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Lynda E. Frost
The University of Texas at Austin

Rick Ybarra
The University of Texas at Austin

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RESULTS

Funding Cultural Adaptations to Promote Effective and Efficient Mental Health Service Provision

Lynda E. Frost, J.D., Ph.D., The University of Texas at Austin; and Rick Ybarra, M.A., The University of Texas at Austin

Key Points

- Given the changing demographics of the U.S. and documented racial and ethnic health disparities, behavioral health service providers must look at adapting their services to better meet the needs of their diverse client populations.
- Grantees implemented three types of cultural adaptations: sociocultural/organizational, structural/service delivery, and clinical.
- Most adaptations were not directly related to the specific evidence-based practice and would be relevant in many service-provision settings.

The quality of available behavioral health services is a concern nationwide. In recent years, attention has focused on evidence-based practices (EBPs) – prevention and treatment approaches that are validated by documented scientific evidence, such as randomized, controlled research studies – as opposed to tradition, convention, belief, or anecdotal evidence. In the behavioral health field, the Substance Abuse Mental Health Services Administration has identified interventions that have reached the level of proof necessary to be considered EBPs (National Registry of Evidence-based Programs and Practices, 2010). In part due to concern over the average of 17 years for research to be incorporated into real world clinical practice (Balas & Boren, 2000), funders such as major foundations and the federal government increasingly have promoted the use of EBPs and some state mental health agencies require EBPs in contracts with local mental health authorities and contracted providers.

Yet racial and ethnic minorities have expressed concern over the strong emphasis on EBPs in clinical service provision and some providers see a conflict between EBPs and culturally competent services (Lundgren, Amodeo, Cohen, Chassler, & Horowitz, 2011). In many instances the evidence base had inadequate representation of racial and ethnic minority groups (Atkinson, Bui, & Mori, 2001; Bernal & Rodriguez, 2009; Bernal & Scharrón-Del-Río, 2001; Chambless & Ollendick, 2001; Chambless et al., 1996; G. C. N. Hall, 2001; Hohmann & Parron, 1996; Miranda, Nakamura, & Bernal, 2003; Miranda et al., 2005; Muñoz & Mendelson, 2005; Vera, Vila, & Alegría, 2003). A fundamental assumption of the research was that documented evidence of effectiveness with a certain population could be generalized to other populations, including culturally and linguistically diverse communities. However, small sample sizes of racial and ethnic populations in randomized, controlled trials research prevent strong and clear conclusions about the effectiveness, generalizability, and appropriateness of EBPs delivered to racial and ethnic minority communities. Prior research indicates the importance of addressing culture in mental health services and treatment, as culturally adapted treatments are more likely to yield positive results (BigFoot & Schmidt, 2010; Harris & Franklin, 2003; Muñoz & Mendelson, 2005; Sue, 2003).

All individuals have a need to receive quality behavioral health services. Major mental disorders have a significant impact on the health and well-being of individuals, their families, and their

communities. Recent data show that this impact is not equally distributed across racial and ethnic groups; in fact, racial and ethnic minorities have less access to quality behavioral health services in the United States (Alegría et al., 2002; Cook, McGuire, & Miranda, 2007; Wells, Klap, Koike, & Sherbourne, 2001; Whaley & Davis, 2007). An Institute of Medicine report (2003) highlighted more than 175 studies documenting ethnic and racial disparities in the diagnosis and treatment of a multitude of conditions, including mental health, even when analyses were controlled by factors including socioeconomic status, location of service, comorbidity, and age.

A number of barriers prevent racial and ethnic communities from accessing and receiving mental health services. The stigma surrounding mental illness creates a powerful barrier. Individuals may feel ashamed and fear discrimination and prejudice. Lack of insurance and underinsurance are additional barriers preventing access to health care services. Inaccurate diagnoses or non-identification of mental health conditions by primary care physicians and lack of referrals of these individuals to appropriate mental health services result in a failure of the health care services across the range of conditions. Even for those who access treatment, premature dropout (often after just the first session) and high rates of missed appointments are a persistent challenge. Although effective communication in the person's primary or preferred language is essential to engage and maintain individuals in treatment, providers of service are challenged to offer services in a language other than English due to a lack of linguistically fluent mental health professionals (Woloshin, Bickell, Schwartz, Gany, & Welch, 1995; Dana, 1998; Annapolis Coalition on the Behavioral Health Workforce, 2005; U.S. Department of Health and Human Services, 2006). Cultural attitudes, beliefs, values, preferences, and behaviors play a powerful role in decisions to seek help for mental health conditions. Among the cultural factors influencing healthcare decision-making are variations in symptom recognition, resistance to seeking help, ability to communicate symptoms to a provider, ability to understand the pharmacological and psychosocial treatment regime, treatment expectations, and adherence to

preventive measures and prescribed medications (Eisenberg, 1979; Kleinman, Eiswenberg, & Good, 1978; Carrillo, Green, & Betancourt, 1999).

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Service providers and policymakers have recognized the need to eliminate these disparities. The Surgeon General and a presidential commission have both called for the elimination of racial, ethnic, and linguistic disparities in access, quality of care, and appropriateness of services through culturally competent service provision (U.S. Department of Health and Human Services, 1999, 2001; New Freedom Commission on Mental Health, 2003). The National Association for State Mental Health Program Directors (2004) urged state mental health commissioners personally to lead cultural competency initiatives in their states. The advancement toward cultural competence is recognized by federal agencies, policymakers, state mental health commissioners, managed care administrators, academicians, providers, and service recipients as a strategy to eliminate ethnic and racial disparities in health care (Betancourt, Green, Carrillo, & Park, 2005; Brach & Fraser, 2000; Denboba, Bragdon, Epstein, Garthright, & Goldman, 1998). There have been some efforts to pass legislation requiring cultural competency. In 2005, the New Jersey Legislature enacted law requiring the New Jersey Board of Medical Examiners in consultation with the Commission on Higher Education to prescribe requirements for physician training in cultural competency (regulations adopted in 2008). Other efforts to pass legislation and rules in state agencies requiring cultural competency have had mixed degrees of success.

The demographic shifts toward a more culturally and linguistically diverse U.S. population have heightened the need and urgency of change in the mental health system to meet the needs of

culturally and linguistically diverse communities (American Psychological Association, 1993, 2003; Atkinson, Bui, & Mori, 2001; Bernal & Castro, 1994; C. C. I. Hall, 1997; Ridley, 1985; Sue, Arredondo, & McDavis, 1992; Sue & Torino, 2005; Sue, 1998).

Addressing Racial and Ethnic Disparities in Service Provision

In 2005, the Hogg Foundation for Mental Health decided to fund a major initiative to improve the quality and availability of mental health services provided to culturally and linguistically diverse populations in Texas. Through its Cultural Adaptation Initiative, the foundation also sought to bridge a gap in the literature by generating knowledge about cultural adaptations of EBPs, thus informing research and service delivery (Bernal & Sáez-Santiago, 2006; Whitley, 2007; Siegel, Haughland, & Schore, 2005).

Demographic shifts have heightened the need and urgency of change to meet the needs of culturally and linguistically diverse communities.

To begin the initiative, the foundation convened two expert panels to clarify what was known about using mental health treatments touted as "evidence-based" with racial and ethnic minorities. For each panel, a dozen national experts representing diverse perspectives on cultural competence and evidence-based practices addressed questions designed to focus the foundation's grantmaking and move forward the collective body of knowledge and the state of practice in Texas.

The expert panels of community advocates and respected scholars challenged the traditional assumption that EBPs developed with a culturally restricted set of research participants will be equally effective in more diverse, real-world environments. They did a frank assessment of

the existing research literature on using mental health treatments considered evidence-based (e.g., cognitive-behavioral therapy) with racial and ethnic minorities. A central theme of both panel discussions was the importance of involving the selected community at all stages when developing and evaluating a treatment program for racial and ethnic minorities. Without the community's input, panel members asserted, attempts to develop culturally appropriate services would not be valid and would ultimately fail. They noted that many EBPs are developed in controlled settings that differ greatly from the settings and populations in which they are implemented (Walker & Bruns, 2006) and most evidence is not very practice-based (Drake et al., 2001; Green, 2006). A few panelists suggested a funding approach to study promising community-based practices to build the research support needed to become an EBP. In the end, though, the foundation followed other panelists' recommendations that the current initiative focus on moving adapted EBPs into the community rather than researching promising practices already used in usual-care settings.

The foundation used the findings from the expert panels to shape a Request for Proposals (RFP) in which mental health providers who serve racial and ethnic minorities were asked to select an EBP from a list compiled by the foundation. The list was based on the available research evidence for the most common psychiatric disorders. Successful grantees would receive training in their selected EBP and would implement an adaptation of the EBP designed to overcome the cultural barriers of their treatment population.

The RFP gauged applicants' interest and expertise in two distinct areas: use of EBPs and cultural competence. In drafting the RFP and developing the rating scale used to assess applicants, the foundation had to prioritize the emphasis placed on each of the two areas. In the end, the foundation decided that it could provide strong technical assistance and training to grantees in order to advance their mastery of their chosen EBP. It could also provide consultation on cultural competence, but it determined that the service providers knew their clientele best and they needed a threshold

TABLE 1 Grantees in Cultural Adaptation Initiative

Community	Ethnicity	Adults or Children	DSM IV-R Diagnoses	Evidence-Based Treatment Model
El Paso	Hispanic	Adults	Depression	Cognitive Behavioral Therapy in individual and family therapy
Fort Worth	African American	Children	Externalizing disorders (hyperactivity and defiant behavioral disorders)	Defiant Child parenting training
Houston	Hispanic	Children	Major Depression, Post-Traumatic Stress Disorders, Panic Attacks, Acute Stress, Obsessive Compulsive Disorders, Adjustment Disorders, Oppositional Defiant Disorders, and Attention Deficit Hyperactivity Disorders	Cognitive Behavioral Therapy for children and families
Houston	Hispanic	Children	General Behavioral Problems, Post-Traumatic Stress Disorders, Depression, Generalized Anxiety Disorders, and Attention Deficit Hyperactivity Disorders	Trauma-Focused Cognitive Behavioral Therapy for children and families
Lower Rio Grande Valley (3 county area)	Hispanic	Adults and Children	General Anxiety Disorders, Panic Disorders, and Post-Traumatic Stress Disorders	Behavioral and Exposure Therapy delivered in individual sessions to adults and in family sessions for children

level of cultural competence for the grant projects to succeed. In the RFP, the emphasis on cultural competency made clear that the foundation was not funding grantees just to learn an EBP, but specifically to address the cultural needs of their clients.

In July 2006, the foundation announced awards of more than \$2.9 million over three years to five organizations to adapt the delivery of EBPs to be compatible with the cultures of their populations of color. The foundation selected organizations skilled in working with racial and ethnic minorities as active partners to adapt the delivery of the chosen EBP. The organizations were in different geographic regions and focused on different populations, different diagnoses, and different EBPs. (See Table 1.)

The foundation worked with the grantees to provide EBPs in culturally consistent ways and evaluate the impact of their adaptations. It hosted a kickoff meeting shortly after the awarding of the grants in order for the grantees to meet one another, learn about the five grant-funded projects, and interact with the experts who would be providing cultural competence training, EBP training, and evaluation services. Approximately three months later, they attended a larger, two-day conference hosted by the foundation. Entitled "Transforming Mental Health Services in Texas: Building Bridges Between Cultural Competence and Evidence-Based Practice," this conference served as an immersion course to build intellectual capital and gather ideas for the implementation of the projects. It allowed grantees to learn from national experts and discuss their goals

and challenges for the next three years. After the conference, the foundation held regular audio-conferences with grantees, foundation staff, and national experts so that grantees could discuss their implementation experiences and learn from each other. Grantees attended an annual meeting at the foundation, during which they had the opportunity to discuss their work and engage in dialogue with other grantees, foundation staff and national experts in cultural competence and related fields. Foundation staff also made annual site visits to learn more about the grantees' work and to assess their needs for additional support. The foundation essentially created a learning community with the grantees to help them solve problems and share knowledge.

Methodology for Assessing the Impact of Culturally Adapted EBPs

The foundation hired an external evaluation team to conduct an extensive assessment of the Cultural Adaptation Initiative, approaching the evaluation with a perspective of “optimizing practice through research” (Kottke et al., 2008). The exploratory evaluation sought to answer the following questions:

1. Did the grantees deliver effective mental health services to clients served?
2. What organizational, service delivery, or clinical processes and practices were changed or implemented in the delivery of culturally adapted EBPs?
3. What factors facilitated the development and delivery of culturally adapted EBPs?

The evaluation consisted of two components: a formative outcome component based on quantitative data submitted by grantees and a summative process component that relied on qualitative data gathered by the evaluation team. The evaluation was approved by the Institutional Review Board at the University of Texas at Austin.

In the outcome evaluation, the dependent variable of interest was the change in each client's mental health disorder that was the focus of the selected EBP. The independent variables

were numerous, including the EBP selected, the organization's fidelity in implementing the EBP, the cultural competence of the organization and clinicians, the mental health diagnoses, the severity of the disorder at initiation of services, therapist characteristics, client characteristics, and characteristics of the services provided. Each grantee assessed the results of the services provided under the grant, typically using an uncontrolled single-group pre-post design, relying on standardized instruments administered before and after the delivery of the intervention. Grantees also administered various client satisfaction surveys. Results were available on an ongoing basis during course of the grant in order to guide changes in the implementation. At the end of the grant period, de-identified data were provided to the external evaluator to be further analyzed and included in the final evaluation report.

In the process evaluation of the implementation of the adapted EBPs, the outside evaluation team used a repeated-measures design, conducting an observational study that was longitudinal in nature. The team videotaped in-person individual and group interviews with project administrators, clinicians, and case managers. In these interviews, they used similar questions at each site. During these site visits, they observed project staff training sessions, staff meetings, and other events. They held conference calls with staff to discuss project implementation strategies and processes. The team collected written materials and information about the treatment models including staff training documents, client records, administrative and management reports, and minutes of board meetings to do content analysis and coding. They also administered surveys to project staff, administration, and board members.

Evaluation Results Relating to Improvements in Mental Health

The quantitative data analyzed from various sites tended to show statistically significant improvements in treatment adherence and symptom reduction. Nonetheless, it was impossible to determine if the improvements were greater with the adapted EBP as opposed to the standard EBP or even as opposed to treatment as usual. In “real-world” settings, numerous trade-offs make it chal-

lenging to conduct effectiveness and translational research on complex health interventions (Mercer et al., 2007).

In this instance, weak evaluation designs limited any conclusions regarding outcomes (VanScoy, 2009). Data indicated reduction in symptoms, but did not allow conclusions as to causality. Important risks to internal validity included history, maturation, testing, mortality, heterogeneity, attrition, and regression (Vonesh & Chinchilli, 1997; Trochim & Donnelly, 2007). Sites varied in their capacity to collect, aggregate, and analyze data for the external evaluation team. A failure to disaggregate some data limited the team's ability to draw conclusions. The lack of pre-intervention data and comparison or control groups made it difficult to identify other possible explanations for improvements. Some of the instruments selected by grantees were used in contexts not supported by the current clinical literature (VanScoy, 2009). Significant attrition in participants volunteering to complete evaluation instruments and the absence of a means to compare those who completed the instruments with those who did not complete the instruments limited the conclusions that could be drawn.

Evaluation Results Relating to Cultural Adaptations

Designing and assessing its Cultural Adaptation Initiative required the foundation to analyze its conception of cultural competence. Experts in the field provided significant guidance and proposed definitions of cultural competence in the context of clinical services (Sue, 1998; Lopez, 1997; Sue & Torino, 2005).

The foundation chose a broad perspective to analyze the results of the Cultural Adaptation Initiative. Betancourt and colleagues argued that culturally competent care acknowledges and incorporates culture, cross-cultural relations, the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of interventions to meet culturally unique needs (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). Based on a review of academic, foundation, and government publications focusing on sociocultural barriers to care, the level of

Culturally competent care acknowledges and incorporates culture, cross-cultural relations, the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of interventions to meet culturally unique needs.

the health care system at which a given barrier occurs, and cultural competence efforts that address these barriers, Betancourt et al. (2002) developed a definition of cultural competence, identified key components for intervention, and described a practical framework for implementation of measures to address racial and ethnic disparities in health and health care. The framework is based on three components: (1) sociocultural, identified at the organizational or administrative level; (2) structural, the process of service delivery; and (3) clinical, provider-consumer encounters. Betancourt's model proved valuable in understanding the extensive qualitative data collected from the grantee sites.

Cultural Adaptations: Sociocultural/Organizational

Health care systems, policies and structural processes are molded by the leadership that designs them and the workforce that is charged to implement them. An impeding factor on both the availability and acceptability of health care for racial and ethnic minority groups is the degree to which the health care leadership and workforce reflect the ethnic and racial composition of the local community.

Below are some examples of sociocultural/organizational adaptations made by grantees:

- Collaborations: One site is part of a local collaboration of more than 50 mental health agencies, which remain supportive of the Cultural

Adaptation Initiative and provide referrals and support for implementation. This project is aligned with and reports its results to the System of Care site, which gives the initiative more visibility and potentially a broader impact on families in the mental health system across the country.

To keep agency staff informed of best treatment practices, sites created “champions” to promote the project and to cross-train staff.

- Penetration of adaptations: Penetration of adaptations throughout the organizations varied. One site reported a high degree of penetration beyond the new intervention. Examples include increased diversity of board members to reflect the demographics of the community; language added to bylaws to insure cultural sensitivity of the local board and its administrator; increased recruitment and retention of linguistically fluent staff, including therapists; development of an agency wide cultural competency plan; and signs posted to lobby areas in both English and Spanish. To keep agency staff informed of best treatment practices, sites created “champions” to promote the project and to cross-train staff.
- Dissemination: All sites made presentations on their project’s processes and outcomes to audiences within the organization and in their communities. Some have presented regionally, statewide, and nationally.

Cultural Adaptations: Structural/Service Delivery

In a complex service delivery system in which the rules are many and economic forces drive structure, function and change, the needs of vulnerable and underserved populations are significantly impacted. Structural barriers arise when persons are faced with the challenge of accessing and receiving health care from systems that are complex, bureaucratic, underfunded, or poorly designed. Examples of barriers include set hours of operation that do not consider or accommodate a per-

son’s work or personal schedule or preference; the lack of trained or certified interpreter services; the lack of culturally and linguistically appropriate health education material and information; the inability of people with limited English proficiency to understand their diagnosis, schedule and necessity of prescribed medications, special instructions, discharge and aftercare plans, and care coordination.

Examples of grantee structural/service delivery adaptations include:

- Training: Project team meetings designed for supervision and staff development were held weekly or biweekly. Case consultation and discussion of the EBP’s components were regular agenda items. The learning community of grantees diffused new knowledge about implementation issues, challenges, and solution-based approaches. In addition to cultural competency training, specialized training focused on recognizing therapists’ personal biases and power differentials, and increased understanding of differences in cultural knowledge, acculturation levels, class, gender, customs, beliefs, history, and traditions.
- Transportation: Transportation was a challenge for many clients. Sites implemented a variety of strategies to enhance and maintain participation. For those sites with public transportation systems, bus tokens were provided. Gas cards in small denominations were issued to families in financial need. One site entered into a contract with a local taxi service to provide transportation to clients who did not have their own automobile or who had to take several buses to arrive to the location (the team worked with the taxi service to ensure the taxi drivers received a cultural-sensitivity orientation and appropriate engagement with clients). The taxi voucher system increased accessibility and retention.
- Parent involvement: One site utilized a strong parent component, including a parent group that met regularly. Parents shared experiences and challenges in accessing mental health services, identified cultural perspectives that affect and influence consumers and families,

and recommended adaptations to increase the program's effectiveness in addressing the issues and needs of community members. Parents were empowered to recommend changes to program materials and other processes, and attended and actively participated in board meetings to share their experience and provide feedback on policies, programs, and services. In an effort to maintain parental involvement, a nominal incentive was provided to each family; child care and dinner were also provided for each meeting.

- Community engagement: One site has reached out to local churches for help in reframing the concept of mental health and to address the stigma that appears to be linked to religious beliefs and positions taken by some clergy and congregations.
- Access: Sites made changes to promote access and participation, including extending their hours to include evenings and/or weekends. One site relocated to a more centralized location. Participants were provided incentives (e.g., food, refreshments, gas cards) to increase and maintain program participation. Telephone greetings were bilingually scripted. At intake, clients were diverted to Spanish-speaking access specialists to determine eligibility and enrollment into program. Multimedia strategies were used to provide program information to participants using print, pictorials, audiotapes, and DVD format. Case managers assisted clients with Medicaid enrollment and with applications to determine eligibility for various entitlements.
- Client/therapist matching: One site utilized eight variables when matching clients and therapists for case assignment. The project director evaluated language, gender, ethnicity, age, time availability, expertise in problem, payment source, and acculturation level when determining which therapist would be assigned to each client.
- Aesthetics of the facility: Sites redid their reception areas to be warm and welcoming to their clients, with pictures and images congruent to the cultural group being served. Sites provided refreshments to clients waiting to be served. One site equipped the reception

area with a television set to Spanish television programming with an adjacent playroom for children.

Sites made changes to promote access and participation, including extending their hours to include evenings and/or weekends. One site relocated to a more centralized location.

Cultural Adaptations: Clinical

Clinical barriers occur in the dynamics of the interaction between the provider and the consumer and/or family. They frequently happen when sociocultural differences between the provider and consumer are not understood, accepted, or further explored. Consumers may have very unique and distinct socioculturally grounded beliefs and practices about health and health care, including use of home and cultural healing rituals and remedies, attitudes toward western medical philosophy and treatment, and mistrust of providers and of the governmental and private health care system (Berger, 1998). As the country becomes increasingly diverse, health care providers of all racial and ethnic backgrounds are interacting with and delivering services to a greater proportion of individuals whose perspectives and world view are much different from those taught in higher education or within the typical health care system through employee orientations and required trainings. Research shows that provider-consumer communication is directly linked to consumer satisfaction, treatment adherence, and, subsequently, health outcomes (Orth, Stiles, Scherwitz, Hennrikus, & Vallbona, 1987; Putnam, Stiles, Jacob, & James, 1985; Stanton, 1987; Stiles, Putnam, Wolf, & James, 1979; Haynes, 1976).

Identified clinical adaptations include:

- Translation of materials: For Spanish-speaking populations being served, all therapeutic mate-

TABLE 2 Dichos: Reframing Negative Cognitions

Dichos: Reframing Negative Cognitions (Villalobos, 2009)	
“Dime con quien andas y te dire quien eres”	Tell me who you are with and I will tell you who you are
“La esperanza nunca muere”	Hope never dies
“Como lazo de cochino”	Being treated like a pig’s rope
“No hay mal que por bien no venga”	There is no wrong that does not come for a good reason
“Camarón que se duerme se lo lleva la corriente”	A sleeping lobster gets swept away by the current
“Mientras hay vida, hay esperanza”	As long as there is life, there is hope
“Al mal tiempo, buena cara”	To a bad time, give a good face
“El tiempo no pasa en vano”	Time does not pass in vain
“Dios dira”	God will say
“No hay mal que dure 100 años”	There is no grief that lasts 100 years

rials were available in Spanish.

- **Language:** For Spanish-speaking clients, therapy sessions were bilingual or monolingual in English or Spanish depending on the client’s or family’s preference. Therapists used the dialect commonly found and used in the geographic area. “Code switching” – the concurrent use of more than one language, or language variety, in conversation – was allowed and found to be a factor in creating a strong relationship between therapist and client and facilitated the therapeutic engagement (Villalobos, 2009).
- **Use of metaphors:** Identification and inclusion into therapeutic sessions of metaphors, stories, or dichos that have historical and cultural meaning for African-Americans and Hispanics. The use of metaphors was beneficial because it helped clients conceptualize ideas and reframe negative cognitions in terms that were familiar to them. Metaphors that conveyed distorted and irrational cognitions were used as opportunities for exploration and reframing. When metaphors that carried negative cognitions emerged as being part of a client’s automatic thoughts, cognitive restructuring was used by therapists to evaluate, challenge the cognition and replace the distorted and irrational cognitions with accurate and realistic ones. One such case example was the case of a newly diagnosed dialysis patient who was feeling worthless and hopeless. The therapist for this client used the Mexican saying “*hoy por mí, mañana por ti*” (today for me, tomorrow for you) and was able to help the client understand that it was his

turn to accept help from others without feeling shame (Villalobos, 2009). Other dichos were used in therapy sessions to explore and reframe negative and irrational cognitions and replace them with positive ones (Villalobos, 2009) (See Table 2).

- **Cultural values and characteristics:** Sites identified multiple cultural characteristics of African-American and Hispanic families that impact therapeutic relationships, such as *personalismo* (trust in the person rather than the institution), *respeto* (respect), and *familismo* (family). Sites trained therapists on these characteristics and collected information to describe how, when, and where these characteristics intersect with the intervention.
- **Rapport:** Sites adapted EBPs to provide therapists time for *plática* (brief conversations) as part of the therapeutic approach. *Plática*, a natural style of interaction in the Mexican culture, is a polite, nonintrusive method to engage individuals in informal brief conversation that allows for self-expression by building trust, comfort, and credibility that is vital to the engagement and therapeutic process. It can also be used as a strategy to lead into a therapeutic process or modality. The use of *plática* tends to increase confidence, informality, and relaxation and consequently facilitates communication and the development of the therapeutic alliance (Ruiz & Langrod, 1992). *Plática* can be used to establish rapport and build trust in the therapeutic relationship (Gonzalez, 1995). One of the sites serving Spanish-speaking clients cre-

TABLE 3 Acronyms for Adaptations

LISTO (Ready)	GENTE (People)
Language & culture are priority	Give personal examples
Involve family members	Engage and educate all persons involved
Share relevant stories	Negotiate the pace in treatment
Talk about traditions & faith	Target the power broker in the family
Overcome stigma	Examine the level of assimilation and acculturation

ated acronyms for how to address adaptations and methodologies in a culturally competent manner. (See Table 3).

Summary of Findings

The majority of grantees appeared to be implementing the selected EBP with cultural adaptations while attempting to preserve fidelity to the model. Grantees made adaptations to their project models based on their implementation experiences and the needs of their service population. Adaptations were made across at least three dimensions:

- adaptations that promote the penetration within the organization and spread or dissemination of the model within the host agency, the local mental health community, or to broader mental health audiences (sociocultural/organizational);
- adaptations that occur to engage or maintain the participation of members of the selected culture in the mental health treatment (structural); and
- adaptations to the EBP itself (clinical).

Each of the grantees made at least two adaptations in each of the three aspects; however, not all of the adaptations made are considered cultural adaptations. One of the cultural adaptations is similar across the four Hispanic project sites: identification and incorporation of culturally based metaphors or *dichos* that have specific relevance and meaning to the clients’ culture and are aligned with the themes and goals of the specific evidence-based practice. Sites serving Spanish-speaking clients translated outreach and therapeutic materials into Spanish. All sites made a cultural adaptation to incorporate time for informal brief conversations or *plática* at the start

of therapeutic sessions as a cultural adaptation. Sites also attended to aspects of Hispanic culture that impact their therapeutic approach, such as *personalismo*, *respecto*, and *familismo*.

All sites created a case-management function to help clients manage basic needs and referrals so that issues and concerns do not disrupt or interfere with the time set aside for the therapeutic encounter. This adaptation does not appear to be culture-driven, but related to the needs of low-income families and the importance of connecting clients with other social and case management services so that they can concentrate more fully on the therapeutic interaction.

Sites report varying degrees of success in disseminating both the concept of evidence-based practice and of cultural adaptation within its agency and more broadly.

Challenges and Key Lessons Learned

The paradigm shift from a “treatment as usual” model or traditional public mental health services approach to an EBP can be difficult for an organization without adequate support to include leadership buy in, strong programmatic supports, ongoing and individualized technical assistance, training on the EBP, clinical supervision of program therapists, adhering to treatment fidelity, dedicated staff without competing priorities and responsibilities, technical assistance in evaluation, and adequate financing of EBP implementation. The launching of the EBP by an organization requires multiple supports, which can be identified in an organizational readiness assessment. Time allocation for rapport (*plática*) to be established as part of therapeutic process increases time spent in the clinical encounter. EBP training and knowledge diffusion and dis-

All sites drew upon their identified strengths and community partnerships to conceptualize and implement the adaptations.

semination of the EBP is not reimbursable. Time allocation for therapists to engage each other formally to share lessons learned and cultivate a learning community results in more time spent in nonclinical encounters. Implementation of EBPs in school systems can be challenging in light of state-based performance testing requirements. Promoting organizational and system change that is sustainable may be the most inherent challenge. This includes changes in service/program delivery, local policies and procedures, multisystem collaboration and cooperation, and fiscal resources to continue the program, building upon the successes achieved and lessons learned beyond the end period of the grant.

Location matters. Although there were adaptation themes and patterns that emerged across all sites, clearly there were unique, site-specific findings that one would expect across five community-based organizations in different regions in Texas with differing community demographics, clientele, organization structures, resources, and differing competencies and expertise in delivery of mental health services, in EBPs, and in cultural adaptations. All sites drew upon their identified strengths (organizational, structural, and clinical) and community partnerships to conceptualize and implement the adaptations necessary to achieve the highest degree of success for this project.

Conclusion

Demographic changes anticipated over the next decade magnify the importance of addressing racial and ethnic disparities in health and health care. A framework for organizational, structural, and clinical adaptations to increase cultural competence of interventions can facilitate the elimination of these disparities and improve care for all.

Identifying and implementing a grant program to facilitate appropriate cultural adaptations in EBPs was a complex process. Challenges to the grantees were already noted. The complexity of the grant program tested both foundation staff and grantees, resulting in mixed and varying measures of success. Some of the adaptations were categorized as cultural adaptations, others did not appear to be cultural in character but universal adaptations to better serve the community. A majority of the adaptations were not closely linked to the EBPs and therefore did not jeopardize the delicate balance inherent in implementing with flexibility while maintaining fidelity to the EBP (Kendall, Gosch, Furr, & Sood, 2008; Self-Brown et al., 2011). Lastly, the reliance on grantees for rigorous outcome evaluation was difficult in that most community-based organizations are situated to deliver services to their clientele and community and generally do not have expertise in evaluation methodology, data collection, and statistical data analysis.

Funding cultural adaptations was identified as a viable strategy to meet the mental health needs of grantees' African-American and Hispanic clients. Most of the adaptations derived from this investigation do not require additional expenditures of dollars after implementation and thus are likely to be sustained beyond the grant period. The implications of the grant program are significant, as these adaptations have broader utility in the context of health care and social service settings as well as specific application to mental health service provision.

Indications are that the grant program has increased the cultural competency and capacity for providers to deliver effective mental health services through culturally adapted evidence-based practices. The authors offer a cautionary note regarding the limitations of the results based on the design. As mentioned, there are threats to the reliability and validity of the quantitative data. Randomized control groups were not included in the launch of the project (although once implementation began, one site started a control group) for comparison purposes at the five grantee sites. Accounting for the tremendous diversity that exists within in all ethnic and racial groups,

regions, community resources and supports, acculturation levels, literacy levels, and language makes it complex to generalize from results across all groups. Thus, the grantees cannot be considered representative of the racial and ethnic populations across Texas and the U.S. engaged in this investigation. Although the case-study methodology offers limitations in generalizability, the adaptations and implementation processes noted by the grantees may have relevance across a wide range of agencies, health and human service organizations, and the nonprofit sector (i.e., criminal justice, child welfare, social services).

While much remains to be understood about cultural adaptations, much has been learned. The groups served under this grant are historically underserved populations and continue to be cited in the literature as high risk for racial and ethnic disparities. The next step is to fund future investigations and promote, evaluate and disseminate findings and new innovations so that organizations may continue to enhance their ability to provide effective and meaningful services to cultural and linguistically diverse communities through the conceptualization, delivery, and evaluation of cultural adapted services. Replication of these adaptations and evaluation to determine effectiveness and impact may contribute to and expand the current body of knowledge and, most importantly, address the urgent issues of racial and ethnic disparities.

References

- AGENCY FOR HEALTHCARE RESEARCH AND QUALITY. (2009). *Mental health research findings*. Retrieved on January 5, 2010 from <http://www.ahrq.gov/research/mentalth.pdf>
- ALEGRÍA, M., CANINO, G., RIOS, R., VERA, M., CALDERON, J., RUSCH, D., & ORTEGA, A.N. (2002). Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino whites. *Psychiatric Services*, 53(12), 1547–1555.
- AMERICAN PSYCHOLOGICAL ASSOCIATION. (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. *American Psychologist*, 48, 45–48.
- AMERICAN PSYCHOLOGICAL ASSOCIATION. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, 58, 377–402.
- ATKINSON, D. R., BUI, U., & MORI, S. (2001). Multiculturally sensitive empirically supported treatments: An oxymoron? In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 542-574). Thousand Oaks, CA: Sage.
- BALAS, E. A., & BOREN, S. A. (2000). Managing clinical knowledge for healthcare improvement. In J. Bemmel & A. T. McCray (Eds.), *Yearbook of medical informatics 2000: Patient-centered systems* (pp. 65-70). Stuttgart, Germany: Schattauer.
- BERGER, J. T. (1998). Culture and ethnicity in clinical care. *Archives of Internal Medicine*, 158, 2085-90.
- BERNAL, G., & RODRIGUEZ, M. M. D. (2009). Advances in Latino family research: Cultural adaptations of evidence-based interventions. *Family Process*, 48, 169-178.
- BERNAL, G., & SÁEZ-SANTIAGO, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology*, 34(2), 121-132.
- BERNAL, G., & SCHARRÓN-DEL-RÍO, M. R. (2001). Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. *Cultural Diversity and Ethnic Minority Psychology*, 7, 328–342.
- BERNAL, M. E., & CASTRO, F. G. (1994). Are clinical psychologists prepared for service and research with ethnic minorities? Report of a decade of progress. *American Psychologist*, 49, 797-805.
- BETANCOURT, J. R., GREEN, A. R., CARRILLO, J. E., & ANANEH-FIREMPONG, O. (2003). Defining cultural competence: A practical framework for addressing ethnic and racial disparities in health and health care. *Public Health Reports*, 118, 293–302.
- BETANCOURT, J. R., GREEN, A. R., & CARRILLO, J. E. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches*. (Quality of Care for Underserved Populations Field Report.) New York: Commonwealth Fund.
- BETANCOURT, J. R., GREEN, A. R., CARRILLO, J. E., & PARK, E. R. (2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs*, 24(2), 499-505.
- BIGFOOT, D. S., & SCHMIDT, S. R. (2010). Honoring children, mending the circle: Cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska Native children. *Journal of Clinical Psychology*, 66(8), 847-856.
- BRACH, C., & FRASER, I. (2000). Can cultural compe-

- tency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, 57(1), 181-217.
- CARRILLO, J. E., GREEN, A. R., & BETANCOURT, J. R. (1999). Cross-cultural primary care: A patient-based approach. *Annals of Internal Medicine*, 130, 829-34.
- CHAMBLESS, D. L., & OLLENDICK, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, 52, 685-716.
- CHAMBLESS, D. L., SANDERSON, W. C., SHOHAM, V., BENNETT JOHNSON, S., POPE, K. S., CRITS-CHRISTOPH, P., BAKER, M., JOHNSON, B., WOODY, S. R., SUE, S., BEUTLER, L., WILLIAMS, D. A., & MCCURRY, S. (1996). An update on empirically validated therapies. *The Clinical Psychologist*, 49, 5-18.
- COOK, B. L., MCGUIRE, T., & MIRANDA, J. (2007). Measuring trends in mental health care disparities, 2000-2004. *Psychiatric Services*, 58(12), 1533-1540.
- DANA, R. H. (1998). *Understanding cultural identity in intervention and assessment*. Thousand Oaks, CA: Sage.
- DENBOBA, D. L., BRAGDON, J. L., EPSTEIN, L. G., GARTHRIGHT, K., & GOLDMAN, T. M. (1998). Reducing health disparities through cultural competence. *Journal of Health Education*, 29(5), 47-53.
- DRAKE, R. E., GOLDMAN, H. H., LEFF, H. S., LEHMAN, A. F., DIXON, L., MUESER, K. T., & TORREY, W. C. (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services* 52(2), 179-182.
- EISENBERG, J. M. (1979). Sociologic influences on medical decision making by clinicians. *Annals of Internal Medicine*, 90, 957-964.
- GREEN, L. (2006). Public health asks of systems science: To advance our evidence-based practice, can you help us get more practice-based evidence? *American Journal of Public Health*, 96(3), 1-4.
- GONZALEZ, F. (1995). Working with Mexican-American clients. *Psychotherapy: Theory, Research, Practice, Training*, 32(4), 696-706.
- HALL, C. C. I. (1997). Cultural malpractice: The growing obsolescence of psychology with the changing U.S. population. *American Psychologist*, 52, 642-651.
- HALL, G. C. N. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology*, 69, 502-510.
- HARRIS, M. B., & FRANKLIN, C. G. (2003). Effects of cognitive-behavioral, school-based, group intervention with Mexican American pregnant and parenting adolescents. *Social Work Research*, 27(2), 71-83.
- HAYNES, R. B. (1976). A critical review of the 'determinants' of patient compliance with therapeutic regimens. In D. L. Sackett and R. B. Haynes (Eds.), *Compliance with therapeutic regimens* (pp. 26-39). Baltimore: Johns Hopkins Press.
- HOGUE, M. A., MORRIS, J. A., DANIELS, A. S., STUART, G. W., HUEY, L. Y., & ADAMS, N. (2007). *An Action Plan for Behavioral Health Workforce Development: A Framework for Discussion*. Retrieved from <http://www.annapoliscoalition.org/pages/images/WorkforceActionPlan.pdf>.
- HOHMANN, A. A., & PARRON, D. L. (1996). How the new NIH guidelines on inclusion of women and minorities apply: Efficacy trials, effectiveness trials, and validity. *Journal of Consulting and Clinical Psychology*, 64, 851-855.
- INSTITUTE OF MEDICINE. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health-care*. Washington, DC: National Academies Press.
- KENDALL, P. C., GOSCH, E., FURR, J. M., & SOOD, E. (2008). Flexibility within fidelity. *Child and Adolescent Psychiatry*, 47(9), 987-993.
- KLEINMAN, A., EISENBERG, L., & GOOD, B. (1978). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine*, 8, 251-258.
- KOTTKE, T. E., SOLBERG, L. I., NELSON, A. F., BELCHER, D. W., CAPLAN, W., GREEN, L. W., LYDICK, E., MAGID, D. J., ROLNICK, S. J., & WOOLF, S. H. (2008). Optimizing practice through research: A new perspective to solve an old problem. *Annals of Family Medicine*, 6(5), 459-463.
- LOPEZ, S. R. (1997). Cultural competence in psychotherapy: A guide for clinicians and their supervisors. In C. E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision* (pp. 570-588). Hoboken, NJ: John Wiley.
- LUNDGREN, L., AMODEO, M., COHEN, A., CHASSLER, D., & HOROWITZ, A. (2011). Modifications of evidence-based practices in community-based addiction treatment organizations: A qualitative research study. *Addictive Behaviors*, 36, 630-635.
- MERCER, S. L., DEVINNEY, B. J., FINE, L. J., GREEN, L. W., DOUGHERTY, D. (2007). Study designs for effectiveness and translation research: Identifying trade-offs. *American Journal of Preventive Medicine*, 33(2), 139-154.
- MIRANDA, J., BERNAL, G., LAU, A., KOHN, L., HWANG, W.-C., & LAFROMBOISE, T. (2005). State of the

- science on psychosocial interventions for ethnic minorities. *Annual Review of Clinical Psychology*, *1*, 113–142.
- MIRANDA, J., GREEN, B. L., KRUPNICK, J. L., CHUNG, J., SIDDIQUE, J., BESLIN, T., & REVICKI, D. (2006). One-year outcome of a randomized clinical trial treating depression in low-income minority women. *Journal of Consulting and Clinical Psychology*, *74*, 99–111.
- MIRANDA, J., NAKAMURA, R., & BERNAL, G. (2003). Including ethnic minorities in mental health intervention research: A practical approach to a long-standing problem. *Culture, Medicine and Psychiatry*, *27*, 467–486.
- MUÑOZ, R. F., & MENDELSON, T. (2005). Toward evidence-based interventions for diverse populations: The San Francisco General Hospital prevention and treatment manuals. *Journal of Consulting and Clinical Psychology*, *73*, 790–799.
- NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS & NATIONAL TECHNICAL ASSISTANCE CENTER FOR STATE MENTAL HEALTH PLANNING. (2004). *Cultural competency: Measurement as a strategy for moving knowledge into practice in state mental health systems* (pp. 1–28). Alexandria, VA: Authors.
- NEW FREEDOM COMMISSION ON MENTAL HEALTH. (2003). *Achieving the promise: Transforming mental health care in America. Final report* (Pub. No. SMA-03-3832). Rockville, MD: U.S. Department of Health and Human Services.
- ORTH, J. E., STILES, W. B., SCHERWITZ, L., HENNRICKUS, D., & VALLBONA, C. (1987). Patient exposition and provider explanation in routine interviews and hypertensive patients' blood pressure control. *Health Psychology*, *6*, 29–42.
- PUTNAM, S. M., STILES, W. B., JACOB, M. C., & JAMES, S. A. (1985). Patient exposition and physician explanation in initial medical interviews and outcomes of clinical visits. *Medical Care*, *23*, 74–83.
- RIDLEY, C. R. (1985). Imperatives for ethnic and cultural relevance in psychology training programs. *Professional Psychology: Research and Practice*, *16*, 611–622.
- RUIZ, P., & LANGROD, J. (1992). Substance abuse among Hispanic-Americans: Current issues and future perspectives. In J. Lawinson, P. Ruiz, R. Millgram, & J. Langrod (Eds.), *Substance abuse: A comprehensive textbook* (pp. 868–874). Baltimore: Williams & Wilkins.
- SELF-BROWN, S., FREDERICK, K., BINDER, S., WHITAKER, D., LUTZKER, J., EDWARDS, A., & BLANKENSHIP, J. (2011). Examining the need for cultural adaptations to an evidence-based parent training program targeting the prevention of child maltreatment. *Children and Youth Services Review*. doi:10.1016/j.childyouth.2011.02.010
- SIEGEL, C., HAUGHLAND, G. & SCHORE, R. (2005). The interface of cultural competency and evidence-based practices. In R. E. Drake, M. R. Merrens, & D. W. Lynde (Eds.), *Evidence-based mental health practice: A textbook* (pp. 273–299). New York: Norton.
- STANTON, A. L. (1987). Determinants of adherence to medical regimens by hypertensive patients. *Journal of Behavioral Medicine*, *10*, 377–394.
- STATE OF NEW JERSEY (2004). S. Bill 144, 211th Leg.
- STILES, W. B., PUTNAM, S. M., WOLF, M. H., & JAMES, S. A. (1979). Interaction exchange structure and patient satisfaction with medical interviews. *Medical Care*, *17*, 667–681.
- SUE, D. W., ARREDONDO, P., & MCDAVIS, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development*, *70*, 477–486.
- SUE, D. W., & TORINO, G. C. (2005). Racial-cultural competence: Awareness, knowledge, and skills. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling: Training and practice*, Vol. 2 (pp. 3–18). Hoboken, NJ: John Wiley.
- SUE, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist*, *53*(4), 440–448.
- TRÖCHIM, W., & DONNELLY, J. (2007). *The research methods knowledge base, 3rd edition*. Cincinnati: Atomic Dog Publishing.
- U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. (2011). *National registry of evidence-based programs and practices*. Retrieved on February 18, 2011, from <http://www.nrepp.samhsa.gov/>
- U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. (2006). *The rationale for diversity in the health professions: A review of the evidence*. Health Resources and Services Administration. Rockville, MD: Author.
- U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. (2001). *Mental health: Culture, race and ethnicity: A supplement to mental health: A report of the Surgeon General*. Rockville, MD: Author.
- U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Author.
- VANSCOY, H. (2009). *The CAI project evaluation: An*

examination of mental health multi-tasking at the interface of culture and evidence-based practice.

Unpublished manuscript.

- VERA, M., VILA, D., & ALEGRÍA, M. (2003). Cognitive-behavioral therapy: Concepts, issues, and strategies for practice with ethnic and racial minorities. In G. Bernal, J. E. Trimble, A. K. Burlew, & F. T. L. Leong (Eds.), *Handbook of racial and ethnic minority psychology* (pp. 15–64). Thousand Oaks, CA: Sage.
- VILLALOBOS, G. (2009). *The mediating effect of acculturation on the effectiveness of culturally adapted cognitive behavioral therapy with Mexican Americans suffering from depression.* (Unpublished doctoral dissertation). University of Texas, Austin.
- VONESH, E. F., & CHINCHILLI, V. G. (1997). *Linear and nonlinear models for the analysis of repeated measurements.* London: Chapman and Hall.
- WALKER, J., & BRUNS, E. (2006). Building on practice-based evidence: Using expert perspectives to define the wraparound process. *Psychiatric Services, 57*(11), 1579-1585.
- WELLS, K., Klap, R., KOIKE, A., & SHERBOURNE, C. (2001). Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. *The American Journal of Psychiatry, 158*(12), 2027–2032.
- WHALEY, A. L., & DAVIS, K. E. (2007). Cultural competence and evidence-based practice in mental health services. *American Psychologist, 62*(6), 563-574.
- WHITLEY, R. (2007). Cultural competence, evidence-based medicine, and evidence-based practices. *Psychiatric Services, 58*(12), 1588-1590.
- WOLOSHIN, S., BICKELL, N. A., SCHWARTZ, L. M., GANY, F., & WELCH, H. G. (1995). Language barriers in medicine in the United States. *The Journal of the American Medical Association, 273*(9), 724-8.

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Lynda E. Frost, J.D., Ph.D., serves as the director of planning and programs at the Hogg Foundation for Mental Health, where she oversees major initiatives and grant programs, leads strategic and operational planning, and manages program staff. She joined the foundation as associate director in 2003.

Dr. Frost is an experienced administrator and attorney with legal expertise in human rights, juvenile justice, criminal law and mediation. She also holds an appointment as a clinical associate professor of educational policy and planning at The University of Texas at Austin. She previously taught at the University of Iowa, the University of Richmond, the University of Virginia and American University in Cairo, Egypt.

Dr. Frost has a law degree and a doctorate in educational administration from the University of Iowa, a master's degree in international education from Lesley University, and a bachelor's degree in English and American studies from Amherst College.

Correspondence concerning the article should be addressed to Lynda E. Frost, Hogg Foundation for Mental Health, University of Texas, P.O. Box 7998, Austin, TX 78713-7998 (email: lynda.frost@austin.utexas.edu).

Rick Ybarra, M.A., serves as Program Officer for the Hogg Foundation for Mental Health and leads the Foundation's Integrative Health Care Initiative. He has served as the project lead for the Cultural Adaptation Initiative, a grant program focused on the culturally competent delivery of evidence-based mental health services. He also directs the Bilingual Scholarship Initiative, a \$2.5 million investment to fund full tuition scholarships for bilingual students pursuing a graduate degree in social work in Texas.

With over 20 years of clinical and administrative experience in both private and public behavioral health, Rick's experience extends to county, state and national efforts to develop and promote cultural competency and public policies to eliminate mental health disparities to racial/ethnic populations.

Ybarra earned his master's degree in clinical psychology and his bachelor's degree in psychology from Saint Mary's University in San Antonio, Texas.