# Toolkit for Modifying Evidence-Based Practices to Increase Cultural Competence

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# 1 Introduction

Since the beginning of the 21st century, there has been broad recognition of the impact of culture on mental health service utilization and service delivery. This understanding has been documented in seminal works such as *Crossing the Quality Chasm: A New Health System for the 21st Century*, The President's New Freedom Commission on Mental Health report—*Achieving the Promise: Transforming Mental Health Care in America*, and the Surgeon General's report entitled *Mental Health: Culture, Race and Ethnicity*. These works have explained how culture plays a role in how mental health is expressed and managed in the US. They have also discussed how the culture of providers impacts service delivery and enumerate barriers to help-seeking in cultural groups. Additionally, recommendations have been made for improving the mental health care system in the US by addressing systemic weaknesses and eliminating culture-specific barriers.

Culture impacts how people exhibit symptoms of mental illness, the use of coping mechanisms, social supports, and willingness to seek care. Additionally, cultural and social factors, such as poverty, racism, and other forms of discrimination, may impact mental well-being. Help-seeking behaviors and types of mental health services utilized vary by culture, and cultural minorities are underserved in the current mental health system.

Cultural factors also impact mental health providers. These factors contribute to how consumers are diagnosed and treated. In addition to the culture of consumers, overall service delivery is impacted by the culture of both providers and organizations.

Lack of cultural competence can also contribute to barriers to engagement or continued utilization of available mental health services. These barriers can include stigma perceived by consumers, mistrust of the mental health care system based on previous experiences, conflicting ideas about what constitutes mental health and illness, culturally-based help-seeking behaviors, historical oppression, lack of insurance, and individual and institutional discrimination.

Elimination of barriers to care and improved access to high quality care are thought to increase service utilization and improve outcomes for cultural groups. It is widely understood that culturally competent services are necessary in order to improve the mental health system in the US. The New Freedom Commission has identified six goals for transforming the mental health care system. One of these is to eliminate disparities in mental health services by improving access to culturally competent quality care. Access to care can be improved by locating services in areas convenient to cultural groups, improving language access for people with limited English proficiency (LEP), and improving efforts to overcome shame, stigma, and discrimination. Additionally, recommendations have been made to engage consumers, families, and communities in developing services that are congruent with cultural norms, promote evidence-based treatments, and understand and respect the world views and experiences of consumers of all cultural groups.

In November 2007, the Nathan Kline Institute for Psychiatric Research (NKI) received funding from the NYS Office of Mental Health, establishing a Center of

Culture impacts how people exhibit symptoms of mental illness.

Assumption: There is an identified need for services in the cultural community.

Excellence in Culturally Competent Mental Health. Its charge is to "identify, assess the outcome and disseminate best practices of demonstrated behaviors, attitudes, policies and structures" that work effectively across varied cultures and modalities of care. The Center strives to move the cultural competency field forward.

The NKI Center focuses on evidence-based practices for cultural groups that reside in New York State. Community representatives, consumers and family members serve on an advisory panel and have input into the Center's projects. Center collaborators include the NYS Office of Mental Health Central Office, NYS Multicultural Advisory Committee, the Psychiatric Institute Center of Excellence in Cultural Competence, NKI Center for the Study of Recovery in Social Contexts along with the NKI/New York University clinical affiliates. Development of this Toolkit is one of many projects within this Center with the goal of providing a methodology for modifying evidence-based practices to better serve specific cultural groups.

## 1.1 Purpose of the Toolkit

The purpose of this Toolkit is to provide mental health services organizations a structured method for modifying Evidence-Based Practices (EBPs) to better meet the needs of the cultural groups they serve. It is targeted to assist organizations facing one or more of three service-delivery challenges:

- EPBs have not been developed for specific cultural groups.
- EPBs have been developed, but not tested for effectiveness for specific cultural groups.
- EBPs have been developed and tested for cultural groups, but materials such as training manuals do not reflect the breadth of cultures served.

While the Toolkit has primarily been developed for organizations already providing services by using EBPs, its methods and recommendations also apply to services that are not currently considered EBPs.

It should be noted that the need for EBP modification will be based on many factors, but not every implementation will require cultural modifications nor will every implementation require the same level of effort in order to achieve a high degree of cultural competence. The decision whether or not modifications are necessary should be made while working with communities.

## 1.2 The Rationale for Evidence-Based Practices

The field of mental health is rapidly moving towards providing services by utilizing intervention strategies that have been assessed for effectiveness based on empirical criteria, often referred to as Evidence-Based Practices (EBPs). It is widely accepted that the use of EBPs will improve the quality of mental health services. Since they have been subject to rigorous scientific testing, EBPs should provide consistent outcomes for consumers when they are implemented as designed.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is helping the field determine which programs and practices meet a set of "evidence" standards. SAMHSA has established a registry of mental health EBPs – the National Registry of Evidence Based Programs and Practices (NREPP) – which is growing as developers present their programs and practices for review.

In general, the interventions listed in NREPP have proven to be effective. It is clear after close review, however, that EBPs have not been tested or proven to be effective across all cultural groups. Two factors compound the difficulties in modifying EBPs for cultural groups:

### There is no systematic method for considering modifications to EBPs for cultural groups.

Mental health professionals aim to offer the most effective, comprehensive, and evidence-based services to consumers in a way that is culturally appropriate. But culture-specific needs are often not addressed within the manuals and materials available for implementing EBPs. Without this guidance, organizations and providers have chosen to modify EBPs on their own using many different methods with varying outcomes.

### EBP implementation may be perceived by practitioners as rigid.

All EBPs have guidelines but some are highly scripted, with tightly defined requirements and recommendations. This can make it difficult to determine how and what parts of EBPs can be modified to address the needs and preferences of specific cultural groups while maintaining desired outcomes.

The concept of modifying mental health interventions for diverse consumer groups is not new. To do it effectively, however, may call for a more systematic, thoughtful method. Doing this increases the likelihood that practitioners will stay faithful to the modified EBP and, thus, deliver expected outcomes.

## 1.3 The Need for Cultural Modification of EBPs

An important assumption underlying the material presented in this Toolkit is that there is an identified need for services within a cultural group in the community. This need may have emerged in several different ways. However, the Toolkit assumes that, in each case, an EBP is warranted to address the identified need. Three specific situations are described below to highlight the differing circumstances in which the need for EBP modification would take place:

### Organization/provider recognition of need for mental health services for specific cultural group(s)

In this case, organization personnel come to realize that there is a clinical problem within a cultural group in the community, and that there are no services addressing the problem. For example, an organization serving Caribbean immigrants may notice that parents in the community are having difficulty parenting in the face of separation from partners who have not yet immigrated. In this case, the organization selects New Beginnings Program, an appropriate EBP, with the help of community members, and makes modifications as necessary to serve the community's cultural groups.

EBPs have not been tested or proven to be effective across all cultural groups.

A bullying prevention program addresses the clinical needs in the school community in a culturally sensitive way.

### A problem is identified in the community and the community requests help from the mental health organization

This is a more "grassroots" approach: an organization or community group, within a particular cultural group, presents a mental health organization with a problem and asks for help in developing an appropriate intervention. For instance, a social service organization serving the Orthodox Jewish community in the greater New York City area provides private religious day schools with treatment and prevention services. A school principal has come to the organization requesting help addressing "bully-type" behavior in his elementary school. The organization has modified a bullying prevention program – "Success in Stages: Build Respect, Stop Bullying",– to address the clinical needs in the school community in a culturally appropriate way.

### Mandates or requirements to provide EBPs or to serve specific cultural groups

Finally, some organizations are required to utilize EBPs in compliance with regulations or funding rules. Increasingly, both funders and oversight organizations are relying on EBPs to ensure treatment consistency in the belief that they will improve effectiveness. EBPs will be most successful if they are culturally appropriate for all the groups they serve. There may be a mismatch between the cultural group for which the EBP was designed and tested, and the cultural group(s) served by the organization. In this case, EBP modifications for cultural groups should be considered in order to ensure the effectiveness of the intervention.

## 1.4 Foundation of the Toolkit

### The Toolkit is an outgrowth of the Center's previous work

This Toolkit is a direct outgrowth of previous work done by the Nathan Kline Institute Center of Excellence in Culturally Competent Mental Health. It follows the development and testing of the Cultural Competency Assessment Scale developed by staff at the Center for the Study of Issues in Public Mental Health. This scale helps organizations measure their current level of cultural competence and identify areas in which they can make improvements. The scale was developed within a multicultural working group context, and lessons learned from the process have been incorporated into this Toolkit, particularly in the *Working with Communities* section.

### The Toolkit follows the helping process

Most mental health providers, regardless of their profession, utilize a formal helping process that includes consumer engagement, clinical work, and termination/discharge. This helping process model forms the basis for examining EBPs and breaking them down into intervention components for possible modification.

### The Toolkit is based on experience from the field

This includes input and consultation with mental health practitioners and researchers who have worked through the modification process for different cultural groups. Input from two such consultations have been highlighted in the *Case Studies* featured in this Toolkit. Development of this Toolkit has also benefited from work in other fields, such as the well-documented and successful work of the Centers

for Disease Control and Prevention (CDC) to disseminate and modify HIV/AIDS prevention interventions for use by cultural groups around the globe. Finally, current literature in the field was reviewed (see the *Annotated Bibliography*) and focus groups were conducted with social workers who routinely adapt interventions based upon the diverse cultural groups they serve.

### The Toolkit emphasizes outreach into the cultural group community

Community outreach is conducted throughout the modification process. This is a major differentiator between an EBP modification for cultural groups and other types of EBP modifications.

## 1.5 Users of the Toolkit

This Toolkit has been developed for use by mental health organizations or provider groups that have the resources to fully modify implement and evaluate an EBP. In most cases, this will require the organization to enlist a "champion" (clinical or administrative) who is responsible for leading the modification process. In order to effectively lead the effort, however, the "champion" needs both access to the cultural group community and the commitment within the organization to work through and complete the cultural modification. This commitment can be in the form of time, staff, funds, administrative support and adjustment of other work responsibilities to permit the work to take place.

While the Toolkit is geared toward EBP modification within an organizational context, it is also a useful tool for mental health practitioners in individual or small group practices. The information and recommended procedures contained in each section of the Toolkit can be scaled down to fit the needs of the solo-practitioner or small organization.

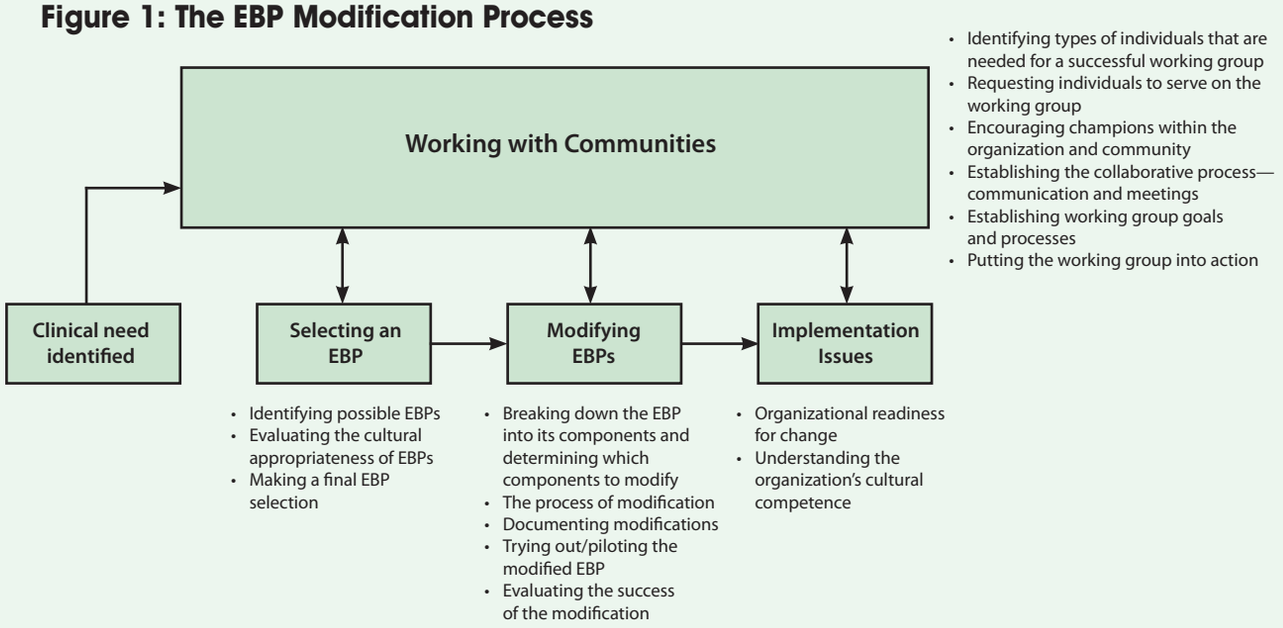
## 1.6 Overview of the Toolkit

The cultural-modification process laid out in this Toolkit has four phases once a clinical need has been established: 1) *Working with Communities*, 2) *Selecting an EBP*, 3) *Modifying EBPs*, and 4) *Implementation Issues*. While organizational cultural competence and readiness for change are discussed in the *Implementation Issues* section, organizations may want to consider doing these assessments early on, as doing so may help organizations understand strengths and weaknesses in this area and how that may impact the modification process. For example, organizations that are more culturally competent and ready for change will likely have an easier time completing the cultural modification process than organizations that are less culturally competent and less ready for change.

The process described in the Toolkit is illustrated in Figure 1, on page 6. The Toolkit has separate sections dedicated to each of the four phases plus an *Annotated Bibliography*. In addition, the Toolkit includes several accompanying documents, which provide users with additional information and tools to assist in the EBP modification process. These accompanying documents are referred to throughout the Toolkit and include: a checklist and workbook to assist users implement the methodology set out in the Toolkit, a glossary, scales, and assessment tools.

Community outreach is conducted throughout the modification process. This is a major differentiator between an EBP modification for cultural groups and other types of EBP modifications.

**Figure 1: The EBP Modification Process**




## 1.7 Definition of Key Terms

To fully understand the orientation of the Toolkit, several important terms are defined below. Additional terms and their definitions can be found in an accompanying document.

***Evidence-Based Practice (EBP)*** is an approach to prevention or treatment that is backed by documented scientific evidence demonstrating positive outcomes in multiple research studies. Evidence can be obtained through a variety of methods such as randomized clinical trials, experimental studies, or meta-analyses. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has defined an EBP as an "intervention which has been consistently shown in several research studies to assist consumers in achieving their desired goals of health and wellness." (SAMHSA, 2008). EBPs include individual prevention or clinical interventions, population-based interventions, and administrative and system-level practices or programs.

Evidence-Based Practices (EBP) are interventions backed by documented scientific evidence.

There are many EBPs for mental health treatment and prevention and several sources for locating them. To develop this Tookit, we have relied on the list of EBPs assembled by SAMHSA in its National Registry of Evidence-based Programs and Practices (NREPP). Programs and practices on the NREPP list have been examined by experts and experienced professionals in the field using strict criteria and are judged to be "evidence-based."

***Culture*** is the way of life of a group of people. It encompasses behaviors, beliefs, values, and symbols that are accepted and passed along by communication and imitation from one generation to the next. Culture can be shaped by the society in which one lives. Large societies often encompass cultural variations which differentiate some members from the larger group. These can be based on domains such as age, race, ethnicity, class, gender, political affiliation, religion, geographic location, and/or sexual orientation, among other factors. Throughout the Toolkit, we refer to the local cultural group served by the EBP as the ***community***.

With this definition in mind, it is not difficult to understand that EBPs designed to address concerns of a given cultural group may not be suitable for those who differ from the dominant culture or for other cultures, thus creating a need for cultural modification.

***Cultural Accommodation*** to an EBP involves modifying the way a practice is delivered so that it can be utilized with a particular culture or community (e.g., translating forms, using interpreters).

***Cultural Adaptation*** to an EBP involves reviewing and changing the structure of a program or practice to more appropriately fit the needs and preferences of a particular cultural group or community.

It should be noted that both accommodations and adaptations for cultural groups are types of modifications to EBPs. In some situations, EBPs will require both accommodations and adaptations in order to meet the needs of the community of focus.

Culture is the way of life for a group of people. It encompasses behaviors, beliefs, values, and symbols that are accepted and passed along by communication and imitation from one generation to the next.

When members from cultural groups are included in the EBP modification process, ownership of the EBP is shared with the community.

# 2 Working with Communities

Organizations reaching out to and working with communities has become a widely recognized and accepted modality to improve mental health care interventions, utilization, and outcomes. This chapter provides reasons for working with communities and a methodology for doing this. As demonstrated in Figure 1, working with communities spans the EBP modification process and directly impacts all phases of these projects.

## 2.1 Why Work with Communities?

Community engagement is the first step in EBP modification for cultural groups, but should continue throughout the process (see Figure 1). Once a clinical need is identified either by the organization or by community groups the organization should engage and stay connected with community participants while selecting an appropriate EBP, making modifications, and implementing the EBP.

Organizations that have experience working with community groups may find it natural to start the EBP modification process by involving community members. Other organizations, however, may be instituting this process for the first time. For these organizations, it is vital to commit resources, particularly in terms of staff time, to facilitate the development of these connections. It is especially wise to enlist an internal "champion" to engage and foster relationships with community representatives. This improves the likelihood of a successful modification.

Developing working relationships with communities is particularly important for traditionally underserved populations who, by definition, are not connected to larger behavioral health systems and have limited access to services. However, community members may be wary of participating in the EBP modification process or utilizing organization services. Based on previous experiences, they may feel they are not heard or that their involvement is not meaningful. Underserved populations may have had negative experiences previously with service organizations and, therefore, may require time to build trust and develop working relationships. The goal is to create an environment in which community stakeholders' input is valued and will directly impact EBP selection and modification. Time spent up-front on community engagement will result in the selection of a practice that is appropriate for the population to be served and in stakeholders being committed to its implementation.

Collaboration among communities, providers, and other interested stakeholders requires time, patience, and respect. Organization members participating in the modification process need to recognize and appropriately acknowledge the expertise of community members. This can be shown by a willingness to learn from and collaborate with communities and by listening respectfully and completely. This collaboration is enhanced when participating community members are interested in being a part of the modification process and have leadership roles in their communities and/or specific knowledge that is important to the modification work.

### The community gain

When members from cultural groups are included in the EBP modification process, ownership of the EBP is shared with the community. This enhances the likelihood of its successful and effective implementation. Community collaboration is key to the identification and incorporation of cultural beliefs and values into the modified EBP. Community participation needs to occur early on in the process, beginning with an understanding of the identified clinical need and pursued with sensitivity through all phases including the EBP selection process, EBP modification and implementation.

Another important outcome of community collaboration is the development of trust and rapport. Establishment of a collaborative working group can lead to a continued dialogue between interested community groups and service providers. Subjects for discussion could include: the type of services that would be most useful, the resources and services needed in the community, the unique considerations for a particular community and/or organization, and the clinical need for additional services.

### The organization gain

Organizations working with cultural groups in the community benefit by increasing their knowledge of the values, beliefs, and world views of that cultural group.

Even the most well thought-out EBP modification process will be unsuccessful if consumers and/or family members reject the practice because it does not fit their culture.

## 2.2 The Process of Working with Communities

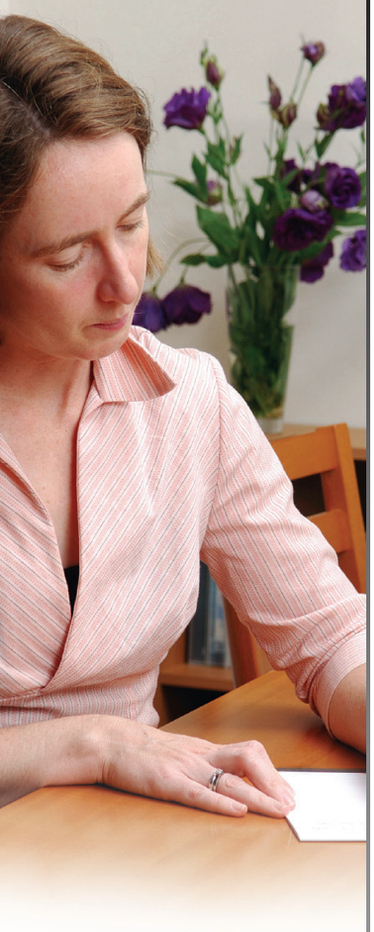
This section presents a step-by-step process for establishing and working with an EBP modification working group made up of community members and organization staff.

**STEP 1:** *Identifying the types of individuals that are needed for a successful working group*

The unique characteristics of the cultural group, as well as the nature of the mental health issue that is the focus of the EBP modification effort, influences the types of individuals needed to participate in the working group.

The first step in identifying community collaborators is to understand the cultural community they represent. This cultural community is defined by the neighborhood, religious or ethnic group, school district, refugee or immigrant population, or other natural grouping for whom services are being developed. It is important to consider who in the community is in need of services. Is it the entire community or a portion of it? It may be useful to consider why the need is being identified. Are there recent changes in the community that might have contributed to the need for services?

Working group participants should be representative of the cultural groups to be served and/or knowledgeable about the mental health issue.



In order to ensure comprehensive community participation, it may be helpful to develop a list of attributes, organizations, professions and other characteristics of individuals that adequately cover all aspects of expertise needed within the working group.

The roles played by community members may also be a factor in their selection to join the working group. For example, in some communities, elders will take the lead on providing input, while in other communities, youth might be considered to participate. In addition, it is important to include types of people who have in-depth knowledge of the community such as elders, teachers, healers, and spiritual leaders. Individuals who are in positions of authority such as community leaders, policy makers, and organization directors are also valuable assets to the working group. Having working group members that represent various types of service agencies (e.g., social services, mental health, and justice) also helps in gaining a broader perspective of service needs, as does the presence of service recipients who can speak first-hand of their experiences with services. Additionally, it is important to enlist mental health professionals into the working group who can advise the working group on the clinical needs of those for whom services are being developed. In some cases, there may already be a cultural or multi-cultural working group established within the organization from which the EBP modification working group can recruit or share members.

In order to ensure comprehensive community participation, it may be helpful to develop a list of attributes, organizations, professions and other characteristics of individuals that adequately cover all aspects of expertise needed within the working group. Depending on the community and the estimated effort to complete the modification project, a working group of eight to twenty members is desirable.

**STEP 2.** *Requesting individuals to serve on the working group*

Identifying and engaging working group members can be an iterative process. Community members in the working group may recommend others in the community who would be interested in joining the group. Recommendations are then used to find people with specific skills that might still be missing from the group. The goal is to identify resources within a community and to identify those people who would add value to the EBP modification process. This is done repeatedly until a full team of potential stakeholders is assembled that represents all interested parties.

Requests for participation in the working group must be clear and accurate and include:

- The purpose of the project,
- The working group's goals,
- The time each member is expected to commit to the group (including hours, frequency of meetings, and expected duration of the project),
- The reasons why the person is being asked to join the group, and
- The potential benefits of being a member of the working group for the individual, organization that they represent, and community.

It is best to be prepared with answers to these questions in advance, even if the answer is that this is to be determined later by the group.

Attending pre-existing community meetings that include mental health consumers, family members, advocates, and community leaders is another means of identifying group members. Consulting with community allies can be helpful in determining culturally appropriate ways to recruit and engage working group members.

Information can also be gained from community members who are not able to participate in working groups. This may occur through town hall meetings, focus groups, interviews, and surveys.

**STEP 3:** *Encouraging champions within the organization and community*

Identifying champions within the community and the organization increases the likelihood of project success. It ensures that the EBP modification process stays on track and that the work is completed in a reasonable timeframe. These champions are involved in the modification process from the earliest stages of EBP selection and review through the full implementation of the EBP.

Champions from within the organization should ideally be individuals who are representative of the cultural group to be served with the EBP and have positive relationships with multiple organization staff members. In addition, they should be committed to cultural modification, respected within the community, and, ideally, have some type of leadership role within the organization.

Ongoing participation of champions in a consistent and positive manner is critical to successful implementation, as it helps ensure engagement of both cultural group members and providers. Champions from both the organization and community can assist by moving the modification process along, motivating staff, and ensuring the cultural relevance of the modification. Champions can also serve as modification leaders, scheduling meetings to work on the project, taking notes, facilitating dialogue, and modifying EBP manuals and training curriculum. These champions then serve as onsite resources to others implementing the practice by providing technical assistance, guidance, and peer support/mentoring.

While it is ideal to have champions both in the community and the organization, it is important to consider in what capacity these individuals will contribute to the project. It is helpful to define roles and responsibilities of these champions prior to them accepting these positions in order to encourage collaboration. Efforts to build strong working relationships between champions are likely to benefit the overall project.

**STEP 4:** *Establishing the collaborative process – communication and meetings*

Communications and meetings should be planned and undertaken within the context of the needs and preferences of the cultural group to be served. It is vital to acknowledge constraints on working group members' time as well as cultural constraints. It is also important to acknowledge their efforts on behalf of the project. Working group members can be compensated for travel expenses as well as time spent attending meetings or participating in the process in other ways. Meetings should be scheduled at times and in locations that are convenient to group members. For instance, meetings can be scheduled over the lunch hour with food provided.

Champions from within the organization should ideally be individuals who are representative of the cultural group to be served with the EBP.

Establishing goals and processes is an excellent way for a group to begin its work.

Meeting evaluations should be conducted regularly to determine whether stakeholders are satisfied with the process or if changes are necessary. Finding and retaining a core group of community stakeholders in the working group can make or break the modification process. Therefore, ensuring that input from community members is heard and acted upon is critical.

**STEP 5:** *Establishing working group goals and processes*

Establishing goals and processes is an excellent way for a group to begin its work. The working group should start by reviewing the *Selecting an EBP* or the *Modifying EBPs* sections of this Toolkit, depending on whether an EBP is being selected by the group or mandated by an authority such as the state. This will help the working group begin establishing their goals and the steps needed to conduct their work.

**STEP 6:** *Putting the working group into action*

Discussing behavioral health issues within the community and barriers to accessing current prevention or treatment practices can help jump-start a working group by generating cohesiveness and a larger sense of purpose. Current effective practices and potential EBPs are then reviewed with the goal of selecting an EBP. This working group then meets on an ongoing basis to review each component of the practice, determine fit with the community, and modify accordingly.

# 3
# Selecting an EBP

## 3.1 When is it necessary to select an EBP?

EBP selection may be necessary for a variety of reasons. An organization or community may identify a clinical issue occurring more often in the community recently. This may prompt the need for additional services that are not part of the existing service array. The demographics of communities often change or an event may occur prompting the need for services. As a result, working groups may consider whether a modification of the current clinical approach is necessary to ensure effectiveness with this new population or situation. Finally, organizations may be mandated by licensing, accreditation, or payor sources to provide services that are evidence-based.

This section provides a step-by-step method for selecting an EBP with the best clinical, organizational and community fit. Selection may occur through consultation with community members through development of a working group (see *Working with Communities*). Gaining input from individuals who have a thorough knowledge of community norms and values is critical.

## 3.2 The EBP Selection Process

**STEP 1:** *Identifying possible EBPs*

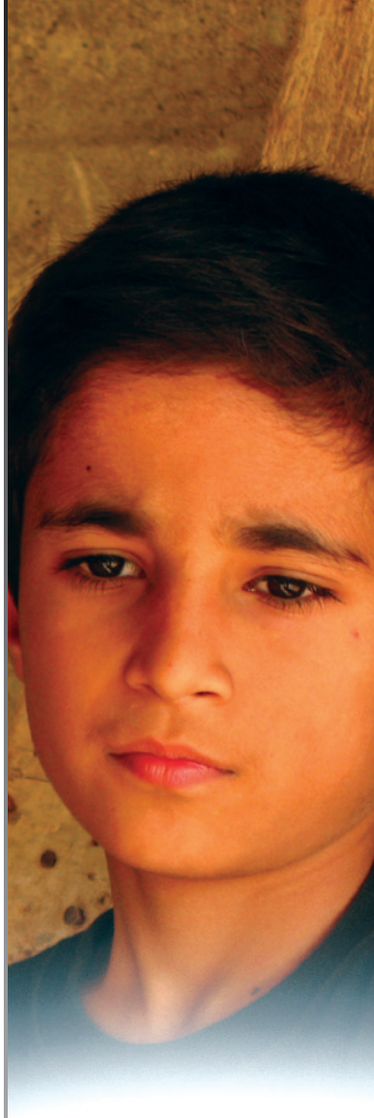
In some instances, organizations will be mandated to implement specific EBPs or choose from a catalogue of practices. In other cases, organizations will need to "start from scratch" in their identification process. In general, it is desirable to begin with a comprehensive list of EBPs that are designed to address the identified clinical issue. During this first step, working groups would benefit from casting a wide net in their search for EBPs, gathering multiple possibilities for review.

One resource for identifying EBPs is SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP). The NREPP database (http://www.nrepp.samhsa.gov/index.asp) currently includes over 100 interventions that can be searched by topic, areas of interest, study populations (age, race/ethnicity, and gender), settings (rural, urban, suburban, and tribal), evaluation/study designs, implementation history, and public vs. proprietary practices. NREPP does not include all EBPs, but can serve as a first step in identifying potential practices.

Another source for locating EBPs is state registries. Oregon's Department of Human Services' Addiction and Mental Health Division, for example, maintains an up-to-date inventory of EBPs that are used within the State. This information is updated regularly and can be found at: http://www.oregon.gov/DHS/mentalhealth/ebp/practices.shtml#complete.

**STEP 2:** *Evaluating the cultural appropriateness of EBPs*

Once a universe of EBPs is identified, the next step is to conduct a thorough analysis of each EBP to assess its fit with the clinical and cultural needs of the community. Each EBP component should be reviewed to ensure optimal success. For instance, the analysis may



The demographics of communities often change. As a result, working groups may consider whether a modification of the current clinical approach is necessary to ensure effectiveness.

EBPs whose values are congruent with the community of focus would likely be a better match than those that are less similar.

examine linguistic accessibility, intervention format (e.g., individual, family, group), and provider credential requirements (e.g., professional vs. paraprofessional), as all can be vital factors for successful implementation in a particular community. Community members in the working group can speak to the fit of an EBP with community norms and values. Ultimately, the analysis enables the working group to determine if an EBP is acceptable as is, requires modification, or is not an appropriate fit.

### Tools for Determining the Cultural Fit

Kleinman's explanatory model may be a helpful tool for looking at a cultural group's understanding of mental illness. This may be helpful in assessing the appropriateness of an EBP for a particular cultural group or to begin the modification process in the event that an EBP has already been selected. Use of this model within the working group creates a dialogue in order to understand consumers' perceptions of their problem in order for providers to understand the orientation of consumers. Working groups can use this model as a springboard for discussion whether selecting an EBP or beginning the modification process.

Kleinman and others task providers with posing the following questions to consumers:

1) What do you call this problem?
2) What do you think has caused the problem?
3) Why do you think the problem started when it did?
4) What do you think the problem does? How does it work?
5) How severe is the problem? Will it have a short or long course?
6) What kind of treatment do you think is appropriate for this problem? How can this organization help?
7) Who do you usually turn to for help? Who is involved in decision making?
8) What are the most important results to receive from treatment for this problem?
9) What are the chief problems caused by this condition?
10) What is the biggest fear about the problem?

Kluckhohn's Value Orientation Model is another helpful tool for determining the appropriateness of an EBP for a particular cultural group. This model provides a way of thinking about cultural values in relation to underlying practice values. Cultures and EBPs can be evaluated individually across dimensions such as innate predisposition, people's relation to nature, time, human activity, and organization of society. Evaluating the community of focus on each of these dimensions can be compared to an evaluation of the EBP on these same dimensions. EBPs whose values are congruent with the community of focus would likely be a better match than those that are less similar.

The table on page 15 provides a way of looking at a range of human concerns using the Value Orientation Model. Dimensions identified in the model appear in the left-hand column. A range of possible value orientations that correspond to these dimensions are described beside each dimension.

The Toolkit workbook, located in an accompanying document, provides templates to assist Toolkit users evaluate the values of cultural groups and compare these to values inherent in possible EBPs.

## HUMAN CONCERNS AS IDENTIFIED BY KLUCKHOHN AND A RANGE OF POSSIBLE RESPONSES

| DIMENSION | VALUE ORIENTATION | | |
|---|---|---|---|
| **INNATE PREDISPOSITION** What is the basic nature of people? | ***Good*** - Most people are innately good; people are born good | ***Neither Good Nor Evil-*** There are both good and evil people in the world; people can change if guided properly. | ***Evil*** – Most people are innately evil and can't be trusted. People need to be controlled. |
| **HUMAN RELATIONSHIP TO NATURE** What is the appropriate relationship between people and the natural environment? | ***Mastery*** – It is the mission of people to conquer and control nature. | ***Harmony*** - People should live in harmony with nature. | ***Subjugation*** – People can't change nature so they are often at the mercy of fate and genetics. |
| **TIME DIMENSION** How should people think about time? | ***Future-Oriented*** – Planning and goal setting are necessary in order to make things happen. It is important to sacrifice a bit now for a better future. | ***Present-Oriented*** – The here-and-now is the most important. Live for today. | ***Past-Oriented*** – History and tradition are very important. People need to learn from the past and embrace "old fashioned" values. |
| **HUMAN ACTIVITY** What is an appropriate level of activity? | ***Activity*** – If people work hard, they will accomplish great things. Human accomplishment is a measure of self-worth. | ***Being-in-Becoming*** – It is the mission of people to develop themselves as individuals. | ***Being*** – It is enough to just "be." Accomplishments are not a measure of how worthwhile an individual is. |
| **MODALITY OF RELATIONSHIP** How is society best organized? | ***Individual*** – People are in charge of their own destinies. Each person is equal in importance to all others. | ***Collateral*** – It is important to make group decisions, and everyone should participate in that process. Big decisions should not be made by one person. | ***Hierarchical*** – Some people are born leaders and others are followers. Decisions should be made by those in charge. |

Adapted from:
Gallagher, 2001

### Additional Considerations in the Selection Process

Additional considerations for determining the appropriateness of an EBP within the cultural context of the community include:

- ***modality*** – is the intervention delivered in a group or individual format?
- ***type of person providing services*** – is this a mental or behavioral health provider, peer, spiritual leader, elder or someone else?
- ***place services are provided*** - is the location an organization, community center, or religious setting?
- ***people involved in services*** – should services include individuals, families, and/or natural supports?

Again, these are examples of factors to consider. Others are included in relation to specific intervention components on Tables A, B, D, E, and F provided on pages 19-28.

### Identifying the Need for Cultural Modification

If an EBP is deemed appropriate, then examining the larger cultural context of the community will help determine whether there is a need for cultural modifications. For instance, if a monolingual Spanish-speaking community mental health organization is implementing Illness Management and Recovery, then such accommodations as translating all associated documents into Spanish and ensuring the availability of bilingual providers and/or properly trained and credentialed interpreters to implement the practice will be necessary. A thorough review of the model with community input will also help determine whether modification beyond linguistic accommodation is required.

In some cases, more than one EBP may suit an organization's clinical needs, but little or no cultural modification is needed for one, and major modifications are required for others.

### Recognizing When an EBP is Not Culturally Appropriate

Examining an EBP within the context of a community's culture may indicate that the EBP is not a good fit. For instance, an EBP might require a particular format (e.g., individual vs. group therapy) that would be considered disrespectful or inappropriate to a particular community. Similarly, an EBP might dictate a treatment process that is not congruent with the community's values.

### Case Example

*Recently, a Native American community in the southwest attempted to implement an evidenced-based family treatment approach. After reviewing the model, identifying needed cultural modifications, participating in training, and implementing the EBP for a six-month period, the community decided that the model did not fit for several reasons. First, fidelity to the model required providers to carry a full case load of ten families, an impossible feat for this rural and isolated tribal community. Second, fidelity required strict adherence to the model's sequential treatment phases whose order did not fit with the cultural needs identified by the community. Finally, fidelity to the EBP required that family members participate in all activities together as a family unit. However, the cultural modification separated family members by gender for participation in cultural activities (e.g., women were taught traditional cooking). This separation was incongruent with the theoretical underpinning of the EBP. Although the EBP had strong scientific support and theoretically was attractive to the community, ultimately the mismatch between the EBP and the community's culture could not be overcome.*

## **STEP 3:** *Making a final EBP selection*

The final step in EBP selection involves weighing all options and making a final decision. In many cases, after identifying and evaluating possible EBPs, it will become evident that one EBP is more appropriate than others based on clinical or cultural needs. For example, an EBP might have a good theoretical fit with a community, but was clinically designed to serve children rather than adults. If all evidence is based on children, the EBP would lack scientific evidence to support implementation with adults. Similarly, an EBP might target the clinical population of need, but fail to match the community culture (see case example above).

When narrowing down choices, working groups would benefit from considering additional issues such as cost, ability to bill for services, and resources needed to support services (e.g., space, staffing, translated materials). In addition, more detailed information about the EBP may come to light and illuminate the selection process. This can be accomplished by communicating with the developer and/or speaking with other organizations about their experience implementing the EBP. Finally, considerations such as time and staff resources may guide the selection. In some cases, more than one EBP may suit an organization's clinical needs, but little or no cultural modification is needed for one, and major modifications are required for others. In this instance, selecting the EBP with the best fit would be appropriate.

Ultimately, this three-step selection process will result in the selection of an EBP that meets the needs of the organization and fits within the context of the community.

# 4
# Modifying EBPs

**NOTE: If Toolkit users have not gone through *Selecting an EBP*, they should, at this point, complete *STEP 2: Evaluating the Cultural Appropriateness of EBPs* in that section in order to understand the values espoused by the EBP as well as those embraced by the cultural group for which services are being developed.**

To develop this section, both treatment and prevention EBPs for children and adults were reviewed from the NREPP website. Fifteen prevention programs and fifteen treatment programs were included in the review. A comprehensive list of practice components was identified that are common to EBPs. Each practice component was associated with a stage of the helping process and then assessed for how the component might require cultural modification. A list of cultural factors that impact all phases of the helping process was also developed and is included in this section as Table A. Tables D, E and F address how components of the helping process might require modification, reasons for the modification, and examples.

This chapter begins with a discussion of cultural factors that should be considered as the EBP modification process is implemented. The next section addresses issues of access. In the final section, EBP modification is presented as a five-step process:

1) Breaking down the selected EBP into its components using the helping process model and determining which components to modify
2) The process of modification
3) Documenting modifications
4) Trying out/piloting the modified EBP, and
5) Evaluating the success of the modification

It is assumed that the work during these steps will be conducted within the framework of the working group as discussed in the *Working with Communities* section of the Toolkit.

### Fidelity and Outcomes

For EBPs to consistently produce predictable outcomes on the same scale as demonstrated in supporting research studies, it is important that they be implemented as the developer intended or very close to that. Programs and practices with high fidelity, or likeness to the tested model, are thought to provide the most consistent outcomes. However, these assumptions have rarely been tested with culturally diverse populations.

Cultural modifications can change the model such that existing fidelity scales are no longer relevant. Until more studies examine the possible benefits of cultural modification of EBPs, it is difficult to predict the impact of these modifications on EBP outcomes and effectiveness. It should be noted that even if fidelity is adhered to closely, in cases where an EBP is used with a cultural group for which it was NOT tested, disparate outcomes may occur solely due to cultural factors.

Some types of modifications, such as language accommodations, are widely accepted and are undertaken to enhance outcomes for specific cultural groups. Other modi-

Factors, which include domains such as view of mental illness, social positioning, lifestyle, health, family/kin relationships, and world view, may impact all stages of the helping relationship.

Contacting the EBP developer may help in predicting likely outcomes of cultural modifications.

fications, such as those that might result in major changes to the EBP, could change the nature of the practice or program and lead to unintended outcomes. These modifications include reducing the number and length of sessions, eliminating important messages or skills, and removing topics.

With this in mind, organizations and practitioners should consider how to implement culturally modified EBPs to produce the best possible outcome without compromising the integrity of the interventions.

Contacting the EBP developer may help in predicting likely outcomes of cultural modifications. The developer may have considered the impact of modification on the EBP and may also have knowledge of other attempts to modify the EBP which can help the working group work through issues of model fidelity.

## 4.1 Cultural Factors

A list of factors that vary by culture and are expected to impact all phases of the helping process are provided in Table A. These factors, which include domains such as view of mental illness, social positioning, lifestyle, health, family/kin relationships, and world view, may impact all stages of the helping relationship regardless of the type of intervention selected and regardless of whether modifications are ultimately made to the EBP.

Because of the ubiquitous nature of these factors, it is important for the working group to consider how each of these impact use of the EBP by members of the cultural group. The working group may spend time reviewing this table, closely examining and discussing these cultural factors before moving on to the actual EBP modification work. This table should prove useful as a guide throughout the modification process.

## 4.2 Access

## 4.2 Access

Without adequate access to a practice, consumers may not be able to reap the benefits of the intervention. Therefore, access considerations are relevant to any clinical practice, regardless of whether it is an EBP. Tables B and C identify access features that are viewed as "deal breakers."

Language access is particularly significant since mental health interventions rely heavily on oral communication. For cultural groups with limited English proficiency (LEP), language accommodations need to be made. This includes recognizing that a cultural group may have many dialects (e.g., Mandarin, Cantonese). If multilingual staff are not available, interpreters are required; however, these interpreters must be trained in the meaning of mental health terms and the features of the intervention itself. Interpreters should understand the concepts providers are using, as they may be foreign to the consumer's culture. It is, therefore, important to consider hiring staff that are bi-lingual and bi-cultural in order to increase access for consumers.

**Table A:** Factors that vary by culture and may impact mental health services

| Cultural Factor | Cultural Variation |
|---|---|
| **View of Mental Illness** | |
| Holistic health view | Does the culture recognize mental illness or consider it part of an holistic view of mind/body? |
| Attribution | What is the source of mental health problems? Are they biological, magical, psychosocial, or a form of punishment? |
| Degree of Stigma | Stigma reduces access to mental health care. The way stigma is demonstrated and its intensity may vary by culture. |
| **Social Positioning** | |
| Discrimination | Discrimination occurs when one group is given preferential treatment over another based on certain characteristics. Discrimination often takes the form of intentional exclusion from a location or activity. How this is experienced can vary by culture. |
| Equality | People may have different roles in their culture. It is important to consider equal treatment of people vs. equal status in a community. |
| Stereotypes | It is important to consider both the provider's and consumer's preconceived notions about the other's culture, particularly in situations where there is a mismatch. |
| Acculturation | Level of acculturation can impact attitudes towards seeking and accepting services. |
| Formality | Providers need to consider how people are addressed. Are titles used? At what point, if any, is it appropriate to use familiar terms? |
| **Lifestyle** | |
| Housing | In some cultures, many generations reside together. It is important to understand the dynamics of families based on where they live. |
| Education | It may be important to consider the value that the consumer's culture places on education and educational attainment. |
| Social Class | In Western culture, social class is dictated primarily by income. Other cultures may ascribe primacy to other factors (e.g., level of education, social connections, and/or family history). |
| Development through life | Western viewpoints on how individuals develop are based on the works of individuals such as Piaget, Erickson and Freud. Some non-Western cultures may conceptualize different developmental milestones, timing, and goals throughout the life cycle (e.g., independence from parents). Norms for life-cycle events may differ across cultures. |
| Age | It is important to consider cultural norms and beliefs about age, as some cultures value elders while others value youth. |
| Gender | In some cultures, gender roles are prescribed while other cultures may be more fluid. It is important to remember that Western gender roles may not be the norm in other cultures. |
| Dating | In some cultures, dating may be limited or non-existent or, conversely, it may be very open and up to the individual. |

**Table A:** Factors that vary by culture and may impact mental health services (continued)

| Cultural Factor | Cultural Variation |
|---|---|
| **Lifestyle (continued)** | |
| Marriage | In some cultures, marriages are arranged or semi-arranged. Whether monogamy, polygamy, or bachelorhood is acceptable varies by culture. In some cultures, marriage is the most desirable state for adults, while others may value independence. |
| Divorce | In some cultures, divorce is commonly accepted while in others it is unacceptable. Couples may physically separate without the formality of a legal divorce. |
| Sexual activity | Cultures view sex differently. In some cultures, discussions around sex are completely taboo while others are more open. |
| Sexual orientation | Attitudes about sexual orientation vary across cultures. |
| **Health** | |
| Use of drugs and alcohol | Drug and alcohol use and abuse can impact mental health care. For instance, differences in beliefs about the appropriateness of attitudes, amounts, and patterns vary across cultures. |
| Specific health problems | The prevalence of health problems vary by culture and these problems can impact mental health care. Examples include metabolic syndrome, obesity, diabetes, STDs, and HIV/AIDS. |
| **Family/kin Relationships** | |
| Family constellation | In some cultures, the nuclear family is the central unit, while in others extended family or even close non-family members are important members of the family unit. |
| Disciplining children | Styles of discipline can vary. In some cultures, physical discipline (e.g., spanking) is the norm. |
| Power in relationships | In some cultures different family members have more power based on age, gender, role, or other factors. |
| Communication | Communication styles are also often culturally dictated, with patterns and styles of communication differing across cultures. |
| **World View** | |
| ***Religion/clergy*** | |
| Religion/religious practice | Religion may impact consumers' views regardless of level of religiosity, particularly if facets of the religion impact the consumer's daily life or the consumer has familial history with the religion or its practices. Many persons from cultural groups seek first line help for mental disorders from clergy. |
| Views of human nature | Views of human nature differ across cultures with some believing that people are basically good and others believing that people are inherently bad. |
| ***Spirituality*** | |
| Views of interconnectedness of people | Some cultures believe that people are highly interconnected and responsible for promoting social good while others may emphasize the autonomous nature of human action. |
| Views of nature | Views of nature differ across cultures with some cultures believing that humans should conquer nature and others believing we should live in harmony with nature. |

**Table A:** Factors that vary by culture and may impact mental health services (continued)

| Cultural Factor | Cultural Variation |
|---|---|
| **World View (continued)** | |
| ***Concepts of self*** | |
| Individuality vs. collectivism | In some cultures, individuals identify primarily with the self while in other cultures, individual's needs or desires are typically subordinate to those of the family or larger community. |
| ***Control*** | |
| Locus of Control | Cultures differ in views about where individuals see their locus of control. Is it more external or internal? |
| ***Other*** | |
| Outlook | Cultures may view life with differing levels of optimism, pessimism, or realism. |
| Time | In some cultures, there is great emphasis placed on time and managing time. It other cultures, time is not of concern and events unfold much more slowly. These concepts of time can impact appointment keeping and scheduling. |

**Table B:** Access: Structural components that may require modification for cultural groups

| INTERVENTION COMPONENT | REASONS FOR CULTURAL MODIFICATIONS | SELECTED EXAMPLES OF MODIFICATIONS |
|---|---|---|
| **Location** | | |
| This is where the intervention is physically located and includes where consumers have to go in order to participate in the intervention. | The location of an intervention can be an absolute determinant of whether consumers can access services. | A mental health clinic located in the heart of a community may be convenient, but may create stigma for those seen entering the facility.<br>For some cultures, it may be more acceptable to co-locate services at locations that are not labeled "mental health clinics" such as churches or community centers. |
| **Transportation** | | |
| This includes how consumers get to the intervention site, such as access via public and private transportation. | Lack of adequate transportation to the intervention site can be a barrier to entry or continuation of care. | Consumers who live in the city may not own vehicles to drive to mental health care facilities, so it is important to consider locating intervention sites near bus, train or subway lines or to provide taxi/bus/shuttle vouchers.<br>For private use of cars, ample free or inexpensive parking must be available. Consumers may prefer the use of private cars if they do not want others in their community to know that they are going to a mental health services location. |
| **Building** | | |
| This includes the internal and external design of the intervention site. | The exterior access to a building and interior design (including waiting areas) can be inviting or a barrier to entry or continuation of care. | Pictures hanging in the office or in waiting areas should be representative of the community served and not portray images that are offensive to community members. Pictures that contain members of the cultural group are desirable. |

**Table C:** Access: Process/operational components that may require modification for cultural groups

| INTERVENTION COMPONENT | REASONS FOR CULTURAL MODIFICATIONS | SELECTED EXAMPLES OF MODIFICATIONS |
|---|---|---|
| **Hours** | | |
| Hours refer to the times when an intervention can be offered to consumers. | Intervention hours that conflict with consumers' work or school hours or religious observances are direct barriers to accessing or continuing care. | A group designed to prevent substance abuse in school-aged children should be rescheduled when religious or cultural holidays or events interfere with meeting times. |
| **Language** | | |
| This includes both direct person-to-person contact and printed materials. Interpretation relates to verbal communication, whereas translation relates to written communication. | Language mismatches may lead to consumers not being able to access an intervention or lead to misunderstandings. | An organization may employ a single interpreter skilled for mental health interpretation to be present routinely at certain times. Others may use an interpreter service for specific visits or a telephone-based service for immediate use with a broad range of languages as needed. |
| **Payor** | | |
| How do consumers pay for mental health services? | Ability to pay for services is an absolute determinant of whether consumers can access services or not. It is important to determine whether members of the cultural community have private insurance, Medicare, Medicaid or pay out-of-pocket for mental health services. | An organization providing family therapy, which may not be covered by insurance, might consider looking to outside funders such as government agencies or private foundations to offset out-of-pocket expenses for consumers. |
| **Provider** | | |
| This can be a psychiatrist, psychologist, social worker, counselor or one of many other professionals or paraprofessionals such as physicians, educators, and law enforcement personnel. | While many helping professionals have training or awareness regarding cultural competence, others may not. It is important to consider the cultural background and cultural competence of all providers. | An organization tries to hire bi-cultural staff members from each cultural group they serve.<br><br>The receptionist or greeter should be able to communicate in the preferred language of most of the consumers that come to the organization. The first impression and ongoing relationship sometimes depends on this first contact. |
| **Intervention-specific training and materials** | | |
| This encompasses all facets of provider training on the EBP including manuals, scales, audio-visual materials, and teaching methods. | Cultural competence and awareness needs to be incorporated into all facets of EBP training. | The EBP modification working group reviews all of the training materials and makes changes to reflect the culture-specific world view of a particular population. |
| **Who is included in treatment** | | |
| While the treated person is usually an individual, the family, a kinship network or even the entire community may be engaged in treatment. | While the consumer is generally identified as an individual, treatment and prevention interventions can also be provided to couples, families or communities | Therapists may ask consumers about important members of their families and flexibly incorporate these members into treatment. |

There are also considerations for the choice of interpreter. It is a common practice, for instance, to use family members (particularly children) to translate between providers and consumers. This is particularly inappropriate since, in most cases, the consumer-provider relationship is meant to be confidential. If interpreters are bi-cultural (i.e., from the culture of the group being served), they can also serve as cultural brokers for providers, offering insights into cultural issues, values, and the beliefs of consumers.

When translating written material, content should be translated and then back-translated by separate people to ensure the intended meaning remains intact. Ideally, the translation should be in the regional language or dialect of the community of focus. Many assessment forms have already been translated for different cultural groups and should be made available within an organization, when appropriate.

## 4.3 EBP Modification Process

**STEP 1:** *Breaking down the EBP into its components using the helping process model and determining which components to modify*

The working group should collect and review all relevant print and non-print documentation that pertains to the EBP. Much of this may have been collected earlier when *Selecting an EBP.* This may include manuals, hand-outs, workbooks, fidelity instruments, web-based programs, CDs, and DVDs. The goal of this review is to enumerate those specific components of the EBP to be modified and implemented. Collected materials will be used to generate such a list. In most cases, this will include all those components listed and described in Tables D, E, and F that follow. However, the group may also identify additional components which make the EBP innovative and unique.

The recommended method for breaking down EBPs into their components is to examine EBPs as they relate to the helping process model familiar to mental health service providers. The model consists of three sequential stages: engagement, clinical work, and termination/discharge.

Practice components for each of these three stages are presented in Tables D, E, and F, respectively. For each stage of the helping process, the Tables list and describe a set of common components. The Tables include a sampling of the rationales for modification of the components as well as examples of how a practice component might be modified. Neither the notes nor the examples are exhaustive, however, as there is an almost infinite number of ways that a component can be modified depending on the nature of the intervention and the cultural group(s) to which it is being applied.

When reviewing the Tables, working groups should be aware that practice components in one stage may take place again at another stage of the helping process. For instance, in many treatments, a provider will conduct an initial assessment during engagement, but further assessments will be a part of clinical work and may take place again prior to termination/discharge. Cultural modifications made to a component in one stage of the intervention should be considered for modification in subsequent stages.

The receptionist or greeter should be able to communicate in the preferred language of most of the consumers that come to the organization.

It is critical to consider how the provider will be perceived by the consumer, taking into account both the consumer's culture as well as the biases and preconceptions that the provider may have of the cultural group.

### Identification of the "key" components essential to the EBP

Review of the compiled materials should include an identification of components that are "key" to the success and effectiveness of the EBP. Extreme care should be taken in considering "key" components for modification.

Some EBPs have a lot of documentation, and it will be relatively easy to analyze their components. In cases where it is difficult or unclear, however, it is advisable to contact the EBP's developer. EBP developers may be able to provide a range of assistance during this process including supplying additional materials, discussing planned EBP modifications and other uses of the EBP with similar cultural groups. Contact information for developers is generally available through manuals, published materials and, in many cases, on the developer's website or through NREPP. If there is any question about which components should or should not be modified or how components can be modified. EBP developers may be able to provide answers and insights.

## Engagement

Engagement is comprised of initial consumer-provider contact and is when relationship building, assessment, and contracting take place.

During this initial stage of an intervention, it is essential that the therapeutic consumer-provider relationship is developed, as the success of subsequent work is frequently dependent upon this relationship. When working with consumers, it is critical to consider how the provider will be perceived by the consumer, taking into account both the consumer's culture as well as the biases and preconceptions that the provider may have of the cultural group. An organization may have addressed cultural-sensitivity issues in its staff's cultural-competency training sessions, but this could be reinforced with respect to the EBP. Additionally, reviewing literature on the cultural group and conducting a cultural assessment of the consumer is beneficial to enhancing the therapeutic alliance and gaining insight into the clinical problem. Several cultural assessment instruments are available and referenced in an accompanying document.

Table D examines three practice components in the engagement phase: initial relationship-building, diagnostic and cultural assessment, and contracting.

## Clinical Work

Clinical work is the stage in which direct intervention with the consumer occurs using the philosophy and materials of the EBP. It also includes reassessing the consumer's progress over time and re-contracting with the consumer when necessary.

In this phase, the provider uses the strategies of the EBP to intervene with the consumer. The clinical work phase is typically the longest period of the helping process. What happens during this phase differentiates one intervention from another.

To consider this phase for cultural modification, the activities of a specific EBP can be categorized into the following components: intervention content, homework, medication, feedback to consumer/rewards, internalization and generalization, duration of sessions, and outside resources. Table E describes the modifications that may be required in each of these components, the rationale for doing so, and select examples.

### Termination/Discharge

Termination/discharge is the stage in which providers and consumers acknowledge that clinical work has been completed. The consumer's accomplishments during the intervention are evaluated and planning for aftercare takes place.

Table F describes the practice components of the termination/discharge phase of interventions. In this phase, separation of provider and consumer occur when clinical work is complete. In some cases, the consumer will continue on with treatment and/or recovery past the work of the EBP. This continuation is referred to as "aftercare." Tasks associated with termination include providers and consumers acknowledging the conclusion of work, an evaluation of the consumer's accomplishments during the intervention, and planning for aftercare.

**Step 2:** *The process of modification*

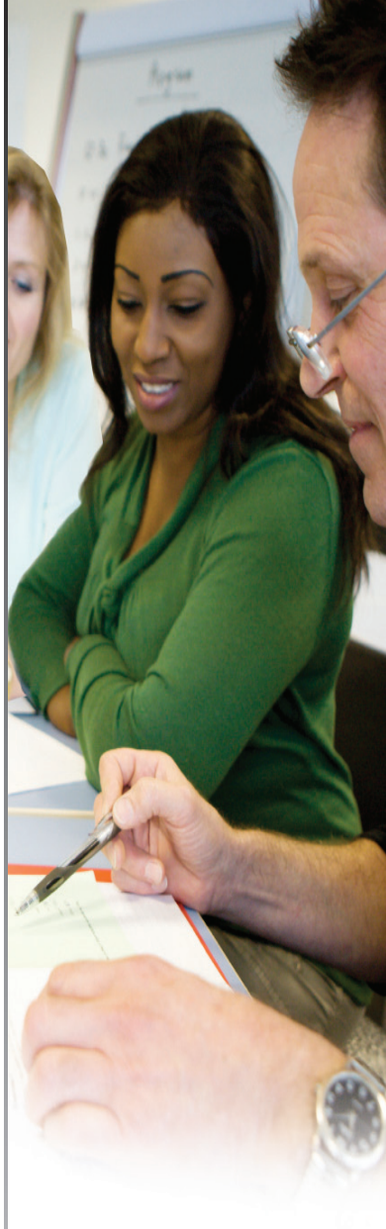
The actual process of developing modifications to EBP components is likely to be iterative as the working group moves through the EBP manuals and materials. The process can be organized and focused around the tables provided in this section. First, Table A can be used to discuss the working group members' perceptions of the cultural factors that are important to their cultural group. With these factors in mind, Tables B, C, D, E and F can then be utilized to examine those specific components that have been identified for modification. For example, the working group can rely on input from providers for modification suggestions that in their experience, are effective. Input from community and consumer representatives should be sought regarding likely acceptability of the modification.

**Step 3:** *Documenting modifications*

Working groups should document any modifications made to the EBP. This information can be used in the future to evaluate the modified EBP or to modify the EBP again for another cultural group. Documentation can be in the form of a revised EBP manual, working group meeting minutes, changes to training documents, and/or development of a separate document dedicated to the description of the modification process and results.

**Step 4:** *Trying out (piloting) the modified EBP*

Once cultural modifications are incorporated into the model, they should be tested in the clinical setting to determine if they are congruent with the clinical and cultural needs of consumers. In some organizations, a subset of providers may try out the modified EBP with consumers with whom they work. Both consumers and providers can then provide feedback regarding benefits and challenges. Outcomes for individual consumers can also be examined. Trying out the modified EBP offers an opportunity to improve its effectiveness before implementing it across the organization.



Working groups should document any modifications made to the EBP.

**Table D:** EBP engagement components and how they may be modified for cultural group

| INTERVENTION COMPONENT | REASONS FOR CULTURAL MODIFICATIONS | SELECTED EXAMPLES OF MODIFICATIONS |
|---|---|---|
| **Initial Relationship building** | | |
| Most treatment interventions and many prevention interventions are dependent on a strong provider-consumer relationship. During engagement, providers work to build a trusting relationship in order to effectively work with the consumer(s) throughout the intervention.<br><br>This component begins with the consumer's first contact with the organization. | Relationship building strategies are very much culture dependent; therefore, providers must consider cultural styles, values, and norms and adjust relationship-building activities accordingly. | Expressed interest by the provider in the consumer's culture, customs, and way of life may help develop the relationship. Literature on the cultural group should be reviewed.<br><br>Providers seeking to engage a consumer in a religious community might consider dressing in a way that is consistent with the consumer's values in order to help build a trusting relationship.<br><br>Consumers from some cultural groups may enter the intervention involuntarily. In this case, additional time and effort may be required to sufficiently engage consumers.<br><br>Other considerations are appropriateness of gender of provider with respect to gender of consumer, eye contact, physical proximity to consumer, communication styles including the use of silence, body language and privacy issues. |
| **Assessment – Diagnostic and Cultural** | | |
| This is based on symptoms, functioning and level of distress viewed within a cultural context. | Thoughts and actions that may be identified as symptoms of mental illness in one culture may be "normal" in a different culture (e.g., visions vs. hallucinations).<br><br>Cultural assessments are made to learn of specific cultural views, practices and taboos that might impact the helping process. Also immigration history, historical trauma, refugee status, acculturation, and other factors may need to be explored to make an accurate diagnosis and assess the appropriateness of the intervention. | Specific culture bound syndromes should be considered when assessments are made. The DSM-IV-TR contains a listing and description of some of these syndromes that are unique to various cultures. When assessing these, it is important to consider all of the aforementioned factors along with the consumer's cultural identity, the consumer's explanations for his presenting problem, and cultural factors related to the consumer's environment and level of functioning.<br><br>E.g., hallucinations should be considered within the context of the culture. Visions might be culturally accepted and recognized, and should not be confused with psychosis. |
| **Contracting** | | |
| These are the specific, agreed upon goals of the intervention and often vary from one consumer to another. Goals are usually highly defined and specified. | An EBP needs to be consistent with cultural norms and values. Obvious goals in one culture may not be important or valued in another. | While a treatment goal may be to create independence in adult children by moving into their own homes, this value may not be endorsed in some cultures which advocate living with parents until marriage. |

**Table E:** EBP clinical work components and how they may be modified for cultural groups

| INTERVENTION COMPONENT | REASONS FOR CULTURAL MODIFICATIONS | SELECTED EXAMPLES OF MODIFICATIONS |
|---|---|---|
| **Intervention content** | | |
| This includes all manualized and non-manualized information transmitted to consumers. This can include workbooks, audio-visual content, handouts, and verbal information exchanges. | Content should be meaningful and based on norms of the consumer's cultural group.<br><br>Written materials should be at an appropriate reading level and have culturally relevant references. It is important to understand that some consumers may not be literate in their native tongue.<br><br>As an increasing number of interventions use technology (such as on-line diaries and videos), the consumer's access to the required technology and comfort in using technology needs to be taken into account. | Toys in play therapies should include items that are familiar to the consumer and might include dolls which are representative of their ethnicity/race, age and gender. |
| **Homework** | | |
| This includes any written or task assignments for consumers to complete outside of sessions. | Assignments must be selected that take into account the consumer's cultural context and living situation. | Work done outside of sessions to challenge a social anxiety with social activity should clarify whether engaging with extended family members feels "social" or not. |
| **Medication** | | |
| Some interventions advocate the use of medication as a primary or secondary treatment method. | Some cultural groups are apprehensive and can be less receptive to psychotropic medications and some may have their own "traditional" remedies that could substitute for pharmaceutical medications or negatively interact with pharmaceuticals.<br>Attribution of the mental illness may influence agreement to take medication. | Where use of traditional or alternative substances is common, providers may wish to explore these with the consumer. Additionally, effects of prescription medicines can be discussed in terms of commonly understood roles of "traditional" treatments. |
| **Internalization and generalization** | | |
| This includes everything the consumer does to change his/her thoughts, feelings, beliefs, behaviors, or values in reaction to the intervention | A review is required of whether the changes sought by the intervention will be supported by the consumer's culture and what can be done to support changes. | In a preventive parenting intervention, parents may learn alternative forms of discipline. It is important to discuss ways in which the parents' culture supports or does not support discipline changes and how parents using the intervention can feel supported outside of the group. One way of doing this would be to create an informal mentorship of program of "graduates" from the same culture that could provide support to those just beginning to use these techniques. |

continued

**Table E:** EBP clinical work components and how they may be modified for cultural groups

| INTERVENTION COMPONENT | REASONS FOR CULTURAL MODIFICATIONS | SELECTED EXAMPLES OF MODIFICATIONS |
|---|---|---|
| **Feedback to consumer/rewards** | | |
| This includes positive and negative feedback and any rewards that may be part of a behavioral intervention. | As feedback and rewards can be motivating factors, incentives must be chosen that are valuable to the consumer and culturally appropriate. | Some incentives for attending groups include providing meals for attendees. If these meals do not respect the consumer's culture, they could be ineffective or even offensive. One example would be serving hamburgers to Hindu consumers. |
| **Duration and number of sessions** | | |
| Many interventions are prescribed for a particular number of sessions that are each of a certain length (e.g. 5 weekly 90 minute group therapy sessions). | It is important to consider whether the time allotted to cover intervention "curriculum" is consistent with the cultural and allows for the appropriate cultural modifications. | The number of sessions can be expanded or sessions can be lengthened in duration in order to allow time for additions due to cultural modifications. |
| **Outside resources** | | |
| Some EBPs require use of resources available within the larger community. These can include both formal and informal support services. | Additional support services must meet criteria for accessibility, and cultural competency in order for them to be useful. | Providers investigate and identify organizations or social groups where the consumer may practice social skills or seek peer support in a way that supports both the consumer's culture and the goals of the intervention. |

**Table F:** EBP termination/discharge components and how they may be modified for cultural groups

| INTERVENTION COMPONENT | REASONS FOR CULTURAL MODIFICATIONS | SELECTED EXAMPLES OF MODIFICATIONS |
|---|---|---|
| **Conclusion of work** | | |
| This is when the consumer and provider acknowledge that clinical work is ending | Providers may need to explore the meaning of separation and the end of the relationship in a culturally appropriate manner. Some consumers may need additional intervention time in order to make the gains "stick." This may be especially true if the consumer's culture does not support the overall change. | Providers are open to and accept consumers' ways of expressing gratitude or concern (gifts, invitations to events). |
| **Evaluation of work** | | |
| This is a review of the progress made during the intervention | Gains need to be discussed within a culturally appropriate context. | In communities that value collectivism, it may be difficult for consumers to identify personal goals for treatment. |
| **Planning for aftercare** | | |
| Some interventions may require additional care in other settings. Consumers frequently are interested in knowing how to seek care if problems return or increase in intensity. Aftercare can include both formal and informal support services | Additional support services must meet criteria for accessibility and cultural competency by consumer groups in order for them to be accessible and useful. | Provider explores consumer expectations about contact after termination with the consumer. This includes available social and emotional supports, ways to seek treatment after termination and use of "traditional" supports. |

**Step 5:** *Evaluating the success of the modification*

Cultural modifications may change the EBP's outcomes from the research studies that support it. Many EBPs have a set of standards or fidelity measures that can be used to determine the extent to which a particular implementation of an EBP reflects the developer's intent and prevailing outcomes.

Once the modified EBP is implemented throughout an organization, administrators should consider evaluating the effectiveness of the practice.

Organizations should consider measuring outcomes from either the entire consumer population using the modified services or, at least, a select group, randomized, if possible, in order to determine the effectiveness of the modified EBP. As previously stated, outcomes for cultural groups may vary from those determined during scientific outcome studies for the EBP even in the case of a successful modification project. In addition to looking at developer outcomes, outcomes from the modified EBP can be compared with outcomes for the cultural community prior to the implementation of the modified community if they exist. These could include changes in symptoms, quality of life, and/or relationships with others.

Since outcome studies are not always feasible, organizations should consider examining additional factors to measure the success of a cultural modification to an EBP. Additional domains to examine include rates of service utilization, which should increase for the cultural group with a successful modification, and drop-out rates, which should decrease for the cultural group with a successful modification.

Organzations and practitioners should consider how to implement culturally modified EBPs to produce the best possible outcome without compromising the integrity of the interventions.

# 5 Implementation Issues

There are several factors to consider before offering a culturally modified intervention to the community-at-large. Foremost among these are understanding and preparing the organization for change and understanding the cultural competency of the organization.

## 5.1 Organizational Readiness for Change

Organizational readiness for change may include the motivation and personality characteristics of program leaders and staff, the institutional resources, and the organizational climate. These characteristics influence the likelihood of significant change occurring in an organization. Therefore, assessing organizational readiness to change is critical when planning the implementation and dissemination of EBPs.

Several organizational readiness scales are available to indicate how ready an organization is to undertake an implementation project and areas that require further consultation, technical assistance, or other organizational/system support. An accompanying document provides a list of seven measures compiled by the NASMHPD Research Institute for assessing organizational readiness for implementation of EBPs in substance abuse, mental health, and health care.

## 5.2 Understanding the Organization's Cultural Competency

The cultural competence of an organization impacts its ability to appropriately implement and support the EBP. The Cultural Competency Assessment Scale (CCAS) can be used for this evaluation process (see accompanying document). The CCAS covers ten domains, each rated on a five-point scale. Four points on the scale are related to a specific performance measure and its benchmark, with one point indicating no action. In addition to measuring organizational cultural competence, the CCAS suggests ways in which an organization can become more culturally competent.

The cultural competence of an organization impacts its ability to appropriately implement and support the EBP.

# THE WAIANAE WELLNESS PROJECT AT HALE NA'AU PONO: A VOYAGE TO RECOVERY

By: Poka Laenui, JD and Deborah Altschul, PhD

## Introduction

Hale Na`au Pono is a private non-profit corporation created by the people of the Wai`anae Coast in Hawai`i to meet the needs of the community. The Wai`anae Coast, on the leeward side of O`ahu, is comprised of the communities of Nanakuli, Ma`ili, Wai`anae, Makaha, and Makua. Of the estimated 50,000 people on the Coast, the majority are Native Hawaiian. Other prominent ethnic groups include Caucasian, Filipino, Samoan, Japanese, Chinese, Korean, Puerto Rican, Vietnamese and others. One-half of Wai`anae's population is under 20 years old. Hale Na`au Pono, a Hawaiian name interpreted as "The House for Inner Balance", provides culturally and socially sensitive, community-based, behavioral health services for children and adults.

## An Overview of the Process

In 2005, Hale Na`au Pono partnered with the University of Hawai`i and Hawaii's Adult Mental Health Division to complete a cultural modification of the evidence-based practice Illness Management and Recovery EBP Toolkit. The result was the development of "A Voyage to Recovery", a curriculum that incorporates Native Hawaiian concepts in the practice of mental health recovery. The cultural modification represents a significant effort to incorporate culture into clinical practice, a quality that defines treatment practice at Hale Na`au Pono. Always a frontrunner in cutting edge practice, Hale Na`au Pono provides a broad array of services that are community-based, recovery-oriented, and culturally matched to the needs of the community.

## Working with Communities

The cultural modification process at Hale Na`Au Pono began with a serious dialogue between administrators, clinical staff, board members, consumers, and researchers. This dialogue centered on sharing information about the Illness Management and Recovery (IMR) model, determining the relevance of the model to the Wai`anae community, and assessing organizational readiness for implementation. After several meetings, Hale Na`au Pono determined that the model had relevance to the community and agreed to partner in the cultural modification project.

The next step in modifying this intervention involved engaging the clinical community. This occurred through a two-day orientation to the model attended by all Hale Na`au Pono stakeholders (i.e., administrators, providers, consumers, family members, and clerical, business and finance, and janitorial staff). Consumers and family members were individuals who were from Wai`anae and who had participated in at least one of the many services available through the organization (e.g., clubhouse, supported housing, supported employment, Assertive Community Treatment, intensive outpatient).

The working group met with community elders and traditional healers who were familiar with the community and with Hale Na`au Pono through their relationships

with the staff and/or their participation as board members to the organization. The significance of their participation cannot be overstated, as they provided the cultural context to the entire project.

In addition, champions of the model were identified to serve as supervisors to other providers implementing the model. These champions served as onsite resources providing technical assistance, guidance, and mentoring.

## Selecting an EBP

IMR is an evidence-based practice developed by a coalition of researchers, providers, administrators, policy makers, consumers, and family members, and supported by the Substance Abuse Mental Health Services Administration (SAMHSA) and the Robert Wood Johnson Foundation (RWJF). The practice is a manualized treatment intended to help adult consumers set and pursue personal goals and implement action strategies toward recovery. IMR is provided in either group or individual formats, with consumers meeting weekly for three to six months. Topic areas covered by the program include: recovery strategies, practical facts about mental illness, the stress-vulnerability model and treatment strategies, building social support, reducing relapses, using medication effectively, coping with stress, coping with problems and symptoms, and getting needs met in the mental health system. The Toolkit consists of a practitioner's guide, with practical tips for teaching people about the aforementioned topics, educational handouts, checklists, and planning sheets for each of the nine topic areas, a short introductory video, informational brochures, a fidelity scale to measure whether a program is being implemented as designed, outcome measures to assess whether the program is having a positive impact on participants, and a section on cultural competency in relation to EBP implementation.

The IMR Toolkit addresses the components of the clinical model and many practical considerations for successful implementation. It also highlights the need for communities to adapt the model to meet their unique characteristics, and states that, "careful attention to unique community needs, coupled with fidelity to the key ingredients of the practice, equals successful implementation" (SAMHSA, 2003, pg.3).

More information about IMR can be found on the SAMHSA EBP Toolkit website: http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/illness/

## Modifying EBPs

During the first half of day one, university personnel provided an overview of the IMR model and began a dialogue about potential areas of modification. The remainder of the time was spent in small working groups, each working on modifying a chapter of the IMR provider manual. After the two day period, the working groups met independently over a month long period to complete their first draft of the cultural modification. This process resulted in a tremendous sense of ownership and commitment to the project.

Following the initial meetings, the second step was to form a smaller modification working group that was representative of providers, consumers, family members, administrators, and cultural experts. At bi-monthly meetings, this working group went through each page of the manual to incorporate suggestions generated by the

larger community, and to determine which parts of the model did or did not require modification.

The working group was encouraged to consider linguistic changes, relevance of suggested activities and examples in the original EBP, conceptual framework of mental health and illness, and natural healing methods to determine which aspects of IMR required modification. In addition, the working group considered family roles, caretaker roles, relationships with healers, concepts of time, gender roles, acculturation levels, and cultural values and beliefs regarding mental illness and stigma. Finally, the working group developed modification recommendations on variables such as dosage (number of sessions), provider characteristics (values, professional trajectory, spirituality, ideas on boundaries, age, gender, etc.), language, time, setting for intervention, and cultural strengths. The goal was to develop a model that was culturally relevant, accessible to consumers, and useful to providers.

The third step was the core of the modification and included capitalizing on the strengths of the community by integrating a Native Hawaiian guiding philosophy, revising wording in the Toolkit to be more relevant to the community (e.g., *pilikia* vs. "problems" and "exercise" vs. "homework"), integrating Native Hawaiian proverbs throughout the text, using local examples and locally identifiable landmarks (e.g., referring to bipolar disorder as "like surfing the top of a wave and then crashing into the sand") and including consumer drawings and stories. These modifications came from the community and were integrated throughout the Toolkit. The goal was to ensure that the content delivery method was culturally meaningful, relevant, and appropriate, thereby avoiding potential barriers related to the accessibility and the relevance of the intervention to the underlying values of the community. The Native Hawaiian Guiding Philosophy, for instance, was based on OLA, a Native Hawaiian word for health, healing, and contentment. Each of the letters in OLA also represent a Native Hawaiian word that spoke to the foundation of the model, with O for *Olu'olu* (agreeable, pleasantness), L for *Lokahi* (unity, harmony, balance) and A for *Aloha* (love, respect, tenderness). Another example is the integration of Native Hawaiian proverbs such as, "*Hoomoe Wai Kahi Ke Kaoo*"- Let us travel like water in one direction (re: building rapport); and "*A `ohe Pu`u Ki`eki`e Ke Ho`a`o Ia E Pi`i*"- No cliff is so tall it cannot be eliminated (Things can change. Believe in yourself). In addition, a module was added to the beginning of the practice in order to provide a culturally relevant way for consumers to get to know their provider and feel comfortable in the clinical setting. This "Talk Story Module" added a culturally appropriate means of engaging the consumer in treatment through the sharing of stories about family history, including the meaning of a person's name, the place where a person was born, the story of their family, etc. The goal was informal sharing, information gathering, and the fostering of culturally appropriate communication patterns. Although this module was not part of the original IMR EBP, it was a necessary modification that was important for developing rapport and engaging consumers in treatment. Importantly, the modification did not contradict with the core components of the IMR model.

Another modification example was the inclusion of culturally relevant information. For instance, the original IMR module that describes schizophrenia includes infor-

mation about visual hallucinations. Although the descriptor is maintained in the adapted Toolkit, there is also an added caution stating, "In some cultures, communicating with ancestors is a common practice. You may need to check with family or community members to see if the voices you hear are culturally-based before labeling them as hallucinations." The goal is to recognize and help the consumer to determine the cultural context that may be present, and avoid inappropriate assessment and misdiagnosis.

## Implementation Issues

Throughout the modification process, clinical members of the stakeholder group piloted various intervention strategies to determine cultural appropriateness and relevance. At bi-monthly meetings providers would report back on the benefits and challenges of various strategies, and the group would revisit the appropriateness of these approaches.

Following completion of the culturally adapted Toolkit, the fourth step was to host a celebration with all the participating stakeholders. The goal of the celebration was to recognize the tremendous contributions of the participants, and to create enthusiasm within the organization for the upcoming implementation.

The final step was to train all staff on the adapted model, and provide ongoing support in implementation. This support was provided locally by identified champions and through consultation with the university partners. Today, the model has become part of the organization's core philosophy, and Hale Na`au Pono helps to advance culturally responsive behavioral health practice globally by disseminating the model to other communities.

## Conclusion

Several lessons can be learned from this cultural modification process that can be capitalized upon by communities interested in modifying and implementing evidence-based practices. For instance, it was absolutely critical to have all Hale Na`au Pono staff present at the initial orientation meeting in order to gain buy-in for the process. Although a smaller working group was formed to complete the modification, various staff members floated through the bi-monthly modification meetings to provide input and see how the project was evolving. The inclusion of all staff members throughout the process created a tremendous sense of ownership for the model. Thus, it is important to ensure that all staff are aware and supportive of the projects goals and objectives.

Additionally, paramount to the success of the modification was the deep cultural knowledge of several stakeholders, including Hale Na`au Pono staff, community members, and cultural leaders, elders, and healers. This cultural knowledge permeates the final manual. For instance, the manual harnesses the wisdom to include the introductory "Talk Story module" to help consumers feel comfortable, recognizing the importance of building trust and developing foundational relationships. In addition, the manual incorporates a Hawaiian world view about health and wellness, highlighting the need to move away from talking about "symptoms and problems" and move toward more culturally appropriate terminology such as the Hawaiian word *pilikia* (trouble, nuisance, or annoyance). The final product is a manual that is

uniquely suited to the community. Thus, having individuals with in-depth cultural knowledge actively involved in the cultural modification process is vital.

Identifying and supporting a dedicated staff member at Hale Na`au Pono to champion IMR and the cultural modification process was also critical. Fortunately, the adaption was part of a larger SAMHSA-funded EBP implementation grant, and dollars were allocated to buy-out a portion of time from a clinical staff member to serve in this capacity. Because resources are extremely limited in community mental health settings, the funding alleviated some of the burden of the project on the organization. However, Hale Na`au Pono's executive director and quality improvement manager were also both extremely committed to the project, and had the unique ability to motivate staff to participate, both through their positive relationships with staff and their leadership positions. Therefore, it is not necessary to obtain additional funding, but rather to carefully identify staff to champion the modification in an ongoing, consistent, and positive manner.

Finally, the project was enjoyable. During bi-monthly meetings stakeholders shared stories, laughed, learned, and got to know one another in an intimate fashion. The meetings were held over the lunch hour, and food was provided in abundance. Stakeholders shared their achievements with one another beyond the scope of the project, sharing their joys and sorrows. This environment fostered a commitment to the project and a desire to participate on an ongoing basis. Creating such an environment is critical to the cultural modification process, as it opens communication so that individuals feel comfortable sharing, supporting, and disagreeing.

# PARENTCORPS: A CASE IN THE PROCESS OF DEVELOPING AND ADAPTING A CULTURALLY-INFORMED MENTAL HEALTH INTERVENTION

By: Laurie Brotman, PhD and Esther Calzada, PhD

## Introduction

One way that family and neighborhood poverty influences children's behavior is by interfering with positive parenting practices. Low-income parents are more likely than higher income parents to be stressed, socially isolated, and suffer from mental health problems. All of these factors have been demonstrated to directly hamper parenting practices associated with normal developmental processes (cognitive, emotional and social development).

ParentCorps is a universal school and family intervention that incorporates elements from evidence-based parent and child interventions. It was designed to promote effective parenting practices and prevent behavior problems among ethnically diverse children attending Pre-Kindergarten programs. Parent Corps includes after-school groups for parents, preschoolers and school-age siblings. A key aspect of ParentCorps is that family intervention is delivered in school settings and co-facilitated by Pre-K teachers and other school staff.

This approach provides an opportunity for systematic, non-stigmatizing intervention for families of all children in Pre-K at the transition to formal schooling. A family intervention that is framed around the promotion of school success considers the goal shared by parents from diverse cultures of helping children to do well. A universal approach that brings parents together from the same school community also builds on the assumption that effective parenting skills are learned through exposure to other members of the community, interactions with knowledgeable and experienced parents and modeling by effective parents. Importantly, as shown in numerous prevention studies, a universal approach to prevention, one that is offered to all children in high-risk schools or communities, has the potential to yield the largest benefits for those at highest risk for problems.

*Collaboration*

A primary goal in the parent groups is to create a collaborative process between parents and group facilitators in which parents a) feel open to talking about parenting in an honest and reflective way, b) feel open to learning about new parenting strategies, and c) are empowered that they have the knowledge and skills to raise successful children. Groups are experiential and parents are encouraged to share their views, ask questions, and challenge what facilitators say. Group facilitators rely on the use of group process skills that help the parent think through the issue without challenging her views and without making a decision for her. Through the clinical process, facilitators convey to parents that every parent has the most knowledge about her family situation and that she, not the group facilitator, is in the best position to make decisions about what works best for her family. Ultimately parents make decisions about parenting strategies that are consistent with their values and goals driven by the unique characteristics of their child, their family and their culture while also being informed by evidence-based parenting practices. Parents are also given the opportunity to give feedback on session content and group leader technique by completing a satisfaction questionnaire at the end of each group session. The feedback from these questionnaires is used to inform future groups.

*Flexibility*

Following the idea that parent input is encouraged and enabled throughout the intervention, the clinical process remains flexible and open to the ideas and beliefs of parents. As a result, group facilitators expect and accept that the cognitive behavioral strategies will be individualized to each parent's goals and values rather than following a pre-determined script related to the use of these strategies. Moreover, as parents educate facilitators about their lives and their culture, facilitators incorporate this information back into the intervention so that future groups are informed by past groups.

The clinical process in ParentCorps parent groups follows a sequence that includes: 1) laying the groundwork for parents to think about how their parenting practices are culturally driven; 2) encouraging parents to educate facilitators about their culture; and 3) continually weaving the culture of group members into the fabric of each new session. This give-and-take process around issues of culture results in the identification of themes common to the culture of the parents in the group.

## An Overview of the Process

ParentCorps was developed to provide a culturally acceptable and attractive intervention to introduce evidence-based parenting practices to ethnically diverse parents living in disadvantaged, urban communities. Since most families in these communities are black or Latino, special consideration was given to issues that affect these groups. Despite the great promise of parenting and child social skills training interventions and the greater risk for early conduct problems in low-income urban communities, there is a lack of programming specifically tailored for this population. An intervention that is culturally and ecologically informed in terms of content, delivery model and recruitment strategies is more likely to engage the targeted community to the fullest extent possible, increasing the possibility of long-term benefits and sustained intervention implementation in real world settings.

## Working with Communities

With an understanding of the issues related to parent training interventions in disadvantaged, urban communities, we sought to further understand and incorporate the needs, values and customs of the specific community of focus. We collaborated with a well-respected community service provider in a primarily African American, urban neighborhood. This community partner granted us access to the community by sharing its mailing lists and describing outreach efforts that it had used successfully. Through our relationship with the community partner, we were invited to community events (e.g., block parties, community building efforts) to introduce ParentCorps and recruit community members to participate in intervention development efforts. By participating in community events sponsored by the community partner, we met community leaders, gained knowledge about community needs and services and learned about the local "culture" regarding community meetings (serving food, opening and closing meetings with prayer and encouraging participation throughout the meeting). We established our own ties with local schools, daycare facilities, PTA's, churches, and block associations. Representatives from these organizations were invited to attend an informational meeting about ParentCorps. After hearing information about the intervention, attendees were invited to serve on the ParentCorps Community Advisory Board. Ten community leaders representing health and mental health service providers, educators, clergy, day care providers, block association members, and the community organization served on the board. The Board met six times over the course of two years. The board members served as advocates for ParentCorps, helped identify community needs, and made suggestions about where and how to engage families in the program.

Board members played a central role in the recruitment and selection of twelve community residents who were then trained to deliver ParentCorps alongside group leaders. During training, each parenting skill included in the program was presented didactically and was followed by a discussion on how to adapt the skill to be appropriate and acceptable to the community of focus. The community members provided guidance on what language and teaching strategies would be effective within their community. Their input was particularly informative for intervention content on exposure to community violence, dealing with difficult emotions and issues of loss, African American perspectives on discipline strategies, and shared caregiving responsibilities. These community members also contributed to the development of strategies for engaging families with special attention to logistical and perceived bar-

riers noted in the literature and ways in which to engage fathers and extended family members. In addition, focus groups with community parents were held to inform specific aspects of the program content (e.g., the parent group video series, depictions of families whose "stories" would be portrayed in a workbook for parents).

After initial program development, twelve African American and Latino community members were trained to implement ParentCorps. These collective experiences contributed further to the refinement of the program.

## Selecting an EBP

A team of ethnically and culturally diverse mental health professionals and prevention scientists with extensive experience in working with ethnically diverse families from disadvantaged neighborhoods developed ParentCorps. Individuals were asked to participate in the development process based on their experiences implementing other evidence-based prevention interventions.

First, we turned to the literature for guidance regarding effective parenting skills, parent training interventions and working with African-American and Latino families in disadvantaged, urban communities. For example, our thinking was influenced by an emerging literature suggesting that specific parenting practices might have different effects on children from different cultural backgrounds. Next, we considered our prior experience with parent training interventions and ethnically diverse families in urban communities. For example, ParentCorps follows an interactive, experiential group approach and uses a video series, since these strategies and tools were highly acceptable and engaging to parents in our previous work. In addition, we sought consultation from experts in the field of family intervention and child development to ensure that the presumed key ingredients of effective interventions were maintained even as we considered issues related to culture and context.

Given the particular importance of parent involvement in school for African American and Latino children, ParentCorps was designed to facilitate parent-school involvement by helping teachers to engage families and create family-school partnerships, by addressing the importance of school involvement in the context of the family intervention, and by involving school staff in the delivery of the family intervention.

ParentCorps incorporates elements from evidence-based parent and child interventions. These elements include parenting strategies that have shown to be effective in decreasing or preventing behavior problems in young children. These include strategies to build positive parent-child relationships, which in turn form the basis for implementing effective discipline strategies. Additionally, the developers of ParentCorps had success using these intervention elements in young ethnically diverse children.

## Modifying EBPs

The intervention anticipates potential barriers facing low-income families, stresses associated with living in low-resource urban neighborhoods and cultural values of ethnically diverse families. These considerations are directly addressed in content and delivery strategies and perhaps, most importantly, are incorporated in the philosophy that guides the ways in which group facilitators work with families.

*Logistical barriers*

ParentCorps was developed to reduce as many barriers to attendance and implementation as possible. Groups are held at the child's school, a familiar location which is typically in close proximity to the family's home. Groups are held in the early evening hours to accommodate parents' work schedules. Weekend groups can be scheduled to accommodate families who cannot attend during the week.

Group facilitators introduce the program to parents at their child's school and in person and help parents with barriers to attendance by problem solving. A raffle is conducted every other week to encourage parent attendance. Prizes include gift certificates to local stores or monetary gift cards. Families are encouraged to attend throughout the 13-week program even if they can't come every week, haven't attended the first few groups or need to come late.

Culturally appropriate meals are provided during the groups (e.g., from families' countries of origin, halal meals, pork-free meals). Parent group facilitators are sensitive to the fact that some participants may have limited literacy or otherwise have difficulty reading program materials and all within-group activities are designed so that they do not require parents to read in the group setting. Parents are provided with a Family Care Kit which contains materials they will need to implement the parenting skills covered in the intervention (for example timers for time outs). The Family Care Kit eliminates any monetary cost to families and ensures that parents can start implementing the new skills they learn right away.

*Cultural and contextual issues*

Considering cultural differences that may exist between group facilitators and parents, and between parents themselves, is intrinsic to the intervention both in terms of specific content and in the philosophy for how facilitators interact with participants (i.e., clinical process). To incorporate cultural issues, explicit efforts are made from the start of the program to ensure that all cultures are recognized and respected. Initial parent groups include icebreakers asking parents to identify their cultural group and share cultural family traditions. Parents are asked to define their own goals for their children, which are framed as culturally-driven or informed, and parenting skills covered in the intervention are presented as strategies that will help parents reach those goals. Throughout the sessions, issues of culture are dealt with in a forthright manner. Group facilitators encourage in-depth discussions about how parents' own upbringing and cultural traditions have shaped their parenting. Parents are asked to consider the parenting skills presented in light of their own values and each group session includes a specific time for parents to react to the skills and discuss any barriers or reservations they may have regarding implementing the skills.

ParentCorps materials and video series feature African American and Latino families. The video series is narrated by a popular African American television personality and depicts one day in the life of three families from one urban neighborhood. This allows group leaders to ask parents to discuss their experiences with an explicit focus on how the issue is viewed within their own extended family, culture and neighborhood in each session. For example, one episode focuses on community violence in recognition that children living in disadvantaged urban communities are

often exposed to violence as witnesses and victims and frequently experience related family disruptions and loss.

Group facilitators also express respect for differing family constellations and extended caregiving arrangements. The families featured in the ParentCorps video series represent a variety of family types: a married couple with two children, a single mother raising three children with the help of her own mother and an older married couple raising their grandson. Group facilitators encourage parents or caregivers to invite any adult that is important to their child to groups, including other parents who may not live in the household, grandparents, aunts, uncles, cousins or close family friends who are helping parents raise their preschoolers.

Additionally, group facilitators and program developers have created and consistently update a manual on culture related to parenting and contextual issues related to residence in urban communities. This manual is used in training and supervision of group facilitators.

Building expertise with the target population. In following this philosophy, we have identified themes among African American and immigrant parents that have been explicitly incorporated into program manuals. In working with families, we recognize and emphasize individual variations as much as these commonly identified cultural themes.

## Implementation Issues

ParentCorps was initially pilot tested in one urban community with primarily African American parents. Based on the success of the pilot, and with the aim of further improving engagement by reducing issues of stigma, the intervention delivery model was further developed so that ParentCorps could be offered as a universal intervention for all children attending Pre-Kindergarten in public school settings.

## Evidence

ParentCorps has been tested in a randomized controlled trial with 171 ethnically diverse children. ParentCorps resulted in statistically significant and medium-size effects on effective parenting practices and child behavior problems in school. The intervention effects were of similar magnitude for families at different levels of risk at baseline and for black and Latino families. Attendance at intervention sessions by families at higher risk was similar to that by families at lower risk and the number of sessions attended was meaningfully related to improvements in effective parenting practices. Findings and practical experiences in carrying out this trial informed the design of a more comprehensive school randomized trial with over 1000 African American and AfroCaribbean children from disadvantaged, urban communities. This nearly complete large trial, with recruitment rates of 75% across schools in both conditions, will allow for comprehensive evaluation of long-term intervention outcomes assessed by multiple sources across behavioral and academic domains. This large-scale trial of ParentCorps was designed to test moderators and mediators of intervention effects and will allow for generalization of findings to families of children attending Pre-K programs in public elementary schools in urban communities. Findings from this trial will support an application to SAMHSA for inclusion of ParentCorps in the NREPP directory.

## Conclusion

ParentCorps incorporates a collaborative and flexible intervention philosophy and repeated opportunities for parents of any cultural background to discuss and define their own cultural values and work towards their own parenting goals. As such, it has great potential to be transported into new communities with diverse cultural characteristics.

To date, ParentCorps has been implemented in 18 public schools serving children from disadvantaged urban communities. The program has been shown to be engaging and to achieve important benefits for children from diverse cultural backgrounds, including African American, Latino, and Asian children and children from immigrant families, including large numbers of AfroCaribbean children. Current efforts include further development of the program model to reach families of children who attend preschool programs in settings other than public schools (e.g., community based organizations, head start, day care). Special attention is being paid to the needs of non-English speaking immigrant families.

# Annotated Bibliography


**Abe-Kim, J., Takeuchi, D.T., Hong, S., et al. (2007)**. Use of mental health-related services among immigrant and US-born Asian Americans: Results from the National Latino and Asian American Study. *American Journal of Public Health*, 97(1): 91-98.

Data suggests that Asian Americans are less satisfied with their medical care than their European American counterparts. An investigation of patterns of mental health-related service use among a national sample of Asian Americans indicated lower rates of use compared to the general population, even among those with a demonstrated need for service. US-born Asian Americans were more likely than immigrants to use and to be satisfied with services.

**Anderson, L.M., Scrimshaw, S.C., Fullilove, M.T., Fielding, J.E., Normand, J. & The Task Force on Community Preventive Services. (2003).** Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine, 24*(3S), 68-79.

A review of five interventions to improve cultural competence in healthcare systems including programs that recruit culturally diverse employees, train healthcare providers in cultural competence, use linguistically and culturally appropriate health education materials, or are culture-specific. Effectiveness of programs was not determined due to a lack of comparative studies.

**Betancourt, J.R., Green, A.R., Carrillo, J.E. & Ananeh-Firempong, O. (2003)**. Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Report, 118*(4), 293-302.

Based on a review of the relevant literature, the authors develop a definition of cultural competence, identify key components for intervention, and describe a practical framework for implementation of measures to address racial/ethnic disparities in health and healthcare.

**Bond, G.R., Drake, R.E., McHugo, G.J., Rapp, C.A., Whitley,R. & The National Evidence-Based Practices Project Research Group. (2007)**. Strategies for improving fidelity in the National Evidence-Based Practices Project. Paper presented for the International Conference on Implementation and Translational Research, Stockholm, Sweden.

This paper describes a model developed for facilitating the implementation of 5 EBPs for adults with severe mental illness. A key element studied was fidelity – or the extent to which a program adheres to the EBP model. Factors affecting fidelity were assessed and suggestions were made for achieving fidelity.

**Brach, C. & Fraser, I. (2002)**. Reducing disparities through culturally competent health care: An analysis of the business care. *Quality Management in Health Care*, 10(4), 15-28.

This article reviews the potential role of cultural competence in reducing racial and ethnic health disparities, the strength of health care organizations' current incentives to adopt cultural competence techniques, and the limitations inherent in these incentives that will need to be overcome if cultural competence techniques are to become widely adopted.

**Caldwell, M.B. et al. (2005)**. Community involvement in adapting and testing a prevention program for preschoolers living in urban communities: ParentCorps. *Journal of Child and Family Studies,* 14(3): 373-386.

The authors provide a description of the development and feasibility testing of ParentCorps, an intervention program designed to promote child social competence and prevent conduct problems by strengthening parenting skills, enhancing support for parents, and empowering parents to access community resources. The value of community involvement and challenges of recruiting highly qualified staff and encouraging program permanence are discussed.

**Collins, C., Harshbarger, C., Sawyer, R., Hamdallah, M. (2006)**. The diffusion of effective behavioral interventions project: development, implementation, and lessons learned. *AIDS Education and Prevention*, 18(A): 5- 20.

The Diffusion of Effective Behavioral Interventions (DEBI) project was created by the Centers for Disease Control and Prevention to develop and coordinate a national-level strategy to provide high quality training, technical assistance, and capacity building on evidence-based, group- and community-level HIV/STD prevention interventions to health departments and community organizations. In order to measure effective implementation of EBPs with fidelity to core elements and modifications to fit local needs, the DEBI project emphasized strategic planning, marketing, technical assistance, capacity building and training.

**Deater-Deckard, K., & Dodge, K. A. (1997**). Externalizing behavior problems and discipline revisited: Nonlinear effects and variation by culture, context, and gender. *Psychological Inquiry*, 8(3), 161-175.

Research has demonstrated an association between harsh physical discipline and child aggression and conduct problems, a likely causal mechanism that probably operates as a shared environmental factor. The authors offer four hypotheses about the relation between discipline practices and child externalizing problems including cultural factors.

**Devore, W. & Schlesinger, E.G. (1996)**. *Ethnic-sensitive social work practice* (Fifth Edition). Needham Heights, MA: Allyn & Bacon.

This book covers ethnic sensitivity and the life course, approaches to social work, principles of ethnic-sensitive counseling, strategies for modification, ethnic-sensitive practice with immigrants and refugees, and ethnic-sensitive practice in the public sector and in health care. An outline for a community profile (intended to help to develop a picture of the community within which services are located), and a guide for making an ethnic assessment (intended to help social workers develop systematic approaches for assessing ethnic reality), are provided in the appendices.

**Dix, T. (1991)**. The affective organization of parenting: Adaptive and maladaptative processes. *Psychological Bulletin*, 110(1), 3-25.

Emotions are vital to effective parenting. When invested in the interests of children, emotions organize sensitive, responsive parenting. Emotions undermine parenting, however, when they are too weak, too strong, or poorly matched to childrearing tasks.

**Dodge, K. A., Pettit, G. S., & Bates, J. E. (1994)**. Socialization mediators of the relation between socioeconomic status and child conduct problems. *Child Development*, 65(2), 649-665.

Socioeconomic status assessed in preschool significantly predicted teacher-rated externalizing problems and peer-rated aggressive behavior in kindergarten and grades 1, 2, and 3. Socioeconomic status was significantly negatively correlated with 8 factors in the child's socialization and social context, including harsh discipline, lack of maternal warmth, exposure to aggressive adult models, maternal aggressive values, family life stressors, mother's lack of social support, peer group instability, and lack of cognitive stimulation. These factors, in turn, significantly predicted teacher-rated externalizing problems and peer-nominated aggression and accounted for over half of the total effect of socioeconomic status on these outcomes.

**Downey, G., & Coyne, J. C. (1990)**. Children of depressed parents: An integrative review. *Psychological Bulletin*, 108(1), 50-76.

Reviews the literature on the adjustment of children of depressed parents, difficulties in parenting and parent-child interaction in these families, and contextual factors that may play a role in child adjustment and parental depression.

**Eke, A.N., Neumann, M.S., Wilkes, A.L., & Jones, P.L. (2006)**. Preparing effective behavioral interventions to be used by prevention providers: the role of researchers during HIV prevention research trials. *AIDS Education and Prevention*, 18(A): 44-58.

The Replicating Effective Programs (REP) project is one of many transfer projects created to make HIV/AIDS prevention programs avail able to different communities. REP translates the protocols of effective interventions into packages of materials for use by local HIV prevention organizations. REP provides a checklist of materials to collect, translate, and disseminate. Lessons from the REP for researchers include the importance of documenting details of the intervention and active involvement of providers and communities in the process of research and technology transfer.

**Emshoff, J., Blakely, C., Gray, D. Jakes, S., Brounstein, P., Coulter, J., & Gardner, S. (2003)**. An ESID case study at the federal level. American *Journal of Community Psychology*, 32, 345-357.

This study was designed to assess the D (dissemination) stage of the ESID model, with specific attention paid to program fidelity. Researchers were concerned with whether social programs can be implemented with fidelity, how much fidelity is appropriate or desired, and what organizational dynamics are necessary for adoption with fidelity. Data suggests that high fidelity can be achieved, at least in the context in which programs are mandated to do so as part of the funding agreement and are given technical assistance in achieving fidelity.

**Fadiman, A. (1997**). *The spirit catches you and you fall down*. New York: Farrar, Straus and Giroux.

The Hmong in America are a clannish group with a firmly established culture that combines issues of health care with a deep spirituality that may be deemed primitive by Western standards. In Merced, CA, which has a large Hmong community, Lia Lee suffered an initial seizure at the age of three months. Her family attributed it to the slamming of the front door by an older sister. They felt the fright had caused the baby's soul to flee her body and become lost to a malignant spirit. The report of the family's attempts to cure Lia through shamanistic intervention and animal sacrifices is balanced by the intervention of the medical community that insisted upon the removal of the child from deeply loving parents with disastrous results. This compassionate and understanding account fairly represents the positions of all the parties involved.

**Fornili, K (2005**). Organizational readiness for implementing evidenced-based practices. *Journal of Addictions Nursing*, 16: 87-89.

Adoption of evidenced-based practices involves more than dissemination activities. It involves effective technology transfer, or incorporation of state-of-the-art knowledge that leads to individual and systematic change. Four fundamental conditions must be met for successful technology transfer: exposure, adoption, implementation, and practice. "Change agents" must assume leadership roles in strategic management of change. The author suggests that addictions registered nurses act as change agents in the implementation of evidenced-based programs for substance abuse prevention and treatment.

**Gallagher, T. J. (2001)**. The Values Orientation Method: A tool to help understand cultural differences. *Journal of Extension* [Electronic version], 39(6), Retrieved January 26, 2009, from http://www.joe.org/joe/2001december/tt1.html.

This article introduces the Value Orientation Method (VOM) for identifying differences in core values across cultures. The authors empha size the importance of understanding cultural differences in order to provide appropriate services. The VOM theory recognizes diverse orientations within a culture, and notes differences based on degree of acculturation.

**Gandelman, A. & Rietmeijer, C.A. (2004)**. Translation, adaptation, and synthesis of interventions for persons living with HIV. *Journal Acquired Immune Deficiency Syndroms*, 37(2): S126-S129.

The authors point to problems with the translation of evidenced-based interventions from research to real-world situations. They recommend increased capacity of HIV prevention providers and better understanding of evidenced-based research interventions before implementation. Collaboration between providers and dissemination of a "Common Elements" guide are suggested for encouraging close modification of effective interventions.

**González Castro, F., Barrera, M. & Martínez, C.R. (2004)**. The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. *Prevention Science* 5(1), 41-45.

This article addresses the tension between fidelity and modification, two essential elements of prevention intervention programs. The authors recommend a hybrid prevention program that has built in modifications to enhance program fit while also maximizing program fidelity and effectiveness. Cultural sensitivity is addressed; hybrid prevention programs should be adjustable to fit the culture of the local community.

**Griner, D. & Smith, T. (2006)**. Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, and Training*, 43(4), 531-548.

There is a pressing need to enhance the availability and quality of mental health services provided to persons from historically disadvantaged racial and ethnic groups. Numerous studies evaluating culturally adapted interventions have appeared, and the present study used meta-analytic methodology to summarize these data. Across 76 studies the resulting random indicates a moderately strong benefit of culturally adapted interventions. Interventions targeted to a specific cultural group were four times more effective than interven--tions provided to groups consisting of consumers from a variety of cultural backgrounds. Interventions conducted in consumers' native language (if other than English) were twice as effective as interventions conducted in English.

**Hallenbeck, J., Goldstein, M.K. & Mebane, E.W. (1996)**. Cultural considerations of death and dying in the United States. *Clinics in Geriatrics*, 12(2), 393-406.

Death and dying occur in a cultural as well as a medical context. Most cultures have traditions, customs, and beliefs related to the dying process. We present a discussion of potential problems in cross-cultural communication. The concepts introduced include the cultural faux pas, cultural insensitivity, and cultural misunderstanding. Decision-making processes that emphasize individual patient autonomy may conflict with beliefs of patients and families from cultural backgrounds that emphasize familial obligation rather than autonomy. Strategies for health professionals to address possible cross-cultural difficulties include recognition of one's own cultural beliefs, patient-directed disclosure, and the elicitation of cultural information from patients or cultural guides.

**Harshbarger, C., Simmons, G., Coelho, H., Sloop, K. & Collins, C. (2006)**. An empirical assessment of implementation, modification, and tailoring: The evaluation of CDC's National Diffusion of VOICES/VOCES AIDS Education and Prevention, 18, Supplement A, 184-197.

This article assesses how different organizations adopted, adapted and implemented the DEBI project's VOICES/VOCES program. Evidence suggests that the majority of organizations implemented with fidelity, and adapted to make the program more appealing to target populations and to ensure sustainability.

**Hernandez, M., Nesman, T., Isaacs, M., Callejas, L.M., & Mowry, D. (2006)**. Making children's mental health services successful [Electronic version]. Tampa, Florida: Louis de la Parte Florida Mental Institute. Publication #240-1. Retrieved November 10, 2008, from http://rtckids.fmhi.usf.edu/rtcpubs/CulturalCompetence/services/CultCompServices.pdf.

The link between lack of access to appropriate mental health services and supports and health disparities has emerged as an important area of focus. Accordingly, this monograph examined literature available through typically accessed bibliographic databases in order to provide an assessment of the current status of research related to access and disparities in children's mental health services. Findings of this review reinforce the call to reduce disparities in access, availability, and utilization of services in racially/ethnically diverse communities. In addition to understanding the socio-historical context of the underserved populations targeted in this study, providers must make the effort to understand particular cultural characteristics that can shape the way particular communities and families address mental health issues and needs.

**Hill, N. E., & Craft, S., A. (2003)**. Parent-School Involvement and School Performance: Mediated Pathways Among Socioeconomically Comparable African American and Euro-American Families. *Journal of Educational Psychology*, 95(1), 74-83.

Children's academic and social competencies were examined as mediators to explain the often positive relation between parent–school involvement and achievement. Ethnic variations in the relation between parent–school involvement and early achievement and the mediated pathways were examined. Because much of the comparative research confounds ethnicity with socioeconomic status, the relations were examined among socioeconomically comparable samples of African American and Euro-American kindergarten children and their mothers. For reading achievement, Academic skills mediated the relation between involvement and reading achievement for African Americans and Euro-Americans. For math achievement, the underlying process differed across ethnic groups. For African Americans, academic skills mediated the relation between school involvement and math performance. For Euro-Americans, social competence mediated the impact of home involvement on school achievement.

**Hill, H. M., Soriano, F. I., Chen, S. A., & LaFromboise, T. D. (1994)**. Sociocultural factors in the etiology and prevention of violence among ethnic minority youth. In L. D. Eron & J. H. Gentry (Eds.), Reason to hope: *A psychosocial perspective on violence & youth*. (pp. 59-97). Washington, DC, USA: American Psychological Association.

Socioeconomically comparable samples of African American and Euro-American kindergarten children and their mothers were examined to assess ethnic variations in the relation between parent-school involvement and early achievement. Academic skills and social competence were measured as mediating factors. Differences found in the mediating pathways across ethnic groups suggests that parent-school involvement is different for Euro-American and African American families.

**Hitt JC, Robbins AS, Galbraith JS, Todd JD, Patel-Larson A, McFarlane JR, Spikes P, Carey JW. (2006)**. Adaptation and implementation of an evidence-based prevention counseling intervention in Texas. *AIDS Education and Prevention*, 18(A): 108-118.

This paper outlines a study of the two-session prevention counseling protocol with the strongest evidence of efficacy, Project RESPECT. Brief prevention counseling based on CDC recommendations proved effective at preventing STDs. The study demonstrated that protocol-based counseling can be implemented with limited additional resources in real-world settings. Use of the Project RESPECT protocol was associated with increased ability to meet goals of the counseling session and improved counseling skills.

**Hofstede, G. & Hofstede, G. J. (2005)**. Cultures and organizations: Software of the mind – Intercultural cooperation and its importance for survival (2nd Edition). New York: McGraw Hill Professional.

This volume helps readers look at how they think and how they fail to think as members of groups. This edition features the latest scientific results published in Geert Hofstede's scholarly work Culture's Consequences, Second Edition. This book offers vital knowledge and insight on issues that will shape the future of cultures and nations in a globalized world.

**Holleran Steiker, LK. (2008)**. Making drug and alcohol prevention relevant: Adapting evidenced-based curricula to unique adolescent cultures. *Family Community Health*, 31(15): S52-S60.

Evidenced-based drug prevention curricula have not been systematically adapted and utilized in community settings for youth. Methods for cultural modification are recommended. Specific emphasis is paid to the "Keepin' It Real" modification project, a supervised and structured two phase program, which enlists youth "as experts" of their own culture and engages them in the process of cultural modification of prevention programs. The author envisions directions for cultural modification of drug prevention programs to be distributed in the near future.

**Kelly, J.A., Heckman, T.G., Stevenson, L.Y., Williams, P.N., Ertl, T., Hays, R.B., Leonard, N.R., O'Donnell, L.,Terry, M.A., Sogolow, E.D., & Neumann, M.S.(2000)**. Transfer of research-based HIV prevention interventions to community service providers: Fidelity and adaptation. *AIDS Education and Prevention*, 12(Supplement 5), 87-98.

HIV prevention research interventions usually follow protocols with specific procedures. Community-delivered interventions using the same procedures with the same populations as those in the original research should yield similar effectiveness outcomes. However, community-based providers may not replicate an intervention exactly as it was conducted in the effectiveness study. Modification may be needed to better meet the needs of the consumers, community, or organization. The authors propose that interventions can be defined in terms of core elements likely to be responsible for effectiveness. Core elements cannot be changed without fundamentally changing the intervention, whereas other characteristics may be modified without altering the effectiveness.

**Kleinman, A., Eisenberg, L, & Good, B. (1978)**. Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine*, 88, 251-258.

Major health care problems such as patient dissatisfaction, inequity of access to care, and spiraling costs no longer seem amenable to traditional biomedical solutions. Concepts derived from anthropologic and cross-cultural research may provide an alternative framework for Identifying Issues that require resolution. A limited set of such concepts is described and illustrated, including a fundamental distinction between disease and illness, and the notion of the cultural construction of clinical reality. These social science concepts can be developed into clinical strategies with direct application in practice and teaching. One such strategy is outlined as an example of a clinical social science capable of translating concepts from cultural anthropology into clinical language for practical application. The implementation of this approach in medical teaching and practice requires more support, both curricular and financial.

**Kohn, L.P., Oden, T., Munoz, R.F., Robinson, A., & Leavitt, D. (2002)**. Adapted cognitive behavioral group therapy for depressed low-income African American women. *Community Mental Health Journal*, 38(6), 497-504.

A manualized cognitive behavioral group therapy treatment protocol is modified for depressed African American women. Details related to changes in the structure and content of the therapy are discussed. Attempts are made to determine the effectiveness of the adapted treatment compared to the non-adapted protocol.

**Lehman, W.E.K., Greener, J.M., & Simpson, D.D. (2002)**. Assessing organizational readiness for change. *Journal of Substance Abuse Treatment*, 22 (4), 197-210.

A comprehensive assessment of organizational functioning and readiness for change (ORC) was developed based on a conceptual model and previous findings on transferring research to practice. It focuses on motivation and personality attributes of program leaders and staff, institutional resources, and organizational climate as an important first step in understanding organizational factors related to implementing new technologies into a program. This article describes the rationale and structure of the ORC and shows it has acceptable psychometric properties. Results of surveys of over 500 treatment personnel from more than 100 treatment units support its construct validity on the basis of agreement between management and staff on several ORC dimensions. These results indicate the ORC can contribute to the study of organizational change and technology transfer by identifying functional barriers involved.

**Lempers, J. D., Clark-Lempers, D., & Simons, R. L. (1989)**. Economic hardship, parenting, and distress in adolescence. *Child Development*, 60(1), 25-39.

The relation between family economic hardship and adolescent distress among secondary school students in a small Midwestern community was investigated. Family hardship has both direct and indirect effects on adolescent distress. The indirect effects come about through stress induced changes in parental nurturance and parental discipline. The findings of this study showed that hardship effects varied according to type of distress. Economic hardship had both direct and indirect effects on a depression-loneliness distress factor. The indirect effects occurred through less parental nurturance and more inconsistent discipline. No direct effect of economic hardship was found on a distress factor composed of delinquency and drug use items. An indirect effect of family economic hardship on the delinquency—drug use factor was found with inconsistent parental discipline as the mediating variable.

**Masten, A. S., & Coatsworth, J. D. (1998)**. The development of competence in favorable and unfavorable environments: Lessons from research on successful children. *American Psychologist*, 53(2), 205-220.

This article highlights findings from recent studies of competence and resilience that have implications for social policy. First, these topics are defined. Then, the authors provide an overview of recent research on the origins of competence in early childhood, and the development of competence from middle childhood through adolescence. Final discussion centers around what has been learned from studies of naturally occurring resilience and from efforts to deliberately alter the course of competence through intervention and prevention.

**McKleroy, V.S., Galbraith, J.S., Cummings, B., Jones, P., Harshbarger, C., Collins, C., Gelaude, D., Carey, J.W., & The ADAPT Team. (2006)**. Adapting evidence-based behavioral interventions for new settings and target populations. *AIDS Education and Prevention*, 18(Supplement A), 59-73.

Many HIV prevention funding organizations require the use of evidence-based behavioral interventions. Often, the implementing organization's setting or target population is different from those in the original implementation and evaluation. The CDC, HIV/AIDS Prevention, and partners developed a guidance document to adapt an evidence-based intervention to fit the cultural context, risk determinants, risk behaviors, and unique circumstances of the organizations without competing or contradicting the core elements and internal logic. This document provides a systematic approach to help organizations identify the most appropriate intervention for their target population and organization capacity, monitor the progress, and evaluate the outcomes of the modified intervention.

**McLeod, J. D., & Shanahan, M. J. (1993)**. Poverty, parenting, and children's mental health. *American Sociological Review*, 58(3), 351-366.

Using data from the 1986 National Longitudinal Study of Youth (NYLS) data set, the authors explored the relationships between current poverty, length of time spent in poverty, maternal parenting behavior and children's mental health. Persistent poverty significantly predicts children's internalizing symptoms above and beyond the effects of current poverty, whereas current poverty predicts externalizing symptoms. Mothers' responsiveness and use of physical punishment explain the effect of current poverty on mental health, but not the effect of persistent poverty. The relationships between poverty, parenting behaviors, and children's mental health do not vary by race/ethnicity. These findings support greater emphasis on family processes in studies of children's poverty and greater attention to trajectories of socioeconomic status in analyses of the effects of status on mental health.

**McLoyd, V. C. (1990)**. The impact of economic hardship on Black families and children: Psychological distress, parenting, and socioemotional development. *Child Development*, 61(2), 311-346.

This article reviews family processes affecting the socioemotional functioning of children living in poor families and families experiencing economic decline. Black children are of primary interest because they experience disproportionate shares of the burden of poverty and economic loss and are at substantially higher risk than white children of experiencing attendant socioemotional problems. Reasons for this effect are argued. The extent to which psychological distress is a source of race differences in parenting behavior is considered. Finally, attention is given to the mechanisms by which parents' social networks reduce emotional strain, lessen the tendency toward punitive, coercive, and inconsistent parenting behavior, and, in turn, foster positive socioemotional development in economically deprived children.

**McLoyd, V. C. (1998)**. Socioeconomic disadvantage and child development. *American Psychologist*, 53(2), 185-204.

The authors present a review of the research on poverty and child development, with specific attention paid to duration, timing, and neighborhood context of poverty, mediators of family-level income and socioeconomic status, physical health status, parental behaviors, school characteristics, and discrete and chronic stressors. The most consistent findings are presented. Implications for practice and policy are discussed.

**McMahon, R.J. & Forehand, R.L. (2003)**. *Helping the noncompliant child: Family-based treatment for oppositional behavior* (2nd Edition). New York: Guilford Press.

This popular treatment manual presents an empirically validated program for teaching parents to manage noncompliance in 3- to 8-year-olds. Practitioners are provided with step-by-step guidelines for child and family assessment, detailed descriptions of parent training procedures, effective adjunctive treatment strategies, and complete protocols for conducting and evaluating the program. Nationally recognized as a best practice for treating conduct problems, the program is supported by a substantial body of treatment research.

**Miranda, J., Duan, N., Sherbourne, C., Schoenbaum, M., Lagomasino, I., Jackson-Triche, M. & Wells, K.B. (2003)**. Improving care for minorities: Can quality improvement interventions improve care and outcomes for depressed minorities? Results of a randomized, controlled trial. *HSR: Health Services Research*, 38(2), 613-629.

The authors designed a quality improvement (QI) intervention to increase access to and adherence with some form of appropriate care for depression (either medication or psychotherapy) for minority groups. They evaluated differential responses to treatment among ethnic groups. The authors suggest that QI interventions may offer an approach to improving quality of care equitably with respect to ethnic groups.

**NASMHPD Research Institute. (2006).** Consensus Panel Report: The Development of the Children's Mental Health Implementation Resource Kit: Evidenced-Based Interventions for Children and Adolescents with Disruptive Behavior Disorders. Arlington, VA.

The Children's Mental Health Implementation Resource Kit is being developed by the NASMHPD Research Institute (NRI) as part of SAMHSA's next generation of "toolkits", which promote and facilitate implementation and dissemination of evidenced-based practices. The Consensus Panel offered expert guidance on the objectives, treatment focus, targeted users, content, and format/medium of the Children's IRK. Lessons learned from previous toolkits, results of the stakeholder survey, the federal perspective of the Children's IRK, proposed directions, targeted audience and setting, and overall goals were discussed. Suggestions for fostering the development of the Children's IRK were proposed.

**O'Connor C, Small SA, Cooney SM. (2007)**. Program fidelity and adaptation: meeting local needs without compromising program effectiveness. *What Works, Wisconsin – Research to Practice Series, 4.*

The efficacy of an evidenced-based program depends on its fidelity to the original program design. Modification is described as a serious and important task. This article explores the types of changes that are made to programs and the effects those changes may have. Strategies for maintaining effectiveness are discussed.

**Osher, FC & Steadman, HJ (2007)**. Adapting Evidenced-Based Practices for Persons with Mental Illness Involved with the Criminal Justice System. *Psychiatric Services,* 58(11): 1472-78.

Modifications to standard evidenced-based practices are often required when used to treat persons with mental illness in the criminal justice system. The extent of modification may compromise fidelity to the proven practice. To better understand this issue of fidelity, the Nationals GAINS Center for Evidenced-Based Programs in the Justice System held a series of meetings focused on evidenced-based practices and their applicability to persons involved in the criminal justice system. The Center outlined issues that must be addressed in adapting effective interventions: co-occurring substance use disorders, sociodemographic factors, trauma exposure, legal factors and the role of coercion. Hypotheses were proposed for effective modifications of six intervention programs for each of the issues stated. The Center suggested that clinical outcomes may be obtained but that desired public safety goals may not result from adapted use of EBPs.

**Peace Corps Information Collection and Exchange. (1999)**. *Culture matters: The Peace Corps cross-cultural workbook*. Washington, DC: U.S. Government Printing Office.

This training guide is used by Peace Corps volunteers as part of their independent study cross-cultural training efforts. It gives users information about understanding the concept of culture. The concept of self and understanding the diversity of American culture is illustrated. Cultures are examined from a variety of viewpoints: through the lens of personal and societal obligations, communication styles, concepts of time, culture in the workplace, locus of control, and social relationships. Workbook users are encouraged to compare American culture to that of the host country and tips for adjusting to new cultures are provided.

**Pedersen, P.B. & Ivey, A. (1993)**. *Culture-Centered Counseling and Interviewing Skills: A Practical Guide*. Westport, CT: Praeger Publishers.

This book is directed towards students and professionals studying about counseling, doing research on counseling topics, or delivering direct services as counselors. The book uses a three-stage developmental sequence to address multicultural awareness, knowledge and skills. The first chapter emphasizes cultural similarities and differences that shape the counseling interview. The second chapter develops a cognitive framework for organizing knowledge about culture in a counseling relationship. The third chapter introduces four different dimensions of culture and provides a framework for identifying cultural differences. The rest of the book looks at micro-skills of counseling and emphasizes how to adapt or reframe each micro-skill in order to effectively work with different cultures.

**Prather C, Fuller TR, King W, Brown M, Moering M, Little S, Phillips K. (2006)**. Diffusing an HIV prevention intervention for African American women: integrating Afrocentric components into the SISTA diffusion strategy. *AIDS Education and Prevention*, 18(A): 149-160.

African American women are the largest proportion of women in the U.S. to be affected by HIV/AIDS. The authors describe The Sisters Informing Sisters About Topics on AIDS (SISTA) intervention. Fidelity to its core elements during implementation and diffusion, as part of the Diffusion of Effective Behavioral Interventions (DEBI) project, is measured and assessed in a pilot project. The authors conclude that national diffusion of SISTA, as well as other prevention programs for at-risk communities, is successful when Afrocentric and gender-specific activities are incorporated.

**Purnell, L.D. (2009)**. *Guide to culturally competent health care* (2nd ed.). Philadelphia, Pennsylvania: F. A. Davis Company.

Cultural competency is a hot topic in the health professions. This guide will boost the confidence of students and practitioners who feel uncomfortable dealing with those from a cultural background different than their own. It provides a summary of issues to be aware of, including cultural variations regarding personal space, dietary preferences, activities of daily living, communication, symptom management, activities of daily living, and religious and health practices for 27 different cultures.

**Rapp, C.A., Bond, G. R., Becker, D. R., Carpinello, S. E., Nikkel, R. E., & Gintoli, G. ( 2005)**. The role of state mental health authorities in promoting improved consumer outcomes through evidence-based practice. *Community Mental Health Journal*, 41(3), 347-363.

This paper describes the role that state mental health authorities (SMHA) play in implementing and sustaining evidenced-based practice that is relevant to implementing five EBP's in eight states. Discussions between organizations and researchers highlight seven tasks that the authors recommend SMHA follow in order to effectively implement EBPs.

**Rogers, E.M. (2003)**. *Diffusion of Innovations* (5th Edition). New York: Free Press.

This book is a classic work on the spread of new ideas. The author explains how new ideas spread via communication channels over time. Such innovations are initially perceived as uncertain and even risky. To overcome this uncertainty, most people seek out others similar to themselves who have already adopted the new idea. Thus the diffusion process consists of a few individuals who first adopt an innovation, then spread the word among their circle of acquaintances--a process which typically takes months or years. But there are exceptions: use of the Internet in the 1990s, for example, may have spread more rapidly than any other innovation in the history of humankind. Furthermore, the Internet is changing the very nature of diffusion by decreasing the importance of physical distance between people. The fifth edition addresses the spread of the Internet, and how it has transformed the way human beings communicate and adopt new ideas.

**Rodriguez, O. Lessinger, J. &Guarnaccia, P. (1992)**. The societal and organizational contexts of culturally sensitive mental health services: Findings from an evaluation of bilingual/bicultural psychiatric programs. *The Journal of Mental Health Administration*, 19(3), 213-223.

Utilizing data from an evaluation of three New York psychiatric programs for seriously mentally ill (SMI) Hispanic patients, the paper discusses societal and organizational factors that influenced the programs' development. Among societal forces were the significance of Hispanics as a voting bloc, the political organization of Hispanic mental health professionals, the philosophy of ethnic assimilation in American society, prevailing views about the place of cultural knowledge in psychiatric treatment, fiscal crises, and the shortage of Hispanic mental health professionals. Among organizational factors, hospital administrative support and program leadership mediated the effects of societal forces upon the programs, while ethnic competition and lack of coordination between the program and other organizational units acted as barriers to the programs' development.

**Rotheram-Borus, M. J., & Duan, N. (2003)**. Next generation of preventive interventions. *Journal of the American Academy of Child & Adolescent Psychiatry*, 42(5), 518-526.

The authors examined the life course of prevention programs, identified barriers to dissemination, and outlined an alternative dissemination model. Private enterprise models of product development can be viable strategies for increasing the dissemination of interventions to the general public. However, investigators are likely to be resistant given a priori biases, potential ethical conflicts of interest, and the challenges presented by new technologies (e.g., the Internet and Human Genome Project).

**Siegel C, Haugland G, Schore R. (2005)**. The interface of cultural competency and evidenced-based practices. RE Drake, MR Merrens & Lynde DW (Eds.) Evidence-Based Mental Health Practice. New York: W.W. Norton & Company, Inc.

The authors describe service problems of minority cultures and efforts that have been made to improve service delivery. The construct of Cultural Competency (CC) and tools for its measurement are discussed. The importance of CC for the modification and implementation of EBPs when an organization provides mental health treatment to people from diverse cultures is reviewed. Suggestions for methods of improving CC at mental health organizations are made.

**Siegel C, Davis-Chambers E, Haugland G, Aponte C, McCombs H. (2000)**. Performance measures of cultural competency in mental health organizations. *Administration and Policy in Mental Health*, 28(2): 91-106.

The need for Cultural Competency (CC) in mental health care is addressed. A project was conducted to identify the domains of CC and to create a conceptual framework for addressing CC. Focus groups were formed of Latino-Americans, African-Americans, Asian and Pacific Islanders, and Native Americans to represent minority multicultural groups identified by the federal government as under-served. A final matrix of performance measures for CC at each organizational level was created. Suggestions are made for selecting and implementing the most critical measures. The product is broadly applicable to the concerns of all cultural groups.

**Solomon, J., Card, J.J., & Malow, R.M. (2006)**. Adapting efficacious interventions: Advancing translational research in HIV prevention. *Evaluation and the Health Professions*, 29(2), 162-194.

HIV has infected approximately 1.5 million people in the U.S. Type 1 translation research (basic research, methods development, and efficacy trials) has yielded multiple efficacious behavioral HIV prevention programs. Type 2 translation research (dissemination and effectiveness studies) has been less prevalent or successful. Modification of efficacious interventions for culturally diverse populations has received increasing researcher attention, and empirical validation of modification procedures promises to help bridge the gap between Type 1 and Type 2 studies. In this article, the authors briefly discuss the development, testing, and dissemination of efficacious HIV prevention programs and then focus on research-based principles and processes that can guide researchers' modification efforts and steps that researchers can take to help empower practitioners to conduct science-based modification. Greater collaboration between researchers and service providers to test modification frameworks promises to benefit both research and practice.

**Somerville, GG, Diaz, S, Davis, S, Coleman, KD, Taveras, S (2006).** Adapting the Popular Opinion Leader Intervention for Latino Young Migrant Men Who Have Sex With Men. *AIDS Education and Prevention*, 18(A): 137-148.

Young Latino migrant men who have sex with men (MSM) are at high risk for HIV infection and migration-related discrimination. Together, these factors pose serious challenges to public health practitioners trying to promote protective behaviors. The Popular Opinion Leader (POL) intervention, shown to be effective with White gay men, was adapted for young migrant MSM. This project was implemented over a two-year period in two community-based organizations (CBOs). Challenges specific to MSM, such as language; low literacy skills; lack of knowledge about STIs and HIV; limited access to HIV prevention, treatment, and care; poverty; depression; racism; homophobia; and high mobility were reported. Success, measured as increased knowledge and condom use, was attributed to the integration of culturally appropriate models.

**Stanard, R.P., Sandhu, D.S., Painter, L.C. (2000)**. Assessment of spirituality in counseling. *Journal of Counseling & Development*, 78: 204-10.

The authors suggest that spirituality is a "5th force" in counseling and psychology, based on evidence of its role in the treatment of medical and psychological conditions. The authors define spirituality and compare it to religion. They provide a review of current literature on spirituality assessment instruments: the Spiritual Assessment Inventory, the Index of Core Spiritual Experiences, the Spiritual Well-Being Scale, the Spiritual Health Inventory, the Brown-Peterson Recovery Index, the Spirituality Scale, and the Spirituality Assessment Scale. These tools assess spiritual wellness, health, and maturity. The authors suggest that the instruments lack normative information, but are useful in the context of therapy.

**Sue, D.W. (2000)**. Multidimensional facets of cultural competence. *The Counseling Psychologist*, 29(6): 790-821.

This article is based on a keynote address given at Teachers College, Columbia University. A multidimensional model of cultural competence (MDCC) is proposed with three dimensions: a) racial and culture-specific attributes of competence, b) components of cultural competence, c) foci of cultural competence. The MDCC allows for systematic identification of cultural competence in a number of different service arenas; its use in education, training, practice and research are discussed.

**Torrey, W. C., Drake, R. E., Dixon, L, Burns, B. J., Flynn, L., Rush, A. J., Clark, R. E., & Klatzker, D. (2001).** Implementing evidence-based practices for persons with severe mental illness. *Psychiatric Services*, 52(1), 45-50.

The authors summarize perspectives on how best to change and sustain effective evidenced-based practices from the research literature. They describe an implementation plan for evidence-based practices based on the use of toolkits to promote the consistent delivery of such practices. The toolkits include integrated written material, Web-based resources, training experiences, and consultation opportunities. Special materials address the concerns of mental health authorities, administrators of provider organizations, providers, and consumers and their families.

**U.S. Department of Health and Human Services Substance Abuse & Mental Health Services Administration (SAMHSA). (2003).** *Illness management and recovery toolkit*. Retrieved November 10, 2008, from http://www.ct.gov/dmhas/lib/dmhas/cosig/IMRtoolkit.pdf.

This resource kit provides useful information to professionals involved in all aspects of mental health. It includes specific information about evidence-based practices, a step-by-step planning guide for implementing the Illness Management and Recovery toolkit (IMR), mental health information in English and Spanish for consumers and family members, and provides a full fidelity scale.

**U.S. Department of Health and Human Services Substance Abuse & Mental Health Services Administration (SAMHSA). (2008)**. NREPP: *SAMHSA's national registry of evidence-based programs and practices*. Retrieved November 10, 2008, from http://www.nrepp.samhsa.gov/.

The National Registry of Evidence-based Programs and Practices (NREPP), a service of the Substance Abuse and Mental Health Services Administration (SAMHSA), is a searchable database of interventions for the prevention and treatment of mental and substance use disorders. SAMHSA has developed this resource to help people and organizations implement programs and practices in their communities.

**Webster-Stratton, C., Reid, M. J. & Hammond, M. (2001)**. Preventing conduct problems, promoting social competence: A parent and teacher training partnership in Head Start. *Journal of Clinical Psychology*, 30(3), 283-302.

This article is a review of a study that examined the effectiveness of parent and teacher training as a selective prevention program for 272 Head Start mothers and their 4-year-old children, and 61 Head Start teachers. Fourteen Head Start centers (34 classrooms) were randomly assigned to (a) an experimental condition in which parents, teachers, and family service workers participated in the prevention program (Incredible Years) or (b) a control condition consisting of the regular Head Start program. Assessments included teacher and parent reports of child behavior and independent observations at home and at school. Construct scores combining observational and report data were calculated for negative and positive parenting style, parent–teacher bonding, and child conduct problems at home and at school, and teacher classroom management style. Positive parenting significantly increased and conduct problems in children significantly decreased in the experimental group, and these effects persisted one year later. Implications of this prevention program as a strategy for reducing risk factors leading to delinquency by promoting social competence, school readiness, and reducing conduct problems are discussed.

**Wingood GM, DiClemente J. (2008)**. The ADAPT-ITT Model: a novel method of adapting evidenced-based HIV interventions. *Journal of Acquired Immune Deficiency Syndrome*, 47(1): S40-S46.

The ADAPT-ITT model was developed as a framework for adapting HIV-related evidenced-based interventions (EBIs). It consists of eight sequential phases (assessment, decision, administration, production, topical experts, integration, training, testing) that inform HIV prevention providers and researchers with a prescription for adapting EBIs. The ADAPT-ITT model is suggested as an efficient mechanism of designing culturally-sensitive and efficacious HIV interventions.

**Yoshikawa, H. (1994)**. Prevention as cumulative protection: Effects of early family support and education on chronic delinquency and its risks. *Psychological Bulletin,* 115(1), 28-54.

This paper proposes a model for prevention of chronic juvenile delinquency. A comprehensive review of early risk factors for chronic delinquency is presented with special attention to interactive effects. Interventions combining comprehensive family support with early education may bring about long-term prevention through short-term protective effects on multiple risk factors.

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