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Effective Interventions for Underserved Populations

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FOCAL POiNT Research, Policy, and Practice in Children's Mental Health

Effective Interventions for Underserved Populations

In recent years, there has been increased pressure on the developers of mental health programs and interventions to demonstrate that their approaches are effective. In turn, service providers have felt pressure to increase their use of programs and interventions with evidence of effectiveness. Developers and providers have responded to this challenge, increasing the availability of programs and interventions whose effectiveness has been documented by rigorous research.

Overall, this trend is undeniably a positive one. Providers and consumers of services alike benefit when their work together produces positive outcomes. Members of the general public benefit when their insurance premiums and tax dollars pay for services that produce desired results. And yet, despite the overall progress, it is important to remember that existing evidence-based programs and interventions have demonstrated effectiveness only for certain populations. If an intervention for treating depression is shown to be effective for middle class white adolescents, does that evidence matter when the need is for a program to treat depression with Hispanic pre-teens, homeless young adults, gay and lesbian youth, or adolescents who simultaneously struggle with substance abuse?

One response in the face of such questions is to test existing interventions in new populations. Sometimes the interventions "translate" well and appear to be effective for a new population. Other times, "translation" of existing interventions does not work so well, and expected outcomes are not realized. Still other times, trying to translate an intervention "as is" simply doesn't make sense: The needs or situations of a new population are just too different from those of the original population.

How then should we respond to the needs of underserved populations—those for whom there is a shortage or even a complete absence of well-researched programs? This issue of *Focal Point* describes a number of interventions and programs that have been designed to respond to the specific needs of populations that have been historically underserved. But it is not just the programs themselves that deserve attention. Perhaps of even greater interest is the range of creative strategies that the developers and researchers have used to design their approaches and/or to adapt existing practice strategies into new approaches tailored to the needs and experiences of the target populations.

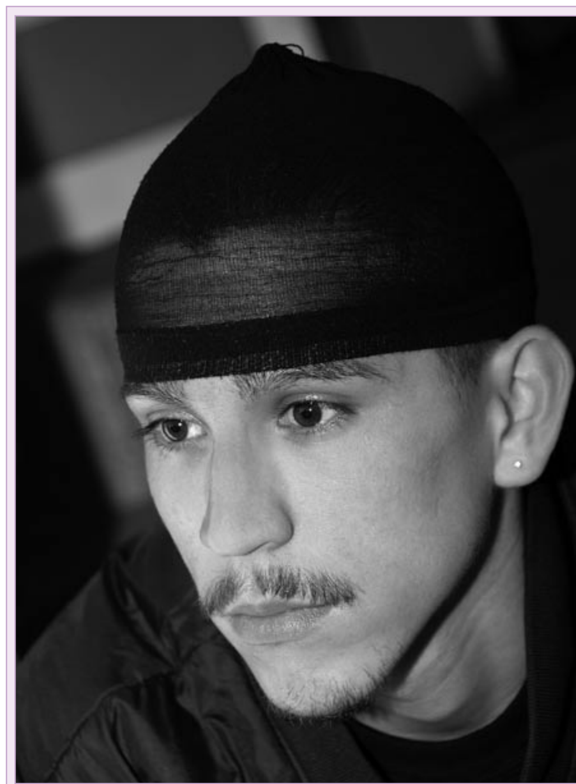
For example, Natasha Slesnick and Amber Letcher describe how differences between two sets of homeless youth—those living on the street and those living in shelters—led them to develop two very distinct therapies, each adapted from a different existing approach. In one of the TeleKidCare studies described by Eve-Lynn Nelson, the treatment approach itself (cognitive behavioral therapy) was not significantly adapted, but it was made accessible to rural populations using televideo. Daniel Santisteban and Maite Mena describe their use of a "flexible treatment manual," which allows clinicians to select treatment modules or components based on child and family needs. The components they are currently evaluating include a module focused on co-occurring disorders and a module responding to the needs of Hispanic families and youth facing acculturation- and immigration-related stressors.

In contrast, several of the other approaches featured in this issue—such those described by Aminufu Harvey and by Terry Cross, Barbara Friesen and Nichole Maher—were developed from "practice-based evidence." These programs draw from the cultural foundations of a particular population, and are designed to resonate with the beliefs and values of those they are trying to reach. These kinds of programs are often most obviously successful because they can engage and retain children, youth, and families from populations that are typically reluctant to attend or complete programs or treatments (regardless of how well researched those treatments may be).

The emerging approaches highlighted in this issue hold promise for meeting the needs of particular populations. Of course, there are many other populations and sub-populations that are also underserved. Our hope is that the articles in this issue offer assistance there as well, by providing inspiration and creative strategies for developing new, effective approaches.

Janet S. Walker and L. Kris Gowen, editors.

New Directions in the Treatment of Troubled Hispanic Youth



With the high number of youth in need of treatment for behavioral, mental health, and substance abuse problems, there is a continuing need for well-designed, culturally-informed, and replicable evidence-based treatments. In the treatment of child and adolescent behavior problems and substance abuse, family therapy approaches are prominent among the lists of empirically supported and evidence-based treatments. The purpose of this article is to present some of the new directions our team is taking to improve the effectiveness of interventions designed to address the needs of our nation's youth.

Why Family Therapy?

Much of the work of our Center for Family Studies has focused on family-based interventions for children and adolescents. The emphasis on family work stems from a literature that highlights the important role of family factors in healthy development, and in the emergence and/or treatment of adolescent behavior problems. Such factors include family support and conflict, communication, parent-youth attachment, and effective monitoring. Of course, association does not necessarily imply causation. That is, many have mistakenly used language that suggests that child and adolescent problems are always "caused" by family dysfunction. This type of thinking disregards the fact that children can be born with vulnerabilities toward such things as aggressiveness and impulsive behavior that can trigger problems very early in life. In some instances, maladaptive family patterns of behaviors can result from child behavior problems and family stress while in other instances the family patterns may precede and contribute to the behavior problems. In all cases, however, we strongly accept the premise that regardless of which came first—the family maladaptive patterns or the child behavior problems—the ability to strengthen and fine-tune family relational patterns can have a powerful effect in ameliorating the presenting problem and changing the direction of youth development toward healthier outcomes.

While much of the successful work that emerged from our Center for Family Studies focused on Brief Strategic Family Therapy with Hispanic youth and families,[3,8,7] other research that has demonstrated the benefits of family therapy has included youth and families of many different races and ethnicities, and has led to the conclusion that the benefit of family work is not limited to one or another ethnic or racial group.[6]

Enhancing Interventions

At the same time that some teams within our Center for Family Studies are focusing on issues of testing and disseminating Brief Strategic Family Therapy on a wide-scale basis, the authors of this article have embarked on a line of work that focuses primarily on enhancing the impact that treatments have on families and youth.

Why worry about improving treatments that are already evidence-based?

Clinical researchers who have been testing treatments to find out what works best for children and adolescents acknowledge that there is still much room for improvement. Although we now have treatments that have been shown empirically to work much better than others and are therefore good candidates for dissemina-

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tion, even the best treatments appear to provide substantial improvements to only about half of the participants. Tests of clinically significant change, which move beyond group means to document the percent of cases with substantial pre- post-treatment change, have shown that 40-50% of cases do not improve substantially.

An important assumption of our treatment development work is that too often we depend on a "one size fits all" mentality that assumes that a given treatment should work to its maximum effectiveness without being tailored to the unique characteristics of the clients. Our new line of work attempts to move closer to a tailoring of integrated adolescent treatments to the unique needs of families in a "flexible treatment manual" approach.

With funding from the National Institute on Drug Abuse, our team has undertaken the task of developing and testing enhanced treatments that may have the potential for succeeding with a great number of youth and families. Two efforts that our team has undertaken have focused on better addressing: 1) the needs of youth with severe co-occurring psychiatric disorders[4] and 2) the unique needs of Hispanic families and youth who are faced with major acculturation- and immigration-related stressors.[5] There are two important features that these treatments share. The first is the idea of a "flexible manual" which gives the clinician choices of treatment modules or components that can be selected only if the adolescent and family appear to require them. The second is that the treatments augment the family therapy models with individual-level work that attempts to accelerate adolescent development. Our newer interventions have incorporated: 1) Motivational Interviewing techniques that trigger the adolescent's own interests and planning, and 2) skills development approaches that teach adolescents to be more effective in their interpersonal relationships with peers and adults. In the remainder of this article we will describe some of the more unique characteristics of these newly-designed treatments.

Addressing Co-Occurring Disorders

One of the biggest challenges to the treatment of adolescents is the often-found constellation of major co-occurring psychiatric disorders such as substance abuse, conduct disorder, depression, ADHD, and anxiety. These co-occurring disorders are particularly problematic because one symptom can trigger another and cause disruptions in treatment progress. For example, depression can trigger a relapse after a period of abstinence from drug use, or a drug relapse can trigger a sequence of explosive and violent behavior. The interplay between symptoms requires that several symptoms be treated simultaneously rather than in any particular sequence. In attempting to address these treatment needs, we borrowed from Marsha Linehan's seminal work with youth suffering from Borderline Personality Disorder to create skills training modules that help adolescents learn interpersonal skills, emotion regulation, crisis management, distress tolerance, and mindfulness. Unlike many other systemic family treatments, our work balances the family focus with an individual focus and emphasizes individual-level factors relevant to behavior problem and addiction processes (e.g., triggers to symptoms, the interactive effect of co-occurring psychiatric disorders), as well as to adolescent developmental processes (e.g., difficulties in skills development, decision-making, relationships, and the creation of life goals). In the initial stages of treatment development for these complex problems, we have not restricted our work to Hispanics but have worked with a more diverse population of youth and families. As we move forward, we will investigate the ways in which culture-related information can be efficiently integrated into the treatment. We found the integration of these individual and family approaches to be highly promising. This work is described in full detail in the article by Santisteban, Muir, Mena and Mitrani.[4]

Responding to Unique Cultural Characteristics of Hispanics

In our work with Hispanic youth and families we found that there are very powerful stressors that can adversely impact family functioning.[5] For example, acculturation processes may disrupt family communication, cohesion, and parenting practices in Hispanic families. During the acculturation process, parents often find themselves shifting in their views regarding parenting and autonomy, and may also often be overburdened because of adaptations needed to survive in the new host culture. Figuring out precisely how to parent in a new culture to which kids acculturate much faster is not a simple matter. In fact this period of readjustment has been linked to less effective parenting practices that can directly impact behavior problems in youth.[1]

During the acculturation process, parents often find themselves shifting in their views regarding parenting and autonomy, and may also often be overburdened because of adaptations needed to survive in the new host culture.

Likewise, immigration-related parent-child separations can be a disruptive force in family relations and child development. Separations can result from parents who immigrate ahead of their children or must send their children ahead of them, or when families are divided because some family members cross the border to take advantage of work-related opportunities. Youth who cannot fully understand the reasons for separations can experience feelings of abandonment and loss, and a reunion can be tense and painful rather than the happy event that was anticipated.[2]

Our work on improving the treatment for Hispanic families has led us to create interventions that specifically target some of these unique situations that Hispanic youth and their families face. It should be noted that

while this type of work is always an option in any type of family therapy, our new approach has sought to create more systematic, structured and focused modules and components for addressing these stressors. Our Culturally Informed Family Therapy for Adolescent Treatment[5] integrates family, individual, and psychoeducational interventions. Thematic/psycho-educational modules provide families with educational content, a vocabulary, and a frame that links key culture-related, family process, and behavior problem and substance abuse themes. Modules focus on such things as parenting practices in a new culture, how to survive immigration-related separations, moving toward biculturalism, and how parents can be successful advocates in the school or legal systems. By creating a better fit between the content of therapy and the unique experiences of any given family, we believe that the treatment will be more attractive and effective with Hispanic families and that therapists will be more satisfied with their treatment options.

Conclusions

In this article we have described some of the new directions that we are taking to improve on the treatments available for troubled adolescents and their families. There is much that we know about working with troubled kids but there is also much yet to be learned. Because we know that a co-occurring disorders profile is more the rule than the exception with severe behavior-problem youth, treatments must be able to handle this complexity. Likewise, we know that factors related to race and ethnicity can indeed impact how symptoms develop, how they are understood and reported, and how they should be treated. In our newest line of work, we have begun to create integrated family-individual-psychoeducational treatments that provide therapists with options for addressing issues of co-occurring disorders and culturally-related characteristics.

As with many other treatment research questions, future research should seek to identify which treatment models work best for which types of clients. We must also better understand the types of treatment tailoring that can optimize the impact of adolescent family-based treatments in the face of complexities such as co-occurring psychiatric disorders and unique cultural realties.

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Intervening in the Lives of Runaway and Homeless Youth

Street-Living Youth

Living on the streets is not good for mental or physical health. Adolescents and young adults who do not have an option to return home (for example, because of abuse or because they are not welcome) and who refuse the option of foster care are one of the most marginalized and vulnerable groups in society. Addressing homelessness is not easy. Researchers and policy experts recognize that homelessness is a social problem with complex causes. Economic and social conditions; social service acceptability and accessibility; and family and individual level variables all interact to cause and sustain homelessness. While homelessness is a social problem, intervention is often focused on the individual. Social change is slow and difficult, and those currently suffering cannot wait until social policy, laws, and social and family services work together to prevent homelessness from occurring.

For homeless youth, living on the streets is often an adaptive strategy for escaping from untenable living situations. Moreover, living on the streets for any long period of time requires significant survival skills. Yet despite their unique strengths and skills, homeless youth are at far higher than average risk for alcohol consumption, illicit drug use, physical and sexual abuse, depression, teen pregnancy, and survival sex. Even with the high rates of mental health and related problems, most homeless youth do not receive needed services. Most avoid the shelter system because they do not want their parents contacted—as is usually required by runaway shelters—or because they do not want to be placed in foster care. Drug addicted and emotionally vulnerable homeless youth often do not conform to the behavioral expectations of treatment programs, and leave or are asked to leave prematurely.

This is a population difficult to reach, engage, and maintain in treatment. What is more, there are many barriers to successfully serving homeless youth. Therapists and health care providers are reluctant to provide services to unaccompanied minors without legal guardian consent. Youth are reluctant to seek or receive services from adults who have not proven trustworthy and who have the power to contact parents, the police, or social services. Minors cannot independently sign a lease for housing, and without housing, it is difficult for youth to obtain and maintain employment and education. Lack of transportation, knowledge of available services, and insurance can also be barriers to receiving assistance. Also, many communities have few, if any, services to offer homeless youth, and may not even have a drop-in center, which can be a gateway for homeless youth to access more services.

Identifying effective interventions is essential to preventing homeless youth from becoming chronically homeless adults. Yet there is a dearth of efforts to develop and evaluate interventions with street youth. In one of the only studies on homeless youth, Cauce et al.[1] reported the findings of Project Passage, an intensive case management program which was evaluated against a drop-in center's treatment as usual, or 'regular' case management. Few outcome differences were found between the regular case management and case management provided by Project Passage on depression, problem behaviors, and substance use at 6 months.

Homeless youth present intertwined problems, and intervention efforts will need to address these complex issues if they are to be successful in helping youth initiate and maintain positive change. Development of a comprehensive intervention that addresses substance use, HIV risk, social stability, and physical and mental health issues is an important goal. In an attempt to address the multiple needs of homeless youth, we engaged homeless youth from a drop-in center in an individual therapy program called Community Reinforcement Approach (CRA), originally developed for adult substance abusers by Meyers and Smith.[2] CRA uses operant conditioning principles, offering rewards (e.g., social/relational reinforcement, financial rewards, and vocational reinforcements) to encourage clients to reach treatment goals. Often this is one of the first times in the youth's life that he or she is being rewarded for positive behavior. This reinforcement for positive behavior can break negative habits of interaction and allow youth to connect to positive social networks. Our intervention helps youth see these connections—including connections to adults working at the drop-in—in a positive light. At the same time, we teach youth the skills they need to increase and maintain positive social connections. More

specifically, our intervention relies on three basic strategies:

1. We engage street living youth by offering unconditional positive regard and by meeting immediate basic needs—offering a place for youth to rest, have meals, shower, and access medical care. We reassure youth that parents, police and social services will not be contacted upon learning that the youth is a runaway. An open door policy is needed so that youth have easy access to their therapist.

2. We retain youth in treatment by earning trust and building hope. Therapy begins with a focus on primary goals identified by the youth, such as finding employment, pursuing education, regaining custody of children, acquiring stable housing, building better relationships, or being happier. Identification of those goals, and reinforcing participation in treatment through achieving mini-goals, helps to build the therapeutic connection.

3. Once trust is established, which can take days or weeks, treatment then focuses on behaviors and problems that may interfere with the youth meeting his or her primary goals. These behaviors or problems may include substance use, sexual risk, unaddressed trauma from physical/sexual abuse, depression and anxiety, underdeveloped interpersonal and employment-related skills, and low self-efficacy.

There is no magic to working successfully with homeless youth. Utilizing a client-centered and trust-building approach to engage and maintain youth is necessary before proceeding further therapeutically with the youth. Increasing youths' skills to interact successfully with individuals and the human service system is important for acquiring housing, jobs, and social services. Helping the youth manage substance use and cope with mental health difficulties is necessary for maintaining successful connections with the larger social system.

To test the effectiveness of our approach, we randomly assigned 180 youth (118 males, 62 females) between the ages of 14 and 22 to our intervention, CRA, or to treatment as usual (TAU) through the drop-in center. Compared to TAU, youth assigned to CRA as described above attended more treatment sessions, and they significantly reduced their frequency of substance use (37% v. 17% reduction in days of use) and depression (40% v. 23% reduction in depression scores) while increasing their social stability

(58% v. 13% increase in days off of the streets) up to 6 months.[6] Youth in both conditions improved in many other behavioral domains including internalizing and externalizing problems, and emotion- and task-oriented coping. These findings suggest that homeless youth can be engaged and retained in therapy and can respond positively to intervention efforts.

While our intervention shows some success, there are many barriers in the larger social and policy context that make it difficult for homeless youth to achieve and sustain positive outcomes. As mentioned previously, minors cannot sign for housing without a guardian's co-signature, and many homeless youth do not want or know how to contact their parents. For many, the foster care system is not an option because that system has already failed them. Homeless young adults between the ages of 18 and 24 tend to avoid adult shelters because they are preyed upon by older homeless people, and many cities do not have alternate services, such as drop-in centers, for homeless youth. Even though many who serve homeless youth are passionate and do what they can to raise community awareness and to push for policy change, they will not be successful until there is a higher level of public commitment to making these changes happen.

Shelter-Residing Youth

Shelter-residing youth tend to be younger than street-living youth. Most shelter-residing youth have never spent a night on the streets, and most return to a home situation following their shelter stay. Youth staying in runaway shelters report that their greatest needs concern living arrangements, family relationships, and communication with their parents. It appears that family relationships should be an important target of intervention for these runaway youth. Improving and clarifying family communication, cohesion, boundaries, and expectations may help to reunify runaway youth with their families, prevent future runaway episodes, and repair the negative impact of high levels of family conflict. Intervention can begin at the shelter, but adolescents stay at the shelter for only a brief time so intervention must extend beyond their stay.[7]

With these goals in mind, we developed Ecologically-Based Family Therapy (EBFT). In developing EBFT, we drew on the Homebuilders family preservation model; however, EBFT includes significantly fewer sessions (16) than is typical for Homebuilders. Both of these family-based approaches share the assumptions that 1) time-limited, intensive, and comprehensive therapeutic services should be provided in accordance with the needs and priorities of each family, and 2) most children are better off with their own families than in substitute care.[3] Treatment is provided in the family's home or wherever the youth might be residing (e.g., a shelter or foster home). Consistent with an ecologically-based framework for understanding and intervening in behavior, in addition to providing family therapy, the EBFT therapist serves as a therapeutic case manager and facilitates and coordinates appointments for family members to address

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various areas of need including medical care, job training, and self-help programs.

In EBFT, both family and individual sessions are used and problems such as substance use and running away are addressed directly. At the beginning stage of therapy, participants are encouraged to consider that current problems and their solutions reside *between* individuals rather than *within* individuals. This is accomplished through the use of such techniques as reframes (e.g., "Maybe Johnny runs away because he knows that you will spend more time with him when he returns and not because he is trying to punish you") and relational questions or interpretations (e.g., "Perhaps you question your ability to hold the family together when Johnny does not go to school?"). Other intervention strategies include cognitive-behavioral techniques that are utilized to interrupt problem behavior patterns so that new skills can be taught, practiced, and applied outside the therapy context. Treatment was guided by the EBFT manual,[4] in which more detailed information regarding the intervention format and guidelines can be found.

Two randomized controlled trials have evaluated EBFT. Youth (N = 240) between the ages of 12 and 17 were recruited through two runaway shelters in the Southwest. To be eligible for participation, adolescents had to satisfy DSM-IV diagnostic criteria for substance abuse or dependence. Youth were randomly assigned to EBFT or TAU at the runaway shelter, and were assessed at 3, 9, and 15 months post-baseline. Overall, at 15 months, youth in both treatment groups showed improvement in family and individual functioning, including depression/anxiety, family conflict and cohesion, and externalizing problems. Youth assigned to EBFT showed a greater decrease in substance use than those assigned to TAU.[5]

Conclusion

While our interventions with runaway and homeless youth improved behavior, integration of treatments into the community requires funding as well as buy-in from those in the trenches. Many shelters are not equipped to deal with youth who have substance abuse and/or mental health problems. Moreover, most cities do not have drop-in centers to provide a place for homeless youth to congregate. Given the constellation of problems of this high-risk group of adolescents, and the potential for preventing continued runaway episodes or chronic homelessness, community and governmental support is needed if we are to significantly impact this social problem.

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Successful Strategies for Improving the Lives of American Indian and Alaska Native Youth and Families

What is success? Who gets to decide what is successful? What evidence does a program need to demonstrate that its practices produce successful outcomes? These are a few of the questions that are at the heart of a five-year project to demonstrate new research approaches aimed at producing "practice-5based evidence." This unique project is a collaboration between the Portland Research and Training Center, the National Indian Child Welfare Association, and the Native American Youth and Family Center, a Portland, OR-based non-profit agency. The project is designed to address a challenge faced by community-based, culturally-specific youth and family agencies—providing evidence that their practices and services are effective in a context where typical research techniques are often neither feasible nor culturally appropriate. Building evidence from the ground up, with the involvement of elders, families, and youth is the ultimate goal of this effort.

The more than 4 million American Indian and Alaska Native (AI/AN) youth and families who live in the United States face many challenges to healthy development and thriving. These problems, which include poverty, substance abuse, low graduation rates, unemployment, and mental and emotional disorders, must be understood within a historical context of oppression, genocide, and government policies of assimilation. Today, especially when compounded by racism and discrimination, these negative social factors present barriers to the healthy functioning of AI/AN families.

Despite these pervasive social challenges, the strengths and resilience of AI/AN people provide opportunities to support positive change and positive community-sanctioned outcomes. For example, the rate of physical abuse among AI/AN is lower than that of mainstream families, despite conditions that are highly correlated with abuse. For Native Americans, cultural strengths such as family and community, spirituality, traditional healing practices, and group identity are key moderators of physical and mental health outcomes and substance abuse.[2] They provide the building blocks for developing effective programs for AI/AN people.

Paradoxically, although the problems faced by AI/AN families and their children are well documented, access to appropriate services is far poorer for them than for other populations. About half live on reservations, often in rural or remote areas with little access to services. Those who live in urban environments are often unable to utilize the available services. In addition, many AI/AN families regard current mainstream mental health and social services as culturally inappropriate or ineffective; thus, many of the existing models for mental health services do not

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meet AI/AN cultural expectations associated with seeking and receiving services.

This problem is even more acute in light of the current emphasis on evidence-based practice (EBP). Increasingly, federal agencies are requiring EBP as a condition for funding, and the State of Oregon has enacted legislation which requires EBP in many health and human services funded by the state. The development of EBP has depended primarily on a "gold standard" of randomized controlled trials, efficacy studies, quasi-experimental designs, or series of single case studies.[1] Many service providers that address the needs of culturally and linguistically diverse populations are concerned about the mandatory use of EBP because many of the research studies that support the use of EBPs have not included large numbers of children and families of color and even fewer have focused specifically on AI/AN populations. Little evidence exists that EBPs are effective for diverse groups and populations with different worldviews and values.

Of course, AI/AN people want the best possible services. Most are not against the idea that evidence of effectiveness is valuable, but there are many aspects of the current approach to EBP that pose difficulties. These include the fact that many EBPs have been developed without consideration of either cultural context or concerns about lack of fit between cultural norms and requirements of some evidence-based practices.

Responses to mandates for community organizations to implement evidence-based practices have led to three strategies among AI/AN researchers and advocates. One approach is to adapt existing EBPs for Native American youth and families. The second is to seek exemptions from EBP mandates, or advocate for extended timelines for Native American populations and agencies. A third strategy is to work to establish evidence of effectiveness of existing practices that are culturally appropriate, acceptable, and believed to be effective, but have not been subjected to rigorous evaluation. This final strategy is the approach adopted by our Practice-Based Evidence project.

For Native Americans, cultural strengths such as family and community, spirituality, traditional healing practices, and group identity are key moderators of physical and mental health outcomes.

Program Examples and Evaluation Challenges

Many community-based practices that are believed to be effective and are highly valued by families, youth, and practitioners have little or no scientific evidence base to support their effectiveness, despite their wide use and apparent success. Two such examples are "Positive Indian Parenting" (PIP), a curriculum designed to promote and support culturally and developmentally appropriate parenting practices in Indian families, and the comprehensive program of the NAYA Youth and Family Center, which serves Native American children and families in the Portland, Oregon metropolitan area.

Positive Indian Parenting

Positive Indian Parenting (PIP) is a parent education curriculum developed by the National Indian Child Welfare Association to promote positive parenting. This curriculum relies heavily on values clarification and development, using traditional cultural teaching as a base for effective parenting. PIP has been in existence and steady use since 1987 and is widely used throughout the United States and internationally. It was recently named as a best practice by the National Association of Minority Behavioral Health Associations, but it has had no formal evaluation of its efficacy or effectiveness.

Built on a foundation of information gathered through a series of interviews with AI/AN elders and practitioners, PIP is based in the idea

that many present-day AI/AN parents have been deprived of the right to learn positive parenting traditions that have been handed down from generation to generation. Through forced assimilation, removal to boarding schools, and forced foster placement and adoption programs, traditional parenting practices were lost or weakened. This curriculum reframes parenting problems as a function of colonial oppression rather than personal deficit and empowers AI/AN parents to reclaim teaching and return to their rightful state as positive parents. PIP taps into the power of culture, identity and belonging, giving Indian parents a positive standard of behavior to emulate and a number of basic skills to actualize the values.

While the specific content of PIP may be flexible from tribe to tribe, core principles are maintained across sites (see box at left). The "fidelity" of this curriculum is not in the specific tribe's teaching from one site to another but in the principles themselves, which were developed in consultation with diverse tribal elders and found to be nearly universal among North American tribes.

To date, PIP evaluation designs have been limited to participant satisfaction and assessment of the achievement of learning objectives. However, effectiveness is evidenced by widespread use, acceptability, approval by elders, low dropout rates of participants, and many testimonials from trainers and parents alike. Randomized control trials have been not been feasible due to the limited size and geographic distribution of groups using the curriculum and because of cultural as well as economic issues. However, as more is learned about evaluation of culturally-specific approaches, the current project is helping to build a framework for evaluation and the options for appropriate research are growing.

PIP CORE PRINCIPLES

- *Traditional culture offers positive parenting that was effective for centuries;*
- *Positive parenting is rooted in spiritual teachings that direct how children should be treated;*
- *The oral traditions of tribes necessitate effective communication skills;*
- *Parents are the first teachers and are responsible for transmission of values;*
- *Nurturing a child is an essential cultural value;*
- *Children can not learn a skill until they are developmentally ready;*
- *Teaching self discipline is the ultimate form of behavior management;*
- *Teaching children their place in the world and helping them develop skills to successfully interact with their environment is an essential part of parenting; and,*
- *Reinforcement based in ceremony, ritual, relationship and non-verbal communication is a powerful tool for shaping positive behavior, identity, and self- and group-esteem.*

NAYA Youth and Family Center

The Native American Youth and Family Center (NAYA Family Center) was founded in 1974 by American Indian/Alaskan Native (AI/AN) parents to keep their children engaged in healthy activities such as sports and cultural arts. NAYA Family Center's mission is "to enhance the diverse strengths of our youth and families in partnership with the community through cultural identity and education." The agency focuses on activities that encourage alternatives to high-risk behavior for Native youth and case management for families experiencing domestic violence, in order to break endemic community patterns of poverty, build youth leadership, job skills, and self-esteem; and support community self-sufficiency. (See related article, page 14.)

NAYA Family Center is an example of a program that has excellent

POETRY BY TEDDY PEREZ

My Feelings

Inside me is a sun shining and shining on everyone.

Inside me is a bird, flying and soaring.

Inside me is a snake it makes me mad and rattles to let you know when you're too close.

Inside me is a tree, tall and shady.

Inside me is a dying flower.

I get sadder and sadder.

Inside me is the sky.

I hold it inside.

I won't let the thunder roar.

Inside me is a heart that is dancing.

The Indian Spirit

As I lie in my bed I listen to the spirits that wander at night.

Suddenly, I hear my grandma's voice calling to me.

I open my eyes seeking her like an owl stalking his prey.

But I don't see her.

My eyes get watery and tears start flowing like rivers.

I picture her in my head,

her black hair,

her brown skin,

representing the great Indian that she was.

Teddy Perez is a Native American youth active in NAYA Family Center.

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evidence of youth outcomes at the organizational level, but none of its culturally-specific interventions qualify as an "evidence-based practice." Examples of good outcomes achieved by enrolled NAYA youth include:

- High school graduation rates 5 times that of all Indian children within the Portland Public Schools (PPS);
- Participants in the Summer Institute have a 90% graduation rate from high school, compared to a graduation rate of 20% for all PPS Indian children;
- NAYA students who participate in the tutoring center complete and exceed state benchmarks in math, science, and reading at more than twice the rate of all PPS Indian students;
- Students who participate in the Culture, Arts, and Sports programs have significant increases in their daily school attendance rates and benchmark achievement rates, as well as decreases in behavioral incidents or referrals.

Through the Practice-Based Evidence project (PBE), NAYA is working to document the effectiveness of the resources and practices that it provides. However, several features of the NAYA program that are seen as culturally congruent also complicate the research/program evaluation task. First, NAYA's program is holistic, comprehensive, and dynamic; the services provided to families change as their needs change. Although this program design is intentional and appropriate to NAYA's mission, it does not lend itself to being manualized. A second program feature is that staff behaviors designed to bring about positive change in children are rooted in NAYA values and practice principles: Staff utilize more than 20 strategic practice elements across program areas and interventions. Examples include mentoring, cultural preservation, role modeling, and identity enhancement. This makes it difficult to identify the effect of any given program component or intervention. Another evaluation issue is that, because enrollment in NAYA's program is voluntary, there may be (unknown) biases due to the self-selection process of participation. Those who enroll in NAYA's school programs may be more motivated or have caregivers who can provide more structure, resources or encouragement; or conversely, they may enroll because they are more in need of intervention.

Though neither is designated as an "evidence-based practice," both PIP and NAYA demonstrate important positive qualities. First, each of them has high acceptability and engagement by intended participants. This feature constitutes an enormous hurdle for many mainstream social service and mental health programs. Secondly, NAYA's program-level data provide strong evidence that it is effective. The PBE research team is working to connect program design, strategic interventions, and outcomes in a systematic way. A third positive quality is connected to increasing evidence of the powerful protective effect of positive cultural identification for AI/AN people, both at the individual level and for communities. This suggests that these two culturally-specific programs are employing program strategies likely to produce positive outcomes for AI AN youth and their families.

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Finding My Roots

Bridgette Mesa is an 18-year old high school senior who lives in Camas, WA. She is very involved in the Native American Youth and Family Center (NAYA), an organization that she reaches by a 20-mile bus ride from home. This fall she will attend The Evergreen State College where she plans to enroll in the Native American Studies program. She plans to focus on politics and family counseling, with the hopes of getting a Master in Public Administration so that she can specialize in tribal government management. Her story is based on an interview conducted by Kris Gowen.

"You must be the change you wish to see in the world"
-Ghandi

I am an urban Indian enrolled in the Pascua Yaqui Tribe of Tucson, Arizona. I am also part Apache, Shoshone, and Mexican-American. I went to a traditional high school for the first two years of my high school career. Though it was really big I still felt caged in. There was no room for me to grow. Then I transferred to CAP (Camas Alternative Program). It's a small credit recovery program (about 200 students) and generally has a bad reputation. Still, I went there to focus and concentrate on school. At the high school I wasn't truly learning anything but at CAP learning and experiencing is the norm. The Camas High School was too strict and impersonal for me. CAP, on the other hand, has structure but is more relaxed and the teachers are more one-on-one.

I soon became close with my garden teacher who helped me with my junior research paper which was on Native American culture and assimilation. Through gardening I was able to get back to my roots. My teacher was very knowledgeable, and we had many discussions about Native American people, assimilation, nature, reconnecting with the land, culture, traditions, spirituality, and much more. Because of my interest in Native culture, my teacher encouraged me to take an active role in her garden class. Within a couple of weeks I became the liaison between the students and the community garden members. It was my first leadership role. We had our first batch of pumpkins and squash last spring.

For most of my life I identified with the Mexican people. Because I am brown, they accepted me, but I knew in my heart I didn't fit into this culture. I felt like an outcast because I didn't speak the language. They called me "India." I laughed along with it and we joked around but in a way I felt they were laughing at me. Then I decided to make a change. Because I could no longer identify with the Mexican people and because of my experience at the garden, I decided to do my senior project on Native American culture, more specifically tribal leadership and assimilation. My paper is about how we need more and stronger leaders on the reservations. Many reservations are not necessarily the best places to be in the world. So I made a list of good qualities a true leader must have, and one of them was to be involved in the community. A true Native leader (any leader, in fact) is connected to her community and heritage. And I wasn't. This is

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where I bumped into something. There were so many things I didn't know about my culture. The only way I had learned about my culture was over the internet. And it is virtually impossible to become an Indian over the internet. So I decided to get more involved in the community by going to NAYA (Native American Youth and Family Center).

My mom had wanted me to go to NAYA for a long time – she had heard about NAYA through her involvement in the Native American Rehabilitation Association. She wanted me to take advantage of all the things NAYA had to offer like the employment program, High School Night, and teen counseling. She didn't want me to end up on the streets somewhere like the other kids. But I resisted just because I am stubborn and like to do my own thing. Eventually, I gave in and participated in NAYA's Summer Institute program and was able to get college credits and a stipend. I took math, writing, and ecology while at the same time working at the American Red Cross. I was able to get the job through the Siletz Tribe in a youth summer job program. I got A's and did really well. I also went to the Bow and Arrow club and helped make a Raven Puppet for a six foot man to be used in an upcoming play performance. I started to attend pow-wows and Native American church meetings.

I was actually able to learn about my culture because of NAYA. There's a strong sense of community here.

Another thing that enabled me to become more involved in my culture was when I found out about my family for my senior project. Like many other Natives back in the day, my great-grandmother was assimilated and was ashamed to even speak our language. So, she didn't teach our culture or speak the language to my grandmother, who didn't teach it to my mother, who couldn't teach it to me. Through the generations, my family's culture was lost. So when my mother talked to me about my family, it hit me here [puts fist to heart]. I realized that I am the result of assimilation. I had been writing about my culture as an outsider. I was detached from all the statistics I researched for my project. Then I found out I have family who live on the reservation in Arizona, but I never met them, because I never ever knew about them. My great uncle is vice-chairman of the tribal council. I was excited to learn this so I emailed him and he emailed me back. I thought it was crazy that I had an uncle who was a leader like that. I also found out that the chair was actually a chair*woman*. I thought, "Whoa, that might be something I could do."

Today things keep coming my way and I think of everything as an opportunity. It feels like I am just floating around, grabbing on to whatever I can, but I know where I'm going. I give myself space, but I have boundaries. I don't do drugs or mess around because that is outside of my boundaries. I can do whatever I want as long as I stay on my path. NAYA is definitely on my path; it is why I come.

I have become more confident in who I am. I have a better sense of who I am. I am a leader. I am stubborn. I can be organized. And I can influence people if I want to. For example, I have a friend who was into gangs. I started talking to her and influencing her, telling her that I used to hang with that sort of people. She has tons of time to change and she can do it gradually; she just needs to be careful and take care of herself, get an education and all. She is going to school more often now because of my words.

By coming to NAYA, I learned that I am not the only one who didn't know her culture. I was actually able to learn about my culture because of NAYA. There's a strong sense of community here. NAYA has definitely become my surrogate tribe. It's important for people like me to find a community and to be with people that we can identify with. Even if we just eat fry bread, it's something we do together. No one wants to feel that they are alone. Thanks to NAYA (and CAP), I was able to see that I will never be alone.

Adapting Attachment-Based Family Therapy for Depressed and Suicidal Gay, Lesbian, and Bisexual Adolescents

Being Gay and Adolescent

Adolescence is both an exciting and challenging time. It is a period of rapid cognitive, emotional, and physical growth, coupled with increasing autonomy. As a result, adolescents are exposed to many new experiences which, ultimately, help shape their definition of self and way of relating in the world.

For most of the approximately 5% -10% of youth who are gay, lesbian, or bisexual (GLB), or who are questioning their sexual orientation, life is more complicated than for their heterosexual peers. These teenagers face not only the normal developmental challenges of adolescence (e.g., identity formation, romantic relationships), but also face additional stressors commonly associated with being a sexual minority, including confusion, shame (i.e., internalized homophobia), fear, rejection by family and peers, and abuse/victimization.

Depression and Suicidality

While the majority of GLB youth are healthy, resilient, and well functioning[7] many end up depressed or even suicidal. A host of cross-sectional studies have found that GLB youth have higher rates of depression, hopelessness, suicidal ideation, and suicide attempts than their heterosexual counterparts. In fact, GLB youth are twice as likely as heterosexual youth to experience suicidal ideation or to report making a suicide attempt.[6] Obviously, there is nothing inherently suicidal about a lesbian, gay, or bisexual orientation. Instead, it is most likely that environmental responses such as discrimination, victimization, and rejection contribute to self-loathing and depression which in turn leads to suicidal ideation and behavior.[6,7]

Family Relationships

One important suicide risk and protective factor is the quality of the adolescent-parent relationship(s). A substantial amount of research, including both prospective and cross-sectional studies of both community and clinical samples, has linked parental criticism, emotional unresponsiveness, rejection, control, and lack of care and support to adolescent suicidal ideation and attempts.[8] Unfortunately, GLB adolescents may be particularly at-risk for conflict with parents, parental criticism, and parental rejection. Because of pervasive societal homophobic messages, some parents may, at least initially, perceive their child's same-sex orientation as unnatural, perverse, immoral, and/or dangerous. Such perceptions can lead to parental feelings such as disappointment, loss, shame, guilt, anger, disgust, and/or embarrassment which, in turn, can produce a range of behaviors, including denial, disapproval, rejection, threats, humiliation, abuse, violence, and ejection of the adolescent from the home.[7] When parents reject, disengage from, invalidate, or otherwise express discomfort with their adolescent's sexual orientation, the message conveyed is that something is wrong with the adolescent. Such a message, delivered from the most important people in the adolescent's life, can exacerbate self-loathing, depression, and hopelessness—all correlates of suicide. Results from a survey of GLB youth in the greater New York City area showed that a history of parental psychological abuse differentiated between those youth who had made a suicide attempt versus those who had not.[3]

In the same way that family conflict, rejection, and other negative processes are associated with greater suicidality, family cohesion appears to protect young people. GLB adolescents who report high levels of parental support and good communication with parents report fewer mental health symptoms and less suicidal ideation and attempts.[3] After controlling for other factors, such as depression and stressful life events, those adolescents describing their families as mutually involved and demonstrating a high degree of shared interests and emotional support were 3-5 times less likely to be suicidal than their peers from less integrated families.[5] When parents accept their adolescent's sexual orientation as an integral and valued aspect of their child, they validate their child and are positioned to support, guide, and advocate for him/her

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as he/she negotiates the challenges of growing up with a minority sexual orientation. Research findings suggest that a strong adolescent-parent relationship can buffer against the effects of gay-related victimization occurring outside of the family.[2]

Treatment

Despite their high-risk status, to date there has been very little written on the development and testing of treatment models for suicidal and depressed GLB youth. The American Psychological Association (APA) has developed Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients. These guidelines emphasize the importance of understanding that homosexuality is not a mental illness and educating therapists to recognize their own potential biases. Therapists must understand and take into account issues and challenges that exist for GLB clients such as: rejection, discrimination, and harassment due to GLB status; internalized homophobia; and shame. In addition, therapists must understand the relationship between these challenges and psychological symptoms such as anxiety and depression; the process of "coming out" and its impact on work, peer and family relations; and the benefits of being GLB, including the community and social support groups available to these clients.[1] While these guidelines provide a necessary and essential frame of reference for work with GLB clients, more work is needed to systematically integrate these themes and processes into coherent, well-articulated models for working with specific sexual minority populations. Such models should include defined targets of treatment, purported change-mechanisms, and specified intervention strategies.

A Promising Approach

One promising treatment model for working with depressed and suicidal GLB youth is Attachment-Based Family Therapy (ABFT). ABFT is promising for three reasons. First, it is a manualized, empirically-based family treatment specifically designed to ameliorate depression and suicidal ideation among adolescents. Second, its primary aim is to improve the quality of the adolescent-parent attachment relationship (i.e., reduce conflict and criticism and increase care, support and warmth)a risk/protective factor robustly associated with adolescent suicidality in general, and suicidality among GLB youth in particular. Third, there is preliminary data regarding the efficacy of the treatment. In a pilot randomized clinical trial comparing 12 weeks of ABFT to a wait-list control condition, 81% of ABFT cases no longer met criteria for Major Depressive Disorder post-treatment, compared to 47% of the control group. In addition, among ABFT cases, average scores on the

Suicidal Ideation Questionnaire decreased from 34 pre-treatment to 21.[4] Importantly, data suggests that up to one third of these clients were of minority sexual orientation.

The first half of ABFT focuses on improving the quality of the adolescent-parent attachment relationship. Once the attachment bond has been repaired, the second half of treatment focuses on promoting adolescent autonomy and pro-social functioning outside the family. The five treatment tasks of ABFT have been designed to meet these goals.

The first task, the relational reframe, aims to shift the focus of the therapy away from parents ascribing negative or critical characteristics to the adolescent (i.e., "stubborn," "manipulative") which fuel adolescent anger and withdrawal, and onto the events/processes which have ruptured or diminished the quality of the adolescent-parent relationship, and reduced the possibility of the adolescent turning to the parent for support. Such shifts are accomplished through relational reframe interventions. For example, a therapist might ask the adolescent, "Why don't you turn to your mother when you feel so bad that you want to die?"

Once the relational frame has been established, the therapist meets with the adolescent and parent separately to build alliances. In meetings with the adolescent, the therapist builds trust and learns more about the adolescent's interests, concerns and aspirations. These sessions are also used to identify core family dynamics that fuel conflict, and to prepare the adolescent to discuss such issues with her/his parent(s).

Alliance-building with the parent focuses on reducing parental distress and improving parenting practices. The therapist shows interest in the parent as a person, expressing care and acknowledgment of the parent's strengths and accomplishments. Next, the therapist supportively explores stressors currently affecting the parent (e.g., marital problems, financial difficulties, traumatic childhood history, psychiatric distress). When parents experience empathy for their own vulnerabilities, they become more empathic regarding their adolescents' struggles. In this softened state, parents recognize the importance of providing support and care for their teenagers, and are more receptive to learning parenting skills that focus on affective attunement and emotional facilitation.

Once alliances with the adolescent and parent(s) have been established, and the adolescent and parent are prepared, reattachment begins. Reattachment episodes are designed to facilitate conversations between adolescents and their parents about past/current relational ruptures. The episodes begin with the adolescent disclosing her/his vulnerability associated with past and present events that have violated the attachment bond and damaged trust. As parents respond empathetically, adolescents are more forthcoming. During these conversations, parents often take some responsibility for attachment failures which, in turn, promotes forgiveness on the part of the adolescent and renews mutual interest in repairing the relationship. This task diffuses family tension and increases the like-

lihood that a suicidal adolescent will seek support from a parent.

Once tensions between the adolescent and her/his parents have lessened, the parents are in a better position to encourage, guide, and support their adolescent in developing autonomy. This fifth task of ABFT, promoting competency, is designed to help parents help their adolescent improve school functioning, successfully navigate peer relations, participate in social activities, and so on. Success in such domains contributes to the adolescent's sense of efficacy, which can buffer against further hopelessness, depression, and suicidal ideation.

Current Project

While ABFT has shown some promise with depressed and suicidal adolescents in general, more work is necessary to insure that the approach addresses the unique content domains and individual, family, and contextual processes and developmental tasks of GLB youth. Thus, a treatment development team at the Center for Family Intervention Science, Children's Hospital of Philadelphia, is working to develop and test a GLB-sensitive version of ABFT for suicidal and depressed GLB adolescents.

This project is planned to span three years and includes two stages. Stage one is to adapt the current ABFT manual to include the specific content, tasks, and therapeutic strategies required to make treatment relevant, acceptable, and feasible for treating GLB suicidal and depressed adolescents and their families. The members of the treatment development team will utilize their clinical experience, results from qualitative interviews, observations from archived videotaped sessions of ABFT delivered to GLB suicidal adolescents, and the extant empirical and clinical literature on treating GLB youth in order to revise the treatment model.

Stage two involves conducting a pilot randomized clinical trial comparing 12 weeks of ABFT-GLB to 12 weeks of Enhanced-Usual-Care for suicidal and depressed GLB adolescents. The purpose of this stage is to examine the treatments' acceptability to therapists, adolescents, and parents; therapist adherence to the model; the characteristics of the outcome and process measures over time; and the relative impact of the two treatments on suicidal ideation, depressive symptoms, family functioning, and internalized homophobia.

Conclusion

This project represents one attempt to develop and test a treatment model for a specific sub-group of GLB adolescents – those suffering from depression and/or suicidal ideation. However, what about those adolescents whose families are not willing or able to participate in the treatment process, or adolescents who don't want their families involved? What about GLB adolescents with co-morbid drug abuse or who suffer from severe anxiety disorders? Such adolescents would clearly need a modified or different approach. Thus, the challenge remains. Much more work is needed to translate the spirit of the APA Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients into practice.

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What Makes Mentoring Effective? How Research Can Guide You in Selecting a Program

Contemporary practitioners and policymakers widely accept that having a significant, positive relationship with an adult is instrumental in helping a vulnerable youth demonstrate resilience or even thrive. This conclusion, rooted in current resilience and mentoring literatures, has led policymakers to promote mentoring programs for children, especially those at risk for developmental difficulties due to the adversities they face. Reflecting widespread public support, mentoring programs have proliferated in recent years. In the U.S., over 4,500 programs existed for mentoring youth in 2002.[9]

Given mentoring programs' national popularity, it may come as a surprise when mentoring researchers advocate for a more critical and specific approach to designing and delivering services.[9] Emerging findings show that not all mentoring programs achieve similar outcomes. Thus, available options should be considered thoughtfully and with clear ideas as to what different programs may and may not provide.[8,11] The nature and quality of mentoring relationships, as well as their impact on the lives of vulnerable youth and families, can vary widely based on factors such as program quality, parent involvement, frequency of shared time, and the stressors affecting the child. The current enthusiasm for mentoring programs may have outpaced what we know about making these programs effective and relevant for improving children's lives.[10] With poorly designed programs or mismatched mentor-protégé relationships, the promised benefits of mentoring may fail to materialize.

This article briefly summarizes some lessons learned about effective mentoring programs and the conditions that promote positive mentoring relationships. We then give examples of promising practices that have been developed to serve youth who have special needs. Finally, we provide recommendations designed to help parents and practitioners make choices regarding mentoring program involvement for their children.

Does Mentoring Work?

Widespread support for mentoring programs that assist at-risk youth is understandable. After all, there is something very attractive about programs that connect caring adult community members with youth who could benefit from extra support. However, this rationale risks being reduced to good intentions unless it is paired with an understanding of the current best evidence on which program features actually promote successful youth mentoring.

In their meta-analysis of mentoring outcomes, DuBois and his colleagues[2] provide both good and not-so-good news about mentoring programs. The good news is that overall, mentoring programs "work" in that they produce desired social/emotional/academic outcomes. On the other hand, the average size of beneficial effects is modest compared with more intensive family and mental health supports.[2] Moreover, standalone mentoring programs appear to have little or no positive impact for youth at highest risk—those already failing school, in the juvenile justice system, or receiving special education services. In some ways, this seems logical; a young person who already has difficulties in relating to others and trusting adults may have trouble forming a connection to a mentor. However, mentoring programs do seem to be particularly beneficial for youth who are at risk for environmental reasons (e.g., from lower-income families) and who have not had contact with other mental health services, special education services, or juvenile

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justice programs.

These findings do not mean that all mentoring programs are inappropriate for young people with more serious individual challenges; it just means current data on mentoring outcomes does not support the assumption that mentoring programs alone will produce positive outcomes for youth in trouble. It may be that program innovations, such as using mentors who are trained in helping professions or integrating mentoring with comprehensive intervention plans (involving family therapy, tutoring, and other supports), will yield better results in the future.

Best Practices

Even when programs are well-targeted to specific youth populations, not all are as effective as they could be. DuBois et al.[2] found that effectiveness increases in direct proportion to the number of specific program practices that are employed. Effective programs incorporate standard recommended procedures in their operations, such as screening the mentor and youth, providing an orientation, making the match, and monitoring the relationship through ongoing supervision of the match.[7] Beyond this, Dubois and colleagues found that effectiveness is enhanced further when a mentoring program also includes the following "best practices":

1. Provides ongoing training for mentors (beyond initial training).

2. Provides structured activities for mentors and protégés.

3. Expects mentors to have regular and frequent contacts with their protégés.

4. Uses mentors with backgrounds in helping professions.

5. Encourages parents to know the mentors and to be involved in supporting the relationship.

6. Monitors program implementation and adjusts the program accordingly.

Evidence indicates that mentoring is more beneficial when relationships are long-lasting and feature frequent and consistent contact between mentor and protégé.[6] More enduring and positive relationships tend to occur when the mentor takes a youth-centered approach that focuses on understanding the individual child's needs, interests, and circumstances. A mentor who is sensitive and responsive can identify ways to offer appropriate support and guidance.

Although fun and friendship are important elements in building and sustaining the relationship, the mentor should try to create opportunities to develop the character and competence of the protégé. Goal-directed activities and projects with purpose can facilitate youth development as well as strengthen the relationship; however, the mentor may need to be creative and flexible to keep the child interested and engaged. Not surprisingly, a mentor who takes a longer view of his or her role in the protégé's life is more likely to persist through the sometimes awkward initial stages of the mentoring relationship.[4]

Improving the Fit

In recent years, the field of mentoring has begun to see practices adapted to the needs and circumstances of special populations of young people. For example, recent attention has been devoted to the role of gender in mentoring relationships, acknowledging the possibility that male and female youth bring different strengths to relationship involvement. DuBois and colleagues[3] have focused on the development and implementation of a mentoring program for urban adolescent girls that targets public health concerns faced by this population (e.g., sexual health, violence prevention, healthy eating and exercise). This program develops strong one-to-one mentoring relationships within a group format that includes psycho-educational sessions. Through this model, girls are able to grow in their relationships with their mentors as well as broaden their networks through connection with other program participants.

Another example of mentoring tailored to the specific needs of young people involves work with youth who have been abused and neglected.[1] Such programs emphasize the recruitment, screening, and training of high-quality mentors who can address the difficulties likely to be encountered in developing a relationship with a youth who has been maltreated. In addition to providing ongoing mentor training and informational support, these programs work to integrate mentoring services within the larger child welfare service network.

These types of program innovations reflect the growing literature on mentoring practices for special populations of youth. In exploring program involvement, should your young person face these or other unique concerns, be sure to inquire about how the program model accommodates your child's particular needs.

The following are some recommendations for parents and practitioners considering mentoring programs:

1. *Make a good program match before you start the relationship.* Learn as much as you can about the mentoring program to determine whether it is a good fit for your young person. Programs come in many varieties, so it is worthwhile to consider the following: Does the program create one-to-one relationships? Where will activities take place? What are the goals of the program? Does the program serve youth of certain ages or with special needs? In addition, find out whether the program offers appropriate support through

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all phases of the relationship. Consult the best practices outlined earlier in this article and inquire as to how many are implemented by the programs you are considering. Should your young person present with particular needs, make sure to examine ways that the program intends to acknowledge these in the context of the mentoring relationship.

2. *Get involved.* Mentoring is increasingly considered a 'systemic' intervention,[5] meaning that parents, mentors, and agency staff all need to communicate and cooperate to make the mentoring relationship successful. Make sure that the program you select has policies regarding parent involvement, and consider yourself a teammate of your youth's mentor. Support the mentor's efforts by sharing information, keeping appointments, and showing appreciation. Research continues to reinforce the critical role that parents play in providing input and support to the mentoring relationship.

3. *Give it time.* Research shows that mentors and protégés both need time together to establish a strong connection. Barring any significant concerns, support your young person in building the relationship. Suggest routines and schedules that promote a predictable pattern in the relationship. Help the mentor and child work through disagreements in a direct way that makes the relationship stronger. Patience, perspective, and persistence will pay off in a positive relationship.

4. *Expect progress, not promises.* One common issue facing mentoring programs nationwide is the promotion of unduly high expectations. Popular campaigns suggest mentoring can address chronic social and educational problems like academic underachievement, gang violence, and poverty. An inspirational mentoring relationship may promote positive development, but a number of risks and hardships still may contribute to youth difficulties. Be realistic in your expectations about how much a mentoring relationship can accomplish in a few hours a week. Look for and celebrate the little improvements along the way.

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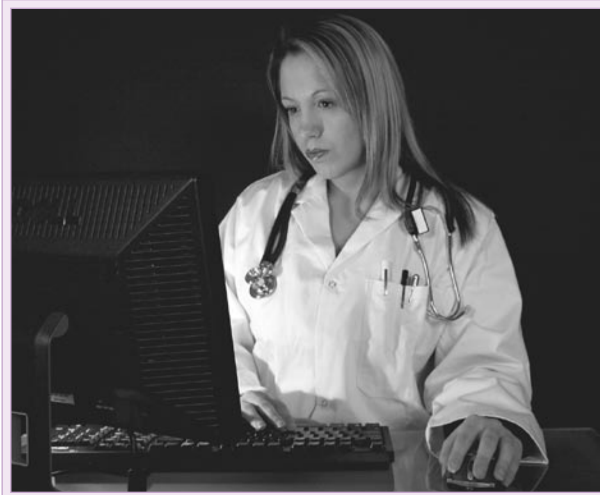
School-based Telemental Health Services: Reaching Underserved Populations

Kansas is an ideal state for mental health using telemedicine because of how service providers and recipients are distributed across the state. Half the population and a majority of specialists live in two urban areas, while the rest are thinly scattered across rural areas. Telemedicine has advantages for rural families, including decreased travel expenses, decreased time lost from work and family, and increased comfort level due to staying in familiar surroundings.



As defined by the American Telemedicine Association, telemedicine is "medical information exchanged from one site to another via electronic communications to improve patients' health status." Kansas became the first state in the nation to utilize school-based telemedicine in 1998 with its TeleKidcare program. In this program, videoconferencing bridges the distance between the school's health office and health professionals at the state's largest teaching hospital, University of Kansas Medical Center. The program has grown from four schools to over 20 urban and rural schools statewide.

Overview

TeleKidcare originally provided ambulatory and mental health services using interactive televideo, allowing the child, family, and school nurse to see, hear, and interact with the University of Kansas Medical Center specialists in real-time. Since 1998, there have been over 3,500 TeleKidcare consults.

Over the last nine years, TeleKidcare has evolved into primarily a mental health services model. Telemental health has been used across urban and rural areas with both adults and children. Settings for telemental health services have included schools, community mental health centers, hospitals, primary care offices, military sites, reservations, correctional facilities, and homes.[4,10] Given these diverse settings, a full spectrum of mental health difficulties has been evaluated and treated via televideo.

Diagnostic efficacy and clinical efficacy over televideo have been found generally equivalent to in-person care, but many research questions remain across diagnoses and settings.[3] School-based telemedicine specifically has resulted in decreased absences[6] and high satisfaction across patients, providers, and presenters;[11,8] and has been shown to be cost-effective.[1]

Ongoing studies are evaluating the accuracy of diagnosis in the TeleKidcare mental health clinic and developmental disabilities clinic.[9] In one of the few treatment outcome studies, Nelson et al.[7] found similar rates of depression remission across 28 children randomized to televideo or face-to-face cognitive behavioral therapy (CBT). While these results are promising, the small number of participants makes it hard to generalize results across different technologies, sites, and mental health conditions.

TeleKidcare Clinic

TeleKidcare's innovation is linking together the provider, the parent/guardian, and personnel from the school, each of whom has a different kind of knowledge about the child. The school-identified telemedicine presenter is most often the school nurse, who serves as the bridge between the telemental health provider and the family. The close communication with the school team assists the telemedicine providers in diagnosis and treatment. In the traditional clinic setting, the family is typically interviewed by the behavioral provider and then the school is contacted. Connecting with the school can be a prolonged process of phone tag and waiting for questionnaires to be returned. The school-based telemedicine conference brings multiple informants together at one time. This allows providers to get a holistic view of the child's strengths and difficulties and allows family and school participants to better understand each others' concerns. The school personnel are in a unique position to describe daily behaviors over time and identify changes over time. They can describe learning difficulties and peer relations in addition to the psychiatric concern. The team evaluation results in a more unified and feasible treatment approach and the parent remains an active participant throughout the entire process.

Telemedicine has transformed the role of school nurse in mental health. She (all TeleKidcare nurses have been female to date) orients the family to both the mental health evaluation process and the technology. She organizes the consultation, arranging for all participants to attend, including teachers, school psychologists, coun-

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selors, and others. After the consultation, she assists the family and the school with implementing medication, behavioral, and referral recommendations. With these expanded roles, the TeleKidcare nurses request and require ongoing training in both technology and mental health services competencies.

The technology is the essential tool that allows this innovative team to "meet" in the child's own school. Therefore, administrative buy-in and appropriate physical facilities are critical to successful school-based telemedicine. The cost of the videoconferencing system ranges from $4,000-$9,000, including costs for videoconferencing equipment, monitor, cart, line installation, and other related costs. In addition, the school pays ongoing costs associated with the high-speed internet connection or ISDN lines. The equipment is user friendly and reliable; technical assistance was required on less than 5% of TeleKidcare consultations.

Table 1 presents TeleKidcare demographics information from 155 patients served within the first seven months of the 2006-2007 school-year. The mean age was 11 years, with 70% of patients from elementary school, 15% from junior high school, and 15% from high school. The overrepresentation of boys is consistent with face-to-face behavioral clinics. While behavioral difficulties are the initial concern in three quarters of the consultations, the telemedicine providers find that many families bring concerns about "internalizing" behavior ranging from anxiety or adjustment reactions to full depression.

The treatment delivery method itself poses few difficulties for families. Children adapt quickly to the technology and often enjoy seeing themselves and even making faces on screen. Families report little difficulty seeing or hearing over the system. The length, content, and relationship within telemental health sessions appear similar to those of traditional sessions. Some differences exist, such as the inability to shake the parent's hand or pat the child on the shoulder for a positive behavior. In the past, families also had to become accustomed to the slight delay in the audio component and adjust the conversation patterns accordingly, although higher speed transmission via televideo makes this less of a concern. Videoconferencing at times adds benefits to the therapeutic process. For example, it may encourage parents to take a more active role as a partner in their child's treatment.

Implementation issues to consider when using psychotherapy over televideo include the following:

1. Introduction to the technology. The behavioral provider and the rural presenter (in this case the school nurse) need to feel comfortable with the technology and practice, ideally shadowing another provider or presenter before initiating services. Information about the technology is reviewed at the first visit and the family is encouraged to practice moving the camera, adjusting the volume, and so on. The child is given a basic description of the technology, such as, "Only you can see me in Kansas City and I can see you at your school using special phone lines. It's not like regular TV." The introduction also includes a backup plan in case of technology difficulties (usually the telephone), as well as a safety plan should any concerns arise during the evaluation. For non-English speaking telemedicine participants, a medical interpreter assists with this introductory description and throughout the session as needed.

2. Confidentiality. Reasonable precautions need to be taken to limit what is overheard from the room and to provide secure data transmission. As Elford and colleagues[2] point out, the "main risk to securing is not line-tapping but eavesdropping at one or other end of the video-link." Precautions also include having a defined waiting area for family members as the child or parent takes turns talking with the care team. Confidentiality related to video transmission is addressed by using dedicated connections or by using video encryption.

3. Materials. Duplicate copies of materials (book, toys, etc.) for both sides of the consult may be necessary in order to create a "shared virtual physical context."[5] Faxes also help create this shared environment by exchanging handouts and child's drawings from the sessions.

4. Room layout. This includes basics such as the ability for both the parent and the child to be viewed from the video screen and for each to have a place to wait while the other talks with the therapist. Space is often at a premium in schools but is a prerequisite to successful telemental health services. The space needs to be large enough to accommodate family and school participants as well as to ensure confidential communications. Good lighting is important to insure that facial expressions can be seen in detail. It is also helpful to remove distractions from the room.

TABLE 1. CONSULTS BY GENDER AND RACE 09/2006 - 03/2007

Gender	%
Female	*40*
Male	*60*
Ethnicity	%
African American	*20*
Caucasian	*55*
Hispanic	*20*
Other Ethnicity	*5*

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New Advances

TeleKidcare clinics continue to evolve based on ongoing assessment of community and school needs. Two new TeleKidcare clinics began in 2006-2007, the ADHD telemedicine clinic and the TeleHelp Clinic, focused on depressive symptoms. The clinics focus on two of the most common presenting concerns in telemedicine and traditional behavioral health settings. The clinics are unique in offering team-based evaluation and treatment. The TeleHelp clinic provides a psychologist and a child psychiatrist and the ADHD telemedicine clinic provides a developmental pediatrician and psychologist. These interdisciplinary teams make joint medication and behavioral recommendations. Children who have been served to date reflect the complexities within underserved populations, with many psychosocial contributors and high comorbidity. The joint clinics have been overwhelmingly popular because the team approach has led to quicker improvement in both academic and home functioning.

School-based telemental health services have enormous potential to be a part of addressing the health care crisis and the burden of suffering. Advances in reimbursement, including Medicaid coverage in Kansas, have increased telemedicine's potential reach and sustainability. To date, TeleKidcare has focused on the elementary school population, but is beginning to expand to middle and high school as returning TeleKidcare students have themselves moved through the educational system. Two other telemental health programs, focusing on younger children, have been developed. They include telepsychiatry services to a large daycare program in Missouri and developmental disabilities services with preschoolers.

Faster and more accessible technologies may make TeleKidcare and similar programs feasible in every school. These programs must not only strive for better technologies, but also continue to build long-term relationships among medical providers, school personnel, families, funding agencies, and community members. Continued evaluation must also be included to quantify telemental health's impact on emotional, behavioral, and developmental concerns in the school setting.

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"This is My Home": A Culturally Competent Model Program for African-American Children in the Foster Care System

While I was a professor at the School of Social Work at the University of Maryland Baltimore, I provided clinical supervision at a transitional foster group home. During my time there, I also became involved in an evaluation of the home and decided that some major programmatic and philosophical changes were necessary if we were to enhance the growth and development of the children who resided in the facility from 60-90 days until a permanent placement was located. This is the story of that transformation.

Background

The residents were almost exclusively African American males ages 7-14 who were from economically and emotionally deprived inner-city environments. Most were removed from their homes of origin due to being deserted, abused and/or neglected. Their neighborhoods reflected racial inequality resulting in city service abandonment and high violence.[4] The environment from which they came usually consisted of derelict houses used for shooting galleries and young men gathering on street corners to sell their "products" to middle-class white consumers. Gangs flourished; but ironically, they acted as a means of protecting younger neighborhood children from sexual predators, exploitation and criminal initiation.[1] Most of the children had developmental problems that started early. Due to high exposure to violence many of the children exhibited symptoms of posttraumatic stress disorder (PTSD), harboring fear of being attacked and/or being abandoned or abused again. A large percentage of the children had a history of poor school attendance, poor academic performance, and in-school behavioral problems. Regardless of the situation, simply being removed from familiar surroundings is stressful, and can cause sleep disturbance, obsessive-compulsive adaptation, somatic complaints, and elimination disorders.

The basic philosophy of the shelter seemed to be one of warehousing the children until a permanent placement was located. Children attended the neighborhood school, and there were no programs in place to address the academic difficulties that most of the children were experiencing. Many of these difficulties were due to the children's irregular school attendance, which was often a problem prior to coming to the shelter and which was further exacerbated when they were removed from their homes of origin and placed in the care of the Department of Social Services (DPSS).

Staff were under-trained; for example, they could not differentiate between normal developmental behaviors and traumatic response behaviors. For the majority of staff this was a part time "gig" and their goal was to keep the children in line and get some rest, if possible, before going home or to their regular job. Due to the agency's failure to provide training to staff, staff used their "mother wit"—their experience of raising their own children—as the basis for working with these children. The general perception seemed to be that the children were bad and had done something wrong to be in this situation; thus, they required discipline, typically in the form of some sort of punishment. The sad fact is that the punishment paradigm is ineffective with this group of children, because their entire existence has been one based on some sort of punishment.

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Most have been in a life situation devoid of any consistent rewards and socially approved behavioral reinforcement. Punishment for these children only reinforced their negative world-view and increased their reactionary behavior.

The new director and I recognized that the children's short-term experience at the foster home provided an ideal opportunity for the shelter to address the biological, social, emotional, educational, and cultural needs of these African-American male children. We had the opportunity to turn a potentially devastating situation into a life success.

A New Approach

The central theme of an Africentric approach is the mutual responsibility that all human beings have to assist each other in developing and maximizing their raison d'etre—their essential being—through their Creator-given talents. The optimal environment for this to occur is in an extended family- and community-oriented atmosphere,[5] inclusive of rituals and ceremonies.[6] The adult's task is to build a strong bonded relationship,[2] something these children often lacked. Attachment was encouraged through a system of "good touch:" special handshakes and safely designed hugs. Thus, the adults formed a community of care and established a safe environment in which these children could express themselves and test out their potential talents.[3] An Africentric philosophy now drove the shelter's programs; no longer was the warehouse mentality the driving force behind the home. Instead, the focus was on preparing children for successful placement by addressing risk factors and stimulating the child's sense of personal empowerment. Personal empowerment resulted from the child's struggle to develop a new repertoire of appropriate behaviors and problem-solving skills.

The shelter's goals now were to foster the socialization and normal development of the children and provide them with the experience of living in a safe, family-like environment.[2] We wanted the children to be able to develop the ability to establish appropriate relationships, negotiate differences, advocate for themselves, and develop critical thinking skills and appropriate social skills. Additionally, the staff aimed to assist the children in cultivating patience, persistence, and the ability to be proactive rather than reactive; that is, to be capable, conscious and competent.

Staff were trained to encourage success by creating a nurturing yet accountable environment. Through the residential living environment and individual and group therapy, children began to formulate new thinking patterns and behaviors. Included in the therapy were visualization techniques and journaling. A reward system was put in place to reinforce successful behaviors. Children earned points for such activities as completing daily tasks, attending school with no negative reports, and completing homework. The more points earned the more money one received for allowance. Additionally, "Behavior Bucks" could be earned through behaviors that supported a child's personal goals and the positive atmosphere of the house. Bucks could be redeemed for toys, games, clothing, CDs, and special privileges available in the house store.

Family Connectedness

Family members were contacted and encouraged to become and/or remain part of the child's support system. Both the program and the program's philosophy were explained to the family, including the point system. The family was encouraged to call the director for updates on their child's progress. Family members were encouraged to participate in the shelter's family therapy program.

Academic Support

Shelter staff were now encouraged to be dedicated to coaching the children's development of successful school behaviors. Shelter policy required that each child be enrolled in the local public school within three days of placement, even if it meant assisting DPSS staff in gathering the child's records. When necessary, staff would ride the school bus with the child and/or sit in the classroom and cafeteria with the child. The director and case manger were trained as parent surrogates for foster children. The director, a tall, slim, blond, blue-eyed female, attended all PTA meetings, and parent teacher conferences/meetings on behalf of the children, which was a little bewildering to the other children in the class.

All children were required to attend a two-hour study session each weekday evening where volunteer tutors were provided to assist students. If a student were suspended from school then he would have all day in-shelter schooling.

Participation in school and after-school activities was encouraged; children participated in plays, recitals, and sports. Staff attended these activities as surrogate family members of the child. On the weekends staff were required to take the children to cultural activities such as museums, plays, concerts, zoos, and sporting activities, just as people do with their biological children.

Focus on Culture

Recognizing that knowledge of one's culture can contribute to a feeling of pride and to the development of self-esteem and a belief of "I can also," the shelter demonstrated a culturally stimulating environment. This was accomplished by hanging pictures of accomplished African-Americans on the walls, field trips to African-American museums and festivals, and having African-American magazines and books in the home.

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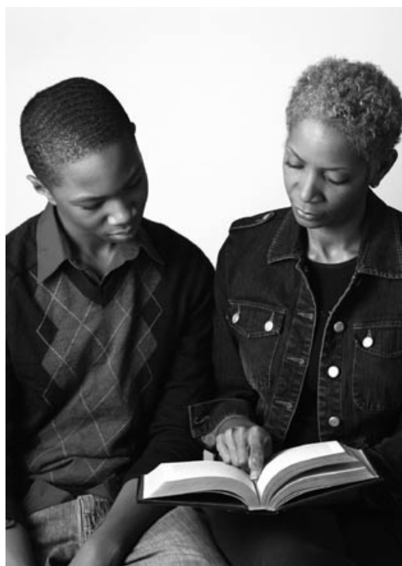
Many of the children did not have the benefit of positive role models who resembled themselves. To address this, African-American males, knowledgeable in child development and behavioral interventions, were hired. All staff were given time off and a pay bonus if they participated in trainings, workshops and/or educational courses that would strengthen their knowledge of positive youth development and/or the importance of cultural relevance. Children were exposed to African American role models during career night. Each Wednesday night a guest speaker was invited into the home. The children prepared the house for the event and one child was selected to introduce the guest. Refreshments were set out on a table, complete with tablecloth and flowers. The speaker shared his personal history and the specifics of his career including its perks and disadvantages. A question and answer period followed the presentation.

The central theme of an Africentric approach is the mutual responsibility that all human beings have to assist each other in developing and maximizing their raison d'etre—their essential being.

Rituals and Ceremonies

The value of ceremonies and celebrations, which were frequently absent from the children's lives, cannot be overemphasized. The shelter celebrated birthdays with special gifts and cakes. Successful efforts in school, sports and other endeavors were celebrated. All the "typical" holidays, along with Kwanzaa, an African-American holiday, were celebrated. Children who were unable to go home for Christmas and Thanksgiving were invited into the home of a staff member. Children who were able to go home were supplied with gifts for family members. Children had the opportunity to attend religious services; some children actually participated in the church choir. At discharge there was a ceremony, which included an exit interview, a departure gift, party, and a gift for the next placement. The exit interview included a review of the child's academic, emotional, and behavioral progress. Departing children were supplied with a luggage bag—not a garbage bag—to transport their belongings.



Results

At the time of program transformation, a quantitative evaluation had not been conducted but qualitative results indicate that at discharge most children demonstrated more positive behaviors: interacting appropriately with peers, staff and other authority figures. Most students became relatively successful students by attending school regularly, remaining in assigned classrooms, and attempting required work; it was not unusual for them to achieve A's and B's during their time at the program. Most children improved their ability to negotiate unstructured environments. There was a drastic decrease in the need for physical restraints, and an increase in social skills, problem solving ability, and critical thinking. In general the children were able to verbalize life-long goals, career choices and the steps necessary to achieve these.

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Notes

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Research and evaluation on programs for Asian American, Native Hawaiian, and other Pacific Islander Populations

The current mental health system has neglected to incorporate, respect, or understand the histories, traditions, beliefs, languages, and value systems of culturally diverse groups. Misunderstanding and misinterpreting behaviors have led to tragic consequences, including inappropriately placing individuals in the criminal and juvenile justice systems.[1]

There is a continuing lack of knowledge as to what constitutes culturally appropriate mental health services for underserved and difficult to access populations, including Asian American, Native Hawaiian and other Pacific Islander (AANHOPI) children, youth, and families. Part of the reason for this is the assumption that "one size fits all" when it comes to program development and implementation. Recently there has been increasing awareness of the need to create programs and interventions that are more culturally sensitive. However, the cultural sensitivity of the evaluation of these programs is often overlooked. Culture should be carefully considered when designing, implementing, and interpreting program evaluation materials. This article focuses on important ways that culture must be considered in the research and evaluation of mental health programs for AANHOPI children and families.

Defining "Asian American"

The growing requirement to implement primarily evidence-based practices (EBPs) in order to receive funding drives the need to delineate different Asian subgroups. It is perfectly reasonable to ask that only effective treatment or intervention strategies be used when offering mental health services to the community. The problem, however, in implementing evidence based practices is "Whose evidence is it anyway?" How do we know if a treatment works for a particular community?

AANHOPI children are frequently missing from mental health program evaluations. When included, their demographic information is often over-generalized. Rarely are ethnicity or generational status considered, and children are merely identified as "Asian American," or in many cases simply "other." Only recently has the "Native Hawaiian or Pacific Islander" designation been included as a category for identification, but usually it continues to be missing altogether.

Research on "Asian Americans or Pacific Islanders" provides only minimal information about the target population, since there really is no such entity as an Asian American or Pacific Islander. There are Chinese, Korean, Vietnamese, Hmong, Filipino, Samoan, Guamanian, and bi- and multi-racial children. There are children who are foreign born, American born to foreign born parents, or who are from families who have lived here for several generations. There are vast cultural differences among these different ethnic groups; a program or intervention strategy that might work for first-generation Americans from Cambodia may have little impact on highly acculturated Filipinos. Research has shown that different men-

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tal health patterns exist among Asian-American subgroups and that several factors, including refugee status, account for these differences.[2]

It would be optimal to evaluate a mental health program or intervention based on its effectiveness among various subpopulations of AANHOPIs; however, this approach can be problematic. A common difficulty is the small number of available subjects within each subgroup—if so few individuals identify with a particular subgroup, researchers cannot generalize to a larger population. This is why researchers oftentimes identify subjects simply as "Asian American" or "Pacific Islander"—they need larger numbers of subjects in order to mathematically measure the effectiveness of a program, and combining the data into larger groups provides a sufficient number of subjects. However, lumping everyone together can limit the usefulness of findings. For example, when investigating the impact of a program designed to decrease the incidence of conduct disorder among Asian-American boys, a Korean whose parents immigrated to Houston five years ago, a youth who was born in Long Beach to parents who were Cambodian refugees, and the son of a bi-racial youth whose father is a third generation Japanese American living in Denver may all be labeled "Asian American male," yet their experiences with the program will be radically different from each other based on their cultural and ethnic backgrounds. Any generalizations made from the results of this evaluation could potentially undermine the effectiveness of the program for a particular population subgroup.

Instruments and questionnaires developed for a more Western-oriented population often include questions about behaviors that are linked to psychological factors that have a completely different manifestation in other cultures.

The "Asian American Experience"

Ideally, when assessing the impact of a mental health program on a particular population, factors such as age, gender, the child's place of birth, parent's place of birth, birth order of child, and primary language spoken (both child and parents), should be considered. However, also important to consider are immigrant or refugee status, and losses due to war or other traumatic events. When assessing for mental health problems in children, it also is important to assess the parents' understanding of mental health and their beliefs regarding the potential causes of the problem. These issues will help shape appropriate intervention strategies. In many instances these factors are at least as important as the specific ethnic group with which the individual identifies.

Likewise, one cannot conduct good research or program evaluation related to AANHOPI children without an accurate picture of the world surrounding the child. This includes a thorough understanding of the parents' current situation and his/her history. The majority (88%) of Asian Americans are either foreign born or have at least one foreign born parent. This alone has tremendous implications for the development, implementation and evaluation of mental health intervention strategies and programs. For example the torture experienced by some Cambodian parents cannot be ignored, nor the traumatic experiences of the Vietnamese, Laotian and Hmong who spent years in refugee camps as they fled the war in Southeast Asia. All is not paradise for Native Hawaiians who continue to face the consequences of the colonization of their land by the United States. Parents' experiences have a profound impact on their children.

Culturally Appropriate Interventions

Assessing the cultural and linguistic appropriateness of mental health services is essential for research and evaluation. This is not an easy task but not an impossible one either. Using key informants, obtaining consultation, working with those who are familiar with the community, and utilizing individuals with the language skills to communicate effectively are all strategies to help assess the cultural appropriateness of a service. In the absence of such effort, what appears as a parent's unwillingness to "comply" with treatment may actually be their reluctance to follow up with culturally and linguistically inappropriate services.

When designing a culturally appropriate intervention, researchers need to consider whether the behaviors observed in somebody from one culture have the same psychological implications as those from a different cultural group. Since the success of a program is often based on evidence of behavior change in a desired direction, it is important to determine whether a particular behavior is linked to particular psychological factors across all cultural groups. For example, the emphasis on collectivism in some Asian cultures may mean that efforts to encourage independence

are not perceived as positively as they are in Western cultures. Similarly, shame, often an accepted emotional response in many Asian cultures, is not as normative in Western cultures and can be perceived as a problematic emotional state. If behavior patterns and symptoms for a particular mental health condition differ across cultural groups, then findings from research that target those behaviors or symptoms will be difficult to interpret.

Cultural Attributions

In many instances, the mental health and the behavior patterns associated with a particular diagnosis are primarily based on Western cultural norms. Unfortunately, unless the relationships between mental health and particular behavior patterns are understood for different cultural groups, psychological diagnoses may result from misleading and erroneous assumptions. Many psychological concepts are universal in human behavior, but how these are manifested behaviorally may be significantly different. For example, Thai children express distress through internalizing problems more than their Western counterparts, leading some researchers to conclude that Thai children, influenced by Buddhist religious ideology, are more likely to exhibit signs of distress in ways that do not disrupt their cultural norms.[3]

Often, assessment and measurement tools are based on specific Western concepts that have few or no parallels with some Asian cultures. Instruments and questionnaires developed for a more Western-oriented population often include questions about behaviors that are linked to psychological factors that have a completely different manifestation in other cultures. The result is that it is not clear whether the standard instruments used to evaluate healthy behavior actually measure similar constructs across cultures. The notion of a culture-free measure is simply an overly broad characterization of human behavior. Since different cultures may have different behavioral manifestations of similar psychological constructs, appropriate measures need to be developed based on each culture.

Culturally Appropriate Evaluations

Analyzing data is important but researchers and evaluators must not lose sight of the fact that the process of data collecting and the content of the questions are equally critical. The use of trained interpreters and translators is one way to address potential language barriers. A standard practice for translating information is to do a forward and backward translation: First, the original question is translated from English into the second language. Then to assess whether the translation still holds the same meaning as the original, a different person must then translate the question back into English. Comparing the newly translated version with the original will help determine if the intent of the question has remained in tact. This takes extra time and resources but is critical to obtaining accurate information.

The next step is to validate the questions with the use of a focus group to assess whether the question is being perceived as intended and is eliciting appropriate information. Translating or interpreting information that does not accurately address

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the concept one wishes to evaluate will only result in inaccuracy in two languages. Another important issue to consider is that the content of the question may not even exist in any language form for some cultures. For example, several Asian cultures have no language equivalents for HIV/AIDS or for many of the high risk sexual behaviors that are associated with its transmission. "Untranslatable" concepts such as these will require a more descriptive definition in order to clarify the construct.

In addition, response options that are frequently encountered in Western cultures may not be comprehensible to members of some Asian immigrant cultures. Likert scales, which typically ask participants to specify their level of agreement with an item, have little meaning with some Asian cultures. For example, the differences between "Never," "Almost never," "Sometimes," "Almost always," and "Always" have few or no language equivalents within most Asian cultures.

Interpretation and Dissemination

Interpreting findings from research and evaluation on mental health programs for different AANHOPI cultures must also be undertaken with caution. Unless a researcher or evaluator is indigenous or well versed in the cultural makeup of a specific Asian ethnic group, findings may prove puzzling and/or the interpretation may be biased by the researcher's perspective. The risk of misinterpretation can be lessened when the research or evaluation process includes consultation with an advisory body consisting of both professionals and lay individuals from the same culture as the research participants. The advisory body serves as a forum for discussion and interpretation of findings, and for deciding which findings should be disseminated and how.

A final question that a researcher or evaluator must ask is an ethical one: Why is the data being collected in the first place? The best interest of the community must be at the core of why the research/evaluation is being conducted. Too often, a community is asked to invest time participating in research, and yet never hears the results of their efforts, and never benefits from the information gathered. Researchers and evaluators must be willing to provide feedback to the community, using their results in ways that promote positive change. Presentations of findings should directly involve parents, youth and other key stakeholders. Failure to respect the community may jeopardize future research efforts.

There is no question that evaluation and research with Asian American, Native Hawaiian and other Pacific Islander populations is a complex process with a unique set of challenges. There are no easy answers, but respecting and understanding the culture and language of the specific population can yield critical information in the quest to improve services for children, youth and families. Failure to identify appropriate questions, use culturally sensitive measurement tools, disaggregate data, or to use proper data collection methods threatens the relevance of study outcomes or findings. This in turn has repercussions for the AANHOPI communities. Funding for community-based organizations may depend on whether or not they can supply evidence of the effectiveness of the programs they implement. Even more importantly, failure to accurately identify what is effective deprives AANHOPI children, youth, and families of opportunities for mental health and thriving.

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