PROCEEDINGS

Culturally Informed Evidence Based Practices: Translating Research and Policy for the Real World
PROCEEDINGS

Culturally Informed Evidence Based Practices:

Translating Research and Policy for the Real World

National Conference

March 13 and 14, 2008
Bethesda, Maryland
# Table of Contents

Foreword ................................................................................................................................................... iv

Funding Agencies and Sponsors .................................................................................................................... vi

Opening Remarks, Eduardo Morales and Nolan Zane ................................................................. 1

Evidence-Based Practice in Psychology, Ronald Levant ......................................................... 2

The Cultural Context of Methods, Practices, and Policy, Luis Vargas......................... 3

“Who Sees Me?” Adapting Psychological Services to the Ethnocultural Needs of Consumers and Families, Nancy Carter ................................. 4

Culturally Informed Evidence-Based Practices: Translating Research into Culturally Informed Prevention Interventions, Felipe Gonzalez Castro .......................... 5

Culturally Informed Treatment: Desperately Needed Research Directions to Optimize Impact, Alan Kazdin ......................................................... 7

Cultural Competence Issues and Evidence-Based Psychological Practices, Nolan Zane ........................................................................................................ 8

Bringing Interventions from the Community to the Clinics: The Case of RQP, Margarita Alegria ........................................................................................................ 9

Treatment Effects for Ethnic Minority Populations: Meta-Analytic Findings, Antonio Polo and Stanley Huey ......................................................... 11

Considering Organizational and Community Contexts: Implications for Studying and Implementing Evidence-Based Practices, Mario Hernandez .......................... 13

Keynote Address, Moving Evidence-Based Interventions to Practice: The Blending Initiative, H. Westley Clark ................................................................................ 14

Conceptual and Measurement Issues in Evidence-Based Clinical Research: The Case of Racial Identity, Mia Smith Bynum ........................................ 16

Indigenous Evidence-Based Effective Practice Model, Valerie Naquin and Shannon Sommer .................................................................................................................... 17

Cultural Differences in Diagnosis and Treatment, Donna Holland Barnes .................. 18
Depression Prevention and Treatment Interventions in Spanish and English, Ricardo F. Munoz ................................................................. … 20

Returning to the Family: Progress in the Treatment of Depression in Latino Adolescents, Guillermo Bernal................................................................. … 22

Engaging African American Children and Their Families, Norweeta Milburn ................................................................................................. … 23

Families Matter, Trina W. Osher................................................................................................................................. … 24

An Overview of the Multicultural Assessment Intervention Process (MAIP) Model, Glenn Gamst ................................................................................................. … 26

Culturally Informed Evidence-Based Practices: “Tell Me a Story” Assessment of Multicultural Children, Giuseppe Costantino................................. … 27

The Process of Culturally Adapting Evidence-Based Treatments for American Indian and Alaska Native Children-Lessons Learned, Dolores Subia Bigfoot................................................................................................................................. … 29

Evidence-Based Treatment for Trauma-Exposed Latino Youth: A Tailored Approach, Michael A. Ramirez de Arellano ................................................................. … 31

Adapting and Integrating Interventions for Tailored Treatment Interventions with Multi-Problem Clients in Community Setting, Barbara C. Wallace ................................................................................................................................. … 32

Neuropsychological Assessment of Minority Substance Abusers, Arthur MacNeill Horton, Jr................................................................................................. … 33

Ethical and Culturally Congruent Research and Interventions in Community Settings, Joseph Trimble................................................................................................. … 34

Successful Collaboration Across the Traditional Divide: Key Considerations When Conducting Intervention Research in Culturally Diverse Communities, Terry S. Gock ................................................................................................................................. … 36

Mixed Methods Research: What is it and How Can We Achieve its Potential? Peter J. Guarnaccia ................................................................................................. … 38

The AAKOMA Project: Utilizing Qualitative and Community Based Participatory Research in a Clinical Trial, Alfiée Breland-Noble........... … 40

Adopting Evidence-Based Treatments for Immigrant Minority Families: Proposed Strategies and Key Questions, Anna Lau................................. … 41
Evidence-Based Treatments for Depression in the Primary Care Sector,
Charlotte Brown............................................................................................... … 43

Linking American Indian Resilience with Suicide Prevention: Lessons
Learned, Teresa LaFromboise ........................................................................ … 45

Understanding within Session Psychotherapy Processes for Culturally
Relevant Family Based Interventions for Violence and Substance Abuse,
Philippe Cunningham....................................................................................... … 46

Foundation as Player in Developing Evidence-Based HIV Community
Programs, Bart Aoki....................................................................................... … 48

Collaborative Community Based Research with California Prevention and
Education Project (CAL-PEP): When and Where We Enter- Sixteen Years
of Participation in Community Based Research, Carla Dillard-Smith ....... … 50

Town Hall Session, Eduardo Morales and Sharon R. Jenkins......................... … 52

Conference Program........................................................................................… 55

Speaker Profiles ..............................................................................................… 83

List of Presenters............................................................................................… 91

Participant Contact List....................................................................................… 95
Foreword

Recently, the American Psychological Association adopted a policy that (a) defined evidence-based practice in psychology (EBPP), (b) affirmed the importance and utility of using EBPs to enhance health, and (c) delineated the various principles that guide EBPP (APA Presidential Task Force on Evidence-Based Practice, 2006). The evidence-based practice movement appears to provide some impetus to reduce ethnic and racial disparities in mental health. First, EBPP involves using those treatments that are effective according to controlled research studies in which the issue of generalizability must be considered. Second, a major competency associated with clinical expertise involves cultural competence, namely, the ability of the clinician to work with a client and provide treatment in a manner that is culturally meaningful and ecologically valid. Finally, EBPP uses the best available evidence on patient characteristics, culture, and personal preferences to adapt the treatment to best serve a particular client. Nevertheless, the substantial promise of EBPP for addressing cultural diversity issues should be tempered by the fact that there is little of this “best available evidence” with respect to ethnic minority populations.

The national conference on “Culturally Informed Evidence Based Practices: Translating Research and Policy for the Real World” took place on March 13-14, 2008 in Bethesda, Maryland. The purpose of the conference was to inform and stimulate interest and activity in generating research and evaluation efforts in the development of evidence-based practices for ethnic minority populations.

This conference was initiated and led by the Society for the Psychological Study of Ethnic Minority Issues, Division 45 of the American Psychological Association. Four other APA Divisions were major collaborators in this effort; they included Division 12 – Society of Clinical Psychology, Division 17 – Society of Counseling Psychology, Division 37 – Society for Child and Family Policy and Practice, and Division 42 – Psychologists in Independent Practice. The Conference Task Force consisted of representatives of these organizations as well as those from federal funders, the Substance Abuse Mental Health Services Administration (SAMHSA) and the National Institute of Mental Health (NIMH). We are very grateful to SAMHSA and NIMH as well as to our other major funders, Alliant University and the Asian American Center on Disparities Research at the University of California, Davis. With 25 APA Divisions and two ethnic minority psychological associations co-sponsoring this conference, this was the largest sponsored national conference in the history of APA aside from the annual APA Convention.

Five themes were highlighted: (1) Are we asking the right questions? (2) Do adaptations work and how are we limited by them? (3) What are proper assessments and how do we match treatment with diagnosis? (4) How do we best capture and investigate interventions that were created from the ground up? (5) Is policy jumping the gun? What are the consequences of establishing policy without evidence of effectiveness with ethnic minority populations? This conference served as a venue to explore these questions, reconsider the current strategies of generating evidence, and present new research and treatment models.
About 200 participants attended the conference including researchers, care providers, federal funders, policy makers, and consumers. As such, the conference brought together perspectives from a diverse array of stakeholders to present and examine specific culturally informed strategies that can enhance the effectiveness of evidence-based psychological practices. Presenters were experts who shared innovations in generating data and evidence for psychological practice with communities of color in the United States.

Research clearly is needed to generate a larger body of evidence that is inclusive of ethnic minority populations but also explanatory in nature regarding the effects of cultural variables. There are many challenges to meeting these objectives, and this conference provided the initial catalyst for addressing these critical issues.

Culturally Informed Evidence Based Practices Conference Task Force
Major Funders
Substance Abuse and Mental Health Services Administration (SAMHSA)
National Institute of Mental Health (NIMH)
Asian American Center on Disparities Research (AACDR), University of California, Davis
Alliant International University

Co-Chairs
Eduardo Morales, Ph.D., Alliant International University
Nolan Zane, Ph.D., University of California, Davis

Planning Committee
Guillermo Bernal, Ph.D., University of Puerto Rico
Cheryl Boyce, Ph.D., NIMH
Alfiee M. Breland-Noble, Ph.D., Duke University Medical Center
Carol Falender, Ph.D., University of California, Los Angeles
Felipe González Castro, M.S.W., Ph.D., Arizona State University
Larke Huang, Ph.D., SAMHSA
Sharon Jenkins, Ph.D., University of North Texas
Fred Leong, Ph.D., University of Tennessee
Ken Martinez, Psy.D., Technical Assistance Partnership, Washington, D.C.
Natalie Porter, Ph.D., CSPP-SF, Alliant International University
Elizabeth Vera, Ph.D., Loyola University

Coordinating/Lead Division
Society for the Psychological Study of Ethnic Minority Issues – Division 45 of the American Psychological Association (APA)

Lead Sponsors
APA Division 12 - Society of Clinical Psychology
APA Division 17 - Society of Counseling Psychology
APA Division 37 - Society for Child and Family Policy and Practice
APA Division 42 - Psychologists in Independent Practice

Supporting Organizations
APA Division 12, Sec 6 - Clinical Psychology of Ethnic Minorities
APA Division 13 - The Society of Consulting Psychology
APA Division 15 - Educational Psychology
APA Division 18 - Psychologists in Public Service
APA Division 20 - Adult Development and Aging
APA Division 22 - Rehabilitation Psychology
APA Division 27 - Society for Community Research and Action
APA Division 28 - Psychopharmacology and Substance Abuse
APA Division 29 - Independent Practice
APA Division 35 - Society for the Psychology of Women
APA Division 38 - Health Psychology
APA Division 39 - Psychoanalysis
APA Division 40 - Clinical Neuropsychology
APA Division 43 – Family Psychology
APA Division 44 - Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues
APA Division 48 - Society for the Study of Peace, Conflict and Violence
APA Division 50 - Addictions
APA Division 51 - The Society for the Psychological Study of Men and Masculinity
APA Division 53 - Society for Clinical Child and Adolescent Psychology
APA Division 54 - Society of Pediatric Psychology
APA Division 56 - Trauma Psychology
American Psychological Association
Asian American Psychological Association
National Latino Psychological Association
This conference is dedicated to Dr. A. Toy Caldwell, in memory of her contribution and dedication to advocating for ethnic minority issues and social justice. The purpose of this conference is to inform and stimulate interest and activity in generating research and evaluation efforts in the development of evidence-based practices for ethnic minority populations. Five themes are highlighted: (1) Are we asking the right questions? (2) Do adaptations work and how are we limited by them? (3) What are proper assessments and how do we match treatment with diagnosis? (4) How do we best capture and investigate interventions that were created from the ground up? (5) Is policy jumping the gun? What are the consequences of establishing policy without evidence of effectiveness with ethnic minority populations? This conference serves as a venue to explore these questions, reconsider the current strategies of generating evidence, and present new research and treatment models. The first day consists of discussing research methodologies, measurement strategies, and ethical issues. The second day is dedicated to generating new models for intervention and program evaluation. A town hall meeting is included at the end of the conference so that participants have an opportunity to voice their recommendations for evidence based practices (EBPs) and their reflections of the conference.

* The slides for this presentation are available on the Presentations document.
Evidence-Based Practice in Psychology

Ronald Levant, Ed.D., ABPP
The University of Akron

As reflected in the scientist-practitioner model, psychologists have been grounded in empirical research to improve patient care. The “three legs” of evidence-based practice in psychology (EBPP) are defined as (a) best available research, (b) clinical expertise, and (c) contextual consideration (e.g., client characteristics, culture, values, and preferences). The “best available research” consists of multiple sources of research evidence, including various practices, approaches and strategies, examination of different clinical problems, client populations, and cultural contexts, and laboratory as well as field settings. Clinical expertise refers to a number of competencies. These competencies include diagnostic judgment, systematic case formulation and treatment planning, clinical decision making, treatment implementation, and monitoring of progress, interpersonal expertise, continual self-reflection and incorporation of new knowledge and skills, and finally, an understanding of the influence of individual and cultural differences on treatment. In terms of the contextual aspect, it is important to consider variations in presenting problems or disorders, etiology, concurrent symptoms/syndromes, and behavior. Other factors such as age, developmental status and history, and life stage also need to be considered. Patient values and sociocultural factors are very important variables to consider as they also may influence treatment. EBPPs are different from ESTs (empirically supported treatments, also known as empirically validated treatments (EVTs). EBPP integrates the best available research with clinical expertise in the context of patient characteristics (e.g. culture, values, beliefs, worldviews, goals, and preferences) in order to produce the best outcomes; EST or EVT consists of a specific treatment for a specific problem under specific circumstances. While ESTs/EVTs are valuable and informative, their approaches can be overly focused and specific. Alternatively, EBPP allows clinicians to appreciate the value of multiple sources of scientific evidence and clinical expertise in assessment, diagnosis, and treatment planning. It also permits clinicians to search for common factors and its applicability in working with diverse groups of people. Hence, the emphasis of EBPP is to attend to the individual. Research indicates that some patient-related variables, such as functional status, readiness to change, and level of social support, influence outcomes. Therefore, these variables are important to consider. The benefits of EBPPs are that they promote effective psychological practice, improve patient outcomes, and enhance public health. They apply empirically supported principles of psychological assessment, case formulation, the therapeutic relationship, and intervention. Clinical decisions should be made in collaboration with the client, and ongoing monitoring of client progress and adjustments are made by trained individuals familiar with the specifics of the case. Some future directions for research include examining patient characteristics as moderators of treatment in naturalistic settings, attending to patients’ cross-diagnostic characteristics in studies, examining the nature of implicit stereotypes and successful interventions for minimizing their activation or impact, and finding ways to make information about culture and psychotherapy more accessible to practitioners.

* The slides for this presentation are available on the Presentations document.
The Cultural Context of Methods, Practices, and Policy

Luis Vargas, Ph.D.
University of New Mexico

“Generic” EBTs for ethnic minorities are not adequate treatments. There is a dilemma of adapting generic EBTs to a specific population. On one hand, differences between ethnic groups may be due to many other variables with which ethnicity has been confounded, and generic EBT has been shown to be superior over “usual care” with minority youths. On the other hand, cultural competency can be hindered by an emphasis on EBTs, which often neglect three essential elements of therapy – the therapist, the therapeutic relationship, and the patient’s non-diagnostic characteristics.

Culturally Adapted Treatments

Currently in the field, “adaptation of treatments” is not clearly defined. This area needs to include better measures and multiple measures of culture (as opposed to simply addressing ethnicity/race group differences), guidelines for what cultural adaptation means in research, and treatments that address within-group variations. The concern with making adaptations is that the treatment changes and compromises the fidelity of an EBT. Despite the field’s current limitations, a meta-analysis of 76 studies on the benefits of culturally adapted interventions demonstrated that those interventions targeted to a specific cultural group were four times more effective than interventions that were applied commonly to various groups.

Efficacy

Currently, randomized clinical trials (RCT) are the “gold standard” of establishing efficacy in EBTs. However, this method has various shortcomings (e.g., omitting crucial elements of what is done in the field, de-emphasizing many aspects of the therapeutic process, decontextualizing cases, and representing an intervention and outcome within one setting at one time with one population). Two alternative and promising approaches include: (1) increasing specificity and improving effectiveness for a smaller segment of population, but decreasing its generalizability; (2) propensity score matching in observation studies to include patients that are more representative of the “real world” than those who are recruited into an RCT. It is questionable whether empiricism and a strong emphasis on operational definitions are the only methods to evaluate efficacy and effectiveness of treatments.

* The slides for this presentation are available on the Presentations document.
“Who Sees Me?” Adapting Psychological Services to the Ethnocultural Needs of Consumers and Families

Nancy Carter
NAMI Urban Los Angeles

Personal Experience

My point of view is that of a consumer, a mother with a mentally ill son, and an advocate. After my son was diagnosed with bipolar disorder, I became involved with NAMI in Los Angeles. Having struggled with similar symptoms for most of my life, I was later diagnosed with bipolar disorder as well. When I joined NAMI, I found a place where people have “been there, done that” and were willing to listen to my story. In the process of advocating for my son, I witnessed how mental health professionals didn’t actually “see” or “hear” my son. Instead, they judged him based on certain racist misconceptions of a mentally ill African American young man (e.g., he’s violent, has a drug problem). This is only one example of the many challenges I and other relatives faced in advocating for our loved ones in the mental health system.

Culturally Sensitive EBTs

Researchers and clinicians must not apply a “one-size-fits-all” approach to evidence-based treatments. Instead, EBTs need to be reframed within a new paradigm when working with communities of color, and people from the community should help inform the development of these EBTs. Moreover, instead of asking direct questions, researchers and clinicians will receive more information by simply listening to the stories of consumers and relatives.

* The slides for this presentation are not available.
Are researchers asking the right questions, such as, “What are the deeper issues related to evidence-based interventions?” There is a gap between the efficacious interventions developed from RCTs and its application in the community. There is also a conflict between implementing the protocol with fidelity to attain validated outcomes and making these adaptations in the field to accommodate the real and unique needs and realities of the local communities. In many scenarios, haphazard adaptations (i.e., mis-adaptations) are being made, which in effect decrease an intervention’s effectiveness. Therefore, questions must be asked in terms of how to make adaptations to enhance a treatment’s effectiveness.

Resource Deficits and Their Challenges

Three obstacles in transferring research to practice are (a) scientist-practitioner communication gaps, (b) conflicting assumptions, imperatives, or approaches between scientists and providers, and (c) social policies that impose unfunded mandates that have not been well conceived. In principle, the foundation of evidence-based interventions should be empirical evidence that points to what works based on established psychological theories and empirical testing. Unfortunately, most psychological theories and models neglect to consider certain sociocultural factors in their theoretical constructs, thus, excluding people of color in their conceptualization. As a result, many of these interventions were designed for conventional mainstream American populations and excluded crucial cultural variables. While some treatments are validated, they may not be relevant to certain groups of people.

Combining Relevance with Effectiveness and Community Implementation

The next step to bridge this efficacy-effectiveness gap with special populations is to combine relevance with effectiveness by paying attention to: (1) efficacy (under optimal conditions), (2) effectiveness (in real world conditions), (3) sustainability with support from political and training structures, and (4) operating broadly in the community and within institutions.

Improving Interventions

While these are ideals to strive for, providers and administrators often have conflicting agendas that prevent them from achieving these basic goals. There is significant pressure to implement manualized interventions “that work” to improve the quality of care and its efficacy. But complaints have been voiced that this level of specificity coupled with mandates and the demand for delivery with fidelity to the “optimized” protocol unfairly constrains clinicians from taking actions in their client’s best interest. Therefore, establishing common ground and partnerships between providers and researchers is the next critical step. Key stakeholders such as clinicians, scientists, consumers, and others should pay attention to the common interest of maximizing
therapeutic gains (both efficacy and effectiveness) of evidence-based interventions while at the same time maximizing the cultural sensitivity and practical feasibility of such standardized interventions. To accomplish this, clinicians and researchers need to: (1) incorporate cultural sensitivity into interventions, (2) develop cultural competence among the intervention delivery staff, (3) create logic models that include sociocultural variables as part of their total intervention approach, and (4) develop theories and models that explicitly include sociocultural variables as an integral part of their frameworks. There should be continuous collaboration between researchers, lay health workers, and community members to ensure successful contact, communication, and motivation. A three-stage approach to building a new generation of prevention interventions includes: Stage 1 -- Assessment and evaluation of unique needs of a specific population; Stage 2 -- Development of culturally-relevant adaptations to a previously tested effective program to add relevant content; and Stage 3 -- Implementation of the culturally-adapted intervention with high fidelity in the community to test whether it is as effective or more so in comparison to the original model. Therefore, the critical question is not, “Should we implement evidence-based interventions?” Rather, the critical question is, “How can we establish partnerships to design evidence-based interventions that are culturally relevant and have maximum effectiveness for those they intend to help?”

* The slides for this presentation are available on the Presentations document.
Culturally Informed Treatment: Desperately Needed Research Directions to Optimize Impact

Alan Kazdin, Ph.D., ABPP
Yale University

According to the current models, mental health needs are not being met, and the field demands new models on rethinking these disparities. Over half of the people requiring mental health services do not receive it, and among the people who do obtain services, half end up dropping out of treatment. In consideration of contextual issues, there is an absence of services for people of color, individuals without English language skills, and people who live in rural areas.

Innovative Methods

Novel approaches to combat these health disparities include the use of technology (e.g., online self-help manuals, online parent-management training, and use of cell phones to monitor stress levels or food intake) and brief treatment models including single session interventions. In accordance with the current models, we use culturally insensitive interventions to work with people of color when a culturally sensitive treatment for a specific group is not yet available.

Considering the Bigger Picture

In 2000, over 500 psychological techniques were developed in English. In consideration of the hundreds of psychiatric disorders and ethnicities and cultures worldwide, it would not be feasible to conduct research and adapt these treatments for each individual group. Instead, the field has to expand its agenda, look at the bigger picture, and consider a worldwide impact. We should identify superordinate principles (such as neuroscience or brain processes) and broader issues that apply widely to different groups of people and ensure that our work is relevant to all cultures.

* The slides for this presentation are not available.
EBPs do appear to provide some impetus to reduce disparities for ethnic minority mental health care. But there is a need for research. A recent study reviewed 379 NIMH funded clinical trials and found that less than half of the studies provided information on the ethnic composition of samples. Among the ethnic composition that was indicated, Whites continued to be, by far, the largest ethnic group in these samples.

Cultural Competence

Some culturally sensitive elements and dimensions of treatment for clinical research interventions with Hispanics include language, persons, metaphors, content, concepts, goals, methods, and context (Bernal, Bonilla, & Bellido, 1995). The specific factors approach to cultural competence proposes that culture maps onto specific social psychological factors that influence treatment. Certain factors are related to the cultural experiences of ethnic minority clients and affect specific aspects of treatment (e.g., credibility, self-disclosure). Applying and accounting for such factors adds to our clinical conceptual tools, enhances cultural competence, and “individualizes” treatment. It also tends to minimize stereotyping based on group characteristics.

Cultural Values in Treatment

In the examination of cultural influences in mental health service and treatment, certain aspects of culture, like value orientation, must be taken into consideration. It also is necessary to examine the domain of functioning relevant to psychotherapy, such as client-therapist relations. For example, using this framework with Asian American clients, it may be important to consider face concerns and self-disclosure as salient cultural values in treatment. Research shows that face loss has its greatest effect on the self-disclosure of intimate relations, and this suggests that face issues may mitigate the communication of valuable information from client to therapist. Other research has found important cultural variations in emotion regulation and expression. Contrary to Western cultures, emotional suppression in Asian cultures is related to adaptive functioning. Cultural variations in emotion regulation may be a critical domain in view of the fact that much of psychotherapy involves learning or relearning ways of regulating one’s emotions. The specific factors approach allows for a more empirically informed system of examining the influence of culture variables on treatment process and outcomes.

* The slides for this presentation are available on the Presentations document.
Bringing Interventions from the Community to the Clinics: The Case of RQP

Margarita Alegria, Ph.D.
Harvard Medical School

Minority populations are growing exponentially. Some of the major challenges in treating people from diverse cultures include language barriers, the therapeutic alliance, nonverbal communication, and clinician assumptions (e.g., clients not coming to therapy being not interested). A recommended article of the cultural factors that impact the patient-provider interaction is a paper published in 2006 by Suurmond and Seeleman. In terms of the Sociocultural Framework for mental health service disparities, it is important to understand where people come from. Data taken from the National Latino and Asian American Study (NLAAS) indicated that Asians and Hispanics were more likely to feel like they weren’t understood by their provider (compared to Whites).

Right Question Project

*How it works and what it accomplishes?* The Right Question Project (RQP) is a different approach to patient activation: If patients take an active role in their treatment, they will feel better. RQP-MH is not to supply clients with solutions, but to provide them with democratic experiences to develop their own solutions by formulating questions and focusing on key decisions. Patients learn how to formulate questions about their health care (e.g., how will this medication work for me?). Patients learn how to focus on key decisions that are made during the course of treatment (e.g., what will happen if I decide not to continue with medication?) Patients learn to formulate a disease management plan *in conjunction with* their provider (e.g., what treatment options will best work for me given my life circumstances?). The logical flow of RQP is that asking questions leads to increased empowerment and activation, which then leads to increased decision making and participation in care and treatment, which subsequently leads to increased engagement in care. The ultimate endpoint is increased retention in care.

*Training patients and outcomes.* The focus of RQP-MH trainings is that patients are trained to use both closed and open-ended questions. At the end of the training, patients generated 1-2 target questions, focusing on their role in decision of care. They were given homework assignments and role-play and rehearsal techniques. The RQP objective was to test if the trainings were effective. Measures included changes in patient activation, changes in patient empowerment, and engagement and retention in treatment. Results indicated that intervention patients were over three times more likely to be retained in treatment than comparison groups, four times more likely to be engaged in care than comparison patients, and more activated in care. There was no significant effect of the intervention on patient empowerment. Results from qualitative data indicated that respondents described a shift in their level of activation, which included making more and different types of questions, increased decision-making, increased dialogue and interaction with the provider, and increased confidence in their ability to ask questions. Findings illustrate the potential of the RQP-MH intervention for increasing patient activation, and attendance and retention in mental health care for minorities. The assumption that most providers would welcome patient activation and empowerment did not prove entirely true.
Some providers found patients increased questioning challenging, since they did not always have the answers. These findings necessitate adding a provider component to the intervention to facilitate receptivity of patient activation and empowerment.

* The slides for this presentation are available on the Presentations document.
Given the demographic changes in the United States, and the disparities that exist in mental health care, it is necessary to focus on treatment research for ethnic minorities. What are the reasons for this concern? In a study by Telles et al. (1995) looking at behavioral family management with low-income Spanish speaking Latinos, high acculturated Latinos received no benefit from treatment; low acculturation led to exacerbation of risk. In another study looking at trajectories of depressed youth at community based mental health centers, ethnic minority youth had worse outcomes, dropped out of therapy sooner, and did not benefit as much from therapy (Weersing & Weisz, 2002). We need to monitor the literature to see what works for culturally different populations. As for ethnic differences in depression symptoms, in a study of children screened for depression, relative to Whites, African Americans and Latinos had higher symptomatology.

Need for Including Ethnicity

In a study on randomized clinical trials examining anxiety treatment for children (Weisz, Jensen, & Hawley, 2005), 60% of the studies did not report on ethnicity of the clients. A study on ADHD indicated that 75% did report on ethnicity. Many efficacy studies do not document ethnicity. The good news is that studies are getting better at documentation (15% vs. 34%). Miranda et al. (2005) summarized research studies focusing on the treatment and prevention of mental health problems across both adult and youth populations (naturalistic and randomized). Results from that study indicated that although large gaps exist, there is growing evidence suggesting that ethnic minorities (particularly African American and Latinos) benefit in these trials.

Treatment Efficacy for Ethnic Minority Youth

In a study examining treatment effects for ethnic minority youth (in clinical trials), researchers adapted existing guidelines for classification of EBTs and identified and reviewed literature on ethnic minority youth. A search was conducted on PsycInfo for years ranging from 1960 through 2006. As previously noted, the EBT criteria for treatments are that treatments are well established, probably efficacious, or possibly efficacious. A review of the literature indicated that no treatments were classified as well-established for ethnic minority youth. Thirteen studies were probably efficacious, and seventeen studies were possibly efficacious. Ethnicity as a moderator was examined explicitly in 13 studies. Out of those 12 studies, five showed ethnicity by treatment effects: three indicating stronger effects for ethnic minority youth; and two favored European Americans; the other eight studies did not show ethnicity as a moderator. In terms of the effect size results, the posttreatment $d = .44$ (medium effect size), which is equivalent to
improvement in 67% of treated participants; the treatment versus placebo \(d = 0.57\). However, there was a notable absence of Asian American and Native American youth in these studies.

**Future Directions**

Recommendations are that EBTs should serve as the first line of intervention, CBT does dominate, but there’s representation for multiple paradigms. If individuals are going to use cultural adaptations, they should be selective and individualize and adapt as needed. Future directions include expanding representation of ethnic minority youth to include Asian American and Native American youth, and immigrant youth, improving reporting of cultural adaptations, and utilizing designs that directly test the effects of cultural adaptations. Studies also need to document cultural appropriateness of measures.

* The slides for this presentation are available on the Presentations document.
Disparities in mental health services exist in terms of availability and accessibility of mental health services, quality of services, and outcomes of mental health care. All three of these can be addressed at a micro level. As the U.S. population continues to diversify, it becomes increasingly important to develop and implement culturally competent mental health practices to reduce disparities in mental health services. Although important theoretical foundations have been developed, critics have argued that there is a lack of a clear operationalization for cultural competence. It is often misunderstood. Paying attention to the dynamics of the differences is the key of cultural competence. Cultural competence is a salient feature of APA guidelines. This presentation focuses on cultural competence in the mental health care system (as opposed to cultural competence of the individual or the intervention).

**Organizational Factors and Effective Implementation**

The goal of this study was to identify and describe measurable organizational factors associated with the effective implementation of mental health services for culturally diverse children with emotional/behavioral disorders. Researchers reviewed literature published between 1994 and 2004 (N = 274). One of the main findings was that organizational characteristics associated with cultural competence were mostly driven by conceptual and policy frameworks that emphasized cultural alignment or fit. A human service organization’s cultural competence can be described as the degree of compatibility and adaptability between the cultural/linguistic characteristics of a community’s population and the organization’s combined practices and policies. With respect to the community, there are certain characteristics that facilitate service use: (a) a common perception of mental health that is related to the culture, (b) the history of the community or the population and the effect of such a history, (c) primary language of the population, (d) resources available to the population, and (e) strengths of the population. On the other hand, common cultural perceptions of mental health may present barriers to service use. An organization’s responsiveness to community contexts appears to meaningfully influence the ability to successfully reduce mental health service disparities by providing culturally competent evidence based practices. A contextual consideration of factors involved in reducing disparities suggests that efforts within the mental health sector will benefit from being linked with efforts to reduce over-representation in other sectors. Finally, there clearly is a need to attend to and examine how the organizational environment influences this alignment.

* The slides for this presentation are available on the Presentations document.
The Substance Abuse and Mental Health Services Administration (SAMHSA) is one of the eleven grant making agencies of the U.S. Department of Health and Human Services. SAMHSA has a budget of three billion dollars. SAMHSA’s role in addressing substance misuse and abuse is to ensure that science forms the foundation for the nation’s addiction treatment system and to serve health professionals and the public by disseminating scientifically sound, clinically relevant information on best practices in the treatment of addictive disorders. The public health approach taken by SAMHSA and the Center for Substance Abuse Treatment (CSAT) includes being population-based, comprehensive, and holistic, incorporating early intervention, treatment, recovery support, and health promotion, working across systems and professions, involving people in recovery, the community, and the private and public sectors, and, lastly, being evidence-based.

**Rates of Alcohol and Drug Abuse and Treatment**

In 2006, among those aged 12 and older needing but not receiving specialty treatment for illicit drug or alcohol use, 95% did not feel they needed treatment; 3% felt they needed treatment and did not make an effort; 1.5% felt they needed treatment and did make an effort. In 2005, among 12-17 year olds of various backgrounds, 18.5% of Whites and about 17% of Hispanics reported using alcohol within the past month; these two groups had the highest percentage of individuals using alcohol. In 2003 and 2004, out of the 6% of Hispanic or Latino 12-17 year olds who needed treatment, only .2% received alcohol treatment. Out of about 7% of Whites needing treatment, only .6% received alcohol treatment. About 3% of the African American youth in this sample needed treatment, whereas only .2% received treatment. Those who were from different ethnic backgrounds and who needed treatment did not receive treatment at all. Specifically, 14% of American Indian or Alaskan Natives needed treatment but did not receive any. Similar trends were observed among 12-17 year olds who need treatment for illicit drug use.

**Reporting and the Application of Data**

Many challenges exist when interpreting data gathered from various ethnic, racial and cultural groups such as (a) Do terms mean the same thing to every ethnic or regional group? (b) Does the measurement of compliance reflect cultural and regional differences? And (c) How do the various categories affect each other differently within various groups? Moreover, a challenge with respect to the application of data is that there exists a 17 year gap between when research is published and when the findings of such research are put into use by practitioners; many changes can occur within 17 years. To reduce this gap, the National Institute of Drug Abuse (NIDA) and SAMHSA have partnered to disseminate research findings for application in the treatment
community through the blending initiative. This initiative involves a collaboration between NIDA and the Addiction Technology Transfer Center (ATTC) in an innovative effort to make the best substance use disorders treatments available to those who need them. One of the goals is to harness the skills, resources, and knowledge of NIDA and SAMHSA to facilitate the translation of important scientific findings into practice for substance use disorders treatment.

* The slides for this presentation are available on the Presentations document.
Conceptual and Measurement Issues in Evidence Based Clinical Research: The Case of Racial Identity

Mia Smith Bynum, Ph.D.
Purdue University

The Multidimensional Model of Racial Identity (MMRI) has four dimensions: salience, centrality, regard (public and private regard), and ideology (assimilation, humanism, oppressed minority, and nationalism). This model is focused on an individual’s status; it is not a developmental model. Salience is not a stable component. Centrality is the relevance of race to an individual’s identity over time. Regard is the feeling of positivity or negativity toward one’s race (private regard is one’s own feelings; public regard is the perceptions of how others view one’s group). Ideology is the beliefs, opinions, and attitudes about how one’s group (e.g., African Americans) should act. Racial identity may be a protective factor against racism. Lower public regard and higher nationalism were found to be adaptive psychologically. Also, greater centrality makes individuals more attuned to racism. Racism experiences were associated with greater anxiety and depressive symptoms.

Racial Socialization

Racial socialization can also serve as a protective factor. There are four dimensions of racial socialization: salience about race/egalitarianism, preparation for bias, cultural socialization, and promotion of mistrust. In a recent study, findings demonstrated that cultural pride was associated with less psychological distress, while cultural resource coping was positively linked with psychological distress. In a study examining racial socialization in action, the goal was to determine which vignettes elicited a variety of perspectives on the meaning of the event. Interactions between mother and teenager were coded by trained graduate students. Researchers wanted to look at the initial reactions, the parent reactions, and adolescent strategies for coping. The sample included 24 mother-adolescent dyads. Parent and adolescent listened to the vignettes in a counterbalanced order. Results indicated that observed racial socialization behaviors were positively correlated with some aspect of parent self-report. Also, the mutuality of the exchange affected the content transmitted and received.

* The slides for this presentation are available on the Presentations document.
The Cook Inlet Tribal Council’s values are partnership, opportunity, innovation, leadership, and giving. Indigenous peoples make up 370 million people and reside in 70 countries worldwide. They have distinct social, economic, and political systems. According to the World Health Organization (WHO), at least 80% of the population in developing countries rely on traditional healing systems as their primary source of care. An important implication of this is that for many indigenous people, mental and physical health problems were perceived as a function of being out of balance. As such, healers served to bring the person back into balance, however, many of the healers were currently diagnosed as mentally ill. Thus, mentally ill persons played a key role in indigenous societies rather than being stigmatized and separated from them.

Alaskan Natives

Similar to other members of ethnic minority groups, Alaskan natives also face barriers in accessing mental health services. Some of the barriers experienced by Alaskan natives include (a) being distally located from services due to the tribal people being isolated, (b) having a history of culturally inappropriate services, (c) awareness of the lack of respect and stigma towards the indigenous people historically, (d) poverty, (e) stigma associated with seeking help, and (f) misdiagnosis. Some diagnostic issues are (1) cultural transition, (2) disenfranchisement in the greater community and society, (3) poverty, and (4) language. Fetal alcohol spectrum disorder (FASD), intergenerational trauma, post-traumatic stress disorder (PTSD), depression, and alcohol abuse are other related issues that complicate diagnosis.

The Continuum of Cultural Competence

Cultural competence occurs by (1) acquainting oneself with the people of the culture, (2) determining one’s own biases and being aware of them, and (3) not applying cultural stereotypes. Frameworks for cultural congruence include service models that “fit”; those that are drawn from practices that have demonstrated promise locally and culturally; and realizing that indigenous peoples are not homogenous. Some strategies for program design are that (1) the facility must reflect culture, (2) program leadership must be the same ethnicity as the client, and (3) the curriculum must be appropriate towards that culture. Solutions include (1) culturally congruent services, (2) EBPs, and (3) alternative culturally congruent methods for establishing EBPs. The Cook Inlet Tribal Council convened the Alaska Native Best Practices Conference in 2005. They took preliminary steps to identify existing “promising practices.” They defined several stages in a continuum of treatment development. The conference adopted the “Indigenous Evidence-Based Effective Practice Model.” Level I included client-based evidence. Level II included practice-based evidence. And finally, Level III included research-based evidence.

* The slides for this presentation are available on the Presentations document.
Cultural Differences in Diagnosis and Treatment

Donna Holland Barnes, Ph.D.
Howard University and founder of the National Organization for People of Color against Suicide

Cultural competence should exist in all levels of care. First, the right questions need to be asked when conducting intake assessments. People must be identified accurately by race/ethnicity. Ethnic diversity is increasing; there is a need for cultural competence in care.

Black Americans are less likely than Whites to have major depressive disorder (MDD), however, when they do, it tends to be more chronic and severe. This presentation introduces the critical correlation between cultural differences and standard care and diagnosis and how stereotyping on behalf of the provider and lack of trust from the patient affects the diagnosis.

Inequitable Care

Some Americans receive less than standard care due to their race, immigrant status, language proficiency, educational attainment, and socioeconomic status. How do well meaning providers still provide inequitable care? “The Medical Gaze” is a power structure that exists where dominant knowledge reigns in medical care. Training for psychiatric residents on suicidal clients can serve as one example: they practice regressive vs. progressive therapeutic techniques. Some examples of regressive measures include: no calls home, no normal contact with family, and no responsibility. Progressive techniques allow personal responsibility to be given back to the patient gradually. The following can contribute to inequities in care: how one enters the medical arena, what life experiences one has, what problems such experiences can cause for the health provider, if the health provider racially profiles the patient, and if the patient describes problems outside the “scope” of the medical gaze (especially psychological issues).

Ethnic Barriers in Seeking Help

Does the culture of medicine exclude patients that are not easy to treat? It is well documented that ethnic minorities do not seek help. If they do, they are less likely to comply. They are marginalized, discriminated against, and they encounter communication barriers. Often, ethnic minorities suffer disproportionately from mental illness. Some barriers to treatment for different ethnic groups include: African Americans – mistrust of providers, high dropout rate; Asian Americans – stigma, high dropout rate; Latinos – lack of ethnic specific facilities, language barriers, and problems associated with immigration (e.g., lack of insurance); Native Americans – high turnover rate of providers, reluctance to lose traditional practices, lack of trust or fear of confidentiality breaches, lack of affordable care, failure to meet tribal criteria for government services (e.g., living in different reservation away from own tribe).
Consequences

Some of the ramifications of barriers to treatment are misdiagnosis, undertreatment, and mistreatment. Immigration is a risk factor for mental illness. Because of acculturative stress and loss of protective factors, rates of mental disorders for immigrants are higher than for their counterparts in their native country. Misdiagnosis can often occur for minority populations due to cultural differences in expression of symptoms and to the prevalence of culture-bound syndromes/symptoms. Clinicians may be biased and may misdiagnose. For example, visions are considered hallucinations, protectiveness can be treated as paranoia, and anger can be perceived as violence. Schizophrenia is the worst disease affecting humankind; it affects 1% of the population. The social tolls are great, and it is diagnosed more frequently in African Americans. Might this be because African Americans are over-diagnosed? Some provider characteristics that can lead to over-diagnosis include: failure to involve the patient in decision-making, failure to listen, monopolizing the conversation, lack of perceived respect, failure to engage, failure to get adequate information, and socioeconomic distance.

Assessing Cultural Competence

Cultural competence can be developed by using appropriate measures within an operation. Is there a commitment present? Are there policies to support cultural competence? Is cultural competency being monitored? Are the lines of communication open between provider and client? Are there adequate resources available? To develop and maintain cultural competence, there must be leadership, board development, staff input, support of different communication styles, training (staff must be willing to be trained), and an adequate budget. How is it possible to create a realistic dialogue and deeper cultural understanding that is not just about creating stereotypes in training? It involves asking the right questions, questions beyond what one is required to ask. It also requires seeking understanding from the client in the session, and keeping in mind that engagement with the client is necessary in order to understand what the problems are. It is important to remember that there are cultural commonalities, but they are not absolute. Everyone will be different. For example, South Asian women, aged 16-25, have high rates of suicide in the United Kingdom, but most of the deaths are not attributed to depression. How can one better understand this in the context of culture? Different cultures have different perspectives on suicide, and more research needs to be done to understand what the motives for suicide are. Perhaps it is necessary to move beyond examining suicide as a mental health problem and more as a public health problem.

* The slides for this presentation are not available.
There are elements about being a human being that are universal, and then there are individual differences. There is a middle-ground where some aspects are shared, but others are not, and this poses a problem for creating evidence-based interventions. We learn universalities and translate that into what our clients need, but clients may differ in many aspects.

San Francisco General Hospital

Evidence-based practices must be developed in the front lines: Clinicians must provide services to diverse populations and then test whether they work. Training manuals must then be developed and they need to be specific. More providers must be trained. It is important to go beyond treatment -- to prevention. More people must be served wherever they are – inexhaustible interventions (vs. consumable interventions). San Francisco General Hospital is a very realistic setting; it is diverse ethnically, socially, economically, and serves the Mission District, which is a barrio of San Francisco. It has a public sector and minority focus. SFGH Psychiatry has a mission to provide services to those most in need, train professionals dedicated to the underserved, and promote research.

Establishing and Maintaining Services for the Public Sector

In establishing and maintaining services for the public sector, we have to (a) define the target condition or disorder, (b) specify the theory behind the intervention, (c) define the population, (d) specify the intervention methods so they can be applied reliably (manuals), (e) evaluate process/outcomes in ours and others’ settings, and (f) disseminate the interventions. An example could be the following: The target is depression. The theory is social learning/social cognitive theory. Then the theory is applied to a select group. In Bandura’s Social Learning Theory, human beings learn to think and behave based on their social environment. Gaining greater control over their thoughts and behavior can allow patients to gain greater levels of self-efficacy, which gives them more freedom and self-direction.

Treating Culturally Diverse Public Sector Patients

SFGH Depression Clinic patients tend to be primary care patients who are mostly women (75%) and culturally diverse with low education and little employment. More than half have medical problems. Depression is a function of response-contingent positive reinforcement. Pleasant activities serve as the major source of human reinforcement. Thinking is also an activity: it can serve as a pleasant activity, a reinforcer or punishment, and is the source of meaning in human life. Depression affects all aspects of life; thoughts, behavior, interpersonal contacts, and biology are all connected. Social learning theory and the behavioral approaches can be adapted for low-income populations. Patients have major life problems, and need to change internal and external reality; just changing how one thinks is not sufficient. Personal reality consists of two realms –
internal and external. The internal can be modified by changing the way one thinks and the external can be modified by changing the way one behaves. Emotions are products of both internal and external processes. By learning which thoughts and actions influence our feelings, we can learn to have more control over our feelings.

**Mood Management and Depression**

Manuals are important. Open-ended graphics should be used so clients can use their own words to describe their conditions. Samples of different thought patterns and personal anecdotes should be included, and translated materials and manuals should be used to accommodate clients from different cultures. For example, some comics can be used to demonstrate that some choice sequences can lead to feeling very bad while others have a better effect. The expectant mothers program teaches mothers awareness of moods to better understand how their babies react to them and how to teach their children better mood control. The program also produces positive effects for the mothers. Empirical tests show that depressed mood is reduced, but not to levels comparable with those in the general population. The methadone maintenance study was a randomized mood management program in which weekly CES-D scores were noted. The intervention was evaluated, and it was found that mood management was effective. Other studies show that interventions reduce emergency room use and cost for treatment. Yet other studies have found that cognitive behavioral therapy is effective along with anti-depressant treatment in reducing the negative mood associated with depression. It is important to circumvent other barriers like language differences, lack of recognition for care, provider turnover, and problems in the transfer of knowledge.

**Web-based Interventions**

Evidence-based internet interventions have many advantages in cost and effectiveness and can still be developed and tested. We will never train enough health care providers to serve all populations who need them, so using the internet is an effective way to reach more people around the world. Many countries, including underdeveloped countries, now have some access to internet resources. Some studies indicate that an intervention involving web-based smoking cessation is more effective than the nicotine patch. Such approaches can be tested using randomized-control trials nationally and internationally. The same intervention strategy can be applied to other health problems and delivered in different languages.

Websites for smoking cessation: [www.stopsmoking.ucsf.edu](http://www.stopsmoking.ucsf.edu), [www.dejardefumar.ucsf.edu](http://www.dejardefumar.ucsf.edu);
UCSF internet world health research center: [www.health.ucsf.edu](http://www.health.ucsf.edu)

* The slides for this presentation are available on the Presentations document.
Returning to the Family: Progress in the Treatment of Depression in Latino Adolescents

Guillermo Bernal Ph.D.
University of Puerto Rico

Some important questions to consider when working with culturally adapted measures are: (a) Do they work with this population? (b) Are they measuring what they are intended to measure? (c) Is there measurement equivalence? There are eight elements of treatment for evaluating cultural sensitivity in clinical interventions: language, concepts, persons, goals, metaphors, methods, content, and context. For example, is the patient comfortable with the similarity (or difference) in the ethnicity of the therapists? Are sayings or “dichos” familiar to the patients? Are treatment concepts, goals, and methods framed within the cultural values of the patient?

Effectiveness of Cognitive Behavioral Therapy vs. Interpersonal Therapy

In the first study in which cognitive behavioral therapy (CBT) and interpersonal therapy (IPT) were compared among 71 Puerto Rican adolescents, there were no significant differences in depressive symptoms measured by the CDI between these two therapies until post follow-up, where it became clear that CBT reduced levels of depression compared to IPT. The second study examined individual vs. group CBT and individual vs. group IPT among 112 adolescents from Puerto Rico. In this study, differences were found again in favor of CBT, with no differences between group therapy and individual therapy. Specifically, CBT produced significantly greater decreases than IPT in depressive symptoms. Even after controlling for sub-syndrome depression, CBT was superior to IPT, showing a greater decrease in depressive symptoms.

Treatment, Assessment and Resources for Adolescents (TARA) Study

How are families impacted? Forty percent of adolescents reported the majority of their problems involved the family, and this led to creating a focus group with parents. Parents voiced the need for support in dealing with their child’s depression, educational intervention, and both supportive and educational intervention rather than solely therapeutic. Information gleaned from the focus groups led to the Treatment, Assessment, and Resources for Adolescents (TARA) study in which the aim was to test the efficacy and effectiveness of the Parent Psychoeducation Intervention (PPI) with CBT; essentially this includes cognitive and interpersonal approaches to depression. The final sample for TARA consisted of 121 adolescents of which 60 received CBT alone and 61 received CBT and PPI. Preliminary results indicate that involvement of parent education does not seem to make a difference. However, when examining co-morbid individuals and depressed-only individuals, an interaction effect indicated that for EBP treatments that are culturally informed, family does matter, but more for the depressed-only group.

* The slides for this presentation are available on the Presentations document.
Engaging African American Children and Their Families

Norweeta Milburn, Ph.D.
University of California, Los Angeles

It is important to understand the trajectories of homeless adolescents and the characteristics of at-risk youth, specifically ethnic minority homeless adolescents. In general, homeless adolescents are at greater risk for HIV, substance abuse, mental illness, and victimization. One of the goals of the studies discussed is to change the negative perception associated with this issue by examining the pathways to homelessness.

**Heterogeneity of Homeless Youth: New and Experienced Homeless Adolescents**

The first project compared new homeless adolescents (i.e., those who have spent between two nights and six months away from home) to experienced homeless adolescents (i.e., those who have spent more than six months away from home) in the U.S. and Australia. Australia was chosen because both countries share similar contexts, however, there are also some important differences that exist in social structure and policy. There were significant differences between new and experienced homeless adolescents; this is considered a major finding in the field because it underscores the heterogeneity of homeless youth. The trajectories of going home (i.e., operational definition of going home is living in familial housing) over the course of time (i.e., past six months) found that American new homeless adolescents were more likely to return home compared to their Australian counterparts. Those with lower family bonds reported less social support and more externalizing behavior. This finding suggests that homeless adolescents are not isolated but are still connected to their families. Lastly, some important predictors of exiting stably out of homelessness over two years are being female, being younger, having family support, and having peers who connect with their families.

**Project STRIVE**

Project STRIVE is a family intervention based on CBT which includes five session interventions that target newly homeless adolescents and their parents. The sample thus far consists of 235 individuals (118 adolescents); the African American sample consists of 49 individuals, less than the ideal amount. This study involved some anticipated and unanticipated challenges. The anticipated challenges were (a) issues with cultural variables (e.g., intergenerational acculturation levels) and (b) daily issues (e.g., potential barriers with interview scheduling such as feasibility with time and location for interventions). Some unanticipated challenges included: (a) finding eligible participants, (b) IRB issues, and (c) reunification among parents and adolescents (i.e., 30% of parents and adolescents were not interested in reuniting and thus did not want to participate). Some lessons learned from this project that would assist in recruiting more African American adolescents and their families include (a) going beyond homeless adolescents and examining youth in the judicial system, (b) understanding what motivates one to participate in these types of studies to increase subsequent recruitment, and (c) conducting a pre-session to obtain feedback from families that may be useful before beginning the intervention.

*The slides for this presentation are available on the Presentations document.*
Families Matter

Trina W. Osher, M.A.
President of Huff Osher Consulting, Inc., Former Director of Policy at the Federation of Families for Children’s Mental Health

Family involvement is a key ingredient in the success of any intervention for children and youth. Families have a perspective on “evidence”. Families can contribute to the processes of identifying, describing, evaluating, and promoting evidence-based practices. They can also contribute to creating strategies to study effective practices for which there is no scientific evidence base. Parents need to be assured that their children are receiving quality care. Therapy is possible with parents’ insurance, parents often are the ones who drive their children to therapy, and parents are usually the ones who can convince their children to get help. Such usefulness is often overlooked. Also, attention to diversity and cultural competence is critical. Overall, families are the engine for change for a culturally competent, evidence-based culture of practice and research.

Helping Parents Understand EBPs

It is important for families to know about evidence-based practices (EBPs). For example, a parent bringing in her daughter for a treatment designed for boys may lose trust in the treatment because it may not be applicable to her daughter. Practitioners may not always remember to address this. Parents may not always ask the right questions so it becomes important to help them know which questions are the important ones. EBPs are important for families because they can assist families in making good decisions about assessing appropriate treatment for their children. Families may fear EBPs because they feel that (a) generalization will occur, (b) what is currently working may be replaced because it may not be supported by research, (c) EBPs may stifle innovation, or (c) their own voices will be restricted. For EBPs, outcomes are essential hence (a) standards need to be followed with integrity to the underlying model, (b) there needs to be quality assurance, (c) client drop-out need not be blamed on client but may be due to the practitioner, and (d) involvement by participants is important because they can provide an “insider’s” perspective to supplement the data.

Moreover, diversity needs special attention. Behavior, emotional, and mental health problems affect children and youth in all populations, regardless of race or ethnicity. However, the unmet need for mental health services is highest among minority youth.

Shift in Current System: Keeping in Mind the Family

There needs to be a change in research from being researcher and provider system-focused to being more family-driven. When applying this change to research and evaluation, some issues to consider are that (a) the sources for questions must include families, policy, and providers, (b) a collaborative relationship must exist among these three groups of stakeholders, (c) alternative orientations must be used (i.e., taking into account multiple factors, not just using single factor designs), (d) the research’s major purpose must be explicit, (e) study designs should be diverse (i.e., action oriented and qualitative designs combined with quantitative methods and not
aggregating everyone), and (f) findings should be disseminated broadly (i.e., families should also have access, not only scholars and care providers). The outcomes and indicators of family-driven research include high participation, strong relationships, varied and valid data sources, and shared responsibility. Permission, skills, persistence, knowledge, and attitudes are needed to make this important shift.

* The slides for this presentation are available on the Presentations document.
The Multicultural Assessment Intervention Process (MAIP) Model, which was developed based on the theoretical work by Richard Dana, is a mental health service delivery model that focuses attention on key cultural variables assumed to impact clinical outcomes. These variables include: consumer-provider ethnic/racial match, consumer acculturation status, consumer ethnic identity, and provider self-perceived cultural competence. The MAIP Model is informed by both psychological science (e.g., multicultural research guidelines, evidence-based culturally sensitive assessments, culture-specific interventions) and practice (e.g., evidence-based practice, multicultural education). The MAIP model encompasses seven components: (1) measurements of performance based on individual client, systems/program, and public-community data, (2) disposition coordination to assign cases by accommodating client preferences for gender/language/racial/ethnic match, (3) computerized tracking system of MAIP variables, (4) simultaneous appraisals of key MAIP variables, (5) multicultural competence measurement and evaluation, (6) the California Brief Multicultural Competence Scale (CBMCS) Multicultural Training Program for clinicians, and (7) ethnic specific/general intervention based on the client’s matching preferences, acculturation status, identity orientation, and available staff resources. These components are meant to be implemented simultaneously within an agency.

Usefulness of MAIP

To date, there are seven published articles that examine various combinations of MAIP parameters with both adult and child community mental health center clients. One study found that ethnically matched Asian and Latino American clients’ global assessment functioning (GAF) scores improved but ethnically matched African and White Americans’ adjusted GAF-difference scores declined. At another clinic, Asian American adult and child outpatient clients’ adjusted GAF-difference scores did not differ significantly based on ethnic matching, but matched clients had significantly more agency visits. In another study involving Asian American children, parents/caregivers of Asian American clients who were ethnically matched reported higher client satisfaction; also, the children had higher GAF-posttest scores. Regarding adult and child Latino American outpatient clients, a significant acculturation and ethnic identity interaction was found. Less acculturated Latino clients who were more “Anglo-oriented” (those who reported low ethnic identity) had lower GAF outcomes than ethnic-oriented clients. Another study surveyed 1,244 California mental health practitioners using five self-report cultural competence scales. From these findings, researchers developed the 21-item California Brief Multicultural Competence Scale (CBMCS). Future MAIP directions include refining the current model, utilizing additional instruments to measure MAIP parameters, and conducting an experimental study using a control group to test the effectiveness of MAIP in two different community mental health agencies.

* The slides for this presentation are available on the Presentations document.
Culturally Informed Evidence Based Practices: “Tell Me a Story” Assessment of Multicultural Children

Giuseppe Costantino, Ph.D.
Lutheran Medical Center, Lutheran Family Health Centers

Previous projective/narrative test pictures (e.g., TAT) are often not culturally congruent with the cognitive schema and present experiences of ethnic minority individuals. A lack of identification with the characters, themes, and settings depicted in the pictures is likely to inhibit the examinee’s verbal fluency and precludes criterion-related validity. The TEMAS (Tell-Me-A-Story) test was developed in light of the dearth of psychological literature on the personality assessment of culturally and linguistically diverse children and adolescents. The TEMAS test is a narrative assessment technique developed to reduce/eliminate test bias in assessing minority youth. The test presents culturally relevant pictorial stimuli, a psychometrically reliable problem-solving scoring system, and a standardization sample of Black, Hispanic and White children and adolescents. Several studies indicate that the TEMAS demonstrates adequate reliability and validity to accommodate children’s cultural diversity.

What Does TEMAS Entail?

The TEMAS consists of two parallel sets of stimulus cards -- one for minority children and the other for non-minorities--making it multicultural in nature. The test also abandons the construct of pictorial ambiguity found in the TAT and Rorschach, but instead, pulls for specific conflicts and utilizes structured stimuli with pictorial problem-solving. The stimulus cards are also in color, which attracts and maintains children’s interest, making the TEMAS more applicable for use with children. These cards embody a wide variety of problematic life situations and experiences in inner-city, impoverished environments, such as familial scenes within the home, solitary dreamlike and fantasy states, street scenes involving peers and adults, sports activities, and school-related situations. These pictures enable positive or negative feelings to be projected into stories and manifested as adaptive or maladaptive resolutions of the underlying primary need or motivation. These situations pull for themes expressing varying degrees of adjustment, ranging from severe pathology to highly adaptive functioning.

The TEMAS scoring system presents a systematic, psychometrically reliable, and valid system to score the complexity of personal narratives. It provides a description of the examinee’s personality functioning, including interpersonal relations, aggression, anxiety/depression, achievement motivation, delay of gratification, self-concept, sexual identity, moral judgment, and reality testing. It also provides information on the examinee’s affective functioning. In sum, the rationale for developing TEMAS by departing from the traditional features of the projective/narrative techniques by such modifications as the use of color, reduced ambiguity and an objective scoring system is based on empirical research (Dana, 1993, 2000; Ritzler, 1993, 1997).
Testing the TEMAS

A group of 210 Puerto Rican children screened for behavior problems were administered a number of measures along with the TEMAS, and their adaptive behavior in experimental role-playing situations was observed and rated by psychological examiners. Finally, the children participated in four experimental role-playing situations, designed to elicit adaptive behavior. Results of indicated that TEMAS profiles significantly predicted ego development, disruptive behavior, and aggressive behavior. Results of these analyses showed that pre-therapy TEMAS profiles significantly predicted all therapeutic outcomes, ranging from 6% to 22% variance increments. Clinical information provided by TEMAS profiling of personality, cognitive and affective functioning is generalizable with a high degree of confidence to multiple ethnic/racial groups in the 5 to 13 year-old range. For the most part, participants in TEMAS research have fallen into three categories: normal, borderline behavior problems, and ADHD clinical cases. No research has been conducted with children experiencing other specific DSM disorders of childhood and adolescence. More research in this area is warranted. However, multicultural and cross-cultural research indicates that the test shows validity and clinical utility with culturally diverse children and adolescents in the U.S., Puerto Rico, Argentina, Peru, Italy and Taiwan.

* The slides for this presentation are available on the Presentations document.
The Process of Culturally Adapting Evidence Based Treatments for American Indian and Alaska Native Children – Lessons Learned

Dolores Subia BigFoot, Ph.D.
University of Oklahoma Health Sciences Center

The mission of the Indian Country Child Trauma Center (ICCTC) is to improve and adapt evidence-based treatments for Native children and adolescents in Indian country who have experienced traumatic events. Funded by the Substance Abuse and Mental Health Services Administration, the ICCTC is a member of the National Child Traumatic Stress Network (NCTSN), whose mission is to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States.

Incorporating a Cultural Perspective

Cultural ways and knowledge must be viewed as equal to social science knowledge in order to work effectively with Native American communities. Tribal communities have long known culturally appropriate ways of instruction and principles of behavior management, and adaptations of evidence based practices (EBPs) must identify ways of teaching and learning from the Native American worldview. Four adapted evidence based interventions include: (a) honoring children – mending the circle (trauma-focused cognitive behavioral therapy), (b) honoring children – respectful ways (treatment of children with sexual behavior problems), (c) honoring children – making relatives (parent-child interactive therapy), and (d) honoring children – honoring the future (American Indian skills development curriculum (revised for younger age). This project used the de Arellano (2007) model for cultural adaptation and implementation of EBPs:

- Study target population
- Key stakeholder and other community involvement
- Integrate while maintaining fidelity
- Learn through implementation
- Learn through evaluation

Culturally Adapted Treatments for Native Americans

The difference between evidence-based practices and practice-based evidence is that the latter is more grounded in tradition, culture, and the community. Indigenous ways of knowing (e.g., observing, listening, modeling, intuition) were integrated into the program adaptations. Specifically, the cultural adaptation process included: (a) identification of Native therapeutic teachings and concepts, (b) identification of core concepts of evidence based treatments, (c) collaboration with experts/developers, and (d) utilization of Native words and concepts that are meaningful to Native people (e.g., the circle, wisdom, harmony, respect and honoring). The four interventions mentioned above were developed. Treatment manuals, training materials, evaluations, consultation activities, and formal agreements were developed for each of the four interventions.
* The slides for this presentation are available on the Presentations document.
Cultural factors may impact reactions to trauma, expression of symptoms, and utilization of and adherence to mental health treatment in Latino youth. However, research on evidence based treatments among Latinos is limited. The current intervention focuses on (a) adapting Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2003) to be culturally appropriate and (b) maintaining fidelity to the model. The intervention, called Culturally Modified Trauma-Focused Treatment (CM-TFT), has been developed for use with trauma-exposed children of Latino descent based on research and clinical work with this population. This adaptation is a tailored approach that attempts to increase engagement by enhancing the cultural relevance of the intervention. It is important to understand the trauma-exposed child as a “whole person” in the context of his/her community, family, culture, and language. Cultural modifications for the multi-site intervention were made in the assessment, intervention and evaluation processes to include such cultural factors as spirituality, familismo, traditional gender roles, beliefs about sex, views of mental health and mental health treatment, racism/discrimination, and exploitation. In collaboration with several National Child Traumatic Stress Network sites across the country, the intervention has been further developed to address the needs of Hispanic children from various countries of origin, regions of the United States, and levels of acculturation.

* The slides for this presentation are not available.
Adapting and Integrating Interventions for Tailored Treatment Interventions with Multi-Problem Clients in Community Setting

Barbara C. Wallace, Ph.D.
Teachers College, Columbia University

Understanding how empirically supported treatments perform in different cultures is vital to move the field of addictions forward. Are the current relapse prevention models appropriate for different cultures? It was suggested that practitioners prioritize the use of evidence-based treatments by adapting them to cultural groups. This adaptation should be performed by conducting focus groups, having community informants, and incorporating cultural beliefs about health and disease. This would help address multi-problem clients in contemporary settings where institutional racism may be a problem.

Flexibility Approach

To make services more culturally competent one must question the existing assumptions and conceptions used in treatment and take a flexible, dynamic approach in understanding that ultimately, the individual is the expert of her/his life. A key component of this includes genuine respect (i.e., acceptance, respect, and empathy) for clients as well as providing services that are most convenient for them. Community interventions have been finding a balance between high external validity “effectiveness” and high internal validity “efficacy” but in the future we should move towards effectiveness. A recent meta-analysis showed that in minority clients, motivational interviewing had a higher effect size (almost double) than that found for clients of the mainstream culture (Hettema, Steele, & Miller, 2005). When treating clients with multiple problems, one should have an array of treatment options that have all been empirically supported and always take a flexible client-centered approach. Having multiple treatment options for individuals with addictive disorders while taking an integrated tailored approach may improve the treatment provided to clients. This approach can effectively meet the needs of varied clients—including those presenting dual diagnoses, those in different stages of change for multiple problem behaviors, and those mandated to treatment.

* The slides for this presentation are not available.
Neuropsychological Assessment of Minority Substance Abusers

Arthur MacNeill Horton Jr., Ed.D., ABPP (CL), ABPN, ABPP (BP)

Neuropsychological assessment is based on normative data that is biased to the values and beliefs of the dominant culture and toward the ethnic group of the country in which the test was developed. Very rarely are diverse groups included in normative samples when neuropsychological tests are standardized. There is an increasing concern that neuropsychological assessment procedures may have cultural biases. When working with minority populations, it is important to understand the minority group culture and to find ways to minimize cultural bias. To minimize cultural bias, two factors must be considered: acculturation level of the individual and language issues. Acculturation is the process by which individuals adopt the dominant culture’s beliefs, values, and practices and can be assessed by previously developed measures (e.g., Acculturation Rating Scale for Mexican Americans: ARSMA) or length of time living in the dominant culture. Valid neuropsychological assessment requires that the person being assessed understand the instructions, and the person conducting the assessment understand the answers. This is hampered by differences in language. Although there is a dearth of research on the neuropsychological assessment of minority groups, several differences have been found. With respect to African Americans, multiple studies have found misdiagnosis of normal adults using the level of performance model (Horton, 2008), and published norms misclassified half of a group of normal African American children (Knuckle & Campbell, 1984). For Hispanics, language is a major problem as translations have been found to be inadequate. Studies have shown that as acculturation (i.e., length of time in the U.S) increases, Hispanics perform on tests similarly to individuals from the dominant culture. For Asian Americans and Native Americans, very few studies on neuropsychological assessment are available. Applying multiple levels of inferences (e.g., not only using performance level as a measure) may reduce cultural biases.

Neuropsychological Assessment of Substance Users

The three major goals of neuropsychological assessment of substance users are: (1) to measure degree of impairment, (2) to assess potential of recovery, and (3) to make treatment plans. Psychoactive drugs such as alcohol, marijuana, hallucinogens and sedatives are neurotoxic. Screening assessments are preferred to use with substance users when the incidence of neuropsychological impairment is low, and these assessments can quickly determine patients’ need for treatment (e.g., Trail Making Test). On the other hand, comprehensive assessments require greater administration expertise and time, and more complex and expensive equipment (e.g., the Halstead-Reitan Neuropsychological Test Battery). Neuropsychological findings have shown that most drug users have difficulty with fine motor speed, non-verbal pattern recognition, visual abstraction, and set shifting abilities. The most seriously impaired drug users are those who abuse inhalants/solvents, alcohol, cocaine, and polysubstance users. Future research should focus on the ability of drug users to function in everyday settings.

* The slides for this presentation are available on the Presentations document.
Ethical and Culturally Congruent Research and Interventions in Community Settings

Joseph Trimble, Ph.D.
Western Washington University

A quote from a research participant speaking of the conclusions reached about his/her tribe in Casillas (2006) exemplifies the seriousness surrounding the conduct of researchers in the field and in communities: “We are all people with diseases walking around reservations.” Approximately 3000 researchers committed mispractice in research (e.g., falsifying data) and of those, one-third confessed to committing 1 of 10 misconducts in research. The “helicopter approach” is no longer acceptable and researchers are encouraged to conduct ethical decision making. Margaret Mead quoted William Fielding Ogburn, in saying that researchers should never look for a psychological explanation unless every effort to find a cultural one has been exhausted (Mead, 1959, p. 16). On May 16, 1997, President Clinton apologized to the eight remaining survivors of the Tuskegee Syphilis Experiment. The Tuskegee Institute was headed by a group of University of Virginia physicians (who coincidentally emphasized eugenics). The study ran continuously until Peter Buxton, a former Public Health Service employee raised serious ethical questions. As a result, the experiment was stopped. An overview of the Tuskegee Syphilis Experiment should be a part of every undergraduate research methods course. Two additional examples of unethical research include a book entitled “Darkness in El Dorado: How Scientists and Journalists Devastated the Amazon” by Patrick Tierney (2001) and “The Ax Fight” film by Timothy Asch and Napoleon Chagnon (1989). The Tierney book was chilling, as it documented how researchers injected strains of measles into research participants to observe how these people would react. Similarly, “The Ax Fight” film (1950) illustrated how the entire incident was staged. Individuals all looked in one direction (probably at a director) and the camera used was unnaturally steady, most likely perched on a tripod. Many assumptions about the featured tribe were based on this film (i.e., these people were labeled as aggressive).

Giving Back to Participants

For years, people have been persuaded to participate in research in which they did not fully understand the nature of the risks and benefits. Such research does not respect the basic human dignity of the participants. Information collected from such studies has been taken out of context, and problems have been sensationalized. Despite promises to assist communities, researchers have failed or refused to follow through on promised benefits. Similarly, researchers have failed to respect cultural beliefs and practices of the community. As a result, there can be breaches in ethics and responsibilities to the population under study.

Respecting and Focusing on the Community

Attention should be given to avoid any actions that violate local customs and cultural understandings of the community. This sensitivity and attention should be given to the community throughout every phase of research. Research efforts should take the steps necessary to ensure informed consent and avoid invasion of privacy within the context of the community’s culture. The research should not have, as a latent agenda, the transmission of information or the
modification of attitudes and behavior unless the agenda is consistent with the community’s goals. Ethics and the research approach affect evidence-based practices. Ecosystems approaches call for principled cultural sensitivity (Trickett, Kelly, & Vincent, 1985) which is based on respect for whom the research and interventions are intended and would prohibit interventions that violate cultural norms. The goal is community development and empowerment in which the research becomes a resource for the community, not for the researcher. Emphasis is placed on the importance of culture as an historical and contemporary aspect of the framework within which individuals appraise their situations and their options. The focus is on the community context as a stage within which individual behavior occurs. Thus, context must be incorporated into the design of the research. Research takes time in these communities and professionals are often unable or unwilling to take this time. The goodness of fit model advocates doing good research well in which the researcher and the team embodies values and beliefs that the community finds acceptable (Fisher & Ragsdale, 2005). The model views researchers and participants as moral agents joined in a partnership.

Characteristics of a Virtuous Researcher

According to Maera and Day (2003), a virtuous researcher must be self-regulatory and self-reflective while at the same time, follow normative professional ethics. Six characteristics of virtue include prudence, integrity, respectfulness, benevolence, reverence, and trustworthiness. Carol Gilligan’s (1982; 2003) concept of Relational Methodology in which a truly moral person cares for the welfare and dignity of others is relevant. A responsible, nurturing, relationship will increase the likelihood that the participant will tell researchers what they “really think.” Ward Goodenough states:

The principle that underlies problems of ethics is respecting the humanity of others as one would have others respect one’s own. If field (researchers) genuinely feel such respect for others, they are not likely to get into serious trouble. But if they do not feel such respect, then no matter how scrupulously they follow the letter of the written code of professional ethics or follow the recommended procedures of field (research) manuals, they will betray themselves all along the line in the little things (1980, p. 52).

* The slides for this presentation are available on the Presentations document.
Successful Collaboration across the Traditional Divide: Key Considerations When Conducting Intervention Research in Culturally Diverse Communities

Terry S. Gock, Ph.D., M.P.A.
Asian Pacific Family Center, Pacific Clinics

This workshop presentation highlights the common interests and divergent approaches between researchers and community service providers. Emphasis is placed on exploring ways to develop intervention research protocol that is ethically and culturally congruent with the service structure and context of community based organizations. The goals of this presentation are to: (1) identify the common and divergent worldviews between researchers and community-based behavioral health service providers, and (2) pinpoint some effective strategies to bridge the gap between research interests and community behavioral healthcare service expectations. Both researchers and community service providers should start on common ground and ask questions that address the effectiveness of the program/intervention in addition to the satisfaction of the client/participant. Whereas researchers conventionally emphasize work that is effective, the community tends to focus on patient satisfaction. The traditional medical model of “Dr. Knows Best” has evolved into the new public health model in which the professional collaborates with clients, families, and communities. A case example, the Asian Pacific Family Clinics’ (APFC) organizational chart (layers of the onion with the client at the core), illustrates the public health model.

Obstacles in Implementing EBPs and Strategies to Overcome Them

A number of challenges impede the implementation of evidence-based programs with people of color and within community-based organizations (CBOs). They include, but are not limited to: (1) cultural relevance of EBPs, (2) replicability and fidelity, (3) incentive and resources, (4) confusion between program audit versus research and evaluation, (5) lack of understanding of evaluation and research (e.g., purpose, language, design, intervention protocol, etc.) by service providers, (6) distrust of researchers and program evaluators, (7) cultural appropriateness of instruments used, (8) culture-based social demand characteristics of the self-report approach, (9) the curse of causality, and (10) system, organizational, and structural support (funding) for research implementation. In order to combat the challenges mentioned above, some strategies to enhance collaboration and to counteract analysis paralysis include: (1) conducting dialogue and cross training, (2) including a qualitative approach, (3) sharing ownership of findings and interpretation, (4) always “paying it forward” and giving back to people of color, CBOs, and communities, and (5) utilizing an evolutionary evaluation approach. Although the use of EBPs often means less of a payout for the CBO, the key to success is collaboration. Like a marriage, both the institution and the organization should be willing to compromise in the best interest of the community.

Diversity within the Asian Pacific Family Center

A number of service programs are offered at the Asian Pacific Family Center (APFC) including: Children, Youth and Family Outpatient and School-Linked Mental Health Services; Adult
Mental Health Outpatient Services; Older Adult Outpatient and Field-Based Mental Health Services; CALWORKS Mental Health Counseling Services; Child Abuse Prevention and Counseling Services; School, Community, and Law Enforcement (SCALE) Collaborative; Asian American Family Enhancement Network (AAFEN); and the Youth Development Programs (prevention programs in substance abuse, HIV/AIDS, and gang/violence). A major problem in communication and collaboration is that program evaluators tend to focus on what is wrong or problematic in the program. Instead, program directors want to know what their program is doing right.

* The slides for this presentation are available on the Presentations document.
Mixed Methods Research: What Is It and How Can We Achieve Its Potential?

Peter J. Guarnaccia, Ph.D.
Rutgers University

Qualitative methods can and should be used throughout mental health research. At the beginning of a study, qualitative research can be used to explore topics that have not been intensively studied, identify cultural dimension of issues, adapt and translate instruments, develop new measures, assess how methods will work in particular communities, generate new or check on existing hypotheses, assess acceptability of an intervention, and develop connections with key people in the community. Similarly, in the middle of a study, qualitative research can be used to assess preliminary findings, especially unexpected ones, evaluate responses to questions which may work differently in particular communities, explore findings more in depth, assess preliminary impact of an intervention, and examine problems in reaching reluctant participants. Finally, at the end of a study, qualitative methods can be utilized to again explore research findings more in depth, assess the validity of findings from a community perspective, evaluate the impact of an intervention (such as identifying active ingredients from the perspective of the participants), and generate new research questions and ideas for interventions based on research findings.

Issues in Mixed Methods Research

Qualitative research is often thought of “as in service to” quantitative research. As a result, the qualitative researcher is brought in as a consultant rather than as a full colleague. Whereas the qualitative researcher is expected to understand quantitative research, there is often not a reciprocal expectation. Although qualitative research is seen as relevant to the preliminary phases of research, it is not often integrated throughout the entire research project. Qualitative methods may be utilized during the revision of and translation of questionnaires, to gain additional insight into specific domains of interest, and to receive feedback on methodological approaches. In order to make the most out of mixed methods research, it is important to bring the qualitative researcher in as a full member of the team, to think about how to integrate qualitative research throughout the study, and provide opportunities for regular cross-training in all methodologies for the entire research team.

Approaches to Qualitative Research

One way to incorporate qualitative research into a study design is to start with ethnography. Ethnography is a holistic and comprehensive approach to understanding a culture that begins with participant observation and uses informant interviewing as a key component. Field notes, an integral part of ethnographic research, are qualitative data that can provide insight into (1) what people say they believe, think or do, (2) what people actually do, (3) what people really think or believe, and (4) the context of all the above. Qualitative techniques include key informant interviews, life history narratives, and various structured interviews. The Explanatory Model Interview, introduced by Arthur Kleinman, was designed to help clinicians learn how to better assess cultural ideas about the illnesses of their patients. Focus groups, developed by sociologist
Robert Merton in the 1950’s, serve as a good way to assess cultural consensus about a topic and can be useful for reviewing structured interviews for content and language.

**Publishing Qualitative Research**

Issues may arise in the attempt to publish mixed methods research. Three strategies to combat these challenges are offered. First, aim to publish qualitative and quantitative work in different, relevant venues. Secondly, combine results in a single paper. Finally, publish in a special edition of a journal or edited collection where researchers are able to present a series of papers using qualitative and quantitative methods.

* The slides for this presentation are available on the Presentations document.
The AAKOMA Project refers to African American Knowledge Optimized for Mindfully Healthy Adolescents. It is important to study depression in youth since it is associated with an increased risk of suicidal behaviors (NIMH, 2000). The suicide rate for African American youth (aged 10 - 19) increased from 2.1 to 4.5 or 114% between 1980 and 1995. There exists historical, provider level, and individual level barriers to care for African Americans. In general, the literature suggests that African Americans will initially consult a member of the religious community for guidance and interventions regarding behavioral and emotional problems. The utility of the church and clergy as a means of support for African American families dealing with adolescent behavioral and emotional problems is an emerging area of study incorporated into the present intervention. Community-based participatory research (CBPR) is a collaborative approach to research that involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community with the goal of combining knowledge and action for social change to improve community. Some mechanisms available to people interested in this work include formal training and in vivo training.

The objective of the AAKOMA project is to develop and test an evidence based, culturally relevant behavioral intervention to improve treatment engagement by African American adolescents and families for mental health concerns. The participants will include family members of Black adolescents at risk for or diagnosed with MDD, DD, or BPD. The qualitative aim of the project is to elucidate the psychosocial barriers to participation in clinical treatment and research for mental health concerns. Phase 1 will consist of conducting focus groups, developing the treatment manual, and training therapists. In Phase 2, we will pilot RCT. Some questions to be explored during the focus groups include: What do you think caused the problem? Why do you think it started when it did? What do you think the sickness does? How severe is the sickness? What kind of treatment do you think you should receive? What are the chief problems the sickness has caused? What do you fear most about the sickness? Preliminary findings indicated that African American families think about adolescent depression in terms of active anger and hostility, unexplained withdrawal and sullenness, and defiance of authority. The ultimate goal of this project is to develop and implement an evidence-based behavioral intervention in the area of treatment engagement for depression.

* The slides for this presentation are available on the Presentations document.
The basic rationale for cultural adaptations of EBTs is that it is economical and capitalizes on years of development and controlled trial research. Some EBTs may need modification. This involves the empirical testing of hypothesized strategies for promoting cultural responsiveness. Finally, adaptations can also help identify core elements of EBTs. There are several key concerns. First, although there is limited evidence supporting the effectiveness of EBTs with minorities, there is minimal evidence that they are also less effective with minorities. Second, adaptation may compromise the fidelity and effectiveness of EBTs. Third, the potentially endless proliferation of adapted variants of EBTs seems inefficient and unwarranted. A judicious approach to cultural adaptation would consist of the following: cultural adaptation is specified when there is a reasoned threat of EBT generalization failure. This is indicated by evidence of group differences in treatment response (outcomes), engagement (participation, attrition, compliance), problem etiology (risk, maintenance), and problem phenomenology (symptom patterns).

**Parent Management Training**

Parent Management Training (PMT) is a well-established EBT shown to reduce child conduct problems and abusive parenting. The target of change is child rearing practices. It is characterized by positive attention (play), praise, tangible rewards, effective commands, ignoring misbehavior, time-out, logical consequences, and problem solving. The mechanisms of change may generalize and yet issues of culture are central. Some training indications for adaptation include treatment response (racial disparities—changes positive discipline and child aggression), engagement (racial disparities—harder to enroll minority participants in PMT), and problem etiology (context in which physical discipline issues vary for different cultural groups).

**Culturally Adapting PMT**

Some strategies for cultural adaptation of PMT involve the engagement and therapy process, etiology and therapy content, and practice-based evidence and intensity. In terms of the engagement and therapy process, cultural barriers can interfere with delivery that would otherwise constitute an effective dose. Some therapeutic process adaptations include therapy orientation, framing the intervention to be congruent with cultural goals, anticipating specific misgivings to tailor the approach, and adopting a collaborative style. The Incredible Years approach is an example that is well-suited for the engagement of immigrant families. Using a collaborative, rather than didactic approach, parents first define their goals. In a preliminary study of 145 high-risk immigrant Chinese families in Los Angeles, the treatment consisted of controlling upsetting thoughts (for parents), promoting children’s learning, and communication
training. Results indicated that it was difficult for immigrant parents to learn certain practices, and extra practice was needed.

* The slides for this presentation are available on the Presentations document.
Evidence-Based Treatments for Depression in the Primary Care Sector

Charlotte Brown, Ph.D.
University of Pittsburgh School of Medicine

Approximately 50% of individuals treated for depression are treated by their primary care physician (PCP) (Regier, 1993). Research has shown that racial and ethnic minorities are more likely to seek mental health care in primary care settings. Additionally, many early primary care studies focused on prevalence, symptom profile, and willingness to seek mental health treatment. Patients may be less likely to admit that depression is a psychological problem. As a result, the primary care sector is important for those interested in treating depression in racial and ethnic minorities.

Early Primary Care Treatment Studies

In a study by Charlie Schulberg using a RCT design, researchers compared IPT vs. Medication vs. Usual Care. IPT was delivered by Master’s or Ph.D. level therapists and physicians were trained to use a medication algorithm. Findings demonstrated that IPT was more effective than Usual Care; Medication was more effective than Usual Care; and IPT did not differ significantly in effectiveness relative to Medication. Thus, psychotherapy could be done in primary care settings. In a separate study by Wayne Katon, RCT Collaborative Care for depression was compared to Usual Care in an HMO setting. Collaborative Care addresses changes at three levels: (1) systems level, (2) physician level, and (3) patient level. Findings indicated that Collaborative Care was more effective than Usual Care.

Benefits of Culturally Adapted Interventions

In a research study by Brown and her colleagues (1999), results demonstrated that African American and White depressed primary care patients had similar symptomatic improvement in response to antidepressant medication or IPT. However, African Americans had poorer functional outcomes as well as poorer retention in pharmacotherapy than Whites. The researchers speculate that with the use of cultural adaptations, African Americans may display better functional outcomes and higher retention rates. In one study (Miranda et al., 2003), CBT was administered with case management augmentation for multiracial/ethnic depressed, economically disadvantaged patients with depression. Researchers found no differences in response to CBT, although case management augmentation was effective for Spanish-speaking patients. Results also suggested comparable responses to case management augmentation for English-speaking Whites, African Americans, and Latinos. Araya et al. (2003) demonstrated that multifaceted “Stepped Care” (psychoeducational group and medication management) treatment was superior to Usual Care for depressed women in Santiago, Chile. Similarly, Stepped Care using medication and problem solving therapy resulted in comparable responses to treatment for Whites, African Americans and Latinos (Arean, 2005). Thus, there is an emerging literature suggesting that evidence-based interventions for depression are likely to be effective for diverse populations. Adaptations to treatment include: (1) developing culturally and linguistically appropriate materials, assessments, and techniques, (2) having minority investigators provide...
supervision to local clinicians, and (3) considering patient preference for type of treatment. Adaptations to practice include: (1) providing training in guideline-based medication management, (2) making psychiatric consultation available, (3) using case managers to address non-mental health service needs of clients, and (4) using depression care specialists to monitor adherence and follow-up with patients. The key issue is to transition the patient into specialty mental health service (from the primary care setting). Within this process, it is important to address the patient’s attitudes about depression treatment. The trajectory of depression research appears to support the notion that efficacy research should be used to select promising treatments that can be culturally adapted and implemented effectively in primary care settings. Similarly, effectiveness studies with diverse populations should identify common elements needed to successfully treat depression in primary care.

* The slides for this presentation are available on the Presentations document.
This presentation focuses on the development of an evidence-based prevention intervention for suicide prevention and life skills development with American Indian adolescents entitled the American Indian Life Skills Development Curriculum (AILS; see LaFromboise & Lewis, in press, Suicide and life Threatening Behaviors). The original manual had been used extensively in school and community based programs for youth (e.g., Nation Building for Native Youth, tribal youth employment and training programs, inpatient groups). This manual is available from the Chicago Distribution Center.

Currently, an early adolescent version of the AILS is being developed and plans are underway for its evaluation. In 2007, regional training workshops were offered to 3-person cohorts from 20 Indian reservations to help facilitate the wide scale adaptation of the AILS in Indian Country. Lessons learned from intervention refinement and evaluation were shared. There is a major duality in the widespread adoption of the AILS, namely the desire on the part of tribes for tribal specificity and the mandate on the part of funding agencies for fidelity to evidence-based interventions. Some key assumptions for intervention development with Native communities are that (1) prevention efforts must proceed tribe by tribe, (2) all cultures contain necessary knowledge for prevention, and (3) cultural ways of knowing must be viewed as equal to social science prevention knowledge.

In the Zuni Life Skills Development Cultural Collaboration, community input was provided on local norms, values, and beliefs. There was a historical review of tribal ways of coping, as well as a focus on the impact of suicidal behavior on community well-being. The researchers conducted team-teaching of teachers with tribal members. Finally, there was extensive training of tribal members in suicide intervention skills. In the Zuni Life Skills Development, the skills that were targeted included positive self-talk and problem solving. Results demonstrated a difference in control versus treatment groups. In the Northern Plains Reservation RCT of the American Indian Youth Suicide program, at pretest, 19.6% reported having attempted suicide. In terms of treatment, the Reconnecting Youth treatment was the most effective (i.e., suicidal ideation decreased substantially).

* The slides for this presentation are not available.
The search for cultural competence emerged in response to findings indicating that ethnic minorities are often misdiagnosed, underutilize mental health services, terminate treatment prematurely, and are overrepresented in public mental health institutions. There has been a dearth of psychotherapy process research with ethnic minority populations. Studies that do exist have focused almost exclusively on ethnic match with few studies involving empirically supported treatments. The results of ethnic match studies, however, have yet to yield information to help inform therapists of what to do within sessions that is uniquely beneficial with their ethnically similar clients. The researchers conducted an extensive review of studies on cultural competence.

**What is Cultural Competence and Does it Predict Outcomes?**

The first question of interest addressed whether or not experts agree on the definition of cultural competence, and what the experts agree on (in terms of cultural competence). A list of cultural competence elements were identified by an initial expert group, including cultural knowledge and awareness, cultural sensitivity, therapist flexibility, respect for client, recognizing one’s own biases, client empowerment, culturally appropriate interventions, problem solving, and basic clinical skills. Next, fifteen clinicians (each with at least eleven years of experience working with African American clients) indicated whether each proposed item mapped onto cultural competence. In general, results indicated that experts did not agree on the definition of cultural competence. However, items with high expert agreement included (1) clear communication, (2) problem focused, and (3) positive focus/warmth.

A second question focused on whether or not cultural competence actually results in better outcomes. In particular, do the aforementioned cultural competence items predict better treatment outcomes for African Americans than Caucasian families? Using archival data that assessed delinquent and aggressive behavior in Black and White families, the second study examined the therapy process using a measure containing “culturally competent” items from Study 1. The findings replicated the results of Study 1 in that experts generally did not agree on the specifics of culturally competent behavior. In addition, the behaviors did not reliably predict positive outcomes for African American families. In fact, sometimes the items predicted worse outcomes.

**Therapist Factors and Cultural Competence**

In response to previous work on cultural competence, a third study was designed to identify therapy process behaviors that contribute to caregiver engagement in multisystemic therapy (MST), generally, and specifically, with African American families. The goals of the research were to identify therapist behaviors that contribute to caregiver responsiveness in MST with
African- and European-American families as well as examine the relationship between therapist behavior and caregiver responsiveness in treatment as a function of (1) family race and (2) racial similarity between therapist and caregiver. Using data drawn from a clinical trial examining the effectiveness of juvenile drug court under two MST treatment conditions (drug court with MST vs. drug court with MST enhanced with contingency management), results showed positive outcomes for therapists who used more supportive, validating behaviors with racially dissimilar clients. Results also demonstrated, however, that therapists who did more teaching and storytelling may have contributed to decreased participation by African American caregivers. However, teaching was associated with high engagement and positive response, regardless of race.

Overall, researchers and providers need to move away from promoting general guidelines for cultural competence practice, particularly when such practices do not have empirical support. Second, experts need to further operationalize culturally competent practice based on therapist behaviors that have been found to be useful with specific populations. Failure to operationalize cultural competence behavior and to link such behavior to improved mental health functioning may result in devoting limited resources to the dissemination of empirically unsupported perspectives.

* The slides for this presentation are available on the Presentations document.
Foundation as Player in Developing Evidence-based HIV Community Programs

Bart Aoki, Ph.D.
California HIV/AIDS Research Program

California’s population is quite different than the general population of the United States. Two notable differences include the presence of more foreign-born individuals who reside in California as well as more individuals for whom English is a second language. There are also differences at the state and national level in the composition of ethnic minority individuals with HIV. With regards to California’s HIV epidemiological profile, 76% of reported HIV cases are among men who had sex with men; African Americans comprise 7% of California’s population, despite constituting 18% of HIV cases; and conversely, while Hispanics make up 35% of California’s population, they constitute only 25% of HIV cases. Research has identified factors associated with adoption and implementation of innovative practices, including (a) organizational capacity, (b) fit with organizational and community values, (c) intervention characteristics, and (d) external policy context.

Community Collaborative Research Grants and Translational and Operational Research Grants

The three aspects of the California HIV/AIDS Research Program (CHRP) grant making enterprise model are: (1) community collaborative research grants, (2) translational and operational research grants, and (3) rapid research policy grants. The partnership characteristics of the community collaborative grants include a shared vision, resource commitment, and outputs for all sectors. The key features of these types of grants are community-academic partnerships, collaborative development and implementation, and diverse research questions and methods. The key features of the translational and operational research grants are using the structure of collaborative grants, studying the process of translating and tailoring evidence-based interventions, and specifically focusing on community and organizational fit.

Learning from Street Smart and Mpowerment

The grant review is similar to the NIMH model with the exception of bringing in community experts. Two funded studies are Street Smart and Mpowerment. Street Smart assessed EBPs relevant for young, Latino gay men in Los Angeles, while Mpowerment was tailored to young, African American gay men. Translation of the findings from these two studies suggests that interventions should be adapted by incorporating culture, identity, and empowerment. Also, intervention adaptations focused on enhancing flexibility, consistency, and integration with agency/staff philosophy, values, and practices. Some challenges faced in these projects were the funding environment, staff turnover, and competing interests.

Rapid Policy Research Grants

The key features of rapid policy research grants include: (a) the consensus prioritization of timely policy research questions, (b) the identification of qualified investigator teams, (c) a
collaborative advisory process, and (d) the collaborative dissemination of policy relevant findings. The process for rapid policy research grants works in the following manner: Input process by stakeholders → qualified research teams → collaborative research process → collaborative dissemination process. Further work is needed with (a) communities for sustained involvement in collaborative research and development and for continued creativity and advocacy, (b) scientists to examine indigenous processes and contextual factors and to have the willingness to engage in cross-discipline and cross-sector collaboration, and (c) funders and policy makers to support collaborative community-based research, sustain community level infrastructure for evidence-based practices, and validate cultural and context-specific research and practices.

* The slides for this presentation are available on the Presentations document.
CAL-PEP’s philosophy includes the following three components: (1) approaching the community in a nonjudgmental fashion, being flexible with time, and working with people on their own terms, (2) using incentives for intervention participation, not in a coercive manner, but rather, recognizing the practical needs of people (e.g., money for transportation), and (3) peer based hiring of individuals from the target population. There are also important definitions used to train staff. For example, the definition of culture is a life affirming code of behavior that supports evidence. Cultural competency is a set of congruent behaviors, attitudes, and policies within an agency; cultural competency is CAL-PEP’s capacity to function within the context of cultural beliefs, behaviors, and needs of consumers and their communities. Some of the goals on CAL-PEP’s research agenda include utilizing research to reinforce and support CAL-PEP’s evidence-based HIV prevention interventions, ensuring high quality evidence-based interventions for clients, and developing evidence-based outcome evaluation capacity for behavioral and biological interventions. CAL-PEP began conducting research in 1992 and since then it has emphasized the testing of evidence-based HIV prevention interventions, and the testing and analysis of theories and practices that lead to effective evidence-based service models, which can be replicated.

**Learning from Mobile Clinics**

One particular project was designed to evaluate mobile clinics. Lessons learned from this project include (a) those who came to the clinic acknowledged that they did indeed have a problem with drugs and (b) whereas in this first project we did not promote a message and instead, advised clients on drug safety and distributed the appropriate paperwork, in subsequent projects, we adopted a zero tolerance policy. CAL-PEP has also developed capacity in questionnaire development, qualitative and quantitative methods, process evaluation, outcome evaluation, data and specimen collection and reporting, data management, and quality assurance. It is also building capacity in data analysis.

**Benefits and Challenges in Working with Community Based Organizations and University Partners**

For CAL-PEP, the community and university serve as a key partnership, with each entity being invaluable to the research conducted by CAL-PEP. The collaboration experience requires capacity-building for both partners, training for both partners, and outcomes for both partners. Skills needed for collaboration parallel those skills needed to create a good marriage such as communication, data collection and management, and perseverance, among others. Some challenges related to collaborating with university partners include limited resources, lack of focus by CBO due to competing commitments, limited control of CBO staff, real world issues
that may impact research and intervention, and being too ambitious. Some of the lessons learned from CBOs include: (a) following up poses an ongoing challenge, (b) interventions and projects should be kept simple, and (c) incentives should be maintained at an adequate level. Benefits of the collaboration for CBOs should be noted and these include: (a) collaboration as a means of providing linkages to academic institutions for scientific trainings that reinforce and support the agency’s mission, (b) improving capacity for recruitment and retention of program participants, and (c) improving program capacity. Some benefits of collaboration for universities include (a) improving an understanding of community norms and the target population to develop culturally relevant programs and a better frame for the scientific approach, (b) providing a mechanism to document and disseminate findings derived from effective interventions, and (c) improving the capacity to conduct community-based research, thus, enhancing opportunities for publication.

* The slides for this presentation are available on the Presentations document.
Town Hall Session Details

Eduardo Morales, Ph.D.
Alliant International University

Sharon R. Jenkins, Ph.D.
University of North Texas

The Town Hall session began with participants offering various ideas about using the information obtained from this conference to generate further research on cultural issues in evidence-based practices. Participants also discussed the following: (a) strategies for maintaining this network of conference participants; (b) lessons learned from the conference; (c) assumptions that went unchallenged; and (d) looking ahead to the future and to the next conference.

Maintaining the Network

- Create an interactive website, leave participation open and flexible.
  - Create a log-in to Google docs -- develop template and have people access the website themselves and update their info.
- Include participant profiles/list in the program; include areas of interest as well.
- Is there a way to have participants enter their own data online?
- Have experts volunteer their time to mentor (list mentorship opportunities online).
  - Division 45 (minority psychology) has mentoring opportunities.
- Blogs to start the conversation; include references and other resources.
- Links for participants, resources, online where PowerPoints will be provided.
- There is a need to distill key principles that are important in designing research projects and implementing the interventions.
- Provide information to inform those who may have misconceptions about the process.
- Create an online working group.
- Post information on other conferences that may be relevant.
  - Call for abstracts for the International Society for Psychiatric Nurses for 2009.

Lessons Learned, Key Ideas

- What are we doing to adapt the interventions? Presenters provided a great model for presenting translations of interventions.
- Presenters were great models for junior investigators.
- Learned about the importance of thinking about interventions from an ecological perspective.
- Great discussion about IRB.
- Attention to details surrounding implementation, moving from research to population.
- Tension between the amount of time it takes to appropriately develop culturally appropriate ESTs and the immense need of the minority populations.
• How do we apply these theories to a multicultural population when matching is not feasible?
• Learning how to bridge the gap and reducing the 17 years it takes for ESTs to be disseminated.
• Learning about the community perspective and collaboration was helpful to reduce the feelings of isolation as an academic.
• Learned a lot of good ideas about how to adapt ESTs.
• Make a statement to NIH about the failure of including multicultural populations in EBT research. Issues about engagement and retention need to be addressed.
• Partnerships between academics and community organizations.
• Inspired by the work that has already been done.
• Networking!! (Provide a place where those who attended can continue to connect).
• Collaboration was facilitated between CBOs and academics.
• Great balance between the community organizers and academics; exciting to see the work that has been done.
• 95% of people are not accessing substance abuse services - remember there are still people who need services.
• Don’t think about the process of cultural adaptation as a singular issue, we can apply these lessons to majority populations as well.
• Incorporate biological and medical professionals in future conferences and collaborations.
• We’re never going to be able to adapt all of these instruments for everyone: but it is about the process that is where we learn.
• Good to hear from a consumer organization (NAMI).
  o Bringing together the whole community.
• It is not only about adapting instruments with minority populations.
• It would be helpful to have a product of the conference: guidelines, points to consider, consensus statement that can then be used to inform grant development.
  o Adaptation process
• Incredible opportunities for mentorship, we have gotten to this point despite our training.
• Having access to data in minority populations is vital, we can learn from non-significant findings as well.

Assumptions Not Adequately Challenged

• Western psychological approaches are the only way to elicit healing/change.
• There are researchers in international settings that are already addressing some of these issues.
• Not enough discussion about building upon already established healing systems within cultures, more emphasis on traditional healing practices.
• Child assessment is broader than just ADD/ADHD and learning disabilities.
• Should we look at culture instead of ethnicity?
• Lack of concentration on natural healing, or spiritual ways of healing: Are EBTs the only approach?
• We need to learn the principles of cultural competence.
The Future

- Have clinicians tell us about how they are using EBT to inform their clinical practice (relationship between EBT and clinical judgment).
- Have more multidisciplinary members for the next time (e.g. developmental).
- Integrate this forum into larger conferences to reach a broader audience.
- Find a way to keep it multidisciplinary.
- Keep informed with social policy.
- Remember the impact that we are having on the real people that are suffering.
- There is currently a great amount of developmental research on minority children that we can apply and incorporate into our clinical trials.
- Acknowledging the importance of clinicians in research, including what community members and families are doing to inform research.
- Make sure we don’t stop at ethnicity, include gender, social class, sexual orientation...look at the intersection of all of these factors.
- Collaborate with NAMI - We can have a greater impact together than alone.

Next Conference

- Cost is a huge factor in having this conference.
- Include multidisciplinary members.
- Get a core group of divisions to help move ahead, conference calls among division leaders to think about where we want to go next.
- Provide information to the clinicians who are practicing. Make the information useable to them to help them apply the findings of RCT in their work.

Division 45 invites comments. The division’s theme for this year: Using our traditional teachings to inform practice.

* The slides for this presentation are not available.
March 13, 2008

Dear Conference Attendees and Participants,

Welcome to the first National conference on Culturally Informed Evidence Based Practices: Translating Research and Policy for the Real World. This is the first conference that brings together perspectives from researchers, program evaluators and practitioners who develop and implement interventions from the ground up. Presenters are a mixture of experts to share innovations in generating data and evidence for practice with communities of color in the United States.

This conference was initiated and lead by the Society for the Psychological Study of Ethnic Minorities, Division 45 of the American Psychological Association on April 28, 2006. Four other APA Divisions were the major collaborators of this effort that include Division 12 – Society of Clinical Psychology, Division 17 – Society of Counseling Psychology, Division 37 – Society for Child and Family Policy and Practice, and Division 42, Psychologists in Independent Practice. The Conference Organizing Committee consisted of representatives of these organizations as well as our federal funders, Substance Abuse Mental Health Services Administration (SAMHSA) and National Institute of Mental Health (NIMH). We are very grateful to SAMHSA and NIMH as well as all of our co-sponsors listed in the program who provided financial support for this conference. With 25 APA Divisions sponsoring this conference, this is the largest sponsored national conference in the history of APA aside from the Annual APA Convention.

We hope this conference generates ideas and inspiration to everyone to begin to increase the availability of evidence in interventions with communities of color. There is a great need for having a larger body of evidence that demonstrates effectiveness and integrates culturally appropriate interventions. There are many challenges in meeting these objectives and this conference hopes to generate the dialogue and perspectives to address those challenges and present strategies that have sound innovative methodologies with efficacious outcomes. We expect to have several publications from the presentations of this conference published in peer review publications.

Thank you for your support and in attending this landmark conference.

Sincerely,

Eduardo Morales, Ph.D. Nolan Zane, Ph.D.
Conference Co-chair Conference Co-chair
CSPP-SF Asian American Center for Disparities Research
Alliant International University University of California, Davis
Culturally Informed Evidence Based Practices: Translating Research and Policy for the Real World

March 13 & 14, 2008
Double Tree Hotel and Executive Meeting Center Bethesda, Maryland

Sponsored by:
Substance Abuse and Mental Health Services Administration (SAMHSA)
National Institute of Mental Health (NIMH)
Asian American Center on Disparities Research (AACDR)
Alliant International University
Co-Chairs
Eduardo Morales, Ph.D., Alliant International University
Nolan Zane, Ph.D., University of California, Davis

Planning Committee
Guillermo Bernal, Ph.D., University of Puerto Rico
Cheryl Boyce, Ph.D., NIMH
Allice M. Brelan-Noble, Ph.D., Duke University Medical Center
Carol Falender, Ph.D., University of California Los Angeles
Felipe González Castro, M.S.W., Ph.D., Arizona State University
Larke Huang, Ph.D., SAMHSA
Sharon Jenkins, Ph.D., University of North Texas
Fred Leong, Ph.D., University of Tennessee
Ken Martinez, Psy.D., Technical Assistance Partnership, Washington, D.C.
Natalie Porter, Ph.D., CSPP-SF, Alliant International University
Elizabeth Vera, Ph.D., Loyola University

Coordinating/ Lead Division
Society for the Psychological Study of Ethnic Minority Issues – Division 45 of the American Psychological Association (APA)

Lead Sponsors
APA Division 12 - Society of Clinical Psychology
APA Division 17 - Society of Counseling Psychology
APA Division 37 - Society for Child and Family Policy and Practice
APA Division 42 - Psychologist in Independent Practice

Supporting Organizations
APA Division 12, Sec 6 - Clinical Psychology of Ethnic Minorities
APA Division 13 - The Society of Consulting Psychology
APA Division 15 - Educational Psychology
APA Division 18 - Psychologists in Public Service
APA Division 20 - Adult Development and Aging
APA Division 22 - Rehabilitation Psychology
APA Division 27 - Society for Community Research and Action
APA Division 28 - Psychopharmacology and Substance Abuse
APA Division 29 - Independent Practice
APA Division 35 - Society for the Psychology of Women
APA Division 38 - Health Psychology
APA Division 39 - Psychoanalysis
APA Division 40 - Clinical Neuropsychology
APA Division 43 – Family Psychology
APA Division 44 - Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues
APA Division 48 - Society for the Study of Peace, Conflict and Violence
APA Division 50 - Addictions
APA Division 51 - The Society for the Psychological Study of Men and Masculinity
APA Division 53 - Society for Clinical Child and Adolescent Psychology
APA Division 54 - Society of Pediatric Psychology
APA Division 56 - Trauma Psychology
American Psychological Association
Asian American Psychological Association
National Latino Psychological Association

Accreditation Statement:

Alliant International University is approved for up to 13 hours of continuing education credit by the American Psychological Association to sponsor continuing education programs for psychologists. Alliant International University maintains responsibility for this program and its content.

Alliant International - Continuing Education is approved by the American Psychological Association (APA) to offer continuing education for psychologists. AIU-CED maintains responsibility for this program.
**Conference Schedule**

All events will take place in *(Grand Ballroom B/C)* except where noted

### Day 1: Thursday, March 13, 2008

*The Research Context: Methodological, Measurement, and Ethical Issues*

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 9:00am</td>
<td>Welcome and Opening Remarks</td>
</tr>
<tr>
<td>9:00 – 10:40am</td>
<td>Plenary Panel I: Has Policy Jumped the Gun? The Collision between Science and Community</td>
</tr>
<tr>
<td>10:40 – 11:00am</td>
<td>Morning Break</td>
</tr>
<tr>
<td>11:00am – 12:30pm</td>
<td>Plenary Panel II: Obtaining the Evidence: The Context and Challenges in Methods and Measurement for Racial/Ethnically Diverse Populations</td>
</tr>
<tr>
<td>12:30 – 1:15pm</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:15 – 2:15pm</td>
<td>Keynote Address</td>
</tr>
<tr>
<td>2:15 – 2:30pm</td>
<td>Afternoon Break</td>
</tr>
<tr>
<td>2:30 – 5:30pm</td>
<td>Workshop Presentations</td>
</tr>
<tr>
<td>5:30 – 7:00pm</td>
<td>Reception and Vendor Booths</td>
</tr>
</tbody>
</table>

### Day 2: Friday, March 14, 2008

*Interventions, Implementation with CBOs, and Consumer Participation in Research and Program Evaluation*

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:15am</td>
<td>Overview and Recap</td>
</tr>
<tr>
<td>8:15 – 10:30am</td>
<td>Plenary Panel III: Perspectives from Researchers in the Field: Critical Collaborations from the Ground and Up</td>
</tr>
<tr>
<td>10:30 – 10:45am</td>
<td>Morning Break</td>
</tr>
<tr>
<td>10:45am – 12:15pm</td>
<td>Plenary Panel IV: Innovative Models for Collaboration</td>
</tr>
<tr>
<td>12:15 – 1:00pm</td>
<td>Luncheon Discussion Tables</td>
</tr>
<tr>
<td>1:00 – 3:00pm</td>
<td>Town Hall Meeting</td>
</tr>
<tr>
<td>3:00pm</td>
<td>Closing and Evaluations</td>
</tr>
</tbody>
</table>
### Evidence-Based Practice in Psychology

*Ronald F. Levant, Ed.D., ABPP, The University of Akron*

<table>
<thead>
<tr>
<th>Overview:</th>
<th>Learning Objectives:</th>
</tr>
</thead>
</table>
| This presentation will define Evidence-based practice in psychology (EBPP) as the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. We will contrast Evidence-Based Practice in Psychology with Evidence-Based Treatments, Empirically Supported Treatments, and Empirically Validated Treatments. We will then provide an overview of the first two legs of the stool, best available research and clinical expertise, and then go into some depth on the third leg, patient characteristics, culture, and preferences. | 1. Understand what Evidence-Based Practice in Psychology is, as contrasted with Evidence-Based Treatments, Empirically Supported Treatments, and Empirically Validated Treatments.  
2. Understand the issues that surround patient characteristics, culture and preferences. |
Plenary Session Details

Thursday, March 13, 2008
9:00-10:40am

**Plenary Panel I: Has Policy Jumped the Gun? The Collision between Science and Community**

Chair: Ronald F. Levant, Ed.D., ABPP, The University of Akron

---

**The Cultural Context of Methods, Practices, and Policy**

* Luis Vargas, Ph.D., University of New Mexico

Overview:
This presentation will address methodological issues pertaining to the development of evidence-based treatments (EBTs) and the application of EBTs to culturally diverse populations. The cultural context of current EBTs and evidence-based practice (EBP) will be examined. Strategies to develop culturally responsive EBTs and to engage in EBP will be presented. Policy and ethical implications associated with the dissemination of “standard” EBTs for use with culturally diverse populations will be discussed.

Learning Objectives:
1. Recognize the cultural context of EBTs and EBP.
2. Become familiar with some strategies to develop culturally responsive EBTs.
3. Appreciate some of the policy and ethical implications associated with the dissemination of “standard” EBTs for use with culturally diverse populations.

---

**“Who Sees Me?” Adapting Psychological Services to the Ethnocultural Needs of Consumers and Families**

* Nancy Carter, NAMI Urban Los Angeles

Overview:
This presentation will the perspectives of consumers with diverse backgrounds and needs. The dynamics of families with multiple challenges are discussed and ways of making services more relevant to consumers is presented.

Learning Objectives:
1. Become familiar with the ethnocultural needs of consumers in the treatment setting.
2. Examining ways to adapt the delivery of interventions to meet relevant needs of consumers.
### Culturally Informed Evidence Based Practices: Translating Research into Culturally-Informed Prevention Interventions

**Felipe González Castro, M.S.W., Ph.D., Arizona State University**

**Overview:**
This presentation examines critical issues in the design of scientifically effective and culturally-informed prevention interventions and health promotion programs. Evidence on program effectiveness when applied within a community setting often shows small effect sizes, suggesting that much can be done to increase program effects in changing targeted health outcome variables. Cultural adaptation may improve relevance and effect size, if the adapted intervention can increase consumer interest, participation and motivation for healthy behavior change. The battle to reduce health disparities can benefit greatly from interventions and programs that “work better.” The integration of science and culture within hybrid structural models is key for uncovering the mechanisms of effect that produce the strongest and most enduring health behavior change.

**Learning Objectives:**
1. Identify and understand intervention strategies and structural model components that aid in testing intervention effects and identifying mechanisms of healthy behavior change.
2. Identify major cultural factors that may be incorporated into classic health behavior change interventions and models, in efforts to increase their cultural relevance and efficacy in promoting healthy behavior change in racial/ethnic minority and other special populations.

### Culturally Informed Treatment: Desperately Needed Research Directions to Optimize Impact

**Alan Kazdin, Ph.D., ABPP, Yale University**

**Overview:**
The paucity of available services, the number of different groups in need in our own culture but world wide, and the dominant model of therapy converge to convey the need for a dramatic change our research and practice. The presentation will highlight the need for novel lines of work to improve the applicability of treatments across diverse groups and to improve the impact they are likely to have.

**Learning Objectives:**
1. Understand current models of treatment research in use and their limitations.
2. Identify alternative lines of research that could extend both our understanding and clinical impact of culturally informed treatments.
Plenary Session Details

Thursday, March 13, 2008
11:00am-12:30pm

Plenary Panel II: Obtaining the Evidence: The Context and Challenges in Methods and Measurement for Racial/Ethnically Diverse Populations

Chair: Cheryl Boyce, Ph.D., NIMH

Learning Objectives:

1. Acquire basic knowledge about measurement of constructs.
2. Acquire knowledge about the challenges embedded in conducting empirically-based intervention research with ethnic minority populations.
3. Learn about state-of-the-art research efforts occurring in this area of research.

Cultural Competence Issues and Evidence-Based Psychological Practices

Nolan Zane, Ph.D., University of California, Davis

Overview:

Cultural competence is an important and necessary condition of evidence-based practice in psychology, and, as such, EBPP can be a great catalyst for addressing ethnic and racial disparities in mental health treatment and services. The major problem involves the lack of specific strategies to guide research on developing adaptations to treatments that may be more culturally syntonic for ethnic minority clients. Based on a review the available research on EBPPs and treatment-relevant cultural variations, specific research strategies are presented that can enhance cultural competence in treatment and assessment.

Learning Objectives:

1. Identify important domains of cultural variations that may affect a client’s response to many evidence-based treatments.
2. Present specific research strategies that may prove productive for enhancing cultural competence in evidence-based treatments and assessments.
## Bringing Interventions from the Community to the Clinics: The Case of RQP

**Margarita Alegria, Ph.D., Harvard Medical School**

### Overview:

Few exemplars exist of strategies originally developed in community settings that are adapted to clinical settings for evaluation. This presentation describes an intervention program called the Right Question Project – Mental Health (RQP-MH), which is an adaptation of an education strategy first developed by a community non-profit organization. RQP-MH was developed for use with mental health outpatients in a clinic predominately serving ethnic minorities to identify questions that would help them consider their role, process and reasons behind a decision; and empowerment strategies to better manage their care. We present our findings and discuss the process of integrating community expertise for intervention development.

### Learning Objectives:

1. Identify ways in which community expertise can be integrated into clinical service interventions.
2. Understand a patient activation and empowerment intervention integrating community expertise.

## Treatment Effects for Ethnic-Minority Populations: Meta-Analytic Findings

**Antonio Polo, Ph.D., DePaul University**  
**Stanley Huey, Jr., Ph.D., University of Southern California (co-author)**

### Overview:

This presentation will summarize the findings related to mental health clinical trials conducted on ethnic minority populations. The focus is on time trends, generalizability of findings from randomized clinical trials, and representation of ethnic minority youth in evidence-based treatments.

### Learning Objectives:

1. Identify which evidence-based interventions have been shown to have efficacy among ethnic minority youth.
2. Understand the limited evidence regarding the efficacy of cultural adaptations for well-established treatments for youth emotional and behavioral problems.
**Overview:**

As the US population continues to diversify, it becomes increasingly important to develop and implement culturally competent mental health practices. Although important advancements have been made in the development of such practices, relatively little is known about the conditions that lead to their successful implementation into every day mental health services. This presentation introduces an organizational cultural competence model, based on a 10-year review of the literature, describing the characteristics of those mental health service organizations and delivery-systems that successfully implement and sustain culturally competent practices. Understanding these characteristics is of crucial importance in ensuring that culturally-competent practices are available to the populations that most need them, and for whom they were developed.

**Learning Objectives:**

1. Introduce the crucial role of mental health services organizations in ensuring culturally competent services.

2. Introduce organizational factors associated with the successful implementation of culturally competent mental health practices.
Keynote Address Details

Thursday, March 13, 2008
1:15-2:15pm

Chair: Norman Anderson, Ph.D., American Psychological Association

Salutations: Richard Nakamura, Ph.D., Deputy Director, NIMH
Larke Huang, Ph.D., Senior Advisor on Children, SAMHSA

### Moving Evidence Based Interventions to Practice: The Blending Initiative

**H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, Center for Substance Abuse Treatment (CSAT) of SAMHSA**

<table>
<thead>
<tr>
<th>Overview:</th>
<th>Learning Objectives:</th>
</tr>
</thead>
</table>
| This keynote presentation will focus on thinking out the box in generating evidence for practice. An innovative strategy combining the programmatic efforts of CSAT and NIMH will be presented and discussed. Challenges and workable solutions in blending researchers’ expectations and the reality of providing treatment in the field with real life situations are presented. | 1. Acquire knowledge about different strategies in generating evidence.  
2. Acquire knowledge about the challenges embedded in blending researchers and practitioners in real life settings.  
3. Learn about state-of-the-art research efforts occurring in this area of research between CSAT and NIMH. |
Workshop Details

Thursday, March 13, 2008
2:30-5:30pm

**Empirical and Conceptual Approaches to Ethnically Diverse Populations and the Integration of Indigenous Evidence**

Location: Harmony

---

| **Conceptual and Measurement Issues in Evidence Based Clinical Research: The Case of Racial Identity**  
  Mia Smith Bynum, Ph.D., Purdue University |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview:</strong></td>
</tr>
<tr>
<td>This session will focus on methodological issues and determining outcomes and psychosocial correlates in evaluating programs and doing research on effective interventions. Examples of strategies in designing research and collaborative investigative efforts will be examined. Strengths and weaknesses of different methodological approaches will be explored. The challenges and solutions of measurement of psychosocial and racial identity issues will be presented.</td>
</tr>
<tr>
<td><strong>Learning Objectives:</strong></td>
</tr>
<tr>
<td>1. Increase knowledge of different methodological approaches in designing research and program evaluations.</td>
</tr>
<tr>
<td>2. Examine the challenges and solutions in working with collaborators in the community and involving consumers in the development of research and program evaluation.</td>
</tr>
<tr>
<td>3. Examine measurement issues and solution for studying impact, psychosocial correlates and racial/ethnic identity.</td>
</tr>
</tbody>
</table>
### Indigenous Evidence-Based Effective Practice Model

Valerie Naquin, M.A., Cook Inlet Tribal Council, Inc.
Shannon Sommer, BSW, Cook Inlet Tribal Council, Inc.

<table>
<thead>
<tr>
<th>Overview:</th>
<th>Learning Objectives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The demand for evidence-based behavioral health practices has created a</td>
<td>1. Recognize that the current assumptions around developing evidence-based practice</td>
</tr>
<tr>
<td>cultural challenge for Indigenous people around the world. The nature of</td>
<td>marginalize the knowledge and experience of Indigenous cultures.</td>
</tr>
<tr>
<td>“evidence” and the means by which to acquire it are deeply rooted in a</td>
<td>2. Recognize the need for evidence-based practices that are rooted in culture.</td>
</tr>
<tr>
<td>scientific tradition that emanates from a particular cultural origin.</td>
<td></td>
</tr>
<tr>
<td>As a consequence, prevailing assumptions often marginalize the knowledge</td>
<td></td>
</tr>
<tr>
<td>and experience of other cultures, compromising the utility of interventions</td>
<td></td>
</tr>
<tr>
<td>as exported to other populations. Through the leadership of an Alaska</td>
<td></td>
</tr>
<tr>
<td>Native tribal organization, an international forum was convened to</td>
<td></td>
</tr>
<tr>
<td>address the challenges of evidence-based practice for Indigenous people.</td>
<td></td>
</tr>
<tr>
<td>Forum participants developed a model for gathering evidence that</td>
<td></td>
</tr>
<tr>
<td>integrates rigorous research with Indigenous knowledge and values. Three</td>
<td></td>
</tr>
<tr>
<td>levels of evidence, each building on the others in order of increasing</td>
<td></td>
</tr>
<tr>
<td>rigor, were proposed with corresponding criterion-driven algorithms for</td>
<td></td>
</tr>
<tr>
<td>inclusion. The model facilitates development of practices and programs</td>
<td></td>
</tr>
<tr>
<td>that are culturally congruent for Indigenous people, accepted and</td>
<td></td>
</tr>
<tr>
<td>validated by the research community, and deemed supportable by private</td>
<td></td>
</tr>
<tr>
<td>and governmental sponsors.</td>
<td></td>
</tr>
</tbody>
</table>
### Cultural Differences in Diagnosis and Treatment

**Overview:**
Black Americans are less likely than whites to have major depressive disorder (MDD), however, when they do, it tends to be more chronic and severe. This presentation will be an introduction to the critical correlation between cultural differences and standard care and diagnosis; and how stereotyping on behalf of the provider and the lack of trust from the patient affects the diagnosis.

**Learning Objectives:**
1. Recognize the need to understand cultural differences as it pertains to providing proper care.
2. Understand the differences in interpretations when conducting assessments on minority patients.

### Depression Prevention and Treatment Interventions in Spanish and English

**Overview:**
This workshop will focus on the development of evidence-based prevention and treatment manuals for depression at San Francisco General Hospital over the last 30 years (See: Muñoz & Mendelson, 2005, JCCP, 2005, 73, 790-799). The manuals have been used in both research and direct service contexts in the public sector (e.g., the Depression Clinic at San Francisco General Hospital). They have also been used in several sites in the U.S., Puerto Rico, Mexico, Perú, and Europe. The manuals are available for download from the Latino Mental Health Research Program site (Google “LMHRP”). We will also discuss a major limitation of face-to-face interventions, namely the need to have trained providers available to administer them. How do we reach people in need who cannot or will not come to mental health facilities, or who do not speak the providers’ language? The need to develop and test evidence-based Internet interventions for many health problems and in many languages will be presented, along with proof-of-concept randomized control trials showing that people worldwide will participate in such studies and benefit at levels comparable to traditional interventions.

**Learning Objectives:**
1. Obtain existing cognitive-behavioral manuals in Spanish and English for the prevention and treatment of depression and determine whether they are applicable to the populations they serve.
2. Understand the difference between consumable interventions (such as face-to-face treatment and medications, which can only be used one time) and evidence-based Internet interventions, that, once developed and tested, can be shared again and again, with unlimited users worldwide, exactly as evaluated, and without taking anything away from local populations.
## Family Interventions

**LOCATION:** Juniper

### Returning to the Family: Developments in the Treatment of Depressed Latino Adolescents

**Guillermo Bernal, Ph.D., University of Puerto Rico**

**Overview:**

The presentation will focus on the development, adaptation and testing of a family psycho-educational intervention for Puerto Rican adolescents with depression. A review of a research program that began in 1992 aimed at developing and testing effective treatments are described (instrument development, cultural adaptations of the interventions, and the evaluation of outcomes). The results of two clinical trials will be summarized and preliminary results from an on going efficacy study will be presented. The current study examines the impact of enhancing individual CBT for adolescents by involving parents in psychoeducational workshops. The process of developing the parent intervention is described and the added value of involving parents is discussed.

**Learning Objectives:**

1. Identify the key features of evidence-based family interventions for depressed Latino adolescents.
2. Understand the issues in the cultural adaptation and testing of evidence-based interventions.

### Engaging African American Children and their Families

**Norweeta Milburn, Ph.D., University of California, Los Angeles**

**Overview:**

This presentation will examine the challenges of recruiting, engaging and retaining families of African American adolescents in community-based HIV family interventions. Challenges and lessons learned from an on-going trial of a family intervention for homeless adolescents and their families will be discussed. A culturally appropriate model for recruiting and engaging families will be described and discussed.

**Learning Objectives:**

1. Understand the challenges of recruiting, engaging and retaining African American adolescents and their families in community-based family interventions.
2. Identify strategies for more effectively recruiting, engaging and retaining African American adolescents and their families in research to develop evidence-based family interventions.
**Overview:**

Family involvement is a key ingredient in the success of any intervention. This includes:

1. The roles families can play in the processes of identifying, describing, evaluating, and promoting evidence-based practices;
2. The roles families can play in creating strategies to study effective practices for which there is no scientific evidence base;
3. A family perspective on “evidence.”

**Learning Objectives:**

1. Participants will be exposed to a family perspective on “evidence.”
2. Participants will understand how they might begin to partner with families to develop evidence for practices families believe are effective.
### An Overview of the Multicultural Assessment Intervention Process (MAIP) Model

**Glenn C. Gamst, Ph.D., University of La Verne**

**Overview:**

This presentation will provide participants with an overview of the Multicultural Assessment Intervention Process (MAIP) model. The MAIP is a mental health service delivery model that focuses attention on key cultural variables assumed to impact clinical outcomes. These variables include: consumer-provider ethnic/racial match, consumer acculturation status, consumer ethnic identity, and provider self-perceived cultural competence. A review of current empirical support for the model is provided.

**Learning Objectives:**

1. Participants will understand the basic components of the MAIP model.
2. Participants will be familiar with the empirical support for the MAIP model.

### Culturally Informed Evidence Based Practices: “Tell Me A Story” Assessment of Multicultural Children

**Giuseppe C. Costantino, Ph.D., Lutheran Medical Center**

**Overview:**

The TEMAS (Tell-Me-A-Story) test is a narrative assessment technique developed to reduce/eliminate test bias in assessing minority youngsters. The test presents culturally relevant pictorial stimuli, a psychometrically reliable problem-solving scoring system, and a standardization sample of Black, Hispanic and White children and adolescents. Several studies indicate that the TEMAS show adequate reliability and validity to accommodate children’s cultural diversity.

**Learning Objectives:**

1. Have knowledge of negative effects of test bias.
2. Appreciate the benefits of non-biased, culturally competent, evidence based assessment instrument.
### Interventions with Children
LOCATION: Lilac

#### The Process of Culturally Adapting Evidence Based Treatments for American Indian and Alaska Native Children – Lessons Learned

*Dolores Subia BigFoot, Ph.D., University of Oklahoma Health Sciences Center*

<table>
<thead>
<tr>
<th>Overview:</th>
<th>Learning Objectives:</th>
</tr>
</thead>
</table>
| This presentation will cover the process utilized in the cultural adaptation of evidence-based treatments for American Indian/Alaska Native children. An overview of four adapted evidence based treatments will be presented, Honoring Children-Mending the Circle (TF-CBT), Honoring Children-Respectful Ways (Treatment of Children with Sexual Behavior Problems), Honoring Children-Making Relatives (Parent-Child Interaction Therapy) and Honoring Children-Honoring the Future (Suicide Intervention-Prevention Strategies). Lessons learned will also be discussed. | 1. Identify the process of culturally adapting evidence-based treatments for American Indian/Alaska Native children.  
2. Identify lessons learned from culturally adapting evidence-based treatments for American Indian/Alaska Native children. |

#### Evidence-Based Treatment for Trauma-Exposed Latino Youth: A Tailored Approach

*Michael A. Ramirez de Arellano, Ph.D., Medical University of South Carolina*

<table>
<thead>
<tr>
<th>Overview:</th>
<th>Learning Objectives:</th>
</tr>
</thead>
</table>
| Cultural factors may impact reactions to trauma, expressions of symptoms, and utilization of and adherence to mental health treatment. Unfortunately, research on evidence-based treatments and the potential effects of cultural factors among Hispanic populations is limited. Culturally-Modified Trauma-Focused Treatment (CM-TFT) for Latinos is an adaptation of Trauma-Focused Cognitive Behavioral Therapy (Cohen, Mannarino, & Deblinger, 2003), a well-researched treatment intervention with evidence for use in the general population with victims of child sexual abuse and other types of trauma. CM-TFT has been developed for use with trauma-exposed children of Latino descent based on research and clinical work with this population. This adaptation is a tailored approach that attempts to increase engagement by enhancing the cultural relevance of the intervention. Potential cultural factors are assessed and addressed, including spirituality, familismo, traditional gender roles, beliefs about sex, views of mental health and mental health treatment, racism/discrimination, and exploitation. In collaboration with several National Child Traumatic Stress Network sites across the country, the intervention has been further developed to address the needs of Hispanic children from various countries of origin, regions of the United States, and levels of acculturation. A description of the adaptation process and preliminary evidence from this multi-site pilot project will be presented. | 1. To gain a better understanding of why adaptations may be helpful when working with children from diverse cultural groups, especially Latinos.  
2. To gain a better understanding of potential adaptations that can be made to trauma-focused assessments.  
3. To gain a better understanding of potential adaptations that can be made to trauma-focused treatment interventions.  
4. To become familiar with a sample adaptation of an intervention that has been developed for Latino children and families. |
### Evidence-Based Practice with Ethnic Minority Populations in Community-Based Addiction Treatment

LOCATION: Grand Ballroom A

<table>
<thead>
<tr>
<th>Adapting and Integrating Interventions for Tailored Treatment Interventions with Multi-Problem Clients in Community Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview:</strong> The current state of evidence-based practice with ethnic minority populations in community-based addiction treatment is described via a model that involves selecting from a contemporary menu of evidence-based approaches. This presentation describes the resulting process of adapting and integrating those interventions selected from the menu in order to tailor treatment interventions with multi-problem clients in community settings. The model of evidence based practice described can effectively meet the needs of varied clients—including those presenting dual diagnoses, those in different stages of change for multiple problem behaviors (e.g. for more than one substance being used, for HIV risk reduction behavior, etc.), and those mandated to treatment (i.e. criminal justice system, welfare, to regain child custody, etc.) for whom a shift in motivation from one that is initially extrinsic to one that is intrinsic is warranted.</td>
</tr>
<tr>
<td><strong>Learning Objectives:</strong></td>
</tr>
<tr>
<td>1. Identify numerous evidence-based approaches currently advanced for the treatment of those presenting substance abuse and/or dependence, constituting a menu of options.</td>
</tr>
<tr>
<td>2. Understand and engage in the process of adapting and integrating interventions chosen from a menu of evidence-based approaches, in order to tailor treatment to meet the needs of multi-problem clients in community based addiction treatment settings.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neuropsychological Assessment of Minority Substance Abusers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview:</strong> Neuropsychological assessment of minority substance abusers requires knowledge and understanding of the minority group culture as well as which psychoactive substances may produce brain damage. In addition, ways of minimizing cultural bias must be understood and utilized to prevent misdiagnosis of brain damage.</td>
</tr>
<tr>
<td><strong>Learning Objectives:</strong></td>
</tr>
<tr>
<td>1. List problems in neuropsychological assessment of minority group members.</td>
</tr>
<tr>
<td>2. List psychoactive drugs that are neurotoxic.</td>
</tr>
</tbody>
</table>
Ethical and Culturally Congruent Research and Interventions with Communities and IRB in Community Settings

LOCATION: Grand Ballroom B/C

Ethical and Culturally Congruent Research and Interventions in Community Settings

Joseph Trimble, Ph.D., Western Washington University

Overview:
The workshop presentation poses question to encourage ethical decision making for mental health research with ethnocultural populations that reflect their unique historical and socio-cultural realities. The presentation will follow three ethical dimensions of culturally sensitive research: (1) applying a cultural sensitive perspective to the evaluation of research risk and benefits; (2) developing and implementing culturally respectful informed consent procedures and culturally appropriate confidentiality and disclosure policies; and (3) engaging in community and participant consultation with a standard of “principled cultural sensitivity.”
The need and rationale for the presentation is multifold. It emerges from the increasing distrust ethnocultural communities are expressing towards researchers. Countless community members are intolerant and unforgiving of past research efforts for a variety of valid reasons; much of their suspicion and concerns derives from the cultural incompetence and insensitivity of researchers. Researchers should be prepared to collaborate with the communities, share results that have practical value, and accept the conditions imposed by the community in gaining access to respondents. The general rules of scientific conduct embodied in professional codes of conduct provide critical, yet incomplete guidance for identifying and resolving the complex ethical challenges inherent in research involving ethnocultural populations. Investigators engaged in the critical task of generating information on which psychological services, public opinion, and policies for ethnic and racial groups will be based, are thus faced with the formidable responsibility of ensuring their procedures are scientifically sound, culturally valid, and morally just.

Learning Objectives:
1. Identify and put into action procedures and methods that incorporate a culturally resonant perspective to assess research risks, benefits, protect participant confidentiality, develop respectful participant consent and participation.
2. Recognize the linkages between irresponsible research, cultural incompetence, and ethical pitfalls and the influence they have on successful approaches to engaging communities and participants.

Successful Collaboration Across the Traditional Divide: Key Considerations When Conducting Intervention Research in Culturally Diverse Communities

Terry S. Gock, Ph.D., M.P.A., Asian Pacific Family Center, Pacific Clinics

Overview:
This workshop presentation will highlight the common interests and divergent approaches between researchers and community service providers. Emphasis will be on exploring ways to develop intervention research protocol that is ethically and culturally congruent with the service structure and context of community based organizations.

Learning Objectives:
1. Identify two common interests and divergent approaches between researchers and community service providers.
2. Identify two effective strategies to bridge the gap between research interests and community service structure and context.
### Mixed Methods Research: What is it and how can we achieve its potential?

**Peter J. Guarnaccia, Ph.D., Rutgers University**

**Overview:**
This workshop will define qualitative research and distinguish it from ethnography. We will discuss various types of qualitative methods for mental health research. We will look at how to incorporate qualitative methods throughout a research project. We will discuss how to develop iterative projects that move between qualitative and quantitative research.

**Learning Objectives:**
1. Identify several types of qualitative research methods relevant to mental health research.
2. Evaluate the use of qualitative methods in interaction with quantitative methods throughout the course of a research study.

### The AAKOMA Project: Utilizing Qualitative and Community Based Participatory Research in a Clinical Trial

**Alfiee Breland-Noble, Ph.D., Duke University Medical Center**

**Overview:**
This presentation meets the mandate issued by former Surgeon General Dr. David Satcher in 2001 and the American Psychological Association regarding more research on underserved youth in the area of mental health and the development of new and rigorous research in the areas of Culturally Responsive Treatments, Evidence Based Treatments and Health Disparities reduction for diverse populations. The presenter will share findings from her research conducted with African American youth and families within a Community Base Participatory Research framework. Specifically, she will address the development and implementation of an Evidence Based behavioral intervention in the area of treatment engagement for depression. The presentation will conclude with a discussion of the overall findings and the public health implications of this work.

**Learning Objectives:**
1. Identify culturally relevant approaches to recruitment of diverse populations for behavioral clinical trials.
2. Apply the expert advice of clinical investigators and practitioners who will provide you with insight into the prospects and rewards of engaging in this type of work.
Plenary Session Details

Friday, March 14, 2008
8:15-10:30am

Plenary Panel III: Perspectives from Researchers in the Field: Critical Collaborations from the Ground and Up

Chair: Carol Falender, Ph.D., Independent Practice; University of California, Los Angeles

Adapting Evidence-Based Treatments for Immigrant Minority Families: Proposed Strategies and Key Questions
Annal Lau, Ph.D., University of California, Los Angeles

Overview:
Some experts contend that EBTs require cultural adaptation to be effective and relevant for minority families. However, critics argue there is insufficient data to warrant such adaptation and that minority families must be given access to EBTs delivered with fidelity. To inform this debate, two distinct strategies for adapting evidence based parent management training (PMT) will be contrasted. The first involves culturally-specific adaptation of intervention content, and the second involves manipulation of treatment intensity. These distinct approaches to enhancing PMT for immigrant families are informed by competing models of behavioral change. First, a performance model assumes that otherwise competent immigrant parents can become unable to carry out effective discipline when under stress. By addressing specific cultural risk factors for problem parenting in immigrant families, Augmented PMT may enhance outcomes by lowering the risk of negative parent-child interactions that impede behavior change in PMT. In contrast, an acquisition deficit model asserts that the effective discipline skills taught in PMT are culturally foreign and not represented in the parent’s behavior repertoire. As such, immigrant parents may require Intensive PMT offering more direction and support in enacting core PMT strategies. As such, augmentation calls for culturally-specific changes to intervention content for different newcomer groups, whereas intensification more generically dictates an increased intervention dose to ensure sufficient learning opportunities to acquire core skills. Preliminary data from a pilot effectiveness trial of PMT with high-risk immigrant Chinese families will be used to illustrate the rationale underlying these competing approaches.

Learning Objectives:
1. Identify two distinct strategies for adapting evidence-based treatments for immigrants.
2. Describe specific adaptations of evidence based parent training interventions for immigrant families.
**Evidenced-Based Treatments for Depression in the Primary Care Sector**  
*Charlotte Brown, Ph.D., University of Pittsburgh School of Medicine*

<table>
<thead>
<tr>
<th>Overview:</th>
<th>Learning Objectives:</th>
</tr>
</thead>
</table>
| This presentation will examine the evidence base for treatment of depression in primary care settings. Racial and ethnic minorities are more likely to be treated for depression in primary care. Particular attention will be given to the demonstrated effectiveness of treatments for depression for racial/ethnic minorities and the adaptations to depression treatments for this population. | 1. Identify specific treatments that have been found to be effective for treatment of depression in primary care settings.  
2. Identify specific models of care found to be effective for treatment of depression in racial/ethnic minorities.  
3. Identify limitation of the research base as it pertains to treatment of racial/ethnic minorities. |

**Linking American Indian Resilience with Suicide Prevention: Lessons Learned**  
*Teresa LaFromboise, Ph.D., Stanford University*

<table>
<thead>
<tr>
<th>Overview:</th>
<th>Learning Objectives:</th>
</tr>
</thead>
</table>
| This panel presentation will focus on the development of an evidence-based prevention intervention for suicide prevention and life skills development with American Indian adolescents entitled the *American Indian Life Skills Development Curriculum* (AILS; see LaFromboise & Lewis, in press, *Suicide and Life Threatening Behaviors*). The original manual had been used extensively in schools and community based programs for youth (e.g., Nation Building for Native Youth, Tribal Youth Employment and Training Programs, In-Patient Groups). This manual is available from the Chicago Distribution Center. An early adolescent version of the AILS is currently being developed and plans are underway for its evaluation. In 2007 regional training of trainers workshops were offered to 3-person cohorts from 20 Indian reservations to help facilitate the wide scale adoption of the AILS in Indian Country. Lessons learned from intervention refinement and evaluation will be shared. Additionally, I will discuss a major duality in the widespread adoption of the AILS, namely the desire on the part of tribes for tribal specificity and the mandate on the part of funding agencies for fidelity to evidence-based interventions. The need to determine when evidence-based treatments merit adaptations will be underscored. | 1. Have knowledge of a culturally specific model of risk and resilience factors for suicide among American Indian adolescents.  
2. Understand ways of contextualizing intervention content and enhancing community engagement in evidence based suicide prevention intervention. |
### Understanding Within Session Psychotherapy Processes for Culturally Relevant Family-Based Interventions for Violence and Substance Abuse

**Phillippe B. Cunningham, Ph.D., Medical University of South Carolina**

#### Overview:

There has been a dearth of psychotherapy process research with ethnic minority populations. Studies that do exist have focused almost exclusively on ethnic matching with few studies involving empirically supported treatments. The results of ethnic matching studies, however, have yet to yield information to help inform therapists of what to do within sessions that is uniquely beneficial with their ethnically similar clients. This presentation will review a study designed to identify therapy process behaviors that contribute to caregiver engagement in MST, generally, and specifically, with African American families.

#### Learning Objectives:

1. Appreciate the complexity of developing culturally informed treatments.

2. Participants will be able to state the results of a series of studies designed to examine therapist behaviors that contribute to caregiver responsiveness in family-based treatments.
Plenary Session Details

Friday, March 14, 2008
10:45am-12:15pm

Plenary Panel IV: **Innovative Models for Collaboration**

**Chair:** Natalie Porter, Ph.D., California School of Professional Psychology, Alliant International University

<table>
<thead>
<tr>
<th><strong>Foundation as Player in Developing Evidence-based HIV Community Programs</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Bart Aoki, Ph.D., California HIV/AIDS Research Program</em></td>
</tr>
</tbody>
</table>

**Overview:**
The foundation or grant-maker has potential to play a key role in insuring that its funded research is applicable to specific cultural contexts and communities in the real world. The California HIV/AIDS Research Program uses its position as funder to advance the development of community-researcher equal partner collaborations to evaluate community-based programs addressing HIV/AIDS, particularly those targeting ethnic/racial populations. This model is operationalized through granting mechanisms intended to produce specific outputs, outcomes, and impacts and involve contributions from and gains for all collaborators, including the funder.

**Learning Objectives:**

1. Identify some of the contributions and components necessary to the success of community-research equal partner collaborations.

2. Appreciate the potential benefits to all collaborators and evidence-based practices resulting from foundation support of community-collaborative research.
Collaborative Community Based Research with California Prevention and Education Project (CAL-PEP): When and Where We Enter - Sixteen Years of Participation in Community Based Research  
Carla Dillard-Smith, M.P.A., California Prevention and Education Project

<table>
<thead>
<tr>
<th>Overview:</th>
<th>Learning Objectives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>California Prevention and Education Project has participated in nine research and evaluation projects. Three projects were funded by California HIV Research Program to build the capacity of CAL-PEP for participate in HIV prevention research. The community collaborative also builds the capacity of researchers who desire access to community target populations. It facilitates understanding by researchers of the realities of communities served. The presentation will discuss capacity building, and lessons learned.</td>
<td>1. Identify key elements of capacity building.</td>
</tr>
<tr>
<td></td>
<td>2. Identify skill sets for collaboration.</td>
</tr>
<tr>
<td></td>
<td>3. Understand how to build the capacities of a community based organization to participate with University partners in research.</td>
</tr>
<tr>
<td></td>
<td>4. Understand six different skill sets for collaboration as in metaphor to, “Creating a Good Marriage.”</td>
</tr>
</tbody>
</table>
# Town Hall Session Details

**Friday, March 14, 2008**  
1:00-3:00pm

**Eduardo Morales, Ph.D., Alliant International University**  
**Sharon R. Jenkins, Ph.D., University of North Texas**

<table>
<thead>
<tr>
<th><strong>Overview:</strong></th>
<th><strong>Learning Objectives:</strong></th>
</tr>
</thead>
</table>
| During this session all participants will participate in an active discussion on the recommendations and suggestions that were generated through the two-day conference. Workshop session will report back to this general meeting. Through synthesis and reflection the group will generate next steps in generating data for developing and establishing evidence based practices for ethnic minorities. These recommendations will be incorporated into a document and publications and outcomes of the conference. | 1. Participants will have a more integrated understanding of the complexity of issues related to evidence based practices among minorities.  
2. Participants will have a set of suggestions and recommendations for implementation and integration in their work. |
**Speaker Profiles**

**Margarita Alegría, Ph.D.**, is the Director of the Center for Multicultural Mental Health Research (CMMHR) at Cambridge Health Alliance, and a full professor in the Department of Psychiatry at Harvard Medical School. She has devoted her professional career to researching disparities in mental health and substance abuse services, with the goal of improving access, equity, and quality of these services for disadvantaged and minority populations. She currently serves as Principal Investigator of three National Institutes of Health-funded research studies, as well as one funded by the Robert Wood Johnson Foundation. Dr. Alegría’s published works focus on the areas of services research, conceptual and methodological issues with minority populations, risk behaviors, and disparities in service delivery. She was awarded the 2003 Mental Health Section Award of the American Public Health Association.

**Bart Aoki, Ph.D.**, is a clinical psychologist currently Associate Director of the California HIV/AIDS Research Program in the Office of the President at the University of California. He is responsible for overseeing health systems, health policy, and community research and for developing public-private partnerships between the University, government, private foundations, and industry. Previously (1987-1997), he was Director of Research and Evaluation with the Asian American Recovery Services, Inc., where he served as PI and investigator on SAMHSA and NIH community-based demonstration and research studies on the development and evaluation of substance abuse and HIV/AIDS prevention programs for Asian and Pacific Islander youth and families. He holds a bachelor’s of science degree in psychology from the University of Washington and a doctor of philosophy degree from the University of Colorado.

**Donna Holland Barnes, Ph.D.**, is a Research Associate and Instructor at Howard University’s Psychiatry Department in Washington, D.C. where she teaches suicide risk management to residents and third year medical students. She also conducts research on families who have lost someone to suicide. She is currently the recipient of a $225,000 campus grant for suicide prevention from the Substance Abuse and Mental Health Services Administration. Barnes is co-founder and President of the National Organization for People of Color against Suicide (NOPCAS) and a founding member of the National Council for Suicide Prevention (NCSP). She has served on several national and local committees that pertained to suicidal behavior and appears on radio talk shows and in national magazines frequently on the subject of suicide.

**Guillermo Bernal, Ph.D.**, is Professor of Psychology and Director of the University Center for Psychological Services and Research at the University of Puerto Rico-UPR, Río Piedras. He has developed research, training, and mental health service programs responsive to ethnic minorities. He has published over 120 journal articles/chapters and six books. His current work is in the efficacy of parent interventions in depressed adolescents (funded by NIMH). Also, he directs the NIMH, Minority Research Infrastructure Support Program and COR programs focused on intervention research. His most recent books are Theory and practice of psychotherapy in Puerto Rico (2005) the Handbook of racial and ethnic minority psychology published 2003. He is the Associate Editor for Research of Family Process and he is a Fellow of APA (Div. 45, 12, & 27).

**Dolores Subia BigFoot, Ph.D.**, is an enrolled tribal member of the Caddo Nation of Oklahoma and is an Assistant Professor in the Department of Pediatrics, Center on Child Abuse and Neglect at University of Oklahoma Health Sciences Center. Dr. BigFoot directs the Indian Country Child Trauma Center that is part of the National Child Traumatic Stress Network and Substance Abuse Mental Health Service Administrative. She provides consultation, training, and technical assistance to tribal, state, and federal agencies on child maltreatment, child trauma, and cultural issues. Dr. BigFoot is recognized for her efforts to bring traditional and spiritual practices and beliefs into the formal
teaching of American Indian people and professionals working with American Indian populations. She directed the cultural adaptation for the Honoring Children Series of evidence-based treatments.

**Alfiee Breland-Noble, Ph.D.**, is a tenure track assistant professor in the department of Psychiatry at the Duke University Medical Center. She is a clinical investigator in the area research and clinical treatment engagement for psychiatric illness in African American and other children of color and the diagnosis and treatment of adolescent depression in clinical trials. Currently, she serves as PI of The AAKOMA Project; a study examining treatment readiness in African-American adolescents with major depression. This project is currently funded via an NIMH five-year K01 award. She received a Ph.D. in counseling psychology from the University of Wisconsin-Madison; an M.A. from New York University and a B.A. from Howard University. Dr. Breland-Noble is currently completing a thesis for an M.H.S. (clinical trials) at the Duke School of Medicine.

**Charlotte Brown, Ph.D.**, is Associate Professor of Psychiatry University of Pittsburgh School of Medicine. She completed her clinical training at McLean Hospital, Harvard Medical School, and Post-doctoral training at the Western Psychiatric Institute and Clinic. Her research and clinical interests include depression recognition and treatment in primary care, psychosocial factors affecting women’s health, and the impact of race and ethnicity on depression recognition and management. She has served as Principal Investigator of an NIMH Scientist Development Award, and an RO1. She is currently the Core Principal Investigator of the Research Network Development Core of the NIMH-funded Advanced Center for Interventions and Services Research (Charles Reynolds, III, PI). Dr. Brown is also active in community initiated activities to increase public awareness of depression and available treatments, particularly in African American communities.

**Mia Smith Bynum, Ph.D.**, is Assistant Professor of Psychological Sciences at Purdue University. She is an expert African American mental health, racial identity, family processes, parenting, and adolescent development. She received her doctorate from the University of Virginia in clinical psychology in 1999. Dr. Bynum also completed a postdoctoral fellowship in the Center for Family Research at the University of Georgia before going to Purdue in 2001. Dr. Bynum is a licensed psychologist in Georgia and Indiana.

**Nancy Carter**, is president of the Urban Los Angeles affiliate of NAMI (National Alliance on Mental Illness). Her responsibilities include educating, supporting and advocating for the rights of the mentally ill and their families in Los Angeles. From 2003 until 2005, she served on the California State Board of NAMI and was elected to the NAMI National Board of Directors in June 2006. Her primary areas of interest at both the county and national level are multicultural outreach, criminal justice reform and children’s issues. Ms. Carter is a certified Family-to-Family education teacher for NAMI and a NAMI certified trainer for mental health providers. She conducts support groups, workshops and presentations for the public at local churches, schools and county agencies in the areas of foster parenting, probation sensitivity and cultural competency.

**Felipe González Castro, M.S.W., Ph.D.**, is professor of clinical psychology in the Department of Psychology, Arizona State University. He is a Latino health psychologist interested in the study of cultural factors in the design and evaluation of culturally-sensitive prevention interventions and health promotion programs for Hispanic/Latino(a) and other racial/ethnic minority populations. He uses integrated mixed methods (qualitative-quantitative) approaches within multivariate models to study the influences of various cultural factors, such as acculturation, family traditions, and ethnic pride, on health behaviors to reduce risks for drug abuse and addiction, Type 2 diabetes, and cardiovascular disease. Dr. Castro also studies resilience, and its protective effects on health outcomes. Dr. Castro also serves as associate editor for the journals: Prevention Science and the American Journal of Public Health.
H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, is director of the Center for Substance Abuse Treatment under the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Dr. Clark leads the agency's efforts to provide effective and accessible treatment to all Americans with addictive disorders. Dr. Clark's areas of expertise include substance abuse treatment, methadone maintenance, pain management, dual diagnosis, psychopharmacology, anger management, and medical and legal issues. He is also a noted author, clinician, teacher and spokesperson in the field of addiction and forensic psychiatry. Dr. Clark has received numerous awards for his contribution to the field of substance abuse treatment, including the President of the United States of America, Rank of Meritorious Executive in the Senior Executive Service for his sustained superior accomplishments in management of programs of the United States Government and for noteworthy achievement of quality and efficiency in the public service in 2005. He received his medical degree from the University of Michigan and his law degree from Harvard University Law School. Dr. Clark received his board certification from the American Board of Psychiatry and Neurology in psychiatry and sub-specialty certifications in both addiction and forensic psychiatry. Dr. Clark is licensed to practice medicine in California, Maryland, Massachusetts and Michigan. He is also a member of the Washington, D.C., Bar Association.

Giuseppe Costantino, Ph.D., is Director of Research and New Programs at Lutheran Family Health Centers and former Clinical Director of the Mental Health Center at the same organization (1984-2005). He was Senior Research Associate, Hispanic Research Center, Fordham University (1979-2002). He is the author of TEMAS (Tell-Me-A-Story), Multicultural Test, Cuento Therapy and Hero/Heroine Modeling Therapy for Latino youngsters, and the author of the TEMAS Narrative Therapy Technique. He was the PI of the SAMHSA CATS (Children/Adolescent Treatment and Services) grant on children affected by 9/11 terrorist attacks. He was the PI of several RO1 grants, the PI of several SAMHSA and HRSA grants. He has written 3 books, 20 book chapters and more than 50 articles on culturally competent assessment and treatment.

Phillippe B. Cunningham, Ph.D., is a Professor in the Department of Psychiatry and Behavioral Sciences, Family Services Research Center at the Medical University of South Carolina. Dr. Cunningham is the Principal Investigator on a NIMH funded grant designed to examine children’s differential response to an empirically validated treatment—Multisystemic Therapy. In 2000, Dr. Cunningham received the Theodore H. Blau Early Career Award from the American Psychological Association’s Society of Clinical Psychology. In 2006, Dr. Cunningham participated in the First Lady’s Conference on “Helping America’s Youth.” Dr. Cunningham served as a member of the Behavior Change Expert Panel for the Office of National Drug Control Policy National Youth Anti-Drug Media Campaign, and is currently an advisor of the Media Campaign Advisory Team.

Michael A. de Arellano, Ph.D., is an Associate Professor and a Licensed Clinical Psychologist at the National Crime Victims Research and Treatment Center, Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina. Dr. de Arellano's research and clinical programs focus on developing and evaluating treatment services for trauma-exposed children and adults from traditionally underserved populations (e.g., rural, economically disadvantaged, Latino, African American). He recently completed an NIMH-funded study examining trauma-history and trauma-related problems among Latino youth from immigrant families. Currently, his work involves the evaluation and implementation of community-based service models to overcome barriers to accessing mental health treatment for trauma-exposed children and families. In addition, Dr. de Arellano’s research also focuses the development, evaluation, and dissemination of culturally-adapted, evidence-based treatment interventions for trauma-exposed Latino families.

Carla Dillard-Smith, M.P.A., obtained her Bachelors of Arts Degree from the University of California Berkeley in 1975 and Master of Public Administration Degree from the California State University of Hayward in 1990. Ms. Smith has served as Research and Deputy Director for the past fifteen years. She has directed nine community-based behavioral research and evaluation projects,
which targeted different segments of HIV high-risk populations in addition to a focus on drug users and sex workers. These collaborative projects were conducted in conjunction with the University of California San Francisco, California Department of Health Services, California State University East Bay, and the Center for Disease Control.

**Glenn Gamst, Ph.D.**, is Professor and Chair of the Psychology Department at the University of La Verne (in Southern California). He received his Ph.D in experimental psychology from the University of Arkansas in 1979. His current research focus is on the effects of multicultural variable like client-therapist ethnic match, client acculturation and ethnic identity and provider cultural competence on clinical outcomes for community mental health clients. Additional areas of specialization and research include memory and cognition, conversational memory, and univariate and multivariate statistical and methodological issues. He is co-author of Applied Multivariate Research: Design and Interpretation (Meyers, Gamst, & Guarino, 2006, Sage Publications), and Analysis of Variance Designs: Conceptual, Computational and Applications with SPSS and SAS, (Gamst, Meyers, & Guarino, In Press, Cambridge University Press).

**Terry S. Gock, Ph.D., M.P.A.,** is the Director of the Asian Pacific Family Center (APFC) of Pacific Clinics in the Los Angeles area. He is also a clinical and forensic psychologist in private practice. Dr. Gock has served as the Principal Investigator of a number of SAMHSA demonstration grant projects. He has also coordinated with academic institutions to successfully implement research projects at APFC. He currently serves on the IRB of Pacific Clinics. In addition, he has presented extensively on program implementation and program evaluation issues. Dr. Gock is a Fellow of the Asian American Psychological Association. He is also a member of the APA Council of Representatives and the APA Committee on Professional Practice & Standards (COPPS). He is a Past President of APA Division 44.

**Peter Guarnaccia, Ph.D.,** is Professor in the Department of Human Ecology at Cook College and Investigator at the Institute for Health, Health Care Policy and Aging Research. He received his Ph.D. from the University of Connecticut in 1984 and worked as a Post-Doctoral Fellow at Harvard Medical School from 1984-1986. His research interests include cross-cultural patterns of psychiatric disorders, family strategies for coping with mental illness, and cultural competence in mental health organizations. Dr. Guarnaccia edited a special issue of Culture, Medicine and Psychiatry (2003) on “Methodological Issues in the Cross-Cultural Study of Mental Health: Setting New Standards” and had a paper entitled “Towards a Puerto Rican Popular Nosology: Nervios and Ataques de Nervios” (with R. Lewis-Fernandez & M. Rivera Marano) in that same issue. He appeared in a video training program to eliminate mental healthcare disparities for Latinos entitled “Salud Mental: Crossing the Cultural Divide within Mental Healthcare” (New Jersey Mental Health Institute, 2005).

**Mario Hernandez, Ph.D.,** is Professor and Chair of the Department of Child and Family Studies at the Louis de la Parte Florida Mental Health Institute, University of South Florida. As Chair, Dr. Hernandez’s responsibilities include fiscal management, personnel management, and research development for 5 divisions. Also, he provides leadership for a variety of research and technical assistance projects. Dr. Hernandez has also been instrumental in helping System of Care sites develop theories of change through the use of logic models.

**Arthur MacNeill Horton, Jr., Ed.D. ABPP (CL), ABPN, ABPP (BP),** received his Ed.D. degree in Counselor Education from the University of Virginia in 1976. He also holds Diplomates in Clinical Psychology and Behavioral Psychology from the American Board of Professional Psychology and the American Board of Professional Neuropsychology. Dr. Horton is the author/editor of over 15 books, more than 50 book chapters, and over 150 journal articles. He is a past-president of the American Board of Professional Neuropsychology (ABPN) and the National Academy of Neuropsychology (NAN). He previously worked as a Program Administrator at the National Institute on Drug Abuse (NIDA), of the National Institutes of Health (NIH), with responsibilities for Neuropsychology. He has
taught at the University of Virginia, the University of Maryland Medical School and the Johns Hopkins University and the University of Baltimore.

Alan E. Kazdin, Ph.D., is the John M. Musser Professor of Psychology and Child Psychiatry at Yale University and Director of the Yale Parenting Center and Child Conduct Clinic. He also is President of the American Psychological Association. Kazdin is a licensed clinical psychologist, a Diplomate of the American Board of Professional Psychology, and a Fellow of APA, the Association for Psychological Science, and the American Association for the Advancement of Science. His research focuses on antisocial behavior and processes that contribute both to clinical dysfunction and therapeutic change, and the impact of therapy on child, parent, and family functioning. He has authored or edited over 600 articles, chapters, and books. His 45 books focus on child and adolescent psychotherapy, aggressive and antisocial behavior, parenting, and methodology and research design.

Teresa LaFromboise, Ph.D., is an Associate Professor of Education, Stanford University. She is a recognized contributor to American Indian mental health initiatives having published over 85 articles and chapters in the area of stress-related problems of ethnic minorities. She has authored 7 prevention intervention manuals including: Assertion Training with American Indians, Circles of Women: Skills Training for American Indian Professionalization, Zuni Life Skills Development, and American Indian Life Skills Development Curriculum (AIDS). She is a fellow of the American Psychological Association. Her awards for the AIDS include recognition from the Department of Health and Human Services as a SAMHSA Program of Excellence and the First Nations Behavioral Health Association as One of Ten Best Practices. The AIDS is also listed in SAMHSA’s National Registry of Evidence-based Programs and Practices. In 2006 her work was featured in Prevention Researcher, 13 (3).

Anna Lau, Ph.D., is an Assistant Professor in the Department of Psychology at the University of California, Los Angeles and a licensed Clinical Psychologist. A major objective of her current research is to enhance the effectiveness of psychosocial interventions for ethnic minority families and children at risk of parenting and child behavior problems. Dr. Lau’s research in the areas of racial disparities in children’s mental health services, and cultural factors related to the identification, occurrence and outcomes of child physical discipline and abuse has informed her current intervention work. Dr. Lau is currently partnering with community agencies to disseminate and evaluate evidence-based parent management training with high-risk immigrant Chinese families.

Ronald F. Levant, Ed.D., is Dean and Professor of Psychology, Buchtel College of Arts and Sciences, The University of Akron. Formerly he was Dean and Professor, Center for Psychological Studies, Nova Southeastern University, and prior to that on faculty at Boston, Rutgers, and Harvard Universities, a clinician in solo independent practice, and a clinical supervisor in hospital settings. Dr. Levant helped develop the new psychology of men. He has developed theory and conducted research programs on fathering and masculinity ideology in multicultural perspective. Dr. Levant has authored, coauthored, edited, or coedited fourteen books and more than 150 peer-reviewed journal articles and book chapters. Dr. Levant is a Fellow of the American Psychological Association and a Diplomate of the American Board of Professional Psychology. He was President of APA for 2005.

Norweeta G. Milburn, Ph.D., is an Associate Research Psychologist in the Department of Psychiatry and Biobehavioral Sciences at the UCLA Semel Institute for Neuroscience and Human Behavior Center for Community Health. She received her Ph.D. in Community Psychology from the University of Michigan in Ann Arbor. Prior to coming to UCLA, she was an Associate Professor of Psychology at Hofstra University in New York and a Senior Research Associate/Graduate Assistant Professor at the Institute for Urban Affairs and Research at Howard University. Her research interests include substance abuse and homelessness, and mental health among African Americans. As the principal investigator of National Institute of Mental Health studies of homeless youth, she has examined paths into and out of homelessness, and risk for HIV among homeless youth in the U.S. and Australia and is implementing a behavioral intervention for homeless adolescents at risk for HIV and their families.
Dr. Milburn is a fellow of the American Psychological Association (APA) and currently serves on its Committee on Children, Youth and Families. She is a past African-American member-at-large for Division 45.

Eduardo Morales, Ph.D., is professor of the PhD Clinical Program at CSPP-SF of Alliant International University and co-chair of this conference. Dr. Morales has received numerous awards for his contributions that include the National Latino Psychological Association 2006 Star Vega Distinguished Service Award, a Citation in 2005 for Outstanding Service and Visionary Leadership from the Society for the Psychological Study of Ethnic Minority Issues (Division 45) of the APA, the 2002 Distinguished Career Contributions to Service Award from Division 45; the 1994 Outstanding Achievement Award given by the Committee of Lesbian and Gay Concerns of the APA; and the Distinguished Contribution Award (1991) in Ethnic Minority Issues, Society for the Psychological Study of Lesbian and Gay Issues (Division 44) of the APA. He is Fellow of seven Divisional Associations of APA. Dr. Morales is very active in obtaining research and service grants and founded many programs for Latinos in substance abuse, HIV, and juvenile delinquency prevention. His areas of expertise include health prevention and promotion, HIV, substance abuse, community interventions, program evaluation research, and strategic planning and policy development in various types of communities and organizations. He co-founded and was co-chair of the National Latino Coalition for Community Prevention, Treatment and Recovery of the Center for Substance Abuse Treatment (CSAT). Currently, he is a member of the Hispanic Stakeholders Group of CSAT who was funded to start a National Latino Substance Abuse Resource Center for the United States. He is currently the Executive Director of AGUILAS, an HIV prevention program for Latino gay/bisexual men in SF.

Ricardo F. Muñoz, Ph.D., is Professor of Psychology, Department of Psychiatry, University of California, San Francisco, where he also serves as Chief Psychologist at San Francisco General Hospital (SFGH), Director of the UCSF/SFGH Latino Mental Health Research Program (http://medschool.ucsf.edu/latino/), and Director of the Internet World Health Research Center (www.health.ucsf.edu). He specializes in cognitive behavioral approaches to the prevention and treatment of major depression and evidence-based Internet interventions. He has published over 75 articles and chapters, and co-authored or edited five books: Depression Prevention: Research Directions, The Prevention of Depression: Research and Practice, Social and Psychological Research in Community Settings, Control Your Depression, and Controlling Your Drinking. He is a Fellow of the Association for Psychological Science and the American Psychological Association. His work was featured in: http://www.apa.org/monitor/feb02/reaching.html.

Valerie Naquin, M.A., has worked in collaboration with Indigenous people for over 18 years. She was appointed by the Governor of Alaska to the State of Alaska Mental Health Board and serves on the Governing Board of the Alaska Psychiatric Institute. She has developed five evidence-based practices and is the lead author of a recent journal article on the Indigenous Evidence-Based Effective Practice model, currently being published in the International Journal of Leadership in Public Service. Valerie was appointed to the Editorial Review Board and is a Research Associate for the American Indian and Alaska Native Mental Health Research Journal (2007).

Trina W. Osher, M.A., a recognized leader in the family movement, uses her family experience to build collaborative alliances between families, policy makers, researchers, and providers in the mental health, education, child welfare, and juvenile justice communities. She partners with researchers on studies that result in information that can improve the quality of life for children, youth, and families. She collaborated closely with Child, Adolescent and Family Branch at SAMHSA to develop the definition of family-driven care and the Ambassador’s Guide for its dissemination and implementation. She provides technical assistance to help all stakeholders make the transformation in practice that it requires. Ms. Osher has served as a consultant to a number of government agencies,
family-run organizations, and policy organizations in the United States and abroad. She is widely published.

Antonio Polo, Ph.D., is an Assistant Professor at DePaul University in Chicago, IL. Prior to joining the faculty at DePaul, he was in residence at the Center for Multicultural Mental Health Research (Cambridge Health Alliance/Harvard Medical School). His interests include the development, expression, and risk/protective factors of mental health problems across cultures, particularly among Latino and immigrant youth in the United States. His research also focuses on the treatment and prevention of youth anxiety and depression, particularly interventions which can be shown to work effectively in community and school settings.

Shannon Sommer, BSW, an Athabascan Indian born and raised in Alaska, is the Director of Recovery Services at Cook Inlet Tribal Council (CITC) in Anchorage, Alaska. CITC-Recovery Services operates the largest continuum of care for behavioral health in the State of Alaska and has national accreditation with “exemplary” ratings. Ms. Sommer has been instrumental in implementing the nation's first tribal SBIRT grant, which offers real-world solutions for Alaska Native people struggling with alcohol and other substance abuse. Having been raised in a culture plagued by substance abuse and suicide, Ms. Sommer began her career in Social Work with an emphasis on substance abuse at a treatment facility for adolescents. Throughout the past twelve years she has administered and/or been involved with over fourteen SAMHSA grants. She has presented the Recovery Services best practice models, including SBIRT and the Therapeutic Village of Care, in international and national venues.

Joseph E. Trimble, Ph.D., formerly a Fellow at Harvard University's Radcliffe Institute for Advanced Study, is Professor of Psychology at Western Washington University and a Research Associate for the National Center for American Indian and Alaska Native Mental Health Research at the University of Colorado Health Sciences Center. He has held offices in the International Association for Cross-Cultural Psychology and the American Psychological Association. He is past-President of the Society for the Psychological Study of Ethnic Minority Issues and a Council member for SPSSI. Dr. Trimble has generated over 130 publications on cross-cultural and ethnic topics in psychology including 17 edited, co-edited, and co-authored books. His most recent book with Celia Fisher is titled, the Handbook of Ethical Research with Ethnocultural Populations and Communities. He has received numerous excellence in teaching and mentoring awards for his work in the field of ethnic and cultural psychology, including the Excellence in Teaching Award from Western Washington University, APA’s Division 45 Lifetime Achievement Award, the Janet E. Helms Award for Mentoring and Scholarship in Professional Psychology at Teachers College, Columbia University, the Washington State Psychological Association Distinguished Psychologist Award for 2002, the Peace and Social Justice Award from APA’s Division 48, and the Distinguished Elder Award from the National Multicultural Conference and Summit in 2007.

Luis Vargas, Ph.D., is an Associate Professor in the Department of Psychiatry at the University of New Mexico. He was previously the director of the clinical psychology internship program for fourteen years. Luis’ clinical and scholarly work has focused on providing culturally responsive services to diverse children and adolescents, particularly in Latino communities. He is co-editor (with Joan D. Koss-Chioino) of "Working with Culture: Psychotherapeutic Interventions with Ethnic Minority Children and Adolescents" and a co-author (with Joan D. Koss-Chioino) of "Working with Latino Youth: Culture, Development, and Context," both published by Jossey-Bass. He is a past president of Div. 37, a fellow of Divisions 12, 37, & 37 in APA, and a fellow of the Association of State and Provincial Psychology Board (ASPPB).

Barbara C. Wallace, Ph.D., is a tenured Professor of Health Education, and Founding Director of the Research Group on Disparities in Health, Department of Health and Behavior Studies, Teachers College, Columbia University. Dr. Wallace has consulted for twenty years to inpatient detoxification,

Nolan Zane, Ph.D., is Professor of Psychology and Asian American Studies at the University of California, Davis and Director of the Asian American Center on Disparities Research. The center is the only national research center that focuses on the mental health issues of Asian American populations and communities. Professor Zane is a Fellow of APA (Division 45) and served as a member of the APA Presidential Task Force on Evidence-based Practice in Psychology. His research focuses on the development and evaluation of culturally based sociobehavioral interventions for ethnic minority clientele, ethnocultural moderators of change in psychotherapy, and the determinants of addictive behaviors among Asian Americans. His research examines cultural variations in the role of loss of face and shame in interpersonal relationships with a special emphasis on client and care provider interactions.
Presenters (in alphabetical order)

Margarita Alegria, Ph.D.
Professor, Department of Psychiatry
Harvard Medical School
Cambridge Health Alliance

Norman Anderson, Ph.D.
Executive Vice President and Chief Executive Officer
American Psychological Association

Bart Aoki, Ph.D.
Associate Director, California HIV/AIDS Research Program
Office of the President at the University of California

Donna Holland Barnes, Ph.D.
Research Associate and Instructor, Psychiatry Department
Howard University

Guillermo Bernal, Ph.D.
Professor, Department of Psychology
Director, University Center for Psychological Services
University of Puerto Rico-UPR, Rio Piedras

Dolores Subia BigFoot, Ph.D.
Assistant Professor, Department of Pediatrics
Center on Child Abuse and Neglect
University of Oklahoma Health Sciences Center

Alfiee Breland-Noble, Ph.D.
Assistant Professor, Department of Psychiatry
Duke University Medical Center

Cheryl Boyce Ph.D.
National Institute of Mental Health

Charlotte Brown, Ph.D.
Associate Professor, Department of Psychiatry
University of Pittsburgh School of Medicine

Mia Smith Bynum, Ph.D.
Assistant Professor, Department of Psychological Sciences
Purdue University

Nancy Carter
President, National Alliance on Mental Illness Urban Los Angeles

Felipe González Castro, M.S.W., Ph.D.
Professor, Department of Psychology
Arizona State University

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director, Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Giuseppe Costantino, Ph.D.
Director, Research and New Programs
Lutheran Family Health Centers

Phillippe B. Cunningham, Ph.D.
Professor, Department of Psychiatry and Behavioral Sciences
Family Services Research Center
Medical University of South Carolina

Michael A. de Arellano, Ph.D.
Associate Professor, Department of Psychiatry and Behavioral Sciences
National Crime Victims Research and Treatment Center
Medical University of South Carolina

Carla Dillard-Smith, M.P.A.
Research and Deputy Director
California Prevention and Education Project

Glenn Gamst, Ph.D.
Professor and Chair, Psychology Department
University of La Verne

Terry S. Gock, Ph.D., M.P.A.
Director, Asian Pacific Family Center
Pacific Clinics

Peter Guarnaccia, Ph.D.
Professor, Department of Human Ecology
Rutgers University

Mario Hernandez, Ph.D.
Professor and Chair, Department of Child and Family Studies
Louis de la Parte Florida Mental Health Institute
University of South Florida
Arthur MacNeill Horton, Jr., Ed.D. ABPP (CL), ABPN, ABPP (BP)

Sharon Jenkins, Ph.D.
Associate Professor, Department of Psychology
University of North Texas

Alan E. Kazdin, Ph.D.
John M. Musser Professor, Department of Psychology and Child Psychiatry
Director, Yale Parenting Center and Child Conduct Clinic
Yale University
President, American Psychological Association

Teresa LaFromboise, Ph.D.
Associate Professor, Department of Education
Stanford University

Anna Lau, Ph.D.
Associate Professor, Department of Psychology
University of California, Los Angeles

Ronald F. Levant, Ed.D.
Dean, Butchel College of Arts and Sciences
Professor, Department of Psychology
The University of Akron

Norweeta G. Milburn, Ph.D.
Associate Research Psychologist, Department of Psychiatry and Biobehavioral Sciences
Semel Institute for Neuroscience and Human Behavior Center for Community Health
University of California, Los Angeles

Eduardo Morales, Ph.D.
Professor, Clinical Psychology Program
California School of Professional Psychology, San Francisco
Alliant International University

Ricardo F. Muñoz, Ph.D.
Professor, Department of Psychiatry
University of California, San Francisco

Valerie Naquin, M.A.
Vice President of Development
Cook Inlet Tribal Council, Inc

Trina W. Osher, M.A.
President, Huff Osher Consulting, Inc.
Former Director of Policy, Federation of Families for Children's Mental Health

Antonio Polo, Ph.D.
Assistant Professor, Department of Psychology
DePaul University

Shannon Sommer, BSW
Director, Recovery Services
Cook Inlet Tribal Council

Joseph E. Trimble, Ph.D.
Professor, Department of Psychology
Western Washington University

Luis Vargas, Ph.D.
Associate Professor, Department of Psychiatry
University of New Mexico

Barbara C. Wallace, Ph.D.
Professor, Department of Health and Behavioral Sciences
Columbia University

Nolan Zane, Ph.D.
Professor, Department of Asian American Studies and Psychology
Director, Asian American Center on Disparities Research
University of California, Davis
## Participant List

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Degree</th>
<th>E-mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dyanne D.</td>
<td>Affonso</td>
<td>PhD</td>
<td><a href="mailto:daffonso@hawaii.edu">daffonso@hawaii.edu</a></td>
</tr>
<tr>
<td>Margarita</td>
<td>Alegria</td>
<td>PhD</td>
<td><a href="mailto:malegria@charesearch.org">malegria@charesearch.org</a></td>
</tr>
<tr>
<td>Page</td>
<td>Anderson</td>
<td>PhD</td>
<td><a href="mailto:panderson@gsu.edu">panderson@gsu.edu</a></td>
</tr>
<tr>
<td>Bruno</td>
<td>Anthony</td>
<td>Ph.D.</td>
<td><a href="mailto:bja28@georgetown.edu">bja28@georgetown.edu</a></td>
</tr>
<tr>
<td>Bart</td>
<td>Aoki</td>
<td>Ph.D.</td>
<td><a href="mailto:bart.aoki@ucop.edu">bart.aoki@ucop.edu</a></td>
</tr>
<tr>
<td>Judith</td>
<td>Arroyo</td>
<td>Ph.D.</td>
<td><a href="mailto:jarroyo@mail.nih.gov">jarroyo@mail.nih.gov</a></td>
</tr>
<tr>
<td>Carl</td>
<td>Auerbach</td>
<td>Ph. D.</td>
<td><a href="mailto:carlauer@aol.com">carlauer@aol.com</a></td>
</tr>
<tr>
<td>Martha</td>
<td>Banks</td>
<td>PhD</td>
<td><a href="mailto:banks@ackerman.com">banks@ackerman.com</a></td>
</tr>
<tr>
<td>Donna</td>
<td>Barnes</td>
<td>PhD</td>
<td><a href="mailto:dbarnes@nopcas.org">dbarnes@nopcas.org</a></td>
</tr>
<tr>
<td>Jeffrey</td>
<td>Barnett</td>
<td>Psy.D., ABPP</td>
<td><a href="mailto:djrclassenet1@comcast.net">djrclassenet1@comcast.net</a></td>
</tr>
<tr>
<td>Aline</td>
<td>Barrera</td>
<td>Ph.D.</td>
<td><a href="mailto:alinne.barrera@ucsf.edu">alinne.barrera@ucsf.edu</a></td>
</tr>
<tr>
<td>C. Andres</td>
<td>Bedoya</td>
<td>Ph.D.</td>
<td><a href="mailto:abedoya@partners.org">abedoya@partners.org</a></td>
</tr>
<tr>
<td>Tricia</td>
<td>Bent-Goodley</td>
<td>Ph.D., MSW</td>
<td><a href="mailto:tmgoodley@aol.com">tmgoodley@aol.com</a></td>
</tr>
<tr>
<td>Lauren</td>
<td>Berger</td>
<td>B.A.</td>
<td><a href="mailto:lkberger@ucdavis.edu">lkberger@ucdavis.edu</a></td>
</tr>
<tr>
<td>Guillermo</td>
<td>Bernal</td>
<td>Ph.D.</td>
<td><a href="mailto:gbernal@uprrp.edu">gbernal@uprrp.edu</a></td>
</tr>
<tr>
<td>Dolores Subia</td>
<td>BigFoot</td>
<td>Ph.D.</td>
<td><a href="mailto:dee-bigfoot@ouhsc.edu">dee-bigfoot@ouhsc.edu</a></td>
</tr>
<tr>
<td>Dara</td>
<td>Blachman</td>
<td>PHD</td>
<td><a href="mailto:BLACHMAND@OD.NIH.GOV">BLACHMAND@OD.NIH.GOV</a></td>
</tr>
<tr>
<td>Valerie</td>
<td>Borum</td>
<td>Ph.D., MSW</td>
<td><a href="mailto:vborum@uic.edu">vborum@uic.edu</a></td>
</tr>
<tr>
<td>Beth</td>
<td>Bowers</td>
<td></td>
<td><a href="mailto:bbowers@mail.nih.gov">bbowers@mail.nih.gov</a></td>
</tr>
<tr>
<td>Cheryl</td>
<td>Boyce</td>
<td>Ph.D.</td>
<td><a href="mailto:cboyce@mail.nih.gov">cboyce@mail.nih.gov</a></td>
</tr>
<tr>
<td>Beth</td>
<td>Boyd</td>
<td>Ph.D.</td>
<td><a href="mailto:beth.boyd@usd.edu">beth.boyd@usd.edu</a></td>
</tr>
<tr>
<td>Alfiee</td>
<td>Breland-Noble</td>
<td>Ph.D.</td>
<td><a href="mailto:abreland@psych.duhs.duke.edu">abreland@psych.duhs.duke.edu</a></td>
</tr>
<tr>
<td>Joriele</td>
<td>Brown</td>
<td></td>
<td><a href="mailto:joriele.brown@samhsa.hhs.gov">joriele.brown@samhsa.hhs.gov</a></td>
</tr>
<tr>
<td>Charlotte</td>
<td>Brown</td>
<td>PhD</td>
<td><a href="mailto:brown@upmc.edu">brown@upmc.edu</a></td>
</tr>
<tr>
<td>Lynn</td>
<td>Bufka</td>
<td>PhD</td>
<td><a href="mailto:lubufka@apa.org">lubufka@apa.org</a></td>
</tr>
<tr>
<td>Regina</td>
<td>Bussing</td>
<td>MD</td>
<td><a href="mailto:rbussing@ufl.edu">rbussing@ufl.edu</a></td>
</tr>
<tr>
<td>Ashley</td>
<td>Butler</td>
<td>M.S.</td>
<td><a href="mailto:abutler@php.fiu.edu">abutler@php.fiu.edu</a></td>
</tr>
<tr>
<td>Jaime</td>
<td>Calderon Soto</td>
<td>PhD</td>
<td><a href="mailto:jcalderon20@hotmail.com">jcalderon20@hotmail.com</a></td>
</tr>
<tr>
<td>Katia</td>
<td>Canenguez</td>
<td>Ed.M.</td>
<td><a href="mailto:kcanenguez@gmail.com">kcanenguez@gmail.com</a></td>
</tr>
<tr>
<td>Nancy</td>
<td>Carter</td>
<td></td>
<td><a href="mailto:nancy@namiurbanla.org">nancy@namiurbanla.org</a></td>
</tr>
<tr>
<td>Felipe Gonzalez</td>
<td>Castro</td>
<td>Ph.D., M.S.W.</td>
<td><a href="mailto:Felipe.Castro@asu.edu">Felipe.Castro@asu.edu</a></td>
</tr>
<tr>
<td>L. Kevin</td>
<td>Chapman</td>
<td>Ph.D.</td>
<td><a href="mailto:kevin.chapman@louisville.edu">kevin.chapman@louisville.edu</a></td>
</tr>
<tr>
<td>Deepan</td>
<td>Chatterjee</td>
<td>Ph.D.</td>
<td><a href="mailto:deepan_c@hotmail.com">deepan_c@hotmail.com</a></td>
</tr>
<tr>
<td>Pietra</td>
<td>Check</td>
<td>MPH</td>
<td><a href="mailto:pcheck@cdc.gov">pcheck@cdc.gov</a></td>
</tr>
<tr>
<td>Sarah</td>
<td>Chilenski</td>
<td>PhD</td>
<td><a href="mailto:Sarah.Chilenski@mimh.edu">Sarah.Chilenski@mimh.edu</a></td>
</tr>
<tr>
<td>Joyce</td>
<td>Chu</td>
<td>Ph.D., Clinical Psychology</td>
<td><a href="mailto:jchu@pgsp.edu">jchu@pgsp.edu</a></td>
</tr>
<tr>
<td>H. Westley</td>
<td>Clark</td>
<td>M.D., J.D., M.P.H., CAS, FASAM</td>
<td><a href="mailto:Larke.Huang@SAMHSA.hhs.gov">Larke.Huang@SAMHSA.hhs.gov</a></td>
</tr>
<tr>
<td>Stephanie I.</td>
<td>Coard</td>
<td>PHD</td>
<td><a href="mailto:sicoard@uncg.edu">sicoard@uncg.edu</a></td>
</tr>
<tr>
<td>Giuseppe</td>
<td>Costantino</td>
<td>Ph.D.</td>
<td><a href="mailto:gcostantino@lmcmc.com">gcostantino@lmcmc.com</a></td>
</tr>
<tr>
<td>Name</td>
<td>Degree</td>
<td>Email</td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>--------</td>
<td>--------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Sheila Crye</td>
<td>B.A. Anthropology, R.N. diploma</td>
<td><a href="mailto:Crye4@aol.com">Crye4@aol.com</a></td>
<td></td>
</tr>
<tr>
<td>Phillippe Cunningham</td>
<td>Ph.D.</td>
<td><a href="mailto:cunninpb@musc.edu">cunninpb@musc.edu</a></td>
<td></td>
</tr>
<tr>
<td>Minh Dang</td>
<td>Ph.D.</td>
<td><a href="mailto:bahr.weiss@gmail.com">bahr.weiss@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Tamara Davis</td>
<td>Ph.D., MSSW</td>
<td><a href="mailto:davis.2304@osu.edu">davis.2304@osu.edu</a></td>
<td></td>
</tr>
<tr>
<td>Michael de Arellano</td>
<td>Ph.D.</td>
<td><a href="mailto:dearelma@musc.edu">dearelma@musc.edu</a></td>
<td></td>
</tr>
<tr>
<td>Sheena Demery</td>
<td>BA</td>
<td><a href="mailto:sheena.demery@fedexkinkos.com">sheena.demery@fedexkinkos.com</a></td>
<td></td>
</tr>
<tr>
<td>Manveen Dhindsa</td>
<td>M.A.</td>
<td><a href="mailto:mkdhindsa@ucdavis.edu">mkdhindsa@ucdavis.edu</a></td>
<td></td>
</tr>
<tr>
<td>Carla Dillard Smith</td>
<td>BA, MPA</td>
<td><a href="mailto:cdsnsmith@calpep.org">cdsnsmith@calpep.org</a></td>
<td></td>
</tr>
<tr>
<td>Nancy-Jane Doane</td>
<td></td>
<td><a href="mailto:nancy-jane.doane@umontana.edu">nancy-jane.doane@umontana.edu</a></td>
<td></td>
</tr>
<tr>
<td>Larissa Duncan</td>
<td>PhD</td>
<td><a href="mailto:duncanla@ocim.ucsf.edu">duncanla@ocim.ucsf.edu</a></td>
<td></td>
</tr>
<tr>
<td>Mary Ann Dutton</td>
<td>Ph.D.</td>
<td><a href="mailto:mad27@georgetown.edu">mad27@georgetown.edu</a></td>
<td></td>
</tr>
<tr>
<td>Lindsey Einhorn</td>
<td>M.A.</td>
<td><a href="mailto:lschacht@du.edu">lschacht@du.edu</a></td>
<td></td>
</tr>
<tr>
<td>Mesha Ellis</td>
<td>Ph.D.</td>
<td><a href="mailto:mesha.ellis@vanderbilt.edu">mesha.ellis@vanderbilt.edu</a></td>
<td></td>
</tr>
<tr>
<td>Carol Falender</td>
<td>Ph.D.</td>
<td><a href="mailto:Cfalende@vanderbilt.edu">Cfalende@vanderbilt.edu</a></td>
<td></td>
</tr>
<tr>
<td>Tonya Fancher</td>
<td>MD MPH</td>
<td><a href="mailto:tifancher@ucdavis.edu">tifancher@ucdavis.edu</a></td>
<td></td>
</tr>
<tr>
<td>Linda Forrest</td>
<td>Ph.D.</td>
<td><a href="mailto:forrestl@uoregon.edu">forrestl@uoregon.edu</a></td>
<td></td>
</tr>
<tr>
<td>Michi Fu</td>
<td>Ph.D.</td>
<td><a href="mailto:drmichifu@gmail.com">drmichifu@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Miguel Gallardo</td>
<td>PsyD</td>
<td><a href="mailto:dr.gallardo@cox.net">dr.gallardo@cox.net</a></td>
<td></td>
</tr>
<tr>
<td>Joanne Gampel</td>
<td>Ph.D.</td>
<td><a href="mailto:joanne.gampel@samhsa.hhs.gov">joanne.gampel@samhsa.hhs.gov</a></td>
<td></td>
</tr>
<tr>
<td>Glenn Gamst</td>
<td>Ph.D.</td>
<td><a href="mailto:gamstg@ulv.edu">gamstg@ulv.edu</a></td>
<td></td>
</tr>
<tr>
<td>Terry S. Gock</td>
<td>Ph.D., M.P.A.</td>
<td><a href="mailto:terrygock@aol.com">terrygock@aol.com</a></td>
<td></td>
</tr>
<tr>
<td>Anisa Goforth</td>
<td>School Psychology PhD Student</td>
<td><a href="mailto:goforth2@msu.edu">goforth2@msu.edu</a></td>
<td></td>
</tr>
<tr>
<td>Avigail Goldgraber</td>
<td></td>
<td><a href="mailto:Larke.huang@samhsa.hhs.gov">Larke.huang@samhsa.hhs.gov</a></td>
<td></td>
</tr>
<tr>
<td>Peter Guarnaccia</td>
<td>Ph.D.</td>
<td><a href="mailto:pguarnaccia@ifh.rutgers.edu">pguarnaccia@ifh.rutgers.edu</a></td>
<td></td>
</tr>
<tr>
<td>Alesia Hawkins</td>
<td>Ph.D.</td>
<td><a href="mailto:hawkina@musc.edu">hawkina@musc.edu</a></td>
<td></td>
</tr>
<tr>
<td>Mario Hernandez</td>
<td>Ph.D.</td>
<td><a href="mailto:hernande@fmhi.usf.edu">hernande@fmhi.usf.edu</a></td>
<td></td>
</tr>
<tr>
<td>Lynn Hernandez</td>
<td>Ph.D.</td>
<td><a href="mailto:Lynn_Hernandez@Brown.edu">Lynn_Hernandez@Brown.edu</a></td>
<td></td>
</tr>
<tr>
<td>Susan Hills</td>
<td>Ph.D.</td>
<td><a href="mailto:shills@ahpnet.com">shills@ahpnet.com</a></td>
<td></td>
</tr>
<tr>
<td>Bertha Holliday</td>
<td>Ph.D.</td>
<td><a href="mailto:bholliday@apa.org">bholliday@apa.org</a></td>
<td></td>
</tr>
<tr>
<td>Khiela Holmes</td>
<td>Ph.D.</td>
<td><a href="mailto:jehinanr@med.umich.edu">jehinanr@med.umich.edu</a></td>
<td></td>
</tr>
<tr>
<td>Janie Hong</td>
<td>Ph.D.</td>
<td><a href="mailto:jhj@sfbacct.com">jhj@sfbacct.com</a></td>
<td></td>
</tr>
<tr>
<td>Arthur Horton</td>
<td>Ed.D.</td>
<td><a href="mailto:drmachorton@hotmail.com">drmachorton@hotmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Larke Huang</td>
<td>Ph.D.</td>
<td><a href="mailto:Larke.huang@samhsa.hhs.gov">Larke.huang@samhsa.hhs.gov</a></td>
<td></td>
</tr>
<tr>
<td>Ruth Hurtado-Day</td>
<td>M.S.</td>
<td><a href="mailto:ruth.hurtado_day@samhsa.hhs.gov">ruth.hurtado_day@samhsa.hhs.gov</a></td>
<td></td>
</tr>
<tr>
<td>Mareasa Isaacs</td>
<td>MSW, Ph.D.</td>
<td><a href="mailto:misaacs5548@aol.com">misaacs5548@aol.com</a></td>
<td></td>
</tr>
<tr>
<td>Mareasa Isaacs</td>
<td>Ph.D.</td>
<td><a href="mailto:mshock7448@aol.com">mshock7448@aol.com</a></td>
<td></td>
</tr>
<tr>
<td>Leslie Jackson</td>
<td>Ph.D.</td>
<td><a href="mailto:ljackson4@gsu.edu">ljackson4@gsu.edu</a></td>
<td></td>
</tr>
<tr>
<td>Michelle Jacobo</td>
<td>Ph.D.</td>
<td><a href="mailto:mjacobob@partners.org">mjacobob@partners.org</a></td>
<td></td>
</tr>
<tr>
<td>Sharon Rae Jenkins</td>
<td>Ph.D.</td>
<td><a href="mailto:jenkiness@unt.edu">jenkiness@unt.edu</a></td>
<td></td>
</tr>
<tr>
<td>Daniel Jessica</td>
<td>PhD</td>
<td><a href="mailto:jessica.daniel@childrens.harvard.edu">jessica.daniel@childrens.harvard.edu</a></td>
<td></td>
</tr>
<tr>
<td>Heather Jones</td>
<td>PhD</td>
<td><a href="mailto:jonesheather@email.chop.edu">jonesheather@email.chop.edu</a></td>
<td></td>
</tr>
<tr>
<td>Kathleen Jones</td>
<td>MPH</td>
<td><a href="mailto:kathleen.e.jones@macrointernation.comm">kathleen.e.jones@macrointernation.comm</a></td>
<td></td>
</tr>
<tr>
<td>Lauren Jones</td>
<td>PhD</td>
<td><a href="mailto:LaurenPjones@aol.com">LaurenPjones@aol.com</a></td>
<td></td>
</tr>
<tr>
<td>Aparna Kalbag</td>
<td>Ph.D.</td>
<td><a href="mailto:aparnak7@aol.com">aparnak7@aol.com</a></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
<td>Email</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------------</td>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td>Stacey Kaltman</td>
<td>PhD</td>
<td><a href="mailto:sk279@georgetown.edu">sk279@georgetown.edu</a></td>
<td></td>
</tr>
<tr>
<td>Alan E Kazdin</td>
<td>PhD, ABPP</td>
<td><a href="mailto:alan.kazdin@yale.edu">alan.kazdin@yale.edu</a></td>
<td></td>
</tr>
<tr>
<td>Gwendolyn Keita</td>
<td>PhD</td>
<td><a href="mailto:gkeita@apa.org">gkeita@apa.org</a></td>
<td></td>
</tr>
<tr>
<td>Taleb Khairallah</td>
<td>MS</td>
<td><a href="mailto:tskdkc@mizzou.edu">tskdkc@mizzou.edu</a></td>
<td></td>
</tr>
<tr>
<td>Su Yeong Kim</td>
<td>Ph.D.</td>
<td><a href="mailto:sykim@prc.utexas.edu">sykim@prc.utexas.edu</a></td>
<td></td>
</tr>
<tr>
<td>Cheryl King</td>
<td>Ph.D.</td>
<td><a href="mailto:kingca@umich.edu">kingca@umich.edu</a></td>
<td></td>
</tr>
<tr>
<td>Jeff King</td>
<td>PhD</td>
<td><a href="mailto:jeffking@msn.com">jeffking@msn.com</a></td>
<td></td>
</tr>
<tr>
<td>Angela Knox</td>
<td>MBA</td>
<td><a href="mailto:aknox@tarzanatc.org">aknox@tarzanatc.org</a></td>
<td></td>
</tr>
<tr>
<td>Vesna Kutlesic</td>
<td>Ph.D.</td>
<td><a href="mailto:vikutlesic@aol.com">vikutlesic@aol.com</a></td>
<td></td>
</tr>
<tr>
<td>Teresa LaFromboise</td>
<td>PhD</td>
<td><a href="mailto:lafrom@stanford.edu">lafrom@stanford.edu</a></td>
<td></td>
</tr>
<tr>
<td>Vanessa Landau</td>
<td></td>
<td><a href="mailto:Larke.huang@samhsa.hhs.gov">Larke.huang@samhsa.hhs.gov</a></td>
<td></td>
</tr>
<tr>
<td>Patty LaPlant</td>
<td></td>
<td><a href="mailto:Patty.LaPlant@mso.umt.edu">Patty.LaPlant@mso.umt.edu</a></td>
<td></td>
</tr>
<tr>
<td>Sandra Larios</td>
<td>MS, MPH</td>
<td><a href="mailto:sandra.larios@ucsf.edu">sandra.larios@ucsf.edu</a></td>
<td></td>
</tr>
<tr>
<td>Jeanne Larsen</td>
<td>M.L.S.</td>
<td><a href="mailto:larsenje@georgetown.edu">larsenje@georgetown.edu</a></td>
<td></td>
</tr>
<tr>
<td>Anna Lau</td>
<td>Ph.D.</td>
<td><a href="mailto:alau@psych.ucla.edu">alau@psych.ucla.edu</a></td>
<td></td>
</tr>
<tr>
<td>Charlene Le Fauve</td>
<td>Ph.D.</td>
<td><a href="mailto:charlene.le_fauve@samhsa.hhs.gov">charlene.le_fauve@samhsa.hhs.gov</a></td>
<td></td>
</tr>
<tr>
<td>Christina Lee</td>
<td>Ph.D.</td>
<td><a href="mailto:Christina_Lee@Brown.edu">Christina_Lee@Brown.edu</a></td>
<td></td>
</tr>
<tr>
<td>Celia Lescano</td>
<td>PhD</td>
<td><a href="mailto:CLescano@lifespan.org">CLescano@lifespan.org</a></td>
<td></td>
</tr>
<tr>
<td>Paul Leung</td>
<td>PhD</td>
<td><a href="mailto:pleung@unt.edu">pleung@unt.edu</a></td>
<td></td>
</tr>
<tr>
<td>Ronlad Levant</td>
<td>Ed.D.</td>
<td><a href="mailto:levant@uakron.edu">levant@uakron.edu</a></td>
<td></td>
</tr>
<tr>
<td>Karen Lincoln</td>
<td>Ph.D.</td>
<td><a href="mailto:klincoln@usc.edu">klincoln@usc.edu</a></td>
<td></td>
</tr>
<tr>
<td>Graciete Lo</td>
<td>BA</td>
<td><a href="mailto:gracietelo@gmail.com">gracietelo@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Debra Loabato-</td>
<td>PhD</td>
<td><a href="mailto:DLoabato@lifespan.org">DLoabato@lifespan.org</a></td>
<td></td>
</tr>
<tr>
<td>Barrera</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emilia Lopez</td>
<td>Ph.D.</td>
<td><a href="mailto:lopez@cedx.com">lopez@cedx.com</a></td>
<td></td>
</tr>
<tr>
<td>Teresa Makowski</td>
<td>PhD</td>
<td><a href="mailto:Teresa.Makowski@ihs.gov">Teresa.Makowski@ihs.gov</a></td>
<td></td>
</tr>
<tr>
<td>Gishawn Mance</td>
<td>PhD</td>
<td><a href="mailto:gmance@hsp.harvard.edu">gmance@hsp.harvard.edu</a></td>
<td></td>
</tr>
<tr>
<td>Jennifer Manly</td>
<td>Ph.D.</td>
<td><a href="mailto:jjm71@columbia.edu">jjm71@columbia.edu</a></td>
<td></td>
</tr>
<tr>
<td>Luana Marques</td>
<td>Ph.D.</td>
<td><a href="mailto:lmarques@partners.org">lmarques@partners.org</a></td>
<td></td>
</tr>
<tr>
<td>Lynne Marsenich</td>
<td>MSW</td>
<td><a href="mailto:lmarstenich@csu.edu">lmarstenich@csu.edu</a></td>
<td></td>
</tr>
<tr>
<td>Roger Martinez</td>
<td>B.A. Psychology &amp; B.S.W.</td>
<td><a href="mailto:rogmartinez@epcounty.com">rogmartinez@epcounty.com</a></td>
<td></td>
</tr>
<tr>
<td>Ken Martinez</td>
<td>Psy.D.</td>
<td><a href="mailto:kmartinez@air.org">kmartinez@air.org</a></td>
<td></td>
</tr>
<tr>
<td>Maria Martinez</td>
<td>M.A.</td>
<td><a href="mailto:maria.martinez@unc.edu">maria.martinez@unc.edu</a></td>
<td></td>
</tr>
<tr>
<td>Parvaneh (Pari)</td>
<td>Mazhar</td>
<td><a href="mailto:pmazhar@centralcityconcern.org">pmazhar@centralcityconcern.org</a></td>
<td></td>
</tr>
<tr>
<td>Lisa McCrea Jones</td>
<td>MA</td>
<td><a href="mailto:ljoness04@georgefox.edu">ljoness04@georgefox.edu</a></td>
<td></td>
</tr>
<tr>
<td>Oanh Meyer</td>
<td>M.A.</td>
<td><a href="mailto:olmeyer@ucdavis.edu">olmeyer@ucdavis.edu</a></td>
<td></td>
</tr>
<tr>
<td>Norweeta Milburn</td>
<td>Ph.D.</td>
<td><a href="mailto:NMilburn@mednet.uc.edu">NMilburn@mednet.uc.edu</a></td>
<td></td>
</tr>
<tr>
<td>Ebony Montgomery</td>
<td>MPH</td>
<td><a href="mailto:ebony.r.montgomery@macrointernational.com">ebony.r.montgomery@macrointernational.com</a></td>
<td></td>
</tr>
<tr>
<td>Pablo Mora</td>
<td>Ph.D.</td>
<td><a href="mailto:pmora@ifh.rutgers.edu">pmora@ifh.rutgers.edu</a></td>
<td></td>
</tr>
<tr>
<td>Eduardo Morales</td>
<td>Ph.D.</td>
<td><a href="mailto:DrEMorales@aol.com">DrEMorales@aol.com</a></td>
<td></td>
</tr>
<tr>
<td>Erica Moran</td>
<td>B.A.</td>
<td><a href="mailto:emoran4@du.edu">emoran4@du.edu</a></td>
<td></td>
</tr>
<tr>
<td>Carmen Moten</td>
<td>PhD</td>
<td><a href="mailto:cmoten@mail.nih.gov">cmoten@mail.nih.gov</a></td>
<td></td>
</tr>
<tr>
<td>Ricardo Munoz</td>
<td>Ph.D.</td>
<td><a href="mailto:ricardo.munoz@ucsf.edu">ricardo.munoz@ucsf.edu</a></td>
<td></td>
</tr>
<tr>
<td>Sara Nahari</td>
<td>Ph.D. School psychology</td>
<td><a href="mailto:snahari@aol.com">snahari@aol.com</a></td>
<td></td>
</tr>
<tr>
<td>Valerie Naquin</td>
<td>M.A.</td>
<td><a href="mailto:vnaquin@citci.com">vnaquin@citci.com</a></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Degree</td>
<td>Email</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>--------</td>
<td>----------------------------</td>
<td></td>
</tr>
<tr>
<td>Enrique Neblett</td>
<td>Ph.D.</td>
<td><a href="mailto:eneblett@unc.edu">eneblett@unc.edu</a></td>
<td></td>
</tr>
<tr>
<td>Victoria Ngo</td>
<td>PhD</td>
<td><a href="mailto:vngo@mednet.ucla.edu">vngo@mednet.ucla.edu</a></td>
<td></td>
</tr>
<tr>
<td>Edmund Nightingale</td>
<td>Ph.D.</td>
<td><a href="mailto:night002@umn.edu">night002@umn.edu</a></td>
<td></td>
</tr>
<tr>
<td>Milburn Norweeta</td>
<td>Ph.D.</td>
<td><a href="mailto:nmilburn@mednet.ucla.edu">nmilburn@mednet.ucla.edu</a></td>
<td></td>
</tr>
<tr>
<td>Evelyn Oka</td>
<td>Ph.D.</td>
<td><a href="mailto:evoka@msu.edu">evoka@msu.edu</a></td>
<td></td>
</tr>
<tr>
<td>Lisa Onken</td>
<td>Ph.D.</td>
<td><a href="mailto:lonken@nida.nih.gov">lonken@nida.nih.gov</a></td>
<td></td>
</tr>
<tr>
<td>Trina Osher</td>
<td>M.A.</td>
<td><a href="mailto:tosher3@comcast.net">tosher3@comcast.net</a></td>
<td></td>
</tr>
<tr>
<td>Nancy &quot;Lynn&quot; Palmanteer-Holder</td>
<td>Ph.D., Student</td>
<td><a href="mailto:nh@u.washington.edu">nh@u.washington.edu</a></td>
<td></td>
</tr>
<tr>
<td>Margaret Payne</td>
<td>M.A.</td>
<td><a href="mailto:merpayne@gmail.com">merpayne@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Darlene Perez-Brown</td>
<td>Ph.D.</td>
<td><a href="mailto:browndp@wssu.edu">browndp@wssu.edu</a></td>
<td></td>
</tr>
<tr>
<td>Suni Petersen</td>
<td>Ph.D.</td>
<td><a href="mailto:spetersen@alliant.edu">spetersen@alliant.edu</a></td>
<td></td>
</tr>
<tr>
<td>Nancy Piotrowski</td>
<td>Ph.D.</td>
<td><a href="mailto:napiotrowski@yahoo.com">napiotrowski@yahoo.com</a></td>
<td></td>
</tr>
<tr>
<td>Rebecca Plascencia</td>
<td></td>
<td><a href="mailto:rplascencia@tarzanatc.org">rplascencia@tarzanatc.org</a></td>
<td></td>
</tr>
<tr>
<td>Antonio Polo</td>
<td>Ph.D.</td>
<td><a href="mailto:apolo@depaul.edu">apolo@depaul.edu</a></td>
<td></td>
</tr>
<tr>
<td>Natalie Porter</td>
<td>PhD</td>
<td><a href="mailto:nporter@alliant.edu">nporter@alliant.edu</a></td>
<td></td>
</tr>
<tr>
<td>LeShawndra Price</td>
<td>Ph.D.</td>
<td><a href="mailto:lprice@mail.nih.gov">lprice@mail.nih.gov</a></td>
<td></td>
</tr>
<tr>
<td>Michael Price</td>
<td>MA</td>
<td><a href="mailto:mprice@apa.org">mprice@apa.org</a></td>
<td></td>
</tr>
<tr>
<td>Mary Lou Randour</td>
<td>Ph.D.</td>
<td><a href="mailto:mrandour@hsus.org">mrandour@hsus.org</a></td>
<td></td>
</tr>
<tr>
<td>Stephanie Richards</td>
<td></td>
<td><a href="mailto:steph.richards13@gmail.com">steph.richards13@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Shauna Rienks</td>
<td>Ph.D.</td>
<td><a href="mailto:srienks@edu.edu">srienks@edu.edu</a></td>
<td></td>
</tr>
<tr>
<td>Caryn Rodgers</td>
<td>PhD</td>
<td><a href="mailto:crodgers@jhsph.edu">crodgers@jhsph.edu</a></td>
<td></td>
</tr>
<tr>
<td>Beth Ann Rodriguez</td>
<td>MSW</td>
<td><a href="mailto:brodriguez@hs-trainet.com">brodriguez@hs-trainet.com</a></td>
<td></td>
</tr>
<tr>
<td>George Ronan</td>
<td>PhD</td>
<td><a href="mailto:ronan1gf@cmich.edu">ronan1gf@cmich.edu</a></td>
<td></td>
</tr>
<tr>
<td>Theda Rose</td>
<td>MSW, current PhD Student</td>
<td><a href="mailto:tyerose@gmail.com">tyerose@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Maureen Rubin</td>
<td>Ph.D.</td>
<td><a href="mailto:maureen.rubin@utsa.edu">maureen.rubin@utsa.edu</a></td>
<td></td>
</tr>
<tr>
<td>Delia Saldana</td>
<td>PhD</td>
<td><a href="mailto:saldana@uthscsa.edu">saldana@uthscsa.edu</a></td>
<td></td>
</tr>
<tr>
<td>Eileen Santa</td>
<td>M.A.</td>
<td><a href="mailto:esanta@jsinternational.com">esanta@jsinternational.com</a></td>
<td></td>
</tr>
<tr>
<td>Ingrid Sarmiento</td>
<td>MA</td>
<td><a href="mailto:isarmiento@clarku.edu">isarmiento@clarku.edu</a></td>
<td></td>
</tr>
<tr>
<td>Marcoa Scott</td>
<td>Ph.D.</td>
<td><a href="mailto:mscott@mail.nih.gov">mscott@mail.nih.gov</a></td>
<td></td>
</tr>
<tr>
<td>Robert Sellers</td>
<td>Ph.D.</td>
<td><a href="mailto:rsellers@umich.edu">rsellers@umich.edu</a></td>
<td></td>
</tr>
<tr>
<td>Nancy Shelton</td>
<td></td>
<td><a href="mailto:nshelton@ccsi.org">nshelton@ccsi.org</a></td>
<td></td>
</tr>
<tr>
<td>Joel Sherrill</td>
<td>Ph.D.</td>
<td><a href="mailto:jsherrill@mail.nih.gov">jsherrill@mail.nih.gov</a></td>
<td></td>
</tr>
<tr>
<td>June Shibuya</td>
<td>RN, MSN, PHN</td>
<td><a href="mailto:shibuyaj@hawaii.edu">shibuyaj@hawaii.edu</a></td>
<td></td>
</tr>
<tr>
<td>Anne Simons</td>
<td>PhD</td>
<td><a href="mailto:simons@uoregon.edu">simons@uoregon.edu</a></td>
<td></td>
</tr>
<tr>
<td>Mia Smith Bynum</td>
<td>PhD</td>
<td><a href="mailto:msbynum@psych.purdue.edu">msbynum@psych.purdue.edu</a></td>
<td></td>
</tr>
<tr>
<td>Shannon Sommer</td>
<td>BSW</td>
<td><a href="mailto:ssommer@citci.com">ssommer@citci.com</a></td>
<td></td>
</tr>
<tr>
<td>Erica Sood</td>
<td>M.A.</td>
<td><a href="mailto:esood@temple.edu">esood@temple.edu</a></td>
<td></td>
</tr>
<tr>
<td>Jose Soto</td>
<td>PhD</td>
<td><a href="mailto:jas95@psu.edu">jas95@psu.edu</a></td>
<td></td>
</tr>
<tr>
<td>Bonnie Spring</td>
<td>Ph.D.</td>
<td><a href="mailto:bspring@northwestern.edu">bspring@northwestern.edu</a></td>
<td></td>
</tr>
<tr>
<td>Leah Squires</td>
<td>M.A.</td>
<td><a href="mailto:lsquires@bu.edu">lsquires@bu.edu</a></td>
<td></td>
</tr>
<tr>
<td>Gabriela Livas</td>
<td>Ph.D.</td>
<td><a href="mailto:gabriela.stein@duke.edu">gabriela.stein@duke.edu</a></td>
<td></td>
</tr>
<tr>
<td>Charleta B. Tavares</td>
<td></td>
<td><a href="mailto:ctavares@maccinc.net">ctavares@maccinc.net</a></td>
<td></td>
</tr>
<tr>
<td>Tiffany Townsend</td>
<td>Ph.D.</td>
<td><a href="mailto:tt237@georgetown.edu">tt237@georgetown.edu</a></td>
<td></td>
</tr>
<tr>
<td>Alan Trachtenberg</td>
<td>MD</td>
<td><a href="mailto:atrachte@juno.com">atrachte@juno.com</a></td>
<td></td>
</tr>
<tr>
<td>Joseph Trimble</td>
<td>PhD</td>
<td><a href="mailto:joseph.trimble@wwu.edu">joseph.trimble@wwu.edu</a></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
<td>Email</td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------------</td>
<td>--------------------------------</td>
<td></td>
</tr>
<tr>
<td>George Tsauouchis</td>
<td>BA</td>
<td><a href="mailto:david@reisman-white.com">david@reisman-white.com</a></td>
<td></td>
</tr>
<tr>
<td>Richard Tsujimoto</td>
<td>Ph.D.</td>
<td><a href="mailto:Richard_Tsujimoto@Pitzer.edu">Richard_Tsujimoto@Pitzer.edu</a></td>
<td></td>
</tr>
<tr>
<td>Patrick Uchigakiuchi</td>
<td>PhD</td>
<td><a href="mailto:patricku@hawaii.edu">patricku@hawaii.edu</a></td>
<td></td>
</tr>
<tr>
<td>Nikki Uglow</td>
<td>MA</td>
<td><a href="mailto:nikkiglow@hotmail.com">nikkiglow@hotmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Donald Unger</td>
<td>PhD</td>
<td><a href="mailto:unger@udel.edu">unger@udel.edu</a></td>
<td></td>
</tr>
<tr>
<td>Carmen Valdez</td>
<td>psychology</td>
<td><a href="mailto:cvaldez@wisc.edu">cvaldez@wisc.edu</a></td>
<td></td>
</tr>
<tr>
<td>Gladys Valdez</td>
<td>PhD, Clinical Psychology</td>
<td><a href="mailto:gladys.valdez@gmail.com">gladys.valdez@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Erika Van Buren</td>
<td>Ph.D.</td>
<td><a href="mailto:erika.vanburen@dc.gov">erika.vanburen@dc.gov</a></td>
<td></td>
</tr>
<tr>
<td>Ryan Vandrez</td>
<td>Ph.D.</td>
<td><a href="mailto:rvandreg@jhmi.edu">rvandreg@jhmi.edu</a></td>
<td></td>
</tr>
<tr>
<td>Enrique Varela</td>
<td>PhD</td>
<td><a href="mailto:evarela@tunlane.edu">evarela@tunlane.edu</a></td>
<td></td>
</tr>
<tr>
<td>Luis Vargas</td>
<td>Ph.D.</td>
<td><a href="mailto:lvargas@salud.unm.edu">lvargas@salud.unm.edu</a></td>
<td></td>
</tr>
<tr>
<td>Elizabeth Vera</td>
<td>Ph.D.</td>
<td><a href="mailto:evera@luc.edu">evera@luc.edu</a></td>
<td></td>
</tr>
<tr>
<td>Barbara Wallace</td>
<td>Ph.D.</td>
<td><a href="mailto:wallace@exchange.tc.columbia.edu">wallace@exchange.tc.columbia.edu</a></td>
<td></td>
</tr>
<tr>
<td>Earlise Ward</td>
<td>PhD, LP</td>
<td><a href="mailto:ecward@wisc.edu">ecward@wisc.edu</a></td>
<td></td>
</tr>
<tr>
<td>Bahr Weiss</td>
<td>PhD</td>
<td><a href="mailto:bahr.weiss@gmail.com">bahr.weiss@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Amy West</td>
<td>Ph.D.</td>
<td><a href="mailto:awest@psych.uic.edu">awest@psych.uic.edu</a></td>
<td></td>
</tr>
<tr>
<td>David White</td>
<td>PhD</td>
<td><a href="mailto:david@reisman-white.com">david@reisman-white.com</a></td>
<td></td>
</tr>
<tr>
<td>Monnica Williams</td>
<td>Ph.D.</td>
<td><a href="mailto:monnica@mail.med.upenn.edu">monnica@mail.med.upenn.edu</a></td>
<td></td>
</tr>
<tr>
<td>Elaine Wolf</td>
<td>PhD</td>
<td><a href="mailto:emwolf@communityalternatives.org">emwolf@communityalternatives.org</a></td>
<td></td>
</tr>
<tr>
<td>Ahtoy WonPat-Borja</td>
<td>MPH</td>
<td><a href="mailto:aw258@columbia.edu">aw258@columbia.edu</a></td>
<td></td>
</tr>
<tr>
<td>LaTonya Wood</td>
<td>PhD</td>
<td><a href="mailto:latonyawood@msn.com">latonyawood@msn.com</a></td>
<td></td>
</tr>
<tr>
<td>Briana Woods</td>
<td>M.S.</td>
<td><a href="mailto:bawoods@u.washington.edu">bawoods@u.washington.edu</a></td>
<td></td>
</tr>
<tr>
<td>Lawrence Yang</td>
<td></td>
<td><a href="mailto:lawrenceyang@gmail.com">lawrenceyang@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Miwa Yasui (Ogo)</td>
<td></td>
<td><a href="mailto:mogo@psych.uic.edu">mogo@psych.uic.edu</a></td>
<td></td>
</tr>
<tr>
<td>Rick Ybarra</td>
<td></td>
<td><a href="mailto:rick.ybarra@austin.utexas.edu">rick.ybarra@austin.utexas.edu</a></td>
<td></td>
</tr>
<tr>
<td>Edilma Yearwood</td>
<td>PhD</td>
<td><a href="mailto:ely2@georgetown.edu">ely2@georgetown.edu</a></td>
<td></td>
</tr>
<tr>
<td>James Yokley</td>
<td>Ph.D.</td>
<td><a href="mailto:jyokley@roadrunner.com">jyokley@roadrunner.com</a></td>
<td></td>
</tr>
<tr>
<td>Nolan Zane</td>
<td>Ph.D.</td>
<td><a href="mailto:nzane@ucdavis.edu">nzane@ucdavis.edu</a></td>
<td></td>
</tr>
<tr>
<td>Jessika Zmuda</td>
<td>MPH Candidate '08</td>
<td><a href="mailto:jzmuda@jhsph.edu">jzmuda@jhsph.edu</a></td>
<td></td>
</tr>
</tbody>
</table>