



Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.



Integrating Advocacy for Marginalized Children and Families Into Evidence-Based Care During COVID-19: Clinical Vignettes

Abby Bailin, *Weill Cornell Medicine*

Samantha Burton, *Massachusetts Institute of Technology*

Simon Rego, Jonathan Alpert and Sandra Pimentel, *Montefiore Medical Center/Albert Einstein College of Medicine*

The novel coronavirus (COVID-19) has disproportionately impacted the health and socioeconomic outcomes for low-income populations, people of color, and immigrant children and families in the United States. As inequities in resources (i.e., food, internet, housing), health care, and education increased for marginalized families as a result of COVID-19, child-focused clinicians had to broaden their professional scope and implement new advocacy efforts. The current paper uses clinical vignettes taken from a New York State Office of Mental Health–licensed child and adolescent outpatient clinic in the Bronx, New York. The vignettes highlight the social inequities that impacted marginalized children and families during the pandemic, as well as the clinical team’s response through the integration of evidence-base practice and advocacy. Implications for practice with vulnerable populations as the COVID-19 pandemic persists are discussed.

SINCE early 2020, the novel coronavirus (COVID-19) has encircled the globe, infecting over 118 million individuals so far and resulting in almost 3 million deaths. Despite its wealth and resources and the fact that the United States accounts for just approximately 4% of the world’s population, the U.S. accounts for approximately 25% of the world’s COVID-19 cases. COVID-19 has disproportionately affected people of color as well as low-income and immigrant families in the U.S. These marginalized groups have experienced higher rates of infections, hospitalizations, and deaths (Clark et al., 2020; Finch & Finch, 2020; Martinez et al., 2020; Price-Haywood et al., 2020; Yancy, 2020). Inequities in the social determinants of health, such as poverty and health care access, have influenced a number of health and other quality-of-life outcomes. In addition, there have been related and long-lasting socioeconomic consequences associated with COVID-19. Black and Latinx families have experienced higher rates of job loss (Karpman et al., 2020), as well as greater food insecurity, inadequate access to distance learning, and fewer opportunities to work from home,

obtain paid sick leave benefits, or obtain child care (Dooley et al., 2020).

Multiple emerging research studies point to the far-reaching psychological impact of the pandemic on youth and families (e.g., Cao et al., 2020; Mazza et al., 2020). Early findings suggest that the COVID-19 pandemic may influence youth mental health, particularly for youth who are predisposed to psychological problems like depression and anxiety (Courtney et al., 2020; Liang et al., 2020). In addition, the American Psychological Association’s “Stress in the Time of COVID-19” survey indicated that 70% or more of respondents endorsed stress related to multiple domains such as becoming ill or having a family member become ill with the virus, managing online learning for their children, experiencing disrupted schedules, and meeting basic needs of housing and food (APA, 2020). These stressors, which have disproportionately impacted people of color and low-income and immigrant communities, have significant implications for youth and family functioning, including mental health treatment. A shift in focus for mental health clinicians working with marginalized populations is required to adequately address the pervasive impact of the pandemic.

The current article describes how clinicians serving children and families in an outpatient mental health

Keywords: advocacy; evidence-based treatment; youth mental health; COVID-19

1077-7229/20/© 2021 Association for Behavioral and Cognitive Therapies. Published by Elsevier Ltd. All rights reserved.

clinic in the Bronx, New York, expanded their professional roles to meet the needs of patients during the COVID-19 pandemic. As COVID-19 swept the Bronx, clinicians broadened their scope of advocacy efforts to combat multiple inequities disproportionately impacting the patient population. Advocacy, understood as taking action to achieve goals in clients' environments (Toporek & Liu, 2001), is a tenet consistent with the American Psychological Association's (APA, 2012) competency guidelines, which indicate that psychologists should be trained to safeguard others' welfare and promote systems change that targets the impact of social, political, economic or cultural factors. A position of advocacy, in combination with an ongoing commitment to evidence-based practice, recalibrated existing treatment plans and clinical practice to ensure the welfare of the patient population.

Advocacy in Youth Mental Health Treatment

Efforts to integrate advocacy in both clinical training and practice have been documented in the field of psychology, particularly within counseling psychology (see, Ali & Sichel, 2014; Barrett & Olle, 2016). Advocacy models in psychological practice, such as the anti-oppression advocacy approach (Ali & Sichel, 2014) and systems advocacy (Lewis et al., 2002), posit that a primary role of psychologists is to eradicate systemic barriers that impede the client's progress towards their goals. These approaches suggest that in order to adequately address the mental health needs of marginalized populations, clinicians must address therapeutic change while also contending with the additional mental health risks associated with poverty and racism (Lorant et al., 2003; Smith, 2010).

In the youth mental health service sector, systems of care approaches have been at the forefront of advocacy efforts since the National Institute of Mental Health established the Child and Adolescent Service System Program (CASSP) in 1984 for children with serious and complex needs. Systems of care function as a coordinated network of treatment or clinical intervention accompanied by effective, individualized, and community-based services based on the goals, priorities, populations, and environments of the particular community in which it is embedded (Hernandez & Hodges, 2003; Stroul & Friedman, 1986). Since this model was first recommended, systems of care have been applied more broadly to youth mental health, constituting a "paradigm shift" (Bruns & Walker, 2010) away from individual, siloed service settings to a network of services and supports across agencies. These coordinated networks seek to meet the complex needs of a target population within the least restrictive

environment and in a manner that is culturally sensitive, such that services address and fit clients' cultural factors, including age, cultural values, gender, language, race, and sexual orientation (Cabassa & Baumann, 2013). The current authors drew from advocacy models and systems of care approaches in order to meet the wide-ranging needs of marginalized youth patients and their families during the pandemic. While the integration of advocacy, systems-based care, and evidence-based practice is not novel, the current authors seek to highlight practical approaches to integrating these practices with low-income, people of color during the COVID-19 pandemic.

Current Study

Setting and Context

The clinical vignettes presented in this article are drawn from a New York State Office of Mental Health (OMH)-licensed child and adolescent outpatient clinic in the North Bronx that is part of the psychiatry department in a large urban academic medical center. The Bronx, New York, is one of the most ethnically diverse urban areas in the U.S. The Bronx is the poorest district in the country and is also ranked the least healthy of New York State's 62 counties, as well as the poorest of the five boroughs. According to New York City's Department of Health, residents in the Bronx, who are majority Latinx and Black, were more than twice as likely to die from COVID-19 than anywhere else in the city in the first 3 months of the pandemic. Youths served in the clinic, who range from ages 4 to 21 years, and their families are primarily low-income, with up to 85% receiving public assistance prior to the onset of the COVID-19 pandemic. Many caregivers are monolingual Spanish speakers, and interpreters and bilingual clinicians are involved in the provision of mental health services. The child outpatient clinic hosts several specialty training programs, including an Anxiety and Mood Program, and provides comprehensive evidence-based mental health services to children, adolescents, and emerging adults and their families presenting with an array of psychiatric disorders. Patients are treated in both individual and group therapy settings, using a variety of evidence-based psychotherapies, including cognitive behavioral therapy (CBT) for youth with anxiety, trauma, mood disorders, and disruptive behavior, as well as dialectical behavior therapy (DBT) for self-harming and suicidal adolescents. Rooted in the medical center's mission, there is also a primary emphasis on social justice and advocacy through which the treatment team seeks to support families within their greater community systems as liaisons with schools, foster care agencies, child and family

services, and other relevant organizations. The clinic, staffed by 5 attending psychologists, 5 attending psychiatrists, and 3 licensed clinical social workers, also serves as a training clinic for predoctoral psychology interns, graduate-level psychology practicum students, child psychiatry fellows, and social work interns.

Integrating Evidence-Based Practice and Advocacy. As the COVID-19 pandemic inundated the Bronx in March 2020, the clinic rapidly responded to the crisis in accordance with OMH and federal guidelines. Hospital employees across the system were deployed to different medical units to serve the influx of COVID-19 positive patients, including psychiatrists and social workers from across the department. Along with other programs, the clinic drastically reduced on-site personnel to a basic operational skeleton crew to limit the spread of the virus. The clinic transitioned from in-person psychotherapy to predominantly telehealth (telephone and video) services to limit in-person contact and abide by infectious disease guidelines and state-ordered “shelter in place” policies. A very limited number of youths were seen in person if clinically indicated (e.g., requiring long-acting injectable medication, significant suicide risk).

As clinicians and families made this transition, clinicians began to encounter new challenges emerging for families as preexisting economic and health disparities were exacerbated. Increased anxiety, impaired sleep, and mood lability were in the traditional purview of the clinical team; however, newly emerging problems, like food and internet access challenges, job insecurity, and COVID-19 infection risks, were at the forefront of patient needs and highlighted that mental health interventions alone were not sufficient. Clinicians were well-positioned to address these new needs and challenges given frequent, virtual contact (i.e., weekly or bi-weekly) with patients and families as well as preexisting relationships with their larger systems (i.e., family, school, health care providers).

The broadening emphasis on advocacy was facilitated through a number of factors. First, the team increased the frequency and shifted the focus of team meetings. Team meetings were held three times per week for the first 3 months of the pandemic, an increase from once per week prior to the pandemic. Frequent meetings allowed for information to be disseminated clearly and consistently across the team, for specific topics of concern to be discussed, and for targeted planning and initiation of quality improvement efforts at both the individual and community levels. This frequent collaboration helped team members to identify barriers—factors impeding patient and family well-being and treatment progress—that

were frequently occurring across the patient population, which were then consolidated and defined (i.e., education, finances, food/essential resources, housing, home environment, health, immigration status, internet and technological devices; see [Table 1](#)).

Second, as barriers were identified, targeted quality improvement efforts were initiated. A preexisting health advocacy training series, established as an effort to engage trainees in quality improvement projects targeted at social justice and advocacy for the patient population, provided a foundation from which team members launched quality improvement efforts specific to the pandemic. Preestablished quality improvement teams comprised of trainees and supervised by full-time clinical staff swiftly adapted their projects to address barriers that were identified in team meetings. Additionally, clinician-advocates consulted with personnel across disciplines (e.g., pediatrics, social work, administration, legal) to navigate, connect with, and form relationships with an array of community-based supports (e.g., housing services, food pantries).

The team of clinician-advocates integrated ecological systems theory ([Bronfenbrenner, 1979](#)) in response to patient needs on multiple systems levels (e.g., community, family, individual). At the community level, the team developed a database of Bronx-specific resources and essential services during the COVID-19 pandemic, vetting and confirming operability of each service; a comprehensive guide was then distributed hospital-wide. This resource list included information about internet access, food assistance, financial supports, health information and access, information specific to immigrant and undocumented families, mental health and crisis supports, and educational resources, and was updated on a frequent basis to ensure up-to-date resources were available as the pandemic rapidly evolved. In addition, the clinic coordinated a fundraising campaign in support of a hospital-based food pantry, and clinicians communicated directly with food pantry coordinators about specific needs (e.g., diapers, prepared meals) of the local community. Further, for families who were unable to leave their homes, most often due to family members with vulnerable medical conditions, the team developed a workflow connecting two volunteer organizations to ensure safe, contact-free delivery of food and essential supplies (i.e., toilet paper, school supplies).

At the individual and family levels, team members sought to safeguard the welfare of their patients by adapting evidence-based treatment plans to meet the unique needs of each patient and family. Revised treatment plans were developed from comprehensive and repeated needs assessments, in which clinicians

Table 1
Barriers to Youth and Family Well-Being and Treatment Progress

Category	Definition	Example ^a
Education	Factors that limit ability to obtain fair, appropriate, and equal education.	<i>...the clinician was unable to reach his teacher or other relevant school personnel (Vignette 1)</i>
Finances	Financial concerns due to temporary or permanent discontinuation of work.	<i>Parents lost their jobs due to layoffs related to the pandemic... [leading to] financial strain (Vignette 2)</i>
Food/Essential Resources	Limited or restricted access to food or other essential resources (e.g., toilet paper, school supplies).	<i>...mother expressed concern regarding the family's access to food given that they could not leave the home to get groceries (Vignette 1)</i>
Housing	Loss or risk of losing safe housing.	<i>...family had been threatened with eviction from their home (Vignette 1)</i>
Home Environment	Home environments with limited privacy, overcrowding, or safety concerns.	<i>...difficult for him to find a private, quiet space to participate in group via video conferencing (Vignette 3)</i>
Health	Increased risk for COVID-19 infection/hospitalization, fears of contracting the virus, and barriers regarding access to safe and affordable healthcare.	<i>...mother disclosed significant anxiety related to her health and her family's health, including who would care for her children if she became ill with COVID-19 (Vignette 1)</i>
Immigration Status	Concerns regarding the safety of accessing healthcare services and the availability of healthcare services for immigrant families.	<i>...parents expressed concerns about being able to safely access healthcare services to be tested and treated for the virus due to their immigration status (Vignette 2)</i>
Internet and Technological Devices	Limited, restricted, or total lack of access to the internet or technology for access to necessary services and contacts (i.e., education, telehealth).	<i>Lack of internet access presented a significant obstacle as Jacob's school transitioned to virtual classrooms (Vignette 1)</i>

^a Examples are direct excerpts from the clinical vignettes.

assessed patients' home environments, including availability of resources (e.g., internet, food), personal and familial risk for COVID-19 infection, and environmental factors that may negatively impact telehealth therapy and general functioning (e.g., persons living in the home, private space for therapy). Whereas informal needs assessments may have been conducted prior to the pandemic based on individual clinician inclination or preference, this practice was formalized and adopted as standard clinic practice once the pandemic hit. In addition, clinicians maintained evidence-based assessment of mental health symptoms and functioning—a part of standard practice prior to the pandemic. Clinicians adapted treatment goals and evidence-based practices based on data gleaned from these assessments.

In this report, clinical vignettes exemplify how the professional role of clinicians broadened in the context of the pandemic as team members integrated advocacy and evidence-based practice while serving youth who were disproportionately affected by the COVID-19 pandemic due to factors related to race, ethnicity, socioeconomic status, and immigration status. These clinical vignettes highlight how social inequities impacted the functioning and well-being of such families during the COVID-19 pandemic, and how team members provided comprehensive and individualized care in this context. Last, implications for practice with marginalized populations both within the context of COVID-19 and beyond are discussed.

Clinical Vignettes

All identifying information has been removed from the following clinical vignettes to protect confidentiality. The eight barriers (see [Table 1](#)) that emerged in our patient population are italicized when referenced in the vignettes below.

Clinical Vignette 1: Jacob

Reason for Referral

Jacob, a 10-year-old Black, non-Hispanic cisgender male of Jamaican descent, was treated at the clinic for approximately 6 months prior to the start of the COVID-19 pandemic. He was self-referred by his mother due to increased misbehaviors, including non-compliance (i.e., not following instructions), physical and verbal aggression, and inattention and reduced work completion in school. Jacob experienced significant trauma throughout his life. Per his mother's report, he witnessed intimate partner violence perpetrated by his biological father against his mother, and was physically and emotionally abused by his father. Jacob's mother noted a significant change in Jacob's

behavior in the year leading up to the initiation of treatment. She noted that he performed well academically and rarely required discipline or redirection for misbehavior in the school setting, but recently he began exhibiting reduced interest and motivation to complete schoolwork and was frequently sent to the principal's office for rule-breaking behavior. At the same time, Jacob's mother noted that he became increasingly "disrespectful" towards her and his grandparent, cursing at them and refusing to comply with instructions and requests. Jacob's mother was particularly concerned about his physically aggressive (i.e., hitting, pushing) and verbally aggressive behavior toward his younger brother.

Treatment Prior to COVID-19 Onset

Prior to COVID-19, Jacob and his family were participating in comprehensive treatment at the clinic, including behavioral parent training aimed at supporting Jacob's mother to implement safe, effective, and consistent parenting strategies to increase desired behaviors and reduce misbehavior, individual CBT focused on increasing Jacob's emotional regulation skills, and a behavior regulation movement group that used evidence-based trauma-focused interventions to support emotion regulation, impulse control, and social skills. The treatment team coordinated care with a shared treatment plan, frequent consultation, and ongoing case management with Jacob's school and other systems relevant to his care. Given Jacob's age and the primary concerns related to his disruptive behavior, behavioral parent training was the primary emphasis of the treatment plan.

Treatment Adaptations During COVID-19

As COVID-19 pandemic restrictions were issued, Jacob and his family were transitioned to telehealth services. Jacob's mother and the team of clinicians agreed that the parent-focused clinician would maintain weekly sessions with Jacob's mother and Jacob's individual clinician would maintain bi-weekly check-ins with Jacob. As this transition occurred, clinicians conducted a needs assessment, which highlighted a number of risk factors for contracting and becoming ill with COVID-19 (i.e., multigenerational home, parent with comorbid health conditions) and barriers to access to essential resources.

During this initial needs assessment, Jacob's mother noted several new and unanticipated stressors. First, *lack of internet access* presented a significant obstacle as Jacob's school transitioned to virtual classrooms. In response, Jacob's clinician supported the family by providing accurate and timely information about how to obtain access to the NYC Department of Education's

(DOE) virtual schooling technology, which included hotspots for internet access. Second, Jacob's mother expressed concern regarding the family's *access to food*. Due to her own health concerns, she was fearful of going to the grocery store, food bank, or NYC DOE food pickup locations. With permission from Jacob's mother, the clinician coordinated several food bank dropoffs at their home throughout the lockdown period. These services were free for Jacob's family and were also delivered without any in-person contact to reduce COVID-19 transmission risk. Last, Jacob's family had been threatened with *eviction* from their home prior to the onset of the pandemic. His mother had been in the process of locating a new home and was participating in legal proceedings related to the eviction, both of which were paused once the pandemic hit. Jacob's mother was fearful that the family would be evicted from their home in the midst of the pandemic and have no place to go. In response, the clinician supported Jacob's mother in understanding her rights as a tenant, based on up-to-date city regulations that restricted evictions during the crisis, and provided her with free legal resources for eviction protection.

Once stable access to food, housing, and virtual education was established, the family experienced some relief. Focus shifted to support Jacob's mother in implementing behavioral parent training strategies during quarantine, particularly as she noted Jacob's increased disruption and inattention during the virtual school day. Despite Jacob's mother's desire to improve his behavior, she expressed ambivalence about implementing behavioral techniques (i.e., consistent routines, positive attention, effective commands, consistent consequences for misbehavior). Using motivational interviewing techniques, the clinician sought to understand the barriers to implementation of these strategies which had proven effective prior to COVID-19. Jacob's mother disclosed significant *anxiety related to her health and her family's health*, including who would care for her children if she became ill with COVID-19. She was particularly concerned because she had a pre-existing condition that put her at increased risk should she contract COVID-19. This was not the first time that Jacob's mother had confided in the clinician about her own mental health difficulties. Although the clinician had in the past referred Jacob's mother for outpatient treatment to address her depressed mood and trauma history, Jacob's mother had not followed through with the referrals. Initially, the clinician continued to set clear boundaries outlining her role as the child's therapist and providing referrals to an individual clinician at an adult-focused clinic. However, in the context of the pandemic and the many barriers faced by Jacob's mother, the clinician identified a personal and profes-

sional inclination to push the boundaries of her traditional role and provide more targeted intervention. The clinician, a trainee, discussed this sense of clinical obligation with her supervisor with whom she explored related ethical questions in the context of the larger case conceptualization. This conversation was then raised with the broader treatment team, who considered the potential pitfalls and benefits of treating Jacob and his mother concurrently. As the only available mental health professional to Jacob's mother, the team determined, in the best interests of both Jacob and his mother, it was appropriate for the clinician to extend her role and provide mental health supports to the patient's mother. However, the team also clarified that this role extension be time-limited, in service of improving family functioning (e.g., managing mother's anxiety would support implementation of behavioral parent training techniques), and that the clinician would continue to use motivational interviewing techniques to support Jacob's mother in seeking her own care. With this in mind, the clinician and Jacob's mother began to discuss and practice cognitive behavioral strategies to reduce the intensity and disruption of her worry, improve her sleep, and engage in problem solving when appropriate. To target her illness anxiety, the clinician supported Jacob's mother in completing imaginal exposures in which she gradually recorded and talked through the worst-case scenario related to her worries of contracting COVID-19. Consistent with the literature on exposure therapy for illness anxiety (Weck et al., 2015), the exposure practice helped Jacob's mother to identify distorted thinking patterns and feared scenarios that could be addressed with active problem solving. The clinician supported Jacob's mother in developing a structured plan in case she took sick with COVID-19 that included steps to ensure the safety and protection of her children should she need medical attention. Jacob's mother actively engaged in these telehealth sessions and reported a decrease in the frequency and intensity of her worry.

As Jacob's mother experienced some relief from her own anxiety symptoms, she expressed frustration with the format of Jacob's virtual school and the limited communication she had with school personnel. She noted concern about Jacob's lack of homework completion and his minimal participation in the virtual classroom. She also reported that there was minimal structure to help Jacob get through his virtual school day. In accordance with typical practice, the clinician sought to obtain collateral information from Jacob's teacher and collaborate on strategies to improve his academic performance in the virtual context (Swan et al., 2016); however, the clinician was *unable to reach his teacher or other relevant school personnel*. In order to

support Jacob's academic performance and daily behavior independent of teacher input, the clinician collaborated with Jacob's mother to develop a daily schedule for Jacob based on his attentional abilities. The daily schedule included brief, structured schoolwork time between 10 minutes and 30 minutes in length based on time of day and subject matter, and chunked schoolwork with scheduled breaks and rewards. Planned breaks included opportunities for indoor physical movement, snacks, and brief screen time (e.g., watching two videos online). Jacob also earned rewards in the form of stickers for completion of each structured activity. Stickers could be turned in for privileges at the end of the school day and privileges were selected based on activities most meaningful to Jacob, such as playing video games and getting to pick his snacks. The clinician assisted Jacob's mother in tracking Jacob's progress over time using his sticker chart, which provided data of his adherence to his daily schedule and compliance with house rules. The clinician utilized these sticker charts to reinforce both Jacob's progress and his mother's success in implementing behavioral interventions. While Jacob was on task approximately 25% of the time at the start of the pandemic, after approximately 2 months of consistent adherence to the interventions listed above, Jacob was on task approximately 75% of the time. In the same 2-month period, there were significant reductions in Jacob's aggressive behaviors, including complete remission of physical aggression and a reduction in verbal aggression from an average of three times a day to an average of three times per week.

Wrap-up and Next Steps

As the height of the pandemic waned, the clinician continued to assess family stressors related to the pandemic in addition to Jacob's progress in treatment. Given the nature of a training clinic, the primary clinician, a trainee, prepared Jacob and Jacob's mother for the upcoming transition in care. The trainee collaborated closely with the treatment team and Jacob's mother to develop a disposition plan best suited for the ongoing needs of Jacob and his family. It was determined that Jacob's mother would begin participation in a mentalization-based parenting group in a satellite clinic due to evidence that suggests such interventions are efficacious for individuals with their own mental illness, including trauma histories and difficulties with emotion regulation (Bateman et al., 2016; Suchman & Ordway, 2016), and to give Jacob's mother the opportunity to connect with other mothers with similar histories and parenting experiences given her limited social support network. Concurrently, Jacob would

return to weekly individual therapy with a particular focus on increasing his emotion regulation skills.

Clinical Vignette 2: Gabriela

Reason for Referral

Gabriela, a 15-year-old White and Hispanic cisgender female of Mexican descent, was treated in the clinic for approximately 4 months prior to the start of the COVID-19 pandemic. Gabriela was referred for treatment by her parents due to food restriction and intense fear of gaining weight, accompanied by significant weight loss over a 2-month time period. At intake assessment, due to identification of subthreshold but clinically interfering symptoms of Borderline Personality Disorder, including mood swings, impulsive behaviors, shifting self-image, and engaging in self-harm, Gabriela was admitted into the Adolescent Dialectical Behavior Therapy program. Additionally, given Gabriela's eating disorder symptom presentation, and because she was not underweight, Gabriela was diagnosed with Atypical Anorexia Nervosa, restricting type, and was referred to the clinic's Eating Disorders Program. Subsequently, Gabriela began individual DBT treatment, a multifamily DBT skills group, and attended family-based therapy treatment for her eating disorder, with weekly communication and collaboration amongst treatment team members.

Treatment Prior to COVID-19 Onset

Before the onset of the COVID-19 pandemic, Gabriela's treatment focused on orientation to individual and group DBT treatment, as well as building engagement and commitment. To address her eating disorder, Gabriela and her parents enrolled in Family-based Treatment (FBT) for anorexia, which empowers parents as members of the treatment team and agents of change who are responsible for planning, preparing, and supervising their child's food intake (Lock & Le Grange, 2013). Gabriela and her parents showed consistent DBT and FBT session attendance and engagement. After approximately 2 months in the DBT and Eating Disorders programs, Gabriela began demonstrating consistent weight gain at her weekly weigh-ins, gaining approximately 2 pounds per week. In addition, she denied any self-harm behaviors and noted improvements in mood and anxiety symptoms. After about 4 months, right before the onset of the pandemic, Gabriela's parents reported that she was finishing all of her meals with minimal complaints or hesitation, and even reported increased appetite. At that point, Gabriela had gained approximately 10 pounds, which she maintained week to week, and had reached a healthy weight as determined by her

medical provider. Gabriela reported continued negative thoughts about herself and her body, though these had decreased in frequency and intensity, and noted an improvement in her ability to communicate effectively with family members, peers, and teachers, which was also observed by her treatment team.

Treatment Adaptations During COVID-19

As COVID-19 pandemic restrictions began, Gabriela and her family were transitioned to telehealth services, initially by phone. Given the many treatment team members working with the family, along with the challenging circumstances the family faced as the pandemic began, care coordination meetings among the treatment team members were implemented on a weekly basis for the first 6 weeks after the transition to telehealth. This ensured that efforts to support the family were appropriately delegated, rather than duplicated, and important updates could be shared on a timely basis. There were multiple challenges encountered by the family that led to a transition in treatment focus at the start of the pandemic. First, amidst the shift to telehealth services, Gabriela and her parents disclosed that the entire family was experiencing symptoms consistent with COVID-19. Gabriela's parents expressed *concerns about being able to safely access health care services* to be tested and treated for the virus due to their *immigration status*. Gabriela's treatment team sought up-to-date information regarding access to health care and the safety of receiving care for undocumented families. After obtaining information from the NYC Mayor's Office of Immigrant Affairs and confirming the protocol with personnel within the larger hospital system, the treatment team communicated to Gabriela and her family that medical care, including COVID-19 testing and treatment, was available to all New Yorkers regardless of immigration status, ability to pay, or whether they had a doctor or insurance. Additionally, the treatment team confirmed that hospital staff would not ask about immigration status, nor would obtaining testing or treatment for the virus hurt the family's ability to apply for a green card. After communicating this information to Gabriela and her parents, they subsequently sought out testing and disclosed that all family members received positive results.

Around the same time, both of Gabriela's parents *lost their jobs* due to layoffs related to the pandemic. During the needs assessment, Gabriela's mother expressed *concerns about accessing food* for the family, due to *financial strain* and worries about leaving home and spreading the virus. Gabriela's clinicians coordinated and scheduled contact-free food delivery for the family through a free delivery service in coordina-

tion with a local food pantry. In addition, information was provided to the family about the *eviction moratorium* in NYC to ensure the family understood their protections from eviction amidst the financial challenges they were experiencing. The family declined further financial or employment resources, but expressed understanding that clinicians could assist with resources if needed or desired in the future. Last, while Gabriela and her family disclosed that their COVID-19 symptoms were in the mild-to-moderate range and could be treated from home, clinicians ensured that the family knew the treatment resources available to them, as well as signs (e.g., difficulty breathing) that a higher level of care may be appropriate. Clinicians validated Gabriela and her parents' concerns about spreading the virus, while also helping them to challenge unhelpful or inaccurate thoughts using previously learned cognitive restructuring skills. The treatment team praised and reinforced the family's efforts to quarantine effectively, using these efforts as evidence against persistent worries about spreading the virus.

The treatment team increased flexibility of session format and attendance to reduce barriers associated with multiple family illnesses, parental caretaking responsibilities, and employment searches. Sessions were initially conducted by phone and focused on basic needs assessment, risk assessment, and reinforcing treatment gains through review of relevant DBT and FBT skills. Once the family members reported recovery from the virus, the treatment team set up video telehealth services for the family, conducting multiple test sessions to troubleshoot *internet and technological difficulties*. With immediate health, food, and technology concerns resolved, Gabriela's treatment resumed focus on primary treatment targets established prior to the pandemic. In DBT, Gabriela's individual and group clinicians worked to reintegrate her into the group, after multiple missed sessions. Due to the family's decreased engagement in group services that resulted from competing demands (i.e., childcare), as well as Gabriela's improved symptom presentation, a collaborative decision was reached for Gabriela and her parents to take a break from group DBT. Instead, individual DBT focused on commitment strategies for session attendance, chain analyses of problem behaviors (e.g., urges to restrict food intake, ineffective communication with parents), and skills practice. Gabriela began consistently attending individual DBT sessions and reported improvement in her ability to be open and communicative with her family and her treatment team. Gabriela's FBT treatment resumed focus on supporting Gabriela's move toward independent eating. The family did not own a scale and it was not financially feasible

for them to purchase one; therefore, treatment focused on maintaining adequate portion sizes and eating all meals, as determined by Gabriela's parents, in addition to asking the family to report any noticeable weight changes. The family's food needs were assessed at regular intervals, and free food deliveries were scheduled accordingly. In addition, Gabriela learned to mindfully observe unhelpful automatic thoughts about eating, weight, and body image, to challenge those thoughts in the moment, and to replace them with helpful coping thoughts (e.g., "Eating keeps me healthy", "My weight does not determine who I am as a person").

Wrap-up and Next Steps

After 7 months in FBT, Gabriela showed significant improvement and reduction in her eating disorder symptoms. Given that the FBT clinician was a trainee who was preparing to leave the clinic, various options were discussed for Gabriela's continued treatment. The FBT clinician addressed maintenance and relapse prevention with the family, after which the family and broader treatment team agreed that Gabriela would graduate from FBT, with any remaining eating concerns monitored and addressed by her DBT clinician.

Clinical Vignette 3: Evan

Reason for Referral

Evan, a 14-year-old Black and Hispanic cisgender male, was treated at the clinic for approximately 1 year prior to the pandemic. He was self-referred by his mother due to a long-standing history of social anxiety and depressed mood following the separation of his parents. Per his mother's report, he was spending more time alone in his room and was more irritable towards family members. In addition, he avoided speaking to adults and peers, which began interfering with his academic performance once he entered middle school. He was seen for individual therapy for approximately 9 months and, in January 2020, Evan was referred to the clinic's CBT group for socially anxious teenagers.

Treatment Prior to COVID-19 Onset

In individual therapy, Evan engaged in behavioral activation to target his depressed mood. In response to this intervention, he reported improvements in mood, but it became apparent that his motivation to maintain this practice was limited by his social anxiety. Therefore, the CBT group for social anxiety was initiated to provide in-vivo exposure practice with other teenagers. Upon entry into the group, Evan reported that his goals included speaking more to teachers and peers and improved eye contact when interacting

with others. Within the first couple months of Evan's participation in the group, he indicated notable progress with increased awareness of his avoidant behaviors (e.g., not making eye contact, hiding behind others in the classroom so teachers would not call on him), an understanding of the rationale for exposure therapy, and increased participation in group-based exposure practice for social anxiety (e.g., giving a presentation in front of the group, speaking with unknown confederates).

Treatment Adaptations During COVID-19

When the COVID-19 pandemic began, Evan's primary clinician was deployed to medical units within the hospital to treat COVID-19 patients and thus weekly individual sessions with this clinician were paused. Given Evan's substantial progress in individual and group therapy and low-risk status, Evan continued participating in group therapy via video telehealth services as his primary treatment modality with adjunctive bi-weekly check ins for individual support from one of the group leaders. The group leader assessed his home environment and supported Evan and his primary caregiver—his grandmother—in problem solving barriers that may have interfered with his weekly participation. For example, Evan lived in a two-bedroom apartment with his grandmother, mother, and siblings. Evan noted that because of his home environment, it would be *difficult for him to find a private, quiet space* to participate in group via video conferencing. The group leader collaborated with both Evan and his grandmother to explore the options in their home that would allow for a space for Evan to participate in the group. Evan decided to sit on the floor in his shared bedroom during group sessions with his back against the wall to prevent his siblings from seeing the screen. Evan also wore headphones to maintain the confidentiality of other group members, and muted his microphone when he was not speaking during the group to limit background noise interference. In addition to environmental concerns, Evan expressed worry, in line with his diagnosis of social anxiety disorder, regarding showing his face to others on the virtual group call. Group leaders supported Evan in gradual exposure practice beginning with attending the group with his camera turned off (1 session), then progressing to leaving his video on, without having to appear on video (1 session), then appearing on video for at least half of group, including whenever he was speaking (2 sessions), and finally progressing to appearing in the video frame for the entire group session, which he maintained for the remainder of group (6 sessions). Evan's appearance on screen was reinforced by positive feedback from group members and group leaders.

When another group member rejoined the group after missing four sessions due to not having internet service and avoided showing her face, Evan served as a coping model and coached her through her gradual exposures.

As the patients adjusted to new lockdown orders, group leaders began to assess changes in mood and behavior across group members. While initially Evan and several other group members noted reduced social anxiety as a result of attending school from home and minimizing contact with others, as time passed, these group members noted *increased generalized anxiety and worry related to the virus and its impact on their family and community, and concerns about academic performance in the new virtual classroom setting*. Additionally, Evan, and others in the group, noted a decline in mood. Evan reported increased lethargy, boredom, and irritability, as well as an interrupted sleep cycle with naps in the middle of the day and difficulty falling asleep at night. In response, group leaders adjusted the scope of group CBT for social anxiety to account for these shared, transdiagnostic challenges, with a focus on COVID-19 education, strategies to reduce worry, sleep hygiene, and behavioral activation. For example, group leaders discussed the interplay between mood and sleep, and sought input from Evan and other group members on the ways in which their sleep behaviors changed during the COVID-19 lockdown, and the resulting impact on functioning and mood. Group leaders supported Evan and other group members in developing healthy sleep habits (i.e., setting consistent daily sleep and wake times) and daily schedules.

A common theme among group members was increased anxiety in relation to what group members were hearing and reading about COVID-19. Past research has shown an association between exposure to media coverage of upsetting events (e.g., the Boston Marathon bombing) and posttraumatic stress symptoms, particularly when caregivers are not monitoring exposure or communicating effectively with youth about these events (Comer et al., 2014). Evan, like other group members, noted that social media was his primary source of information, and he reported seeing a lot of “bad things” posted on social media about the virus. With increased anxiety about catching the virus and spreading it to other family members, he eventually stopped going outside entirely. Group leaders sought collateral from Evan’s grandmother, who reported feeling uncertain about how to best ensure the health and safety of her family while balancing the need for her grandchildren to spend time outdoors. Evan’s grandmother also reported uncertainty about how to communicate with Evan about the pandemic.

In response to this growing need, the CBT group leaders sought to help disseminate up-to-date, data-driven information about COVID-19 from reputable sources (i.e., Centers for Disease Control and Prevention, World Health Organization), as well as strategies for accessing reliable COVID-19 information. Group leaders focused a portion of time in two group sessions on identifying and accessing reliable information about the COVID-19 pandemic and setting helpful limits on news intake to prevent worsening mood and anxiety symptoms. Collateral sessions were conducted with caregivers as needed to provide strategies for talking to youth about the pandemic (e.g., validating youths’ feelings, supporting them to limit unhelpful social media exposure). Collateral sessions also supported generalization of cognitive behavioral strategies outside of group sessions. Group leaders provided Evan’s grandmother, a monolingual Spanish speaker, with up-to-date information and safety guidelines (e.g., protocols for going outside) in Spanish. Additionally, group leaders provided psychoeducation to Evan’s grandmother, emphasizing patterns of avoidance that were maintaining and exacerbating Evan’s anxiety and the role of behavioral activation and activity scheduling to target Evan’s mood. With his grandmother’s increased understanding of data-driven COVID-19 safety guidelines, she collaborated with the clinicians on a plan for gradual exposure to the outdoors and activity scheduling that allowed access to fresh air and physical activity to support improvements in mood. Evan’s exposure hierarchy started with imaginal exposures to going outside, then progressed to sticking his head out of the window and observing the outside, eventually moving toward standing outside of his apartment and taking walks around the block while remaining socially distant from others. These procedures (i.e., psychoeducation on mood/anxiety, dissemination of data-driven safety guidelines, steps for accessing reliable information on COVID-19, exposure/behavioral activation) were replicated with other families in the clinic. Clinicians delivered this information and these practices with validation of caregiver and child concerns and consideration of the cultural factors (e.g., primary language spoken, family values), and individual risk factors.

Wrap-up and Next Steps

Evan, along with other group members, reported improvements in mood and functioning (i.e., homework completion) after implementing a consistent daily routine, spending less time on social media consuming information about the virus, improving sleep habits, and increasing time spent outside while still following safety protocols. As the group approached the group termination date, relapse prevention became

the primary focus. For Evan, this meant supporting maintenance of treatment gains related to his mood, particularly in the context of ongoing lockdown guidelines in place for the upcoming summer. Relapse prevention also focused on maintaining gains related to approaching feared social situations (i.e., speaking in his virtual classroom, talking more to teachers and peers). Notably, as the “usual” group end date approached, and group leaders and members discussed termination, all six group members opted unanimously to extend the group by several sessions. Evan’s progress toward his goals related to social anxiety was exhibited in one of the final group sessions when he expressed his desire to continue participation in the virtual social anxiety group throughout the summer months. While initially Evan refused to show his face in the video frame, by the termination of the group, Evan assumed qualities of a leader, often volunteering to share his thoughts and home practice with other group members and volunteering to be the first to practice in-session social exposures.

Discussion

Mental health treatment can be an incredibly valuable resource while navigating major life changes and transitions, such as those brought on by the pandemic. However, to be able to access and attend to mental health care, certain needs must be met. The onset of the COVID-19 pandemic created new challenges and exacerbated preexisting inequities for our marginalized patient population. Increased rates of COVID-19 exposure and illness in the Bronx, along with fewer resources for families to call upon, left many families in need of increased support from their mental health clinicians. As described in these clinical vignettes, many families served in the clinic suddenly found themselves without access to resources such as food, internet, and employment. Concurrently, children and families faced mental health difficulties, which oftentimes were exacerbated by the increased stressors imposed by the pandemic. The needs of the families shaped the evolving roles and treatment targets of the treatment team.

Clinical Implications

The treatment team gained a number of clinical insights and lessons relevant to evidence-based mental health practice amidst an ongoing pandemic. First, as clinicians broadened the scope of their professional practice, it became apparent that advocacy may emerge or take precedence in clinical practice for children and

families, depending on context (e.g., general care of marginalized populations, the COVID-19 pandemic, other acute life stressors). With frequent virtual contact, expertise in evidence-based treatment, and a commitment to advocacy, our team was uniquely positioned to support families who were often isolated from other community resources that were shut down during the pandemic (e.g., school, religious centers). Our team facilitated access to essential resources (e.g., food, internet), sought to reduce systemic barriers (e.g., lack of data-driven information about COVID-19, access to health care), and provided ongoing evidence-based interventions targeting symptoms that predated COVID-19, as well as symptoms that were exacerbated by or newly emerged during the pandemic.

The value of this approach was apparent in the treatment gains achieved by our patients, as exemplified in these clinical vignettes. Our experience echoes decades of research of systems of care for youth mental health that have shown that this model is associated with increased use of evidence-based practices, improved family functioning, improved school attendance, increased cross-systems collaboration, and reduced acuity of mental health problems (e.g., decreased suicide rates, decreased inpatient/residential stays; [Stroul et al., 2012](#)). We contend that mental health clinicians, particularly those who work with marginalized children and families, develop competency in these additional professional activities (e.g., collaboration with other systems, case management, supporting families to access basic needs) through training and supervision as a part of typical practice, not only in times of crisis like a pandemic. This training would ideally coincide with training in evidence-based treatments, in order to prepare clinicians to function as evidence-based clinician-advocates. Given evidence that training alone does not result in clinician behavior change ([Beidas et al., 2012](#)), ongoing supervision may be a practical and feasible practice leveraged to support the implementation and sustainment of advocacy efforts as they are integrated with evidence-based treatment.

Second, maintaining flexibility in relation to treatment plans, treatment goals, interventions, and scope of practice was essential to meet the unique needs of youth and families in the midst of a pandemic. As described in the vignettes, clinicians functionally assessed and addressed patient problems and needs beyond the scope of the prepandemic treatment plans as care transitioned to the virtual format and families began to be affected by COVID-19. As clinicians engaged in ongoing assessment to ensure safety and

adequate resources, they simultaneously integrated evidence-based strategies (i.e., exposure, psychoeducation) to address the mental health needs of both patients and their family members. Amidst the many changes and transitions, a focus on maintaining treatment gains, addressing treatment goals, and responding to emerging mental health issues through implementation of evidence-based care remained paramount. This practice exemplifies “flexibility within fidelity” (Kendall et al., 2008), as evidence-based principles remained integral to the treatment approach but were adapted and delivered flexibly based on the individual needs and circumstances of each patient and family. Since youth in low-income, at-risk communities experience more frequent acute life stressors, which have been shown to adversely affect evidence-based treatment integrity and client progress in community mental health settings (Chorpita et al., 2014; Guan et al., 2017), more practical guides are needed to inform the process of adaptations to evidence-based treatment. This article expands upon the existing literature on adaptations to evidence-based practices (see, Stirman et al., 2013; Lau et al., 2017; Kim et al., 2020) by providing case vignettes that specify adaptations to evidence-based practice in a mental health clinic within the context of an acute stressor—the onset of the pandemic. For example, clinicians assumed a transdiagnostic approach when appropriate (i.e., shifting to evidence-based strategies for depression in a social anxiety group) and integrating strategies outside of the evidence base that were relevant to the context (i.e., teaching how to identify reliable news sources). Additionally, clinicians sought to be culturally responsive in their approach in order to meet the individual needs of each client and family system (e.g., providing services in the primary language of the caregiver). This practice of flexibility within fidelity supported culturally responsive and individualized care that was rooted in best practices.

Third, the importance of conducting needs assessments with every family became clear in the early days of the pandemic. There was a natural increase in contact with caregivers at the onset of the pandemic when collecting the necessary confidentiality and telehealth permissions for remote care. While some caregivers initiated conversations about the challenges their families were encountering due to the pandemic, many families did not voice concerns until specifically asked about their needs by clinicians. This could have been for a variety of reasons, including difficulty asking for assistance or not knowing that the mental health team could provide assistance outside of the traditional scope of mental health care. It was important to clearly communicate to families that the team could find and

connect them to resources, and to specifically name the types of resources available. Additionally, clinicians followed up with families to ensure that resources were accessed successfully and continued to check in, problem-solve, and arrange for additional resources as needed. As the pandemic persists, ongoing and repeated needs assessment, in combination with referrals and links to appropriate resources, is recommended to support access to basic resources and support family functioning.

Last, the changing circumstances brought on by the pandemic required increased communication and collaboration among clinicians. Team meetings occurred more frequently at the onset of the pandemic. These meetings provided a forum for clinicians to collaboratively identify and target advocacy-related goals, maintain ongoing evidence-based treatment, case consultation, and collaboration, and allowed for clinicians to discuss issues related to their own burnout in the context of the pandemic. In addition to frequent, solution-focused meetings, the prior existence of the health advocacy training series also prepared clinicians to broaden their roles as clinician-advocates. In this training series, clinicians developed competencies in building self-awareness (e.g., one’s own biases and social identities), understanding social inequities, and learning strategies to create social change. Clinicians leveraged this training to launch advocacy efforts at the individual, family, and community levels during the pandemic. Integrating advocacy training into child-focused training programs and child clinical settings may facilitate a swift and targeted response for marginalized families in times of crises, like the COVID-19 pandemic.

Limitations and Challenges

We sought to highlight the process of integrating advocacy in conjunction with evidence-based mental health treatment for youth and families during the onset of the COVID-19 pandemic. There are several limitations that should be noted. First, access to patient data (e.g., session progress notes, symptom monitoring data) was limited due to changes in author employment amidst the pandemic, and thus there were restrictions in accessing patient records. Integration and analysis of additional patient data, such as coding of session content, may have yielded rich quantitative findings. Next, it is important to note that the clinical vignettes were drawn from a single youth mental health clinic, and thus there may be limitations to the generalizability of our account. In particular, the barriers (e.g., housing, food) that our team identified for our patient population, comprised of primarily low-

income people of color, may not be generalizable to all clinics or patient populations. Despite this limitation, the process of expanding the clinician-advocate role and the practices described (e.g., needs assessments, adapting evidence-based treatments) can be replicated, adopted, and adapted for different patient populations.

We describe the rollout of an advocacy initiative in its initial phase (approximately 3 months) of the pandemic and thus advocacy efforts are limited in scope (i.e., ensuring the welfare of patients and families). As the pandemic ensues and its long-lasting consequences on marginalized communities become more apparent, continued efforts to address the underlying causes of inequities and inform policy and systems change will be essential. Advocacy within local, state, and national organizations and government has the potential to address many of the disparities highlighted in this article, such as poverty, access to safe and affordable health care, and access to equal education. The article may be used as a guide to inform the initial stages of becoming a clinician-advocate and the practice of integrating advocacy and evidence-based treatment.

Additional challenges emerged as clinicians expanded their professional scope to address systemic inequities. Community clinicians have greater risk for burnout and emotional exhaustion due to long work hours and large caseloads that are characterized by poverty, clinical complexity, and comorbidity (Aarons et al., 2009; Southam-Gerow et al., 2008). Additional training in advocacy implementation is likely to increase demands on already overtaxed clinicians in the community. While our clinic did not systematically assess therapist burnout during the pandemic, based on anecdotal accounts, burnout related to general pandemic stress, increased work hours, and increased demands (e.g., developing resource list) was high. Burnout was addressed in supervision and team meetings where scheduled time was set aside for discussing, providing validation and support for, and problem-solving therapist burnout. It will be essential for clinical practice settings to develop procedures and supports to limit additional burden and burnout to their clinicians as they integrate evidence-based practice and advocacy as a part of their standard professional practice.

Conclusion

Throughout the pandemic, it became apparent that child-focused clinicians were well-positioned to affect change for marginalized families whose physical health and mental health, access to resources, and financial

positions were disproportionately impacted by COVID-19. As COVID-19 and its lasting socioeconomic impact are likely to continue to impact marginalized communities, there is an opportunity and need for mental health clinicians to stretch the bounds of their traditional roles. Given their training in evidence-based psychosocial interventions and ecological systems, as well as their ethical duty to ensure the welfare of their patients, child-focused clinicians have the training and expertise to function as clinician-advocates. Evidence-based mental health clinicians are encouraged to leverage this position and expertise in order to support the safety, well-being, and mental health of entire family systems and to combat the inequities exacerbated by COVID-19.

References

- Aarons, G. A., Wells, R. S., Zagursky, K., Fettes, D. L., & Palinkas, L. A. (2009). Implementing evidence-based practice in community mental health agencies: A multiple stakeholder analysis. *American Journal of Public Health, 99*, 2087–2095. <https://doi.org/10.2105/AJPH.2009.161711>.
- Ali, A., & Sichel, C. E. (2014). Structural competency as a framework for training in counseling psychology. *The Counseling Psychologist, 42*(7), 901–918. <https://doi.org/10.1177/0011000014550320>.
- American Psychological Association (2012). Revised competency benchmarks in professional psychology. Retrieved from <http://www.apa.org/ed/graduate/benchmarks-evaluation-system.aspx>.
- American Psychological Association (2020). Stress in the time of COVID-19, volume one. <https://www.apa.org/news/press/releases/stress/2020/stress-in-america-covid.pdf>.
- Barrett, J. G., & Olle, C. D. (2016). Social justice training in action: A counseling psychologist's role in a police-mental health collaborative serving disadvantaged youth. *Journal for Social Action in Counseling & Psychology, 8*(2), 13–31. <https://doi.org/10.33043/JSACP.8.2.13-31>.
- Bateman, A., O'Connell, J., Lorenzini, N., Gardner, T., & Fonagy, P. (2016). A randomised controlled trial of mentalization-based treatment versus structured clinical management for patients with comorbid borderline personality disorder and antisocial personality disorder. *BMC Psychiatry, 16*, 304. <https://doi.org/10.1186/s12888-016-1000-9>.
- Beidas, R. S., Edmunds, J. M., Marcus, S. C., & Kendall, P. C. (2012). Training and consultation to promote implementation of an empirically supported treatment: A randomized trial. *Psychiatric Services, 63*(7), 660–665. <https://doi.org/10.1176/appi.ps.201100401>.
- Bronfenbrenner, U. (1979). *The ecology of human development*. Harvard University Press.
- Bruns, E. J., & Walker, J. S. (2010). Defining practice: Flexibility, legitimacy, and the nature of systems of care and wraparound. *Evaluation and Program Planning, 33*(1), 45–48. <https://doi.org/10.1016/j.evalprogplan.2009.05.013>.
- Cabassa, L. J., & Baumann, A. A. (2013). A two-way street: Bridging implementation science and cultural adaptations of mental health treatments. *Implementation Science, 8*(1), 1–14. <https://doi.org/10.1186/1748-5908-8-90>.
- Cao, W., Fang, Z., Hou, G., Han, M., Xu, X., Dong, J., & Zheng, J. (2020). The psychological impact of the COVID-19 epidemic on

- college students in China. *Psychiatry Research*, 287, 112934. <https://doi.org/10.1016/j.psychres.2020.112934>.
- 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. <https://doi.org/10.1037/a0037746>.
- Clark, E., Fredricks, K., Woc-Colburn, L., Bottazzi, M., & Weatherhead, J. (2020). Disproportionate impact of the COVID-19 pandemic on immigrant communities in the United States. *PLoS Neglected Tropical Diseases*, 14(7). <https://doi.org/10.1371/journal.pntd.0008484>.
- Comer, J. S., Dantowitz, A., Chou, T., Edson, A. L., Elkins, R. M., Kerns, C., Brown, B., & Greif Green, J. (2014). Adjustment among area youth after the Boston marathon bombing and subsequent manhunt. *Pediatrics*, 134(1), 7–14. <https://doi.org/10.1542/peds.2013-4115>.
- Courtney, D., Watson, P., Battaglia, M., Mulsant, B. H., & Szatmari, P. (2020). COVID-19 impacts on child and youth anxiety and depression: Challenges and opportunities. *The Canadian Journal of Psychiatry*, 65(10), 688–691. <https://doi.org/10.1177/0706743720935646>.
- Dooley, D., Bandealy, A., & Tschudy, M. (2020). Low-Income children and coronavirus disease 2019 (COVID-19) in the US. *JAMA Pediatrics*. <https://doi.org/10.1001/jamapediatrics.2020.2065>.
- Finch, W. H., & Finch, M. H. (2020). Poverty and Covid-19: Rates of incidence and deaths in the United States during the first 10 weeks of the pandemic. *Frontiers in Sociology*, 5. <https://doi.org/10.3389/fsoc.2020.0004>.
- Guan, K., Levy, M. C., Kim, R. E., Brown, T. E., Reding, M. E., Rith-Najarian, L., Sun, M., Lau, A., & 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>.
- Hernandez, M., & Hodges, S. (2003). Building upon the theory of change for systems of care. *Journal of Emotional and Behavioral Disorders*, 11(1), 19–26. <https://doi.org/10.1177/106342660301100104>.
- Karpman, M., Zuckerman, S., Gonzalez, D., & Kenney, G. M. (2020). The COVID-19 pandemic is straining families’ abilities to afford basic needs. Urban Institute. <https://www.urban.org/research/publication/covid-19-pandemic-straining-families-abilities-afford-basic-needs>.
- 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.0b013e31817eed2f>.
- Kim, J., Brookman-Frazee, L., Barnett, M., Tran, M., Kuckertz, M., Yu, S., & Lau, A. S. (2020). How community therapists describe adapting evidence-based practices in sessions for youth: Augmenting to improve fit and reach. *Journal of Community Psychology*, 48, 1–20. <https://doi.org/10.1002/jcop.22333>.
- 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>.
- Lewis, J. A., Arnold, M. S., House, R., & Toporek, R. L. (2002). ACA Advocacy Competencies. Retrieved from: http://www.counseling.org/Resources/Competencies/Advocacy_Competencies.pdf.
- Liang, L., Ren, H., Cao, R., Hu, Y., Qin, Z., Li, C., & Mei, S. (2020). The effect of COVID-19 on youth mental health. *Psychiatric Quarterly*, 1–12. <https://doi.org/10.1007/s11126-020-09744-3>.
- Lock, J., & Le Grange, D. (2013). *Treatment manual for Anorexia Nervosa: A family-based approach*. The Guilford Press.
- Lorant, V., Deliege, D., Eaton, W., Robert, A., Philippot, P., & Anseau, M. (2003). Socioeconomic inequalities in depression: A meta-analysis. *American Journal of Epidemiology*, 157(2), 98–112. <https://doi.org/10.1093/aje/kwf182>.
- Martinez, D., Hinson, J., Klein, E., Irvin, N., Saheed, M., Page, K., & Levin, S. (2020). SARS-CoV-2 positivity rate for Latinos in the Baltimore-Washington. *DC Region. JAMA*, 324(4), 392–395. <https://doi.org/10.1001/jama.2020.11374>.
- Mazza, C., Ricci, E., Biondi, S., Colasanti, M., Ferracuti, S., Napoli, C., & Roma, P. (2020). A nationwide survey of psychological distress among Italian people during the COVID-19 pandemic: Immediate psychological responses and associated factors. *International Journal of Environmental Research and Public Health*, 17(9), 3165. <https://doi.org/10.3390/ijerph17093165>.
- Price-Haywood, E., Burton, J., Fort, D., & Seoane, L. (2020). Hospitalization and mortality among black patients and white patients with Covid-19. *The New England Journal of Medicine*, 382(26), 2534–2543. <https://doi.org/10.1056/NEJMsa2011686>.
- Smith, L. (2010). *Psychology, poverty, and the end of social exclusion: Putting our practice to work*. Teachers College Press.
- 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, 168–180. <https://doi.org/10.1007/s10488-007-0154-7>.
- Stroul, B. A., & Friedman, R. M. (1986). *A system of care for children and youth with severe emotional disorders*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.
- Stroul, B. A., Goldman, S. K., Pires, S. A., & Manteuffel, B. (2012). Expanding systems of care: Improving the lives of children, youth, and families. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children’s Mental Health. Retrieved from <https://web.archive.org/web/20151216164109/https://guchdcenter.georgetown.edu/publications/SOC%20Results%205-7-12.pdf>.
- Stirman, S. W., Miller, C. J., Toder, K., & Calloway, A. (2013). Development of a framework and coding system for modifications and adaptations of evidence-based interventions. *Implementation Science*, 8(65), 65. <https://doi.org/10.1186/1748-5908-8-65>.
- Suchman, N. E., Ordway, M. R., De las Heras, L., & McMahon, T. J. (2016). Mothering from the Inside Out: Results of a pilot study testing a mentalization-based therapy for mothers enrolled in mental health services. *Attachment & Human Development*, 18(6), 596–617. <https://doi.org/10.1080/14616734.2016.1226371>.
- Swan, A. J., Kagan, E. R., Frank, H. E., Crawford, E., & Kendall, P. C. (2016). Collateral support: Involving parents and schools in treatment for youth anxiety. *Evidence-based Practice in Child and Adolescent Mental Health*, 1(1), 3–15. <https://doi.org/10.1080/23794925.2016.1158625>.
- Toporek, R. L., & Liu, W. M. (2001). Advocacy in counseling: Addressing race, class, and gender oppression. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *The intersection of race, class, and gender in multicultural counseling* (pp. 285–413). Thousand Oaks, CA: Sage.
- Weck, F., Neng, J. M. B., Richtberg, S., Jakob, M., & Stangier, U. (2015). Cognitive therapy versus exposure therapy for

hypochondriasis (health anxiety): A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 83(4), 665–676.
Yancy, C. W. (2020). COVID-19 and African Americans. *JAMA*, 323(19), 1891–1892. <https://doi.org/10.1001/jama.2020.6548>.

The authors would like to relay appreciation to the interdisciplinary team of clinicians at the Child Outpatient Psychiatry Division and the children and families we are honored to serve. This research did not receive any specific grant from funding

agencies in the public, commercial, or notfor-profit sectors. The authors declare no conflicts of interest.

Address correspondence to Abby Bailin, Ph.D., 525 East 68th Street, New York, NY 10065. e-mail: abby.bailin@utexas.edu.

Received: September 16, 2020

Accepted: April 19, 2021

Available online 12 May 2021