

<p><b>Engagement</b></p>	<p><b>For which specific cultural group(s) (i.e., SES, religion, race, ethnicity, gender, immigrants/refugees, disabled, homeless, LGBTQ, rural/urban areas) is this treatment tailored? If none, please respond “not specifically tailored.”</b></p> <p>ARC is designed as an adaptable treatment framework; it identifies 10 core targets of intervention within three broad domains, and provides guidelines and examples of intervention. The goal of designing an adaptable framework was to allow for differences in implementation and application across settings and across populations. To date, ARC has been used with a range of populations (including pre-/post-adoptive, internationally adopted, urban high-risk, Native Alaskan, juvenile justice-involved, child welfare involved, and war refugee youth), in a range of settings (including outpatient, community mental health, residential treatment, secure facility, domestic violence shelter, and hospital settings) and age groups (age 5 through late adolescent, and their caregiving systems).</p> <p><b>Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.</b></p> <p>Intervention developers/trainers work with the specific implementing system to tailor implementation and familial engagement in a way that is consistent with their setting. Factors considered in various settings have included ways to integrate caregivers (i.e., parenting groups vs. individual/dyadic treatment), structural supports (i.e., childcare while caregivers attend meetings), web-based engagement of family systems (one site has created a family access page for caregiver-to-caregiver tips, information, and support, and for child-to-child “feelings toolbox” ideas); and integration of cultural values in discussion of the treatment process. In addition, access to treatment has been seriously considered from the point of initial framework development by the primary developers, and the framework was designed in a manner to be adaptable to both clinical and non-clinical settings, with the goal of increasing access to trauma-informed services in the array of settings that trauma-exposed populations access and engage.</p> <p><b>Are there culture-specific engagement strategies (e.g., addressing trust) that are included in the intervention?</b></p> <p>As an adaptable framework, training emphasizes the importance of the assessment process to understanding family norms, values, roles, belief systems, etc. in organizing treatment planning, caregiver involvement, and culturally-relevant goals. For instance, caregiver work may include a primary caregiver or a larger familial system, etc.</p>
<p><b>Language Issues</b></p>	<p><b>How does the treatment address children and families of different language groups?</b></p> <p>No specific adaptations at this time. Caregiver materials (educational and work-sheets) are in the process of being translated to Spanish.</p> <p><b>If interpreters are used, what is their training in child trauma?</b> N/A</p> <p><b>Any other special considerations regarding language and interpreters?</b> N/A</p>

CULTURE-SPECIFIC INFORMATION

<p><b>Symptom Expression</b></p>	<p><b>Is there research or clinical evidence to suggest that the populations served manifest trauma symptoms in differential ways? If so, are there differences in the ways that symptoms are assessed for the various populations?</b></p> <p>Although this question has not yet been specifically examined in the available data, clinical evidence suggests that there is extensive diversity in history and presentation among the populations with which ARC is currently used. Core issues are often relatively similar across sites, but their relative expression, intensity, and specific manifestations may vary. A future research question will involve understanding the ways symptom expression may vary at different sites, and how this factor influences intervention outcomes.</p> <p><b>If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?</b></p> <p>ARC focuses on core underlying issues, rather than specific manifestations and/or techniques.</p>
<p><b>Assessment</b></p>	<p><b>In addition to any differences noted above, are there any differences in assessment measures used across cultural groups? If so, please indicate which measures are used for which cultural groups. Are there normative data available for the populations for which they are being used?</b></p> <p>Currently, sites implementing ARC are primarily using the NCTSN core data set, the Parenting Stress Index (PSI; Abidin); and an ARC-specific assessment measure, currently in development. Despite site/population differences, the goal is to obtain consistent data across implementing sites during this phase of treatment implementation.</p> <p><b>If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?</b></p> <p>The only non-normed measure currently in use is an in-development ARC-specific measure. This measure is designed to integrate assessment results obtained through a variety of means, including objective measures but also including child and dyadic/familial observation, interview, collateral contact, previous reports, etc., due to the understanding that information important to treatment planning may not be captured by formal measures. The purpose of the measure is to identify specific areas of strength and vulnerability within core target areas, and to translate these into concrete goals and treatment methods.</p> <p><b>What, if any, culturally specific issues arise when utilizing these assessment measures?</b> Not yet assessed.</p>
<p><b>Cultural Adaptations</b></p>	<p><b>Are cultural issues specifically addressed in the writing about the treatment? Please specify.</b></p> <p>Consultation has been completed with an expert in cultural competence; culture-specific adaptations and considerations are in the process of being integrated into the treatment manual (these are not specifically contained in the current edition).</p>

CULTURE-SPECIFIC INFORMATION

<p><b>Cultural Adaptations continued</b></p>	<p><b>Do culture-specific adaptations exist? Please specify</b> (<i>e.g., components adapted, full intervention adapted</i>).</p> <p>Yes; developers work with implementing sites to adapt framework methods in a manner that is applicable to their specific population and/or setting; although core concepts remain the same, implementation often varies. For instance, in a rural Alaskan setting, affect regulation techniques integrate native culture and belief systems; attachment-based work has been adapted to be largely non-verbal and parallel (<i>i.e.</i>, rather than face-to-face) in line with cultural norms and typical interaction styles.</p> <p><b>Has differential drop out been examined for this treatment? Is there any evidence to suggest differential drop out across cultural groups? If so, what are the findings?</b></p> <p>Not yet examined.</p>
<p><b>Intervention Delivery Method/ Transportability &amp; Outreach</b></p>	<p><b>If applicable, how does this treatment address specific cultural risk factors</b> (<i>i.e., increased susceptibility to other traumas</i>)?</p> <p>The goal in creating an adaptable framework is that implementers best know their populations and specific areas to target (<i>i.e.</i>, treatment has emphasized different factors in an urban, high-risk setting serving primarily African-American and Latino youth than in a mid-western agency serving primarily internationally adopted youth).</p> <p><b>Is this a clinic-based treatment or is the treatment transportable</b> (<i>e.g., into home, community</i>)? <b>If the treatment is transportable, how is it adapted into the new setting? Is it still efficacious?</b></p> <p>As noted above, ARC was specifically designed to be adaptable to the range of clinical and non-clinical settings in which trauma-exposed youth and families present for services. The framework identifies key targets; implementation varies across setting and population. For instance, within an outpatient setting, the target “Caregiver Affect Management” frequently involves individual or group work with biological, adoptive, or foster parents/other primary caregivers; within milieu settings, the emphasis of that target may involve working directly with milieu staff to monitor, understand, and address their own emotional reactions to clients. Data is currently being collected across settings.</p> <p><b>Are there cultural barriers to accessing this treatment</b> (<i>i.e., treatment length, family involvement, stigma, etc.</i>)?</p> <p>Treatment length varies by setting and client. This framework does specifically highlight the role of familial/caregiver involvement, which may be difficult for some families; however, in recognition of that, it is designed to apply to the range of caregiving systems, including clinicians and other health care providers.</p> <p><b>Are there logistical barriers to accessing this treatment for specific cultural groups</b> (<i>i.e., transportation issues, cost of treatment, etc.</i>)?</p> <p>These factors are site-specific.</p> <p><b>Are these barriers addressed in the intervention and how?</b></p> <p>No.</p>

CULTURE-SPECIFIC INFORMATION

<p><b>Intervention Delivery Method/ Transportability &amp; Outreach continued</b></p>	<p><b>What is the role of the community in treatment</b> (e.g., local groups such as faith-based organizations, community groups, youth and/or parent organizations, first responders, schools)?</p> <p>The ARC framework highlights the importance of the client’s community in the caregiving system, and the importance of building connections. Each manual section includes a sub-section entitled “Beyond the Therapy Room,” specifically addressing integration of external resources into treatment planning. The developmental competency section specifically targets connection to community resources; extent to which these are integrated depends on the client and setting implementing the framework.</p>
<p><b>Training Issues</b></p>	<p><b>What potential cultural issues are identified and addressed in supervision/training for the intervention?</b></p> <p>Identification of specific cultural issues in training is still a work in progress; role of culture in definition of the caregiving system, familial norms regarding parenting, and other caregiver-focused targets; as well as in self and identity development, are routinely integrated into training. Cultural issues are frequently addressed in ongoing consultation. Integration of cultural factors into other target areas is often informal. More formal inclusion of cultural issues into the framework is a work in progress.</p> <p><b>If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?</b></p> <p>Not addressed.</p> <p><b>If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?</b></p> <p>Not addressed within specific ARC training materials</p> <p><b>Has this guidance been provided in the writings on this treatment?</b></p> <p>Not yet available.</p> <p><b>Any other special considerations regarding training?</b></p> <p>No.</p>