural Diversity and Ethnic Minority Psychology*, *27*(3), 471–482. https://doi.org/10.1037/cdp0000357

Raudenbush, S. W., & Bryk, A. S. (2002). *Hierarchical linear models: Applications and Data Analysis Methods* (2nd ed.). SAGE Publications, Inc. https://doi.org/10.2466/pms

Regan, J., Lau, A. S., Barnett, M., Stadnick, N., Hamilton, A., Pesanti, K., Bando, L., & Brookman-Frazee, L. (2017). Agency responses to a system-driven implementation of multiple evidence-based practices in children's mental health services. *BMC Health Services Research*, *17*(1), 671. https://doi.org/10.1186/s12913-017-2613-5

Regan, J., Park, A. L., & Chorpita, B. F. (2016). Choices in Treatment Integrity:Considering the Protocol and Consultant Recommendations in Child and Adolescent Therapy. *Journal of Clinical Child & Adolescent Psychology*, *00*(00), 1–11. https://doi.org/10.1080/15374416.2016.1212360

Richardson, L. P., Ludman, E., McCauley, E., Lindenbaum, J., Larison, C., Zhou, C., Clarke, G., Brent, D., & Katon, W. (2014). Collaborative care for adolescents with depression in primary care: A randomized clinical trial. *JAMA - Journal of the American Medical Association*, *312*(8), 809–816. https://doi.org/10.1001/jama.2014.9259

Robbins, M. S., Mayorga, C. C., Mitrani, V. B., Szapocznik, J., Turner, C. W., & Alexander, J. F. (2008). Adolescent and Parent Alliances With Therapists in Brief Strategic Family Therapy TM With Drug-Using Hispanic Adolescents. *Journal of Marital and Family Therapy*, *34*(3), 316–328. https://doi.org/10.1111/j.1752-0606.2008.00075.x

Rubin, R. M., Hurford, M. O., Hadley, T., Matlin, S., Weaver, S., & Evans, A. C. (2016). Synchronizing Watches: The Challenge of Aligning Implementation Science and Public

Systems. *Administration and Policy in Mental Health and Mental Health Services Research*, *43*(6), 1023–1028. https://doi.org/10.1007/s10488-016-0759-9

Ruiz, B. S., Korchmaros, J. D., Greene, A., & Hedges, K. (2011). Evidence-based substance abuse treatment for adolescents: Engagement and outcomes. *Practice*, *23*(4), 215–233. https://doi.org/10.1080/09503153.2011.597207

Ryan, R., Berry, K., Law, H., & Hartley, S. (2021). Therapeutic relationships in child and adolescent mental health services: A Delphi study with young people, carers and clinicians. *International Journal of Mental Health Nursing*, *30*(4), 1010–1021. https://doi.org/10.1111/inm.12857

Ryan, S. R., Cunningham, P. B., Foster, S. L., Brennan, P. A., Brock, R. L., & Whitmore, E. (2013). Predictors of Therapist Adherence and Emotional Bond in Multisystemic Therapy: Testing Ethnicity as a Moderator. *Journal of Child and Family Studies*, *22*(1), 122–136. https://doi.org/10.1007/s10826-012-9638-5

Salyers, M. P., Fukui, S., Bonfils, K. A., Firmin, R. L., Luther, L., Goscha, R., Rapp, C. A., & Holter, M. C. (2017). Consumer outcomes after implementing commonground as an approach to shared decision making. *Psychiatric Services*, *68*(3), 299–302. https://doi.org/10.1176/appi.ps.201500468

Samalin, L., Genty, J., Boyer, L., Lopez-Castroman, J., Abbar, M., & Llorca, P. (2018). Shared Decision-Making: a Systematic Review Focusing on Mood Disorders. *Current Psychiatry Reports*, *20*(4), 23. https://doi.org/10.1007/s11920-018-0892-0

Sanders, M. R. (1999). Triple P-Positive Parenting Program: Towards an empirically validated multilevel parenting and family support strategy for the prevention of behavior and emotional problems in children. *Clinical Child and Family Psychology Review*, *2*(2), 71–90.

https://doi.org/10.1023/A:1021843613840

Santilli, A., Duffany, K. O. C., Carroll-Scott, A., Thomas, J., Greene, A., Arora, A., Agnoli, A., Gan, G., & Ickovics, J. (2017). Bridging the response to mass shootings and urban violence: Exposure to violence in new haven, Connecticut. *American Journal of Public Health*, *107*(3), 374–379. https://doi.org/10.2105/AJPH.2016.303613

Seale, C., & Silverman, D. (1997). Ensuring rigour in qualitative research. *The European Journal of Public Health*, *7*(4), 379–384. https://doi.org/10.1093/eurpub/7.4.379

Shay, L. A., & Lafata, J. E. (2015). Where Is the Evidence? A Systematic Review of Shared Decision Making and Patient Outcomes. *Medical Decision Making*, *35*(1), 114–131. https://doi.org/10.1177/0272989X14551638

Shirk, S. R., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *71*(3), 452–464. https://doi.org/10.1037/0022-006X.71.3.452

Sibley, M. H., Graziano, P. A., Bickman, L., Coxe, S. J., Martin, P., Rodriguez, L. M., Fallah, N., & Ortiz, M. (2020). Implementing Parent-Teen Motivational Interviewing + Behavior Therapy for ADHD in Community Mental Health. *Prevention Science*, *1*. https://doi.org/10.1007/s11121-020-01105-7

Simmons, Hetrick, S. E., & Jorm, A. F. (2011). Experiences of treatment decision making for young people diagnosed with depressive disorders: a qualitative study in primary care and specialist mental health settings. *BMC Psychiatry*, *11*(1), 194. https://doi.org/10.1186/1471-244X-11-194

Simmons, Hetrick, S. E., & Jorm, A. F. (2013). Making decisions about treatment for young people diagnosed with depressive disorders: A qualitative study of clinicians' experiences.

BMC Psychiatry, *13*. https://doi.org/10.1186/1471-244X-13-335

Smalley, L. P., Kenney, M. K., Denboba, D., & Strickland, B. (2014). Family perceptions of shared decision-making with health care providers: Results of the national survey of children with special health care needs, 2009-2010. *Maternal and Child Health Journal*, *18*(6), 1316–1327. https://doi.org/10.1007/s10995-013-1365-z

Southam-Gerow, M. A., Chorpita, B. F., Miller, L. M., & Gleacher, A. A. (2008). Are Children with Anxiety Disorders Privately Referred to a University Clinic Like Those Referred from the Public Mental Health System? *Administration and Policy in Mental Health and Mental Health Services Research*, *35*(3), 168–180. https://doi.org/10.1007/s10488-007-0154-7

Stadnick, N., Haine-Schlagel, R., & Martinez, J. (2016). Using Observational Assessment to Help Identify Factors Associated with Parent Participation Engagement in Community-Based Child Mental Health Services. *Child & Youth Care Forum*, *45*(5), 745–758. https://doi.org/10.1007/s10566-016-9356-z

StataCorp. (2017). *Stata Statistical Software: Release 15*. https://doi.org/10.2307/2234838

Staudt, M. (2007). Treatment Engagement with Caregivers of At-risk Children: Gaps in Research and Conceptualization. *Journal of Child and Family Studies*, *16*(2), 183–196. https://doi.org/10.1007/s10826-006-9077-2

Stein, G. L., Cupito, A. M., Mendez, J. L., Prandoni, J., Huq, N., & Westerberg, D. (2014). Familism through a developmental lens. *Journal of Latina/o Psychology*, *2*(4), 224–250. https://doi.org/10.1037/lat0000025

Stiggelbout, A. M., Pieterse, A. H., & De Haes, J. C. J. M. (2015). Shared decision making: Concepts, evidence, and practice. *Patient Education and Counseling*, *98*(10), 1172–1179. https://doi.org/10.1016/j.pec.2015.06.022

Street, R. L. (2013). How clinician-patient communication contributes to health improvement: Modeling pathways from talk to outcome. *Patient Education and Counseling*, *92*(3), 286–291. https://doi.org/10.1016/j.pec.2013.05.004

Substance Abuse and Mental Health Services Administration. (2012). *SAMHSA's working definition of recovery*. Author Rockville, MD.

Tabachnick, B. G., Fidell, L. S., & Ullman, J. B. (2007). *Using multivariate statistics* (Vol. 5). Pearson Boston, MA.

Thompson, Bender, K., Lantry, J., & Flynn, P. M. (2007). Treatment Engagement: Building Therapeutic Alliance in Home-Based Treatment with Adolescents and their Families. *Contemporary Family Therapy*, *29*(1–2), 39–55. https://doi.org/10.1007/s10591-007-9030-6

Thompson, L., & McCabe, R. (2012). The effect of clinician-patient alliance and communication on treatment adherence in mental health care: A systematic review. *BMC Psychiatry*, *12*(1), 1. https://doi.org/10.1186/1471-244X-12-87

Tompson, M. C., Langer, D. A., Hughes, J. L., & Asarnow, J. R. (2017). Family-Focused Treatment for Childhood Depression: Model and Case Illustrations. *Cognitive and Behavioral Practice*, *24*(3), 269–287. https://doi.org/10.1016/j.cbpra.2016.06.003

Trinh, N.-H. T., Cheung, C.-Y. J., Velasquez, E. E., Alvarez, K., Crawford, C., & Alegría, M. (2019). Addressing Cultural Mistrust: Strategies for Alliance Building. In M. M. Medlock, D. Shtasel, N.-H. T. Trinh, & D. R. Williams (Eds.), *Racism and Psychiatry: Contemporary Issues and Interventions* (pp. 157–179). Springer International Publishing. https://doi.org/10.1007/978-3-319-90197-8_9

Turner, E. A., Jensen-Doss, A., & Heffer, R. W. (2015). Ethnicity as a moderator of how parents' attitudes and perceived stigma influence intentions to seek child mental health

services. *Cultural Diversity and Ethnic Minority Psychology*, *21*(4), 613–618. https://doi.org/10.1037/cdp0000047

Umpierre, M., Meyers, L. V., Ortiz, A., Paulino, A., Rodriguez, A. R., Miranda, A., Rodriguez, R., Kranes, S., & McKay, M. M. (2015). Understanding Latino Parents' Child Mental Health Literacy. *Research on Social Work Practice*, *25*(5), 607–618. https://doi.org/10.1177/1049731514547907

United States. (1982). President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *United States Code Annotated. United States*, *Title 42 S*, Unknown.

United States Census Bureau. (2019). *US Census Bureau quickfacts: United States*.

Veterans Health Administration. (2012). *Local implementation of evidence-based psychotherapies for mental and behavioral health conditions.(VHA Handbook 1160.05)*. Government Printing Office Washington, DC.

Vohra, R., Madhavan, S., Sambamoorthi, U., & St Peter, C. (2014). Access to services, quality of care, and family impact for children with autism, other developmental disabilities, and other mental health conditions. *Autism*, *18*(7), 815–826. https://doi.org/10.1177/1362361313512902

Vortel, M. A., Adam, S., Port-Thompson, A. V., Friedman, J. M., Grande, S. W., & Birch, P. H. (2016). Comparing the ability of OPTION12 and OPTION5 to assess shared decision-making in genetic counselling. *Patient Education and Counseling*, *99*(10), 1717–1723. https://doi.org/10.1016/j.pec.2016.03.024

Walker, S. C., Sedlar, G., Berliner, L., Rodriguez, F. I., Davis, P. A., Johnson, S., & Leith, J. (2019). Advancing the state-level tracking of evidence-based practices: A case study.

International Journal of Mental Health Systems, *13*(1), 1–9. https://doi.org/10.1186/s13033-019-0280-0

Warnick, E. M., Gonzalez, A., Robin Weersing, V., Scahill, L., & Woolston, J. (2012). Defining dropout from youth psychotherapy: How definitions shape the prevalence and predictors of attrition. *Child and Adolescent Mental Health*, *17*(2), 76–85. https://doi.org/10.1111/j.1475-3588.2011.00606.x

Weisz, J. R., Jensen-Doss, A., & Hawley, K. M. (2006). Evidence-based youth psychotherapies versus usual clinical care: a meta-analysis of direct comparisons. *American Psychologist*, *61*(7), 671–689. https://doi.org/10.1037/0003-066X.61.7.671

Weisz, J. R., Kuppens, S., Eckshtain, D., Ugueto, A. M., Hawley, K. M., & Jensen-Doss, A. (2013). Performance of Evidence-Based Youth Psychotherapies Compared With Usual Clinical Care. *JAMA Psychiatry*, *70*(7), 750. https://doi.org/10.1001/jamapsychiatry.2013.1176

Weisz, J. R., Kuppens, S., Ng, M. Y., Eckshtain, D., Ugueto, A. M., Vaughn-Coaxum, R., Jensen-Doss, A., Hawley, K. M., Krumholz Marchette, L. S., Chu, B. C., Weersing, V. R., & Fordwood, S. R. (2017). What Five Decades of Research Tells Us About the Effects of Youth Psychological Therapy: A Multilevel Meta-Analysis and Implications for Science and Practice. *American Psychologist*, *72*(2), 79–117. https://doi.org/10.1037/a0040360

Weisz, J. R., Ng, M. Y., & Bearman, S. K. (2014). Odd couple? reenvisioning the relation between science and practice in the dissemination-implementation era. *Clinical Psychological Science*, *2*(1), 58–74. https://doi.org/10.1177/2167702613501307

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 & Adolescent*

Psychology, *42*(2), 274–286. https://doi.org/10.1080/15374416.2013.764824

Welmers-Van de Poll, M. J., Roest, J. J., van der Stouwe, T., van den Akker, A. L., Stams, G. J. J. M., Escudero, V., Overbeek, G. J., & de Swart, J. J. W. (2018). Alliance and Treatment Outcome in Family-Involved Treatment for Youth Problems: A Three-Level Meta-analysis. *Clinical Child and Family Psychology Review*, *21*(2), 146–170. https://doi.org/10.1007/s10567-017-0249-y

Westermann, G. M. A., Verheij, F., Winkens, B., Verhulst, F. C., & Van Oort, F. V. A. (2013). Structured shared decision-making using dialogue and visualization: A randomized controlled trial. *Patient Education and Counseling*, *90*(1), 74–81. https://doi.org/10.1016/j.pec.2012.09.014

Whitaker, K., Nicodimos, S., Pullmann, M. D., Duong, M. T., Bruns, E. J., Wasse, J. K., & Lyon, A. R. (2018). Predictors of Disparities in Access and Retention in School-Based Mental Health Services. *School Mental Health*, *10*(2), 111–121. https://doi.org/10.1007/s12310-017-9233-4

Whitley, R. (2009). The implications of race and ethnicity for shared decision-making. *Psychiatric Rehabilitation Journal*, *32*(3), 227–230. https://doi.org/10.2975/32.3.2009.227.230

Wilmots, E., Midgley, N., Thackeray, L., Reynolds, S., & Loades, M. (2019). The therapeutic relationship in Cognitive Behaviour Therapy with depressed adolescents: A qualitative study of good-outcome cases. *Psychology and Psychotherapy: Theory, Research and Practice*. https://doi.org/10.1111/papt.12232

Wiltsey Stirman, S., Baumann, A. A., & Miller, C. J. (2019). The FRAME: an expanded framework for reporting adaptations and modifications to evidence-based interventions.

Implementation Science, *14*(1), 58. https://doi.org/10.1186/s13012-019-0898-y

Wright, B., Lau, A. S., & Brookman-Frazee, L. (2019). Factors Associated With Caregiver Attendance in Implementation of Multiple Evidence-Based Practices in Youth Mental Health Services. *Psychiatric Services*, *288*, appi.ps.2018004. https://doi.org/10.1176/appi.ps.201800443

Wyatt, K. D., List, B., Brinkman, W. B., Prutsky Lopez, G., Asi, N., Erwin, P., Wang, Z., Domecq Garces, J. P., Montori, V. M., & LeBlanc, A. (2015). Shared Decision Making in Pediatrics: A Systematic Review and Meta-analysis. *Academic Pediatrics*, *15*(6), 573–583. https://doi.org/10.1016/j.acap.2015.03.011

Yanos, P. T., O'Connor, L. K., DeLuca, J. S., Fregenti, S., & Reji, P. M. (2019). Assisted outpatient treatment orders and the therapeutic relationship in Assertive Community Treatment: a mixed-methods study. *Psychosis*, *00*(00), 1–11. https://doi.org/10.1080/17522439.2019.1670232

Yeh, Hough, R. L., Fakhry, F., McCabe, K., Lau, A., & Garland, A. (2005). Why bother with beliefs? Examining relationships between race/ethnicity, parental beliefs about causes of child problems, and mental health service use. *Journal of Consulting and Clinical Psychology*, *73*(5), 800–807. https://doi.org/10.1037/0022-006X.73.5.800

Yeh, Hough, R. L., McCabe, K., Lau, A., & Garland, A. (2004). Parental Beliefs About the Causes of Child Problems: Exploring Racial/Ethnic Patterns. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*(5), 605–612. https://doi.org/10.1097/00004583-200405000-00014

Yeh, M., Lambros, K., Tsai, K., Zerr, A., Trang, D., McCabe, K., & Ganger, W. (2019). Multistakeholder Etiological Explanation Agreement and Adolescent/Parent Treatment

Engagement. *Journal of Clinical Child & Adolescent Psychology*, *48*(1), 42–53. https://doi.org/10.1080/15374416.2018.1520120

Young, H. N., Bell, R. A., Epstein, R. M., Feldman, M. D., & Kravitz, R. L. (2008). Physicians' shared decision-making behaviors in depression care. *Archives of Internal Medicine*, *168*(13), 1404–1408. https://doi.org/10.1001/archinte.168.13.1404

Young, & Rabiner, D. (2015). Racial/ethnic differences in parent-reported barriers to accessing children's health services. *Psychological Services*, *12*(3), 267–273. https://doi.org/10.1037/a0038701

Yun, K., Jenicek, G., & Gerdes, M. (2019). Overcoming Language Barriers in Mental and Behavioral Health Care for Children and Adolescents—Policies and Priorities. *JAMA Pediatrics*, *173*(6), 511. https://doi.org/10.1001/jamapediatrics.2019.0400

Zisman-Ilani, Y., Barnett, E., Harik, J., Pavlo, A., & O'Connell, M. (2017). Expanding the concept of shared decision making for mental health: Systematic search and scoping review of interventions. *Mental Health Review Journal*, *22*(3), 191–213. https://doi.org/10.1108/MHRJ-01-2017-0002