Engagement	**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."** Not specifically tailored. **Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.** Yes. The intervention is designed to be used in many different settings that serve a range of individuals with diverse cultural backgrounds. Child-Adult Relationship Enhancement (CARE) is a field initiated modification of the evidence-based Parent Child Interaction Therapy (PCIT). This modification uses specific PCIT skills (i.e., praise, reflection, and behavioral descriptions) for general usage by non-clinical adults who interact with children in a variety of settings. Clinicians are trained to tailor this intervention to their specific setting and to the specific cultural groups they work with (i.e., each of the skills are discussed in terms of the function and utility for the specific population that they work with and adapted as needed). These adaptations have been implemented within homeless shelter settings that serve women and children from a range of ethnic and cultural backgrounds; domestic violence shelters; residential facilities; hospitals; and daycare settings. **Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** The nature of the intervention emphasizes the importance of tailoring CARE to the environment within which it is implemented such as understanding familial and/or organizational norms, values, roles, and belief systems.
Language Issues	**How does the treatment address children and families of different language groups?** Training is provided to staff who are multilingual and therefore are able to use the model with families of different linguistic backgrounds. **If interpreters are used, what is their training in child trauma?** N/A **Any other special considerations regarding language and interpreters?** N/A
Symptom Expression	**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?** Although this question has not yet been specifically examined, clinical evidence suggests that there is extensive diversity in history and presentation among the populations with which CARE is currently used. Core issues are often relatively similar across sites, but their relative expression, intensity, and specific manifestation may vary.

Symptom Expression continued	**If there are differences in symptom expression, in what ways does the theoretical/ conceptual framework of this treatment address culturally specific symptoms?** The intervention is designed to address symptom expression in consistent ways regardless of the specific symptoms, however, emphasis on specific skill areas may change depending on the symptom expression.
Assessment	**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?** Coding is done in order to assess mastery of taught skills. What skills you measure may vary between cultural groups. There is no normative data available at this time.
	If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments? Coding is designed to assess the mastery of taught skills and once mastery is achieved the caregiver/provider is considered to be ready to implement CARE.
	What, if any, culturally specific issues arise when utilizing these assessment measures? Not yet assessed.
Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Not to date.
	Do culture-specific adaptations exist? Please specify *(e.g., components adapted, full intervention adapted)*. Yes; trainers work with implementing sites to adapt skills 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 family homeless shelter settings the implementation of the intervention has been altered so that shelter staff are trained to utilize the skills with the mothers, providing modeling, and then train the mothers to utilize the skills with their children. Given that shelter staff are working with the adults, the skills taught are modified to be more applicable for working with adults in a shelter setting (i.e., behavioral descriptions/play by play has not been taught as a skill).
	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? Not at this time.

Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** Treatment is designed to be adaptable so that implementers who best know their populations and specific target areas make changes as needed (i.e., intervention emphasizes different skills when used with adults in a homeless shelter setting rather than when it is used with children in a residential setting). **Is this a clinic-based treatment or is the treatment transportable** *(e.g., into home, community)***? If the treatment is transportable, how is it adapted into the new setting? Is it still efficacious?** This is not a clinic-based treatment. It is designed to be implemented in community/ milieu settings. **Are there cultural barriers to accessing this treatment** *(i.e., treatment length, family involvement, stigma, etc.)***?** There is no specific length of treatment, but the amount of time clients are exposed to this treatment is dependent on the length of stay in the setting where CARE is being implemented. Additionally, caregivers may choose not to be trained in this intervention despite it being offered in the setting and modeled within the setting. **Are there logistical barriers to accessing this treatment for specific cultural groups** *(i.e., transportation issues, cost of treatment, etc.)***?** These factors are site-specific. **Are these barriers addressed in the intervention and how?** No **What is the role of the community in treatment** *(e.g., local groups such as faith-based organizations, community groups, youth and/or parent organizations, first responders, schools)***?** CARE is a treatment that is designed to be implemented in the community setting including all levels of staff within the setting (i.e., in a shelter setting, case managers, support staff, administrators, and residents are all trained in the intervention).
Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** Identification of specific cultural issues in training is still a work in progress as information is gathered through implementation of this model in a wide range of settings. Information is shared between network training sites who are implementing this model. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** Not yet addressed **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** Not yet addressed.