A Toolkit for Applying the **Cultural Enhancement Model** To Evidence-Based Practice

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INTRODUCTION

Interest in developing and testing cultural adaptations has grown in proportion to the widespread adoption of policies to support the implementation of evidence-based practice (Bernal, 2009; Hwang, 2006). Increasingly, governments at the local, state and national level as well as insurance companies are requiring that behavioral health providers offer Evidence Based Practices (EBPs) as the core of their array of treatment options (see for example, Barnoski & Aos, 2004). The rationale for this policy is that EBPs have scientific grounding and evidence for effectiveness. Research has demonstrated that, when implemented with fidelity, they achieve both positive clinical and financial effects. Despite these findings, just under 10% of clinicians are likely to use or refer to a treatment manual as part of their clinical practice (Morrison, Bradley & Westen, 2003). One significant challenge for EBP dissemination is the perception that EBPs are not responsive to cultural needs and preferences and thus conflict with standards of culturally competent best practice (Bernal, 2009; Lau, 2006).

EBP Implementation Challenges

Just under 10% of clinicians are likely to use or refer to a treatment manual as part of their clinical practice

As outlined by other monographs on the subject of EBP implementation, several common challenges exist within multiple service sectors that work against the wide availability of adherent, evidence-based practices in community-settings (e.g., Fixsen, Blase, Friedman & Wallace, 2005) . First, a fundamental value within social work and psychology is the tailoring of practices to the unique needs and diversity of family

systems and individual cases (APA, 2006; Spring, 2007). Consequently, to the degree that evidence-based practices are seen as rigid, inflexible and "one size fits all" approaches to treatment, there is pushback and reluctance to adopt or even seriously investigate these programs (Addis & Krasnow, 2000).

In addition to philosophical conflicts about best practice, practitioners have concerns about the ability to exercise clinical judgment within a manualized framework that accounts for complexity of real life cases (Nelson & Steele, 2007; Addis & Krasnow, 2000; Aarons, 2004). Others voice concern that EBP clinical trial populations lack cultural diversity and the practices therefore cannot be generalized to minority clientele (Bernal, 2009; Lau, 2006; Mak, Law, Alviderez, & Perez-Stable, 2007). Practitioners may also be skeptical and even offended when implementation is perceived as a "top down" approach with little effort towards collaboration, even when the practice under discussion has good evidence of effectiveness with the targeted population (Kessler, Gira, & Poertner, 2005).

Clinicians often perceive treatment manuals as inflexible and not responsive to the complexity of individual cases.

Finally, when programs are accepted and implemented, ensuring quality access to EBPs in the community may still be hampered by structural or environmental factors such a lack of knowledge by referral sources (social workers, case managers, probation officers) regarding the availability of EBPs and how to appropriately refer. Further, the programs themselves may drift from an evidence-based approach from a lack of quality monitoring and supervision (Fixen, Blase, Naoom, & Wallace, 2009).

Many of the barriers to EBP implementation can be characterized as *social validity* issues (Foster & Marsh, 1999). That is, does the community (community as both practitioners and the surrounding culture) believe that the program will effectively address local needs in a culturally competent manner?

Cultural Competence

At a national level, minority clients are less likely to access mental and behavioral health services and drop out of treatment more frequently than nonminority counterparts (Walker, Trupin, VanWormer & Saavedra, 2009; Miranda, Bernal, Lau et al., 2005). While this phenomenon is driven by social and economic factors, it is reasonable to assume it also may be due to a lack of adequate training in culturally congruent therapeutic approaches. At least one study demonstrated that therapists may be hesitant to directly address ethnicity or ethnic differences in sessions (Harper & Iwamasa, 2000). Indeed, as stated by Hwang (2006), "Many training programs in cultural competency tend to be general and descriptive in nature, leaving professionals with an increased awareness of important issues but with few practical skills to incorporate into clinical practice." Proponents of the cultural adaptation of evidence-based practices argue that adaptations which describe practical cultural and engagement strategies can provide needed instrumental guidance for a clinician/

Minority clients are less likely to access mental health services and more likely to drop out of treatment.

practitioner as a starting point for establishing an effective therapeutic relationship (Wade & Berstein, 1991).

Cultural Adaptation Frameworks

Cultural adaptations are recommended as bridge between the evidence-based practice and cultural competency demands in clinical practice. Indeed, Chorpita, Rotheram-Borus &Daleiden et al. (2011) suggest that to successfully expand the reach of evidence-based knowledge into clinical practice, the co-design (i.e., adaptation) of treatment is likely inevitable. Proponents argue that adaptation addresses the need for cultural competence in practice by allowing practitioner flexibility so that treatment aligns with the client's worldview, i.e., "dynamic sizing" (Sue , 1998). Cultural competency is a best practice emphasis for clinical treatment that has grown concurrently with the focus on evidence-based practice, but with minimal cross-fertilization (Whaley & Davis, 2007; Bernal & Scharron del Rio, 2001). The goals of the two could be seen as potentially in conflict: cultural competence emphasizes the importance of shifting practice towards the individual level and evidence-based practice focuses on ensuring adherence to protocols shown to work (Atkinson, Bui & Mori, 2001). However, as pointed out by Whaley & Davis (2007), the goals of both the cultural competency and evidence-based practice movements are to improve service delivery and outcomes, particularly with minority communities.

To successfully expand the reach of EBPs, the co-design (e.g. adaptation) of treatment is likely inevitable.

While there is a considerable literature on cultural competence in therapeutic practice (e.g. S. Sue, Ivey & Pederson, 1996; D.W.Sue, 1982), only a few formal frameworks specifically focus on the cultural adaptation of existing treatments. One of the earliest frameworks is the Ecological Validity Model (EVM) proposed by Bernal, Bonilla & Bellido (1995). This model delineates eight dimensions to consider when developing a cultural adaptation (or a new treatment). These include *language* (is the language appropriate), *person* (the therapist-client relationship), *metaphors* (symbols and concepts), *content* (cultural knowledge of the therapist), *concepts* (treatment concepts consistent with culture), *goals* (do goals support of positive and adaptive cultural values), *methods* (cultural enhancement of treatment methods) and *context* (consideration of economic and social context). This framework has been used to adapt Cognitive Behavior Therapy (CBT) and Interpersonal Therapy (IPT) for Puerto Rican adolescents (Rossello & Bernal, 1999), Haitian adolescents (Nicholas, 2009), Parent –Child Interaction Therapy (PCIT) for Puerto Rican children and families (Matos et al, 2006) and parent management training – Oregon model with Mexican-American families (Domenach Rodriguez, 2008). The adapted therapies were found to be effective both in randomized and preliminary studies; although, adaptations were not compared to "treatment as usual" approaches.

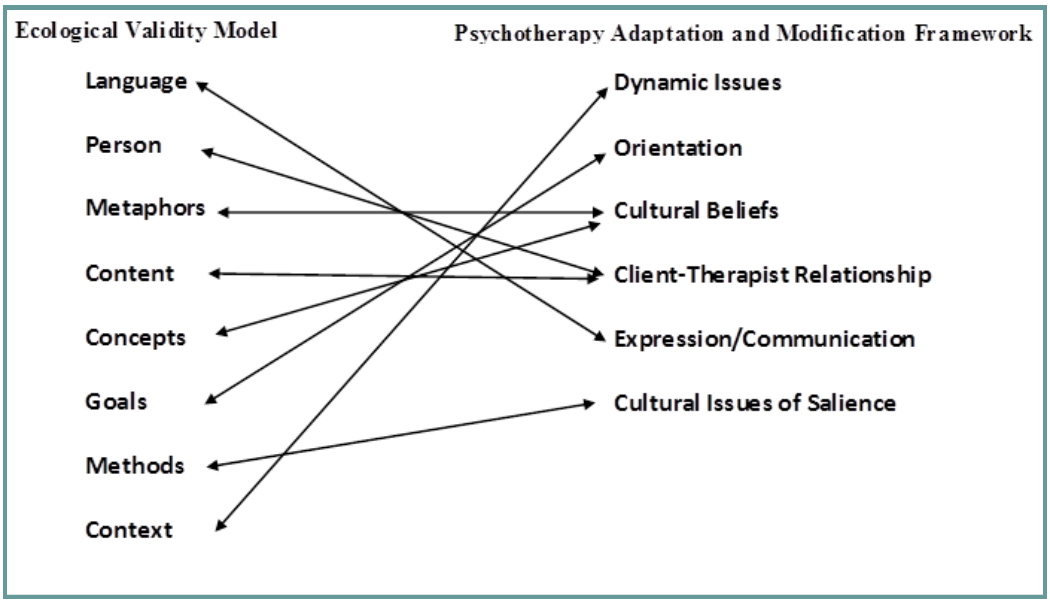
The goal of both the EBP and cultural competency areas of focus is to improve service delivery and outcomes, particularly in minority communities.

The Psychotherapy Adaptation and Modification Framework (PAMF; Hwang, 2006) is another framework for clinical adaptation. It includes a three-tiered format that begins with broad domains, then breaks

these into therapeutic "principles," which then are supported by "rationales." When applied to working with Asian Americans, the framework included 6 domains and 25 therapeutic principles. For example, in the first domain "Dynamic issues and cultural complexities," two of the therapeutic principles are "1. Be aware of dynamic sizing (e.g., knowing when to generalize and when to individualize treatments on the basis of client characteristics)" and "2. Be aware of and address client's multiple identities and group membership." This application of this framework is illustrated in a case study of a phobic Chinese-American youth (Hwang, Wood, Lin & Chang, 2006).

While other frameworks exist (e.g., Samuels, Schudrich & Altschul, 2011; Barrera & Gonzalez-Castro, 2006), to date these two frameworks are the only ones to be used in tested applications for psychosocial interventions. The eight dimensions and six domains of the EVM and PAMF, respectively, overlap significantly. The figure below illustrates the degree of overlap, which reflects our understanding of how the dimensions and domains are similar.

In addition to overlapping content, the two approaches also share similar values



around research and community engagement. The developers are both committed to assessing their respective approaches empirically. Further, both approaches also cite the need to establish the efficacy of adaptations through research trials; Bernal et al (2009) goes even further to state that that adaptation frameworks themselves should be subject to research scrutiny.

The two frameworks are also similar in their focus on community engagement. This is not surprising as the authors are proposing adaptations to more closely align treatments with individual needs; however, each also make a separate point about the process of adaptation being community-driven. Bernal et al (2009) discusses the importance of a treatment having social validity, i.e., being acceptable to the community. Hwang (2009) even goes so far as to adapt the PAMF cultural adaptation framework to explicitly include consumers in the process of identifying and developing areas for adaptation. This new method is called the formative method and is similar in many respects to an adaptation of the EVM model that incorporates the process of development, which includes collaborating with a community opinion leader at each phase (Domenech Rodriguez & Wieling, 2004).

Social validity refers to the perception that an EBP will be appropriate for the local community.

The two adaptations frameworks presented here, as well as other models for incorporating culturally competent elements into clinical practice, are thoughtful and useful guides for thinking through how to improve current programming both from a community and client-level perspective. However,

two primary barriers are likely to keep these adaptation frameworks from deeply penetrating the service sector and, thus, from increasing the spread of culturally sensitive, evidence-based practice. First, the adaptation process can be costly and time-intensive. For example, in the formative method adaptation of the PAMF, Hwang (2009) recommends that a number of stakeholder groups be consulted in the initial and ongoing stages of development: mental health service agencies; mental health providers; traditional healers; and spiritual leaders. The process includes 5 phases of ongoing information acquisition, program development, feedback and revision. Hwang's development team included four master's level therapists, one postdoctoral fellow, 15 undergraduate students, and 4 graduate students and the entire process was externally funded with an NIMH grant. It is unlikely that anyone apart from clinical researchers with substantial grant support would be able to feasibly use these frameworks.

Second, cultural adaptations for broad groups (e.g. "Latino;" "African-American;" "Girls") do not address a fundamental dissemination concern regarding evidence-based practice: that the practice is not responsive to local culture. For example, a Latino-focused adaptation developed with acculturated Puerto Rican families in New York may need additional adaptation to be relevant for a clinic in Los Angeles that services primarily immigrant Mexican families. A feasible adaptation framework would need to be both practical to develop and responsive to the engagement needs of the local community.

Engagement

As described above, both the EVM and PAMF adaptation frameworks explicitly account for the importance of community involvement in promoting the viability of evidence-based practices. Indeed, research on the effectiveness of adaptations (as well as practical demands) suggests that engagement of the community and the individual client may be a more promising route to positive outcomes than altering core treatment components. Although an extensive literature supports the assertion that cultural considerations are critical in the engagement and treatment success of clients (Wade & Berstein, 1991; Yutrzenka, B.A., 1995; Sue, 2003), research also suggests that un-adapted empirically supported treatments are at least promising and are often effective with minority groups (Wilson, Lipsey & Soydan, 2003). While some results are available to support the heightened efficacy of adapted interventions over an "implement-as-is" approach (Huey & Pan, 2006), many argue that it is not feasible to answer this question empirically for every program and every cultural subgroup.

As pointed out by Kazdin (2006) and others, it would require over 100,000 studies to examine how the efficacy of any one treatment varied by cultural group and presenting problem. Rather than embark on an infeasible research effort (that is still unlikely to satisfy critics), an alternative may be to consider what treatment mechanisms are likely to be affected by an adaptation and how this might affect outcomes. Lau (2006) identified improved engagement, or social validity, as a significant benefit of evidence-based

It would require over 10,000 studies to examine how the efficacy of treatment varies by cultural group and presenting problem.

program adaptation. Further, research on "common factors" demonstrates that engagement – the capacity of the therapist to effective engage those with whom they are working to bring about change – explains positive effects across interventions (Barth et al., 2011).

Engagement has become a key issue as researchers and policymakers have focused on the dissemination of evidence-based practices. Both engagement and treatment retention suffer as treatments move from efficacy studies (well-controlled settings) to effectiveness studies (Morrison, Bradley & Westen, 2003). In one of the earliest papers to directly address the issue of modifying treatment for cultural relevancy, Rogler, Malgady, Costantino & Blumenthal (1987) pointed out that aligning services with the needs and cultural perspective of the client increases retention and is a key feature of culturally sensitive and effective interventions.

The Cultural Enhancement Model

The Cultural Enhancement Model presented in this paper addresses engagement factors at the community and individual-level in order to overcome barriers to EBP dissemination and program retention. It is built on the assumption that the core components of the program are viable across multiple cultural groups and that the program can be effectively enhanced through therapist matching, using appropriate language, incorporating culturally relevant metaphors and improving therapist knowledge of

Engagement has become a key issue in EBP effectiveness. Aligning services with the needs and cultural perspective of the client increases retention.

culturally appropriate therapeutic strategies. The model, however, does not adjust core components of the program which could necessitate re-evaluating the program for effectiveness. In addition to improving program factors related to engagement, the model is intended to be an effective way to improve the social validity of a program through targeted, community planning. This approach differs from a "cultural accommodation" approach (Lau, 2006). Cultural accommodation refers to adjusting surface level components such as the translation of materials and providing interpreters. The cultural enhancement model incorporates these practices, as needed, but also considers the ways in which key concepts are presented to clients without adjusting the core message of these themes.

The five phases of the Cultural Enhancement Model (CEM) assume that the program has already been implemented for more than six months. In contrast to other adaptation models (e.g., Bernal et al., 2009; Hwang et al., 2006; Samuels et al., 2009), identifying areas for enhancement in this model occurs from the local experience of therapists and clientele rather than a theoretically-driven set of recommendations. There are likely to be hypotheses concerning the potential benefit of altering some program components, but these are tested rather than applied a priori. This ensures that the process is data-driven and reflects the actual needs of local clientele. Because a critical foundation for the CEM is a program that is congruent with the needs and values of the local clientele, the CEM model would

The Cultural Enhancement Model (CEM) focuses on engagement at the community, therapist and client level.

work well in combination with a prior community-building process to identify a needed program or intervention.

Community enthusiasm, and increased social viability, for a selected EBP can be heightened by engaging community stakeholders in selecting an appropriate practice to implement. There are a few structured community engagement models already in existence which specifically guide a community through the process of identifying existing needs and resources with the purpose of developing an implementation plan. One of these models, Partnerships for Success (Kerns, Rivers & Enns, 2009; Julian, 2006), focuses on building capacity within the community to make decisions about investing in child and family programs (http://cle.osu.edu/projects/partnerships-for-success). The model heavily emphasizes collaboration through cross-agency and community-member workgroups. After identifying needs, community workgroups develop relationships with providers and create a plan for implementation. This community-driven process enhances the likelihood that the resulting implementation plans will have greater social viability given the relationships built between various interest groups. Success for this approach has largely been interpreted in terms of a community's ability to leverage and obtain outside sources of funding for programs.

The CEM would work well with a community planning process such as Partnerships for Success or Communities that Care.

Communities that Care (CTC) is a similar community-engagement model which also guides community coalitions through a 5-phase process to identify needs

and select an appropriate child and family- serving evidence-based practice (http://www.sdrg.org/ctcresource). The model places a greater emphasis on selecting an EBP as a result of the coalition-building and needs/resource analysis. Coalitions are made up of agency directors, funders, cultural representatives, family representatives and other interested parties. A seven-state experimental trial of Communities that Care found fewer delinquent acts, less substance use, slower initiation for substance use and reduced exposure to risk factors among the CTC implementation sites (Hawkins, Oesterle, Brown, Arthur, et al., 2009).

In addition to the benefits of interagency communication and leveraged funding, a community engagement model also enhances the probability of selecting an EBP that will have greater social validity; however, if one of the above community engagement processes is not already being used, it is possible to begin the first phase of CEM prior to implementing an EBP. This group would then assess and select a program with the understanding that it would be implemented "as is" and then evaluated for needed enhancements.

This toolkit is intended to act as a guide for how an agency might implement their own process of developing a localized enhancement of an evidence-based practice. The CEM incorporates what is known in the literature regarding culturally-sensitive and effective practice as well as lessons learned from a pilot test of the model with a transition program for dual-diagnosed adolescent offenders: Family Integrated Transitions.

Family Integrated Transitions (FIT)

The CEM model represents a synthesis of research and experience that was accumulated as the present authors developed a cultural enhancement for an evidence-based juvenile offender program, Family Integrated Transitions (FIT; Trupin, Kerns, Walker, DeRobertis & Steward, 2011). Transition planning is a high priority for policymakers who are struggling to reduce recidivism, particularly for those youth with co-occurring substance use and psychiatric disorders (Trupin, Turner, Stewart & Wood, 2004). As the population of youth with co-occurring disorders in the juvenile justice facilities has increased, the need to address effective transitions has become more urgent (Skowyra & Cocozza, 2007; Teplin, Abram, McClellan et al., 2002).

The FIT intervention is a transition program primarily comprised of three evidence-based programs (Multisystemic Therapy, Dialectical Behavior Therapy, and Motivational Enhancement), plus a parent skills training module. Program components are systematically delivered based on the youth and family's demonstrated needs. FIT was designed to build upon a cognitive-based skills treatment that youth receive while placed in a secure residential setting in one of Washington State's Juvenile Rehabilitation Association (JRA) facilities and serves as a transition program for youth as they return to their community, family or caregiver (Juvenile Rehabilitation Administration, 2002). FIT is also offered as a diversion program from a County detention

Family Integrated Transitions (FIT) is a program for youth with co-occurring disorders transitioning from secure care back into the community.

for with co-occurring disorders on probation. An evaluation conducted by the Washington State Institute of Public Policy found that FIT reduced recidivism by 30% over 18 months (Aos, 2004); a follow up study using the same sample, found this effect held for 36 months (Trupin, Kerns, Walker, DeRobertis & Stewart, 2011). It is currently rated as having an excellent cost-benefit ratio and is included on the Community Juvenile Accountability Act list of funded juvenile justice programs in the State of Washington.

Applying the CEM

The CEM model includes the following phases:

***Phase 1**: Identify Community Advisory Team and Agree on a Work Plan*

***Phase 2**: Information Gathering*

***Phase 3**: Development*

***Phase 4**: Implementation*

***Phase 5**: Evaluation*

Phase 1: Identify Community Advisory Team and Agree on a Work Plan.

The first phase of CEM involves assembling an enhancement team to develop and agree upon a work plan for the process. The team includes both a larger advisory group and a smaller working team. The selection of the advisory group members is critical, as this group will provide guidance on cultural and administrative concerns as well as, ideally, act as champions for the enhancement process in other community settings. Members making up the working team include, at a minimum, the funding agency, the implementing agency, at least

one individual that represents the community/culture of interest, a consultant or supervisor that oversees the program practitioners (therapists/ coaches) and one of the practitioners. It is important to bring consultants and supervisors into the planning process, as these are the individuals that will need to reinforce these skills with the practitioners. An agency-wide effort to implement an enhancement can run into the same kinds of difficulties as trying to implement a new program if personnel are not sufficiently engaged. The developer is also invited to join the advisory and/or working team.

The first task of the working group is to develop a work plan for the project that is reviewed and approved by the larger advisory group members. The enhancement work plan outlines the phases of the

CASE EXAMPLE

For the FIT enhancement, we met separately with our different stakeholder groups and had a core working team that included two staff from our division, a FIT consultant, and a FIT therapist who was also a cultural consultant. We regularly met or spoke with members from our larger advisory group including JRA management team, FIT consultants, FIT supervisors, FIT coaches, Cultural consulting firm. The need for continual outreach to the advisory group members is highlighted by one reaction to the resulting enhancement materials on the FIT project. One supervisor, after sitting through a full day of cultural sensitivity training (and despite high enthusiasm from the actual FIT coaches), insisted that she was reluctant to use all of the enhancement materials because working with Latino families is a "case by case" situation. While recognizing the importance of applying a dynamic sizing model of knowing when to apply general guidelines and when to focus on the individual context, the reluctance of the supervisor to encourage the implementation of these materials suggested to us that we should have done a better job engaging her in the planning process. This highlights the importance of providing the larger stakeholder groups with updates and actively eliciting feedback about the process so that the product is perceived as being directly responsive to stated needs and recommendations.

project, the timeline, the expected activities and outcomes. This facilitates clear communication regarding the goals of the project and how these goals will be achieved. Developing the work plan itself is a good exercise for uncovering concerns about the project that might exist from the developer, agency or community stakeholder perspective. Then, as the project moves forward, this work plan can be reviewed and amended as necessary so that all partners are kept informed about the project's progress.

Phase 2: Information-Gathering

The information gathering phase of the model involves an assessment of what elements of the program are working or not working well with the target clientele. Interviews are conducted with both the therapists/coaches as well as individuals or families receiving the intervention. If it assists with wider community engagement efforts, it may also be helpful to conduct focus groups

CASE EXAMPLE

The process of developing a collaborative work plan was critical in our project when it became clear that referring to the project as an "adaptation" could be problematic from a funding standpoint. In Washington State, FIT is eligible for state funding as an identified best practice by the Washington State Institute of Public Policy (WSIPP). Deviating from the core principles of FIT could put the program in a lower tier "promising practice" level, which could affect its funding status. Upon hearing about this possibility, our team jointly participated in a call with JRA and WSIPP to discuss the proposed project and anticipated activities. WSIPP was able to clarify its standards for fidelity, and because of this call it was clear to all parties what components needed to be retained for FIT to retain its best practice status. A copy of the work plan we used to begin the enhancement process is included in Appendix A. In this version, we use the terminology "adaptation," but subsequent documents referenced the project as an "enhancement."

with families that reflect the cultural background of interest but who are not directly involved in the program (Domenech Rodriquez, 2008). Focus groups should occur with the purpose of generating hypotheses concerning what may be working well, or not, with the clientele; these then can be examined through directly interviewing current and/or former consumers.

The next step after collecting information from various sources, using both interview and focus group formats, is to put this information together in a way that highlights the primary findings and outlines a clear strategy for addressing identified needs. The CEM model suggests organizing this strategy in the context of three areas of focus: *Policy, Training and Conceptual Translation*. The policy focus relates to engagement goals that require changes in administrative-level policies around funding or contract language. An example might be whether therapists have an "engagement or

CASE EXAMPLE

Prior to interviewing coaches and families, FIT consultants were asked to comment on general problem areas or common difficulties that arise in consultation sessions. These were used to structure interview protocols based on engagement, language and translator issues, and the understanding and use of treatment concepts. After developing a draft protocol, it was sent around the consultants for review one last time. Coaches were interviewed first so that they could also be asked about common areas of difficulty or strain with Latino clients. From these interviews, gang issues and parenting style were incorporated into the interview protocol with families. Examples of the interview protocols are provided in Appendix B.

flexible" fund from which they can pay for pizza, small incentives or even temporarily assist clients with bills.

Training will be an inevitable part of the enhancement process, as therapists/ coaches will need, at a minimum, to be introduced to any new materials that are developed as a result of the project. The information gathering process will also uncover other specific needs that can be addressed through training. Interactive, cultural sensitivity training, with ongoing consultation and "booster sessions," that imparts both self-awareness regarding the concept of culture and knowledge of the target population (Sue, 2008) is likely to emerge as an essential enhancement.

Conceptual translation refers to the way in which program concepts are presented and explained to families. This loosely matches the Metaphors/Language/ Concepts categories in the Ecological Validity Model and the Cultural Beliefs/

CASE EXAMPLE

It is likely that the information-gathering process will uncover a number of stated needs that either go beyond the intent of the enhancement or cannot be feasibly addressed. Consequently, decisions will need to be made regarding the elements to include in the training in order to maximize benefit and minimize time and cost. In our information-gathering phase, coaches stated various desires for training including effective gang interventions and working with a translator. Because the need for gang interventions was stated by only coach and had the most relevance for a very specific part of the state, we decided that this need could be addressed by future trainings for the coaches but went beyond what was needed for an enhancement for Latino families in general. In addition, it became clear in the information-gathering phase that the biggest need for training and enhancement involved how to work with newly immigrated or less-acculturated Latino families. It was clear from coach interviews as well as family interviews that there were no obvious barriers to treatment when working with more acculturated Latino families.

Expression-Communication categories in the PAMF (figure 1). The CEM is sensitive in focusing only on developing better translations of existing concepts rather than adjusting the core concepts themselves. Consequently, an enhancement strategy may focus on developing standard translations of key concepts and words for the use of translators and/or offering therapist examples of how to explain core concepts in a culturally relevant way. Once the areas for enhancement are identified, a document that summarizes the results of the information gathering phase and areas for improvement can be circulated to the advisory groups for comment and approval. An example of our development proposal is included in Appendix C.

Phase 3: Development

The development process takes place primarily among the working group members to keep the process moving along quickly.

CASE EXAMPLES

To operationalize the enhancement recommendations, we developed a table that outlined the recommendations and identified products according to the *Training, Engagement/Policy* and *Conceptual Translation* dimensions. Activities were assigned to different members of the working team and a contract was set up with our cultural consultant and a cultural trainer. It was important to have one person oversee the process to keep everyone focused on the objectives and the already agreed upon outcomes. The table on the next page outlines the recommended areas for adjustment and how these objectives were converted into tangible strategies and products.

Recommended Enhancements and Associated Training and Products

Recommended Adjustments	Training/Products
Conduct training on conversational Spanish to encourage engagement with the family. More extensive Spanish language training skills would need to be acquired through the local agency or at an individual level.	Provide conversational Spanish tips and develop handout for training.
Provide specific training on how to work effectively with a professional translator. While bilingual therapists are ideal, this may not be an option for all agencies. However, an effective collaboration with a translator can be a positive tool for the coach. The training would include strategies for talking with the translator before the session as well as working with a translator within the session.	Develop training tools for how to speak with translator including a handout
Develop and train coaches on standardized translations of words commonly used in FIT that represent core principles, e.g., "mindfulness." The coaches would then provide these words to the translators so that the wording and conceptualization of FIT concepts are standardized.	Develop standardized translations. Develop handout and provide at training.
In accordance with expert recommendations for cultural sensitivity training (e.g., Sue & Sue, 2003) implement a recurring training that focuses on both self awareness and awareness of Latino culture. The training should be focused on issues relevant to the shared geographic and cultural backgrounds of Latinos being served through FIT, which would highlight cultural traditions from Mexico and Central America, immigration issues, familial acculturation gaps, parenting styles, gender and power dynamics and cultural psychopharmacology.	Provide training on cultural sensitivity in working with Latino families.
Engagement:	
Recommended Adjustments	
While already a part of MST and FIT, it appears the importance of engaging families by addressing physical or other immediate needs to be reinforced. Given the particular economic vulnerability of many Latino families, this value should be a priority. Emphasis of this principle could occur in at least two ways: 1) Assess the ability of the contracted agency to train and provide coaches with information on community resources that address housing, utilities, legalization, healthcare and other social services through initial site assessments (for new contracts) and in contract renewals of existing contracts. 2) Emphasize that the knowledge of these resources is an essential part of local supervision through consultation.	Clarify with JRA around contract-language regarding agency support in providing coaches with community resource information.
Assess whether discretionary funds are being made available to coaches to identify barriers to participation and engagement. This is a recommended practice for MST that could enhance engagement, particularly for lower income families.	Clarify with JRA around contract-language for the use of discretionary funds toward engagement activities.
Include content on clinician-level barriers to engagement in the FIT manual and through training. For example, look at preconceptions of the clinician that could hinder full engagement with the family. Currently, the manual focuses on family-level barriers exclusively.	Determine with consultants what clinican-level barriers could be. Add to manual. Revise as needed.
Support coaches knowledge and empathy development by acquiring, and making accessible, a resource list of movies, books and other media on immigration, acculturation and Latino culture in America. Incorporate discussion of these materials through supervision as well as booster sessions.	Develop list of resources and/or establish media library for coaches use
Conceptual Translation:	
Recommended Adjustments	
Develop alternate scripts for recently immigrated or less acculturated families for the introduction to DBT skills, e.g., "mindfulness." Work with current coaches and experts in Latino culture to conceptually translate concepts into examples and scripts coaches can potentially use to introduce these principles.	Develop handouts with alternative scripts to present in the training
Use media clips to illustrate conceptual elements. Literacy level as well as cultural factors suggests that less acculturated Latino families may be more receptive to visual presentations of concepts, rather than written worksheets. Develop a list of media resources that are good representations of treatment principles and emphasize, through boosters and supervision, that coaches make use of these in session as an alternative to worksheets alone.	Develop list of resources and/or establish media library for coaches use
Resources permitting, a powerful tool to enhance interest in conceptual principles as well as overall engagement would be a video clip of previous Latino FIT families discussing how elements of FIT helped their family.	Film and produce film of families

The first step is to operationalize the areas of focus identified in the needs assessment.

Operationalizing. A key task in the phase of development is deciding how the needs will be met through either training, policy change or product development. Needs that can be effectively addressed by training include needs related to knowledge or empathy development. Needs that can be addressed by policy changes could include fiscal policy, hiring practices and flexibility in schedules that could impact engagement. Needs to be addressed by product development might be tools for the practitioners to use with clients or as cheat sheet reminders for themselves.

Timeline. Once the objectives are outlined, the working team can move quickly to develop or contract for the identified enhancement products. It is useful to set a definite timeline for the

CASE EXAMPLE

The enhancement materials were presented to FIT coaches and supervisors in a one-day training. The morning was facilitated by two cultural sensitivity trainers who were Latino themselves and had extensive experience conducting trainings on this topic. The morning agenda included a general overview of working in a culturally sensitive and effective manner with Latino families as well as how to work effectively with a translator (action points 2,3 and 4 under "Training" from the enhancement strategy). In the afternoon, a cultural consultant who was also Latino and a former FIT coach presented on conversational Spanish and the alternate scripts for DBT examples (action points 1 under "Training," and 1 under "Conceptual Translation"). Coaches were also provided binders with all the enhancement materials, including resources (action points 2 under "Engagement," and 2 under "Conceptual Translation"). The training emphasized role-playing and practitioner interaction, particularly when discussing how to work effectively with a translator, learning conversational Spanish and discussing DBT scripts.

completion of activities; this can be facilitated by establishing a training date that working team members are focused on meeting.

Phase 4: Implementation

Implementation includes providing the enhancement training to therapists/ coaches and supervisors as well as any policy-level changes identified in the work plan. There is a wide literature on elements of effective training. The Systems-Contextual (SC) frame provides a useful guide for thinking through how to structure a training that targets multiple staff within an agency, and is described in detail elsewhere (Turner & Sanders, 2006; Beidas & Kendall, 2010). The SC approach recognizes that training occurs within the context of an organizational climate and that the effectiveness of training relies on various factors including organizational support, quality of the training, therapist variables and client variables. Attending

CASE EXAMPLE

The FIT enhancement materials are included in Appendix D. For example, therapist/coaches were provided a document titled "DBT Concepts with Latino Clients: Distress Tolerance" which urges the therapist/coach to ask the client about previous struggles in order to identify and build off personal examples of resiliency. If the relationship is sufficiently trusting, it is suggested that the therapist/coach may find it helpful to discuss the struggles the client (overcame while immigrating and adapting to a new life. Further, reconnecting the client with his/her support system can be presented to the client as a distress tolerance strategy that also aligns with a common cultural value: familialismo.

NOTE: The enhancements were developed for newly immigrated and less acculturated families who identified as "Latino/Hispanic." In the enhancements materials, this population is referred to as "Latino" for simplicity.

to all these variables affects how training is implemented as well as evaluated. Interpreting outcomes without considering the above factors will yield an incomplete picture regarding the effectiveness of the enhancement training.

An important consideration when developing or hiring someone to deliver the enhancement training is the style of training, i.e., whether to emphasize techniques or principles. A number of clinical researchers have found that focusing on principles and the purpose of a treatment is the more effective approach, as opposed to walking through discrete techniques without the "big picture" view (e.g., Miller & Mount, 2001; Miller, Yahne, Moyers, Martinez & Pirritano, 2004). Active learning is another well-established training principle. Active learning involves participants in practice opportunities, modeling and interaction (Cross, Matthieu, Cerel & Knox, 2007). Change in behavior is not as strong without in-training practice opportunities (Wyman, Brown, Inman, Cross, Schmeelkcone, Guo , et al., 2008).

Phase 5: Evaluation

The final phase of the CEM model is evaluation. Evaluation serves at least two primary purposes. First, stakeholders will be interested in whether the enhancement improved therapist proficiency and client engagement. Having data to support these outcomes can garner support for additional booster sessions and application of the enhancement method for different populations, if needed, in the future. Second, evaluation will provide process-related information regarding the usefulness of the training, allowing the development team to alter aspects of the enhancement if necessary and/or learn lessons to apply to booster sessions and additional enhancement projects. Up front planning for the evaluation is important in order to

gather similar information before and after the training session. The following is a guide for the types of information to gather to assess satisfaction, use and outcomes related to the enhancement effort.

1. Trainer Evaluation Forms collected at the end of the training day (s)

Trainer evaluation forms are the best way to immediately assess satisfaction with the training and gather information on both process (the structure, presentation style) as well as content (materials and strategies). This provides an opportunity to provide immediate feedback to the advisory group regarding the reception of the enhancement strategy.

2. Practitioner/Therapist Assessment

The next phase of evaluation includes gathering additional information from coaches a month or two after the training to assess how well the enhancement materials are working in the field. This

CASE EXAMPLES

Coaches appeared to particularly like the portion of the training that covered how to work effectively with a translator. When asked if they had ever used interpreter services, 4 out of the 5 coaches said they had; and of the 4 that used interpreter services 3 of them said that the Interpreter training was very useful. The coach that uses interpreter services the most was more specific about the training: "the presentation (about how to work with interpreters) was most helpful, all sections were really helpful. The translated worksheets are helpful as they (the interpreter) can understand right away the terms being used."

provides an opportunity to assess how well the coaches are using the enhancement materials (adherence) and whether positive effects are noted from implementing the new strategies. For purposes of assessing gains in knowledge and competence, it is useful to include questions from the initial survey of coaches during the information gathering phase in the post-training evaluation interview. These questions can then be directly compared to assess changes in attitudes, knowledge and competence.

3. Outcomes evaluation

The final phase of evaluation includes an evaluation of family outcomes, if feasible. Recognizing that a sophisticated evaluation design that controls for multiple factors is the best approach for determining effects, this is likely not feasible and is therefore not recommended in the CEM. Rather, it is recommended that families be interviewed in a similar manner as that from the

CASE EXAMPLES

Our initial survey of coaches included questions that could be used, in a very slightly adjusted form, in the survey after the training. For example, we initially asked FIT coaches how well existing training (provided as part of ongoing program booster sessions) was preparing them to work effectively with Latino families. After the enhancement training, we asked them how well the enhancement training prepared them to work effectively with families. Using only responses from coaches that attended the training (n = 5), we observed a meaningful difference between the two assessments. Before the training, the average rating was 1.75 (std = 1.29) on a 5 point scale, with 5 being the highest rating. After the training, the mean rating was 4.2 (std = 0.84). Because we had a small sample for our enhancement project (only 12 coaches statewide, and only half of these work with Latino families routinely), it was important for us to gather a lot of narrative information in addition to scaled questions. We were particularly interested in responses from coaches who worked with Latino families frequently. Only one coach at the training took on a new Latino family after the training and before our follow up assessment. In the initial survey, she rated the cultural appropriateness of the FIT program (specifically the DBT skils) as low for Latino families. With the enhancement, she rated the appropriateness as "above average," and commented that the DBT enhanced materials were very helpful in her work with the new family.

information gathering phase, and that questions regarding engagement, understanding and use of treatment concepts and language/translator be asked to compare responses pre and post implementation of the program enhancement. Samples of the trainer evaluation and coaches post training assessment are included in Appendix E.

Summary

The Cultural Enhancement Model is intended to provide feasible guidance to agencies and practitioners for how to incorporate culturally-relevant strategies into evidence-based practice to improve both community and client-level engagement. It is built on the research-supported assumption that the benefit of adaptation frameworks is largely due to increased client-level engagement and that an explicit focus on community level (*social validity)* and client level (*cultural competency)* engagement is an effective strategy for encouraging EBP dissemination. It is hoped that this strategy for encouraging the uptake of EBPs can make a significant contribution to the effort to more widely disseminate research-based, culturally appropriate programs in behavioral health, justice and other social systems.

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APPENDIX A: Work Plan

Family Integrated Transitions (FIT) Cultural Adaptation for Latino Families

Proposal for Juvenile Rehabilitation Administration

University of Washington, Division of Public Behavioral Health & Justice Policy

Introduction

Since the Juvenile Rehabilitation Administration began implementing Family Integrated Transitions (FIT), the program has served nearly 700 youth - with 70 (10%) of these youth being Latino. Of the 9 counties that are conducting FIT, the majority of the Latino population being served resides primarily in Region 2 (Yakima and Benton-Franklin), and, to a lesser extent, Region 3 (Snohomish). As Region 2 has just recently begun to support FIT teams, the percentage of Latino youths being served by FIT is likely to increase. Further, as FIT is a family program that relies in great measure on the ability of the therapist to develop a therapeutic relationship with the parents as well as the youth, it is essential that the core components of the program are relatable and appropriate for diverse cultures. To address the growing diversity in the population, the University of Washington is funded to support an examination of whether FIT could be enhanced for Latino youth and families through cultural adaptations. If this project aligns with JRA's mission to support diversity and racial fairness, we are proposing a study that could proceed in two phases.

Phase I

Information gathering

The initial task of the study would be to determine whether cultural adaptations are needed as determined by JRA and FIT staff (coaches, supervisors) and involved families. To identify the key elements to include in the cultural adaptation, we would conduct semi-structured interviews with these participants, which would be recorded and coded for common themes. We estimate that the sample size for the initial information gathering would be approximately 10 families and 10 staff (inclusive of JRA and FIT staff). The questions for the interviews would be developed in cooperation with JRA staff.

Development

The common themes that emerge in interviews would then be used to develop an adaptation plan. This plan could include translation of materials, the re-conceptualization of themes and exercises to better match cultural understanding, or other accommodations to overcome barriers to engagement. Working closely with JRA, we would also create an implementation and evaluation strategy. This may include either a selective implementation of the adaptation to compare across control and experimental groups with current FIT therapists, or a full implementation with the identification of archival data to use as controls. This will depend on the availability of groups, the input of the JRA and considerations in being able to access sufficient information from administrative data.

Phase II

Training

After developing the implementation and evaluation plan with JRA, we would support the training of relevant FIT staff on the adaptation. The results of the information gathering would inform the structure and development of training for all youth-involved staff on the adaptation. Training would be delivered by expert training personnel in addition to additional cultural competency experts as deemed necessary by the project staff and JRA.

Evaluation

We are proposing to conduct both a process and outcomes evaluation. The process evaluation would examine the fidelity of implementation and the engagement of families being served by the adapted program. Specific process measures might include follow-through with assignments, showing up for appointments and satisfaction with treatment. Outcomes of the adaptation would be measured through self-reported psychosocial indicators, school performance, self-reported delinquency and official recidivism data as available.

APPENDIX B: SURVEYS

FIT Enhancement--Pre-Training Interview with Clinicians

Demographics		
1a	**Gender:** Circle one	MALE FEMALE
1b	**Professional Title**: Write in professional title and association with FIT	
1c	*How would you describe your ethnicity?*	
1d	*How many years have you been working as a FIT coach?*	
1e	*What are ethnicities of the families you have worked with in FIT?*	
1f	*What percent of your total clientele is represented by each ethnicity listed above?*	

Training		
2a	*How satisfied are you with how the FIT training specifically equips and prepares you to interact with the diverse cultural backgrounds of your clients?*	1 Not at all 2 3 4 5 Extremely satisfied
2c	*What type of FIT training has been the most helpful?*	
2d	*Is there training you have received from other sources that have helped you work effectively with Latino families? If so, please list.*	
2e	*What areas of training, if any, do you feel would help you to best meet the needs of your Latino clients?*	

Supervision and Consultation		
3a	*How satisfied are you with how FIT supervision only (not consultation) prepares you to interact with Latino families?*	1 Not at all 2 3 4 5 Extremely satisfied
3b	*Are there specific elements to the FIT supervision that have been helpful to you as you work with Latino families? If so, please explain.*	
3c	*How satisfied are you with how FIT consultation (no supervision) equips and prepares you to interact with with Latino families?*	1 Not at all 2 3 4 5 Extremely satisfied
3d	*Are there specific elements to the FIT consultation that have been helpful to you as you work with Latino families? If so, please explain.*	

Interpreter Services		
	Have you ever had to use interpreter services to communicate with your clients?	**If YES:** Proceed to next question. **If NO:** Skip to 8.
7a	*How satisfied are you with the interpreter's services for your Latino clients?*	1 Not at all 2 3 4 5 Extremely satisfied
7b	*How well do you feel the concepts of FIT are being translated effectively?*	1 Not well 2 3 4 5 Extremely well
7c	*Do you feel that the comments that are being translated back to you are reflecting that the clients are understanding the FIT concepts?*	
7d	*In general how much do you feel that interpreter services positively impact how well the families engage with the FIT program?*	1 Not well 2 3 4 5 Extremely well
7e	*In general how much do you feel that interpreter services negatively impacts how well the families engage with the FIT program?*	1 Not well 2 3 4 5 Extremely well
Community Interaction		
8a	*Are there certain environmental or community factors unique to your Latino clients that have affected your interaction with the families in either a positive or negative way? If so, please explain.*	
8b	*Has client gang involvement impacted your ability to be effective with your clients? If so, please explain.*	
Improvements		
9a	*Are there any other aspects of FIT that are difficult to implement with Latino families?*	
9b	*How would you improve the FIT program for Latino families?*	

Engagement		
4a	*Do you feel the motivation to engage with FIT is different for Latino youth and families families than for others? If so, how does it differ?*	
Meeting Needs		
5a	*How well do you think FIT adequately addresses the needs, perspectives, and values of Latino youth and families?*	1 Not well 2 3 4 5 Extremely well
5b	*How well do you feel you can meet the needs of your Latino youth and families given the time constraints and manualized components of FIT?*	1 Not well 2 3 4 5 Extremely well
Understanding of FIT Concepts		
6a	*How well do you think the FIT concepts in general are understood by your Latino clients?*	1 Not well 2 3 4 5 Extremely well
6b	*How well do you think the concepts involved in Dialectical Behavior Therapy are understood by your Latino clients?*	1 Not well 2 3 4 5 Extremely well
6c	*How well do you think the concepts involved in Multisystemic Therapy are understood by your Latino clients?*	1 Not well 2 3 4 5 Extremely well
6d	*How well do you think the concepts involved in Motivational Enhancement Therapy, including Relapse Therapy Prevention, are understood by your Latino clients?*	1 Not well 2 3 4 5 Extremely well
6e	*Are there specific concepts (if any) that do not translate well or require more time to explain to Latino youth and families? If so, please list and explain.*	
6f	*What FIT concepts are working well for Latino families?*	
6g	*What concepts do not work so well?*	

FIT Enhancement--Pre-Training Interview with Families

Demographics	
1 What is your relationship to the youth that was enrolled in FIT? (circle one)	Mom Dad Grandparent Other (specify)
2 *How long has (* youth's name*) been back in the community from JRA?*	
3 *How old was (* youth's name*) when he/she was released?*	
4 *What family members most often interacted with the FIT coach and were involved in the meetings?*	
5 *What language do you usually speak at home?*	
6 *What is your family's country of origin?*	

Questions About the Coach	
1 *How interested did the coach seem to be in really understanding your family's needs? Would you say not at all, a little, a good amount or very much?*	1 Not at all 2 A little 3 A good amount 4 Very much
2 *How well do you think your FIT coach understood your family's culture and values?*	1 Not at all 2 A little 3 A good amount 4 Very much
3 *Was your Coach flexible about meeting times or locations?*	Yes No
4 *What, if anything, got in the way of making or keeping appointments with your FIT Coach?*	
5 *What did you like most about your FIT coach?*	
6 *What would you have improved in your FIT coach?*	
8 *How comfortable were you in letting your coach know when something in FIT wasn't working for you?*	1 Not at all 2 A little 3 A good amount 4 Very much

Understanding Concepts		
1 *What top three things, these could be skills you learned, handouts you received, or advice you got from the coach, were particularly helpful for your family?*	a.	
	b.	
	c.	
	d.	
1a *Refering specifically to each skill listed above* (list out individually), h*ow often are you using these skills today in your interactions with family members?*	1 Not at all 2 A little 3 A good amount 4 Very much	a. b. c. d.
2 *How well did the parenting style that FIT encourages match with your parenting style?*	1 Not at all 2 A little 3 A good amount 4 Very much	
3 *Please list the goals you and the FIT coach set for your family. (list them out below)*	a.	
	b.	
	c.	
	d.	
4 *For each goal listed, I'd like to ask you whether you feel the goal was successfully met or accomplished. So, starting with goal 1 (read from question 3 above), was this goal met? (Continue through each goal).*	a. goal met?	
	b. goal met?	
	c. goal met?	
	d. goal met?	
5 *Do you feel that the FIT program missed or left out anything you wanted to work on? Please explain.*		
6 *How much did you like the FIT program in general?*	1 Not at all 2 A little 3 A good amount 4 Very much	

Interpreter Services		
1 *Did you ever use an interpreter with your coach?*	Yes	No
2 *Did you use a professional interpreter or family member?*		
3 *If you used both, which was more useful or effective for you? Better understand the skill and concept the coach was trying to convey.*		
4 *How well did you think the interpreter did in accurately communicating the important things you and the coach were saying?*	1 Not at all 2 A little 3 A good amount 4 Very much	

Community Interactions	
1 *How well did your FIT coach identify and connect you with community support? For example with school, church, other agencies?*	1 Not at all 2 A little 3 A good amount 4 Very much
1a *Which supports were these? Please list.*	a. b. c. d.

Questions About Youth	
1 *Since you began FIT, has* (youth's name) *gotten into trouble with the court?*	Yes No
2 . *Has* (youth's name) *run away?*	Yes No
3 *Has (youth's name) used alcohol or drugs that you know of?*	Yes No
4 *How well did your FIT coach identify and connect you with community support? For example with school, church, other agencies?*	1 No improvement 2 A little improvement 3 A good amount of improvement 4 A lot of improvement
4 *How much improvement in your home environment in general, for example less conflict, have you observed since your family started the FIT program?*	1 No improvement 2 A little improvement 3 A good amount of improvement 4 A lot of improvement

APPENDIX C: ENHANCEMENT PROPOSAL

Recommended Cultural Enhancements to Improve the Engagement of Latino Families
FAMILY INTEGRATED TRANSITIONS (FIT)

University of Washington, Public Behavioral Health & Justice Policy

BACKGROUND

The Division of Public Behavioral Health and Justice Policy is funded through the MacArthur Foundation, Models for Change Initiative to examine the issue of cultural applicability of evidence-based practices with Latino families. In conjunction with other activities around the state, PBHJP is collaborating with the Juvenile Rehabilitation Administration to assess the need for adjustments to the Family Integrated Transitions (FIT) program to enhance engagement outcomes for Latino youth and caregivers. FIT is a recognized evidence-based practice for youth with co-occurring disorders who are transitioning back into the community from secure care. The project with JRA will occur in three phases: First, a needs assessment will be conducted to determine what adjustments, if any, are recommended to enhance FIT. Second, PBHJP and JRA will collaborate on a strategy to operationalize and implement these adjustments. Third, PBHJP will evaluate the enhanced strategy and develop a toolkit on the adaptation process for other interested agencies.

NEEDS ASSESSSMENT

The needs assessment included interviews with FIT coaches, supervisors, consultants, parents , youth and conversations with clinicians working with Latino clients through MST in other states. Active FIT coaches in Washington State were interviewed (n = 12), including two supervisors and the consultant team at PBHJP. One of the FIT coaches is a first-generation American citizen from Chile and he provided extended consultation on the recommendations presented below.

Three families involved in FIT were interviewed, including two youth. The demographics of the FIT coaches are further described in the *Summary of Interviews with FIT Coaches* document. Of the three families, two caregivers identified as Latino and one identified as African American. The African American caregiver was interviewed to provide a non-Latino perspective of the program for comparison.

All sources of information were examined for common themes. Three major themes emerged from the assessment representing areas of distinct need:

- Training
- Engagement
- Conceptual Translation

Training

The FIT coaches uniformly reported that current training on working with diverse cultures needed to be improved, and that working on how specific tool/techniques can be culturally interpreted would be the

most helpful. Specifically, coaches requested more information on Spanish language skills, gang issues, barriers facing undocumented families and cultural psychopharmacology. The Latino families interviewed did not specifically mention similar issues regarding any perceived lack of support on issues related to gang involvement (although the nonLatino caregiver did) and medication; however, one of the families interviewed expressed some frustration at not feeling able to adequately express themselves through a translator. The FIT consultants similarly noted that more training on working with Latino families is needed for consultants as well as coaches.

Recommended Adjustments

- Conduct training on conversational Spanish to encourage engagement with the family. More extensive Spanish language training skills would need to be acquired through the local agency or at an individual level.
- Provide specific training on how to work effectively with a professional translator. While bilingual therapists are ideal, this may not be an option for all agencies. However, an effective collaboration with a translator can be a positive tool for the coach. The training would include strategies for talking with the translator before the session as well as working with a translator within the session.
- Develop and train coaches on standardized translations of words commonly used in FIT that represent core principles, e.g., "mindfulness." The coaches would then provide these words to the translators so that the wording and conceptualization of FIT concepts are standardized.
- In accordance with expert recommendations for cultural sensitivity training (e.g., Sue & Sue, 2003) implement a recurring training that focuses on both self awareness and awareness of Latino culture. The training should be focused on issues relevant to the shared geographic and cultural backgrounds of Latinos being served through FIT, which would highlight cultural traditions from Mexico and Central America, immigration issues, familial acculturation gaps, parenting styles, gender and power dynamics and cultural psychopharmacology.

Engagement

The needs assessment revealed some mixed results regarding the need for additional tools for engagement, with some coaches reporting that they needed more time to engage Latino families and other coaches reporting that Latino families were not difficult to engage. Both Latino families interviewed reported that they like their coach. In one case, the youth ran away and was not able to continue treatment, but the cessation of treatment did not appear to be due to engagement factors. The mixed results suggest that, in this case ethnic factors may be interacting with other life factors including acculturation level, life stress and attitudes towards mental health treatment. Consequently, recommendations focus on strategies for increasing engagement that address these factors.

Recommended Adjustments

While already a part of MST and FIT, it appears the importance of engaging families by addressing physical or other immediate needs to be reinforced. Given the particular economic vulnerability of many Latino families, this value should be a priority. Emphasis of this principle could occur in at least two ways: 1) Assess the ability of the contracted agency to train and

- provide coaches with information on community resources that address housing, utilities, legalization, healthcare and other social services through initial site assessments (for new contracts) and in contract renewals of existing contracts. 2) Emphasize that the knowledge of these resources is an essential part of local supervision through consultation.
- Assess whether discretionary funds are being made available to coaches to identify barriers to participation and engagement. This is a recommended practice for MST that could enhance engagement, particularly for lower income families.
- Include content on clinician-level barriers to engagement in the FIT manual and through training. For example, look at preconceptions of the clinician that could hinder full engagement with the family. Currently, the manual focuses on family-level barriers exclusively.
- Support coaches knowledge and empathy development by acquiring, and making accessible, a resource list of movies, books and other media on immigration, acculturation and Latino culture in America. Incorporate discussion of these materials through supervision as well as booster sessions.

Conceptual Translation

A majority of coaches reported that Latino families were more accepting of MST elements than DBT elements; that the DBT elements could be difficult to explain and promote for families that were stressed by multiple immediate, physical needs. When asked about preferred aspects of the treatment, Latino families reported that they liked being given information about opportunities for prosocial activities, but also mentioned that parenting information was useful. The parenting skills section was also reported to be challenging to teach, by coaches, when the family constellation included a single mother and son due to gender and power dynamics. The following recommendations provide suggestions for making the conceptual principles of FIT, particularly DBT, more accessible and relevant for Latino families.

Recommended Adjustments

- Develop alternate scripts for recently immigrated or less acculturated families for the introduction to DBT skills, e.g., “mindfulness.” Work with current coaches and experts in Latino culture to conceptually translate concepts into examples and scripts coaches can potentially use to introduce these principles.
- Use media clips to illustrate conceptual elements. Literacy level as well as cultural factors suggests that less acculturated Latino families may be more receptive to visual presentations of concepts, rather than written worksheets. Develop a list of media resources that are good representations of treatment principles and emphasize, through boosters and supervision, that coaches make use of these in session as an alternative to worksheets alone.
- Resources permitting, a powerful tool to enhance interest in conceptual principles as well as overall engagement would be a video clip of previous Latino FIT families discussing how elements of FIT helped their family.
- Estimate feasibility of translating worksheets and supporting documents to target the FIT population.

SUMMARY

The recommendations for cultural adjustment presented above were derived from in depth interviews with families, coaches, consultants and supervisors, as well as the expert consultation of a Latino therapist familiar with FIT. The recommendations focus on strategies to enhance clinician training, family engagement and the interest and application of conceptual skills for Latino families. In general, these recommendations tend to focus on Latino families that are less acculturated, as language and cultural barriers appeared to be more significant in this population. We focus at this time on adjustments that would address engagement and training at a general level rather than on specific issues, e.g., medication management and gang involvement; however, providing continued training on these special topics would be useful as well.

FIT LATINO ENHANCEMENT MATERIALS

Conversational Spanish: *Common Phrases*

Common Spanish Phrases

Sí. Yes.
No. No.
Buenos días. Good morning. (Sunrise to Noon)
Buenas tardes. Good afternoon. (Noon to sunset)
Buenas noches. Good night. (After sunset)
Por favor. Please.
Gracias. Thank you.
De nada. You're welcome.
Perdóneme. Excuse me.
Lo siento. I'm sorry.

Phrases for Meeting and Greeting

¿Cómo se llama Ud.? What is your name?
Me llamo ... Juan. My name is ...John.
Esta es ... Carol. This is ... Carol.
¿Cómo está Ud.? How are you?
¡Que tenga un buen día! Have a nice day!
¿Habla Ud. inglés? Do you speak English?
¿Habla alguien inglés aquí? Does anyone here speak English?
¿Qué hora es? What time is it?
Son las 4:00 de la tarde. It is 4:00 o'clock in the afternoon
No lo entiendo. I don't understand.
¿Qué dijo Ud.? What did you say?
¿Puede hablar más lentamente? Could you speak more slowly?
Lo comprendo perfectamente. I understand perfectly.
¿Cómo ha estado Ud, cómo se ha sentido.? How have you been?
Estoy bien, gracias. I am fine, thank you.
Mucho gusto en conocerlo. I am pleased to meet you

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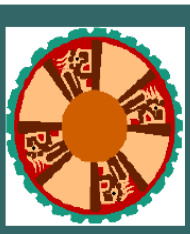
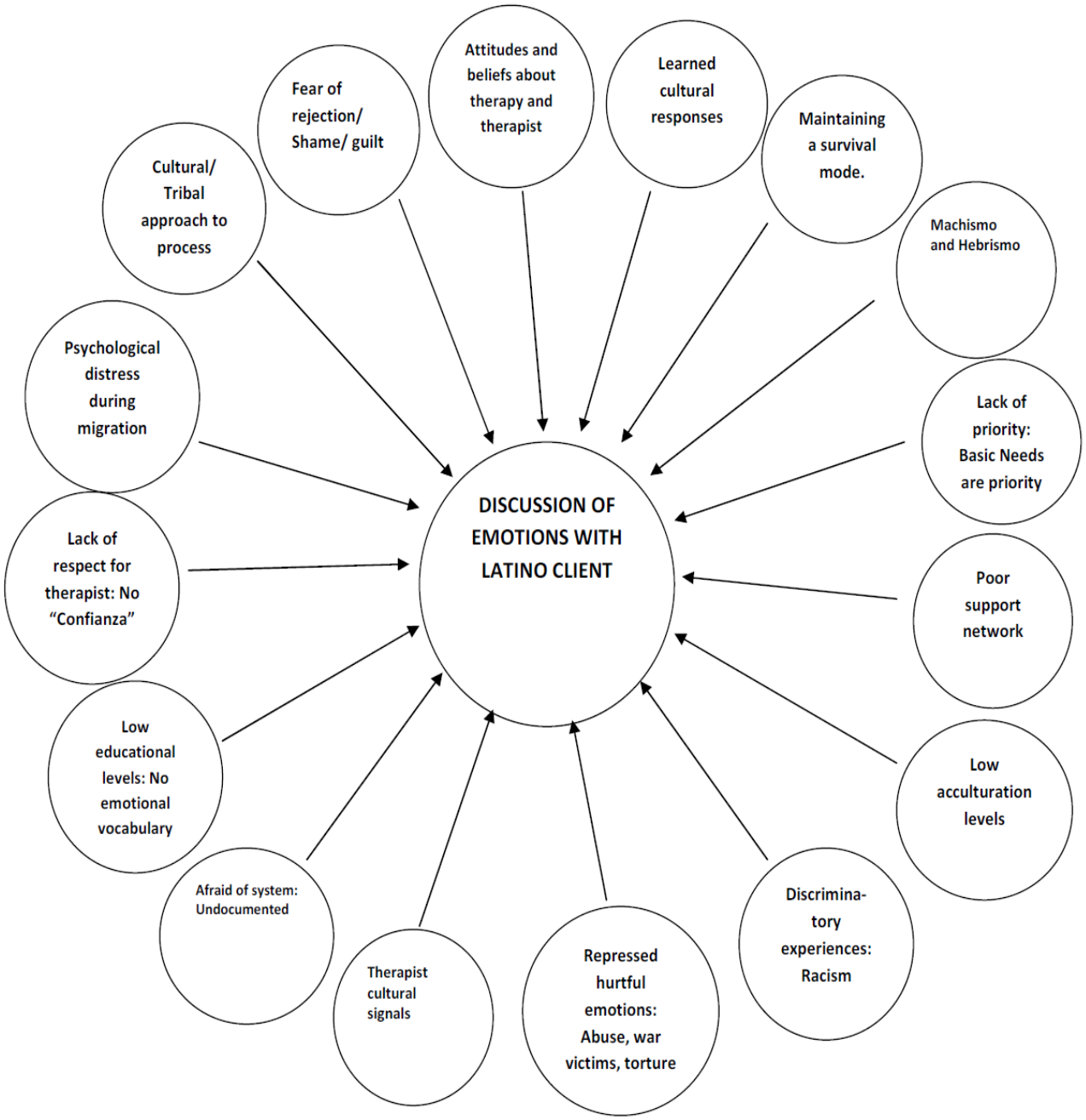
Barriers to Discussing Emotions with Latino Clients





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Conversational Spanish as an Engagement Tool

Engagement

Small details such as offering a warm and genuine greeting, making polite conversation, and having materials, such as books and brochures available in Spanish can play a vital role in engaging Latino families, particularly at the initial stages of services. Below are three conversational strategies that can assist in engagement efforts.

Practicing *Respeto (Respect)*

- *Respeto* is an attitude that shows deference or the acknowledging of authority.
- *Respeto* is mediated by gender and age.

Examples of practices that show *respeto*.

- Address clients via titles (Don, Doña, Señor, Señora, Señorita).
- Include clients' title on appointment cards
- Ask for permission before offering direct feedback
- Provide FIT paperwork in Spanish when possible

Conversational examples indicating Respeto:

Buenos (días, tardes, noches) (Señor, señora, señorita) mi nombre es _____
(Good, morning, afternoon, evening) (Mr, Miss, Mrs) my name is _____

Yo soy consejero del programa FIT y _____ (Use interpreter's name) será mi interprete en las sesiones de consejería familiar. (I am a counselor for FIT and _____ (Use interpreter's name) will be my interpreter in our family counseling sessions.)

¿Cómo le gustaria que me refiera a usted? Señor? Señora?. . (How would you like me to refer to you? Mr..? Mrs? Etc.

Muchas gracias (Thank you)

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Key DBT Terms and Definitions : *English to Spanish Translation*

ENGLISH	SPANISH
MINDFULNESS- Being aware of your emotions, thoughts and all that is happening around you. Mindfulness leads to understanding and wisdom.	**ALERTIVIDAD** (Consciencia Plena)- Estar alerta y consciente de tus emociones, pensamientos y de todo lo que está sucediendo a tu alrededor. La alertividad o la consciencia plena te conduce a entendimiento y sabiduría.
DISTRESS TOLERANCE- Doing something to help you tolerate a very difficult moment, so that you don't do something to make it worse.	**TOLERANCIA PARA ENFRENTAR LOS PROBLEMAS**- Es hacer algo que te ayuda a tolerar un momento muy difícil, de tal manera que no empeore la situación.
EMOTION REGULATION SKILLS- What you can do to change how you feel about yourself or someone else.	**HABILIDADES DE AUTO-REGULACION EMOCIONAL**- Es aquello que puedes hacer para cambiar como te sientes acerca de ti mismo o de alguien más.
ENCOURAGEMENT- Telling ourselves encouraging things to get through a tough time.	**ANIMO**- Cómo damos palabras de ánimo a nosotros mismos, especialmente cuando estemos pasando por momentos difíciles.
ONE THING IN THE MOMENT- Reminding ourselves to do one thing only in the moment.	**UNA COSA A LA VEZ**- Recordarnos a nosotros mismos el hacer una sola cosa en el momento (en vez de preocuparse por el futuro.)
PROS AND CONS- Stopping and looking at the pros and cons of doing something before jumping into it.	**LO QUE CONVIENE Y LO QUE NO CONVIENE (ANALISIS COSTO-BENEFICIO)**- Detenerse y mirar lo que está a favor o en contra antes de decidirse a hacer algo.
OPPOSITE ACTION- Changing unpleasant emotions by acting opposite to what the emotion is telling us to do.	**LA ACCION OPUESTA**- Cambiar emociones desagradables actuando opuestamente a lo que la emoción nos esté diciendo que hagamos.
RADICAL ACCEPTANCE- Fully accepting that something bad has happened, so you can then decide what you want to do about it.	**ACCEPTACION RADICAL**- Es aceptar totalmente que algo malo ha ocurrido y sólo entonces puedas decidir lo que quieras hacer al respecto.
SELF SOOTH- Soothe yourself during rough times by calming your five senses.	**CONSUELO PERSONAL**- Obtenga auto consolación durante tiempos difíciles usando sus cinco sentidos.
DISTRACTING- Do something to turn your attention away from something bad, so you don't get "caught up" in it.	**DISTRACCION**- Es hacer algo que te distraiga o que saque tu atención de lo malo para que no te enredes en esa situación.

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Working with an Interpreter

Meeting with the interpreter before the session:

- Give the interpreter the translated list of commonly used FIT terms and discuss any questions regarding this list.
- Let the interpreter know if the family should call you by your name or title; in a formal or informal manner.
- Discuss your goals for the session so the interpreter gets an overview of the purpose of the meeting.

During the meeting with the family:

- Speak directly to the family.
- Pay attention to non-verbal responses of a client.
- Speak at an even pace and avoid complicated sentence structures. Also avoid changing your thought in the middle of the sentence.
- Speak in a normal voice (not louder or slower!)
- Pause frequently at a natural place to let the interpreter interpret.
- Be sure to pause to let the interpreter or the client ask questions or repeat a statement.
- Avoid technical terms or complicated jargon and idioms that the can confuse the client.
- Do not say something that you do not want the client to hear.

Things to avoid:

- Discussion between the interventionist and the interpreter
- Using children, relatives or friends to interpret can have a negative impact. Children must not be used as an interpreter because they will be placed in a power position that can change the intervention dynamic.

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DBT Concepts with Latino Clients: Discussing Emotions

Potential Challenges

Labeling emotions is perhaps most difficult with Latino males/fathers, as they may be culturally trained to refrain from showing emotion. This has been encapsulated in the popular saying "los hombres no lloran." (Men do not cry.) Consequently, reframing the experience of emotions so that males/fathers come to see the acknowledgement of emotions as requiring courage could be helpful. It can also be argued that Latinos generally "respect" emotions more than American culture. Feelings can be very important in reaching conclusions and making decisions. A general framework might describe the Latino cognitive approach as first, concretely relational; second, intuitional; and finally, conceptual.

Considerations in Discussing Emotions

- Engage the family in labeling emotions by maximizing practicality and daily application to elevate its usefulness. Provide examples of how successful use of this skill can impact family life interactions.
- When practicing Observe, Describe and Participate skills, specifically, it may be helpful to be "alongside" the client as they practice. For example, try eating with the client during session and observe, describe and participate during this experience. Other examples could include having the client imagine eating the best Carne Asada, eating corn or fresh vegetables, fruits, walking to the store, walking in the park or the trail, going into the field, forest, washing dishes, cleaning, sewing, being at home, caring for children, walking at the beach, swimming in a lake, crossing a river.

Example Script

"Did you ever have a meal or eat something quick, and realize when you were done that you did not really notice what you were eating or that you had eaten so much? You had eaten the food without really thinking about what you were doing. That's an example of NOT being mindful. The opposite of this is paying careful attention to the taste and texture of the food. How it feels in your mouth and as you swallow. Noticing eat bite and how it is different from the bite before. This is BEING MINDFUL. Which way makes the food more enjoyable?"

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DBT Concepts with Latino Clients: Distress Tolerance

Potential Challenges

Many immigrants have a great deal of resiliency and have already demonstrated a high tolerance to distress. It is helpful to ask your client about some of the psychological distress that may have occurred during the migration process: including events before migration (extreme poverty, war exposure, torture); events during migration (parental separation, hunger, death of traveling companions); continued rejection and suffering while seeking refuge (chronic deprivation of basic needs); and survival as an immigrant (substandard living conditions, lack of sufficient income, racism). Sometimes, this high tolerance to distress may decrease as life turns to be more complex in the new setting, when a poor support network takes its toll and family systems decay. Discovering and using client's strengths to practice distress tolerance adds meaning and respect for client's life journey and story. It is then appropriate to introduce additional support, such as sensory soothing, square breathing, and distracting. Also, reconnecting the client with his/her support systems can be considered part of the distress tolerance skills learning (familialismo).

Considerations in Presenting Distress Tolerance

- The non-judgmental and one-minded attitude to increase a sense of efficacy is a process that needs to be staged, relationally and with the support of the family. Including other participants, including spiritual leaders or other accepted support persons, can provide additional meaning, acceptance, and practicality to these skills.
- The How Skills can be powerfully presented as tools to help the client achieve a life worth living (e.g, getting a piece of the pie, "el sueno Americano"). Examples related to improving efficacy at work is likely important for the immigrant father or provider, improving parenting/nurturing skills may be salient for the mother. Other typical examples could be fixing a car, or resolving a puzzle, playing checkers, domino, etc.

Example Script

"I would like to share with you a real life story. This is about one of the many immigrants who flee to the U.S. out of desperation. Alfredo told his story to a TV journalist, he said "poverty and the hope of a better life" drove him to make the leap to the US. "We had no food in Mexico. We had no place to live. I went from pulling weeds to pulling tomatoes, to picking cotton loops to picking grapes." Alfredo remembered, as a teenager, finding his father in tears. "I found him crying because he just couldn't provide. And I promised myself that I would do everything within my power to make sure that I provided for not just my parents and my siblings, but for my future family." That commitment led him to cross from

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DBT Concepts with Latino Clients: Wise Mind

Potential Challenges

As noted before, a general Latino cognitive approach (depending on acculturation and education status) may be first, concrete relational; secondly, intuitional; and finally, conceptual. Because of this, discussions about State of Mind may initially feel foreign; if so, it will take time to teach and practice DBT skills. Specifically, discussing Radical Acceptance could present some difficulties for an immigrant client as it could be viewed initially as opposing a needed sense of resiliency for survival in a different socio-cultural context, or a possible threat to cultural parenting structures such as parental authority and control.

Considerations in Presenting Wise Mind

- Using visual aids or "word pictures," especially for illiterate clients, can be useful. Illustrative or word pictures are created using client's environment, history, and personal observations.
- Encourage the client to find someone in their support system with whom they can practice Wise Mind skills and who can keep them accountable.
- Use standardized translations of words when presenting concepts to Spanish-speaking family members to ensure consistency in instruction.
- When discussing opposite action, use examples from family and community relationships. This is could be framed with Hispanic fathers to assume "the caudillo role" or the person in charge of changing ideas and behaviors in his family. Thus, challenging to "start a revolution" against the status-quo of depression, fear, chaos in the family by removing distrust, inferiority and pessimism, resentment of criticism, the tendency to react defensively, etc.

Example Script

"Let's picture in our mind a door or look at the door of your home. There are many shapes, sizes, colors of doors. Doors allow entrance and exiting. They provide a sense of security, warmth and privacy among other things. Can you imagine a home, your home without a door, how cold, insecure it would be? Parents are the door of their home. Parents can willfully and consciously open and close the flow of activities, people and ideas into their home. Just like doors move easily by hinges, we as parents move from states of minds when making important decisions for our family, and personal life. We can move from a rational mind, to emotional mind until they find a more balanced state, the wise mind. Do you remember a time when you allowed your child/youth to bring new friends, ideas, or things to enter into the family? What did you think to yourself when "opening the door" ? What moved you to "open the door" to accept?"

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¿Cómo se Siente Usted?

(How do you feel?)

Enojado(a) (Mad)

Pequeña irritación o molestia
(Mild irritation or discomfort)

Ira incontrolable
(Uncontrollable anger)

1 2 3 4 5 6 7 8 9 10

Contento(a) (Glad)

Suave placer o bienestar
(Mild pleasure or wellness)

Alegría incontenible
(Irrepressible joy)

1 2 3 4 5 6 7 8 9 10

Triste (Sad)

Pequeño desencanto o desilusión
(Mild disappointment or disillusionment)

Completa desesperación
(Utter despair or hopelessness)

1 2 3 4 5 6 7 8 9 10

Miedoso(a) (Scared)

Pequeña inquietud de temor
(Small inkling of fear)

Pánico total
(Total panic)

1 2 3 4 5 6 7 8 9 10

Avergonzado y Culpable (Shame and Guilt)

Leve bochorno, pena o vergüenza
(Slight embarrassment or shame)

Abatido por la culpa y vergüenza, rumia
(Overcome by shame and guilt, rumination)

1 2 3 4 5 6 7 8 9 10

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