IMPROVING
CULTURAL COMPETENCY
— RESOURCE GUIDE —

INSIDE FRONT COVER

IMPROVING CULTURAL COMPETENCY

RESOURCE GUIDE

Central East (HHS Region 3)

PTTC Prevention Technology Transfer Center Network
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The Danya Institute
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Table of Contents

About the Organization of This Document

This document is constructed to allow readers to either read through the entire document or navigate directly to the section(s) that most interest them.

- Section I introduces why cultural competence is important and why this document was created.

- Section II provides the technical methodology behind this document's creation.

- Section III summarizes and provides evidence-based resources to support organizations attempting to improve their cultural competence.

- Section IV provides recommendations for using culturally competent language.

- Section V summarizes known best practices to improve cultural competence, barriers to success, and strategies to overcome barriers identified from published research.

- Section VI provides article records, which include key information from each published article included in this review.

- Section VII houses an appendix that provides definitions of key terms as well as citations for additional references outside the scope of the literature review.

I. Introduction

This document is intended to support substance use prevention stakeholders in improving their cultural competency and capacity to serve minority and vulnerable populations. This document was created through a literature review of recent academic journal publications and evidence-based resource databases. Readers will learn about:

- resources and recommendations from the Substance Abuse and Mental Health Services Administration (SAMHSA) to improve outreach and communication with minority and vulnerable populations (see Sections III and IV)
- the impact cultural competence can have on reducing behavioral health disparities among minority and vulnerable populations (see Sections V and VI)
- evidence-based strategies and conceptual frameworks for implementing organizational change to improve cultural competence (see Sections V and VI)

Cultural competence is an important concern because substance use and other behavioral health conditions are issues that affect all communities, regardless of their populations. There are a wide range of government agencies, community organizations, educators, health care providers, and other stakeholders involved in prevention, many of which lack experience serving some populations (Chu et al., 2017). As U.S. communities grow ever more diverse (U.S. Census, 2011) and research begins to focus more on the behavioral health needs of minorities and vulnerable populations (Burlew et al., 2012), these stakeholders need to improve their cultural competence to be able to serve everyone in need in their communities and reduce behavioral health disparities.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. Cultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time (SAMHSA, 2014).

In other words, cultural competence means changing the internal culture and structure of an organization to understand and be responsive to the needs of minority groups. Cultural competence is about more than implementing a specific program or service that targets a minority group and stakeholders must have the knowledge and resources to plan and implement such a transformation. This resource guide was created with this expansive definition of cultural competence and focuses on resources and research to support organizational efforts to become more culturally competent.

Stakeholders interested in learning more about specific, targeted prevention efforts for minority groups are encouraged to access SAMHSA's Evidence-Based Practices Resource Center (i.e., https://www. samhsa.gov/ebp-resource-center) for additional information.
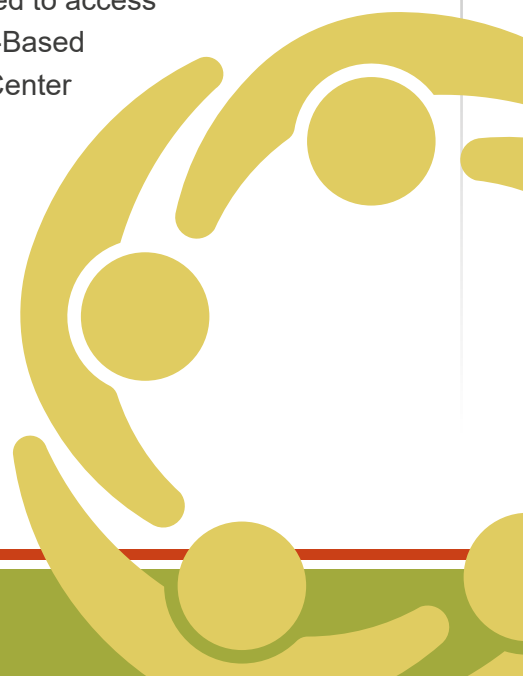
II. Methodology

The Methodology section provides the technical information behind this document's creation. This document was created through a multi-pronged approach intended to capture the latest in peer-reviewed academic-published research and government and non-profit publications and databases. This began with a search of academic journal databases, resource registries, and other key websites. The PubMed, PsychInfo, and SocIndex academic databases were searched using the free text search terms:

- Cultural competen*
- AND prevent*
- AND substance OR opioid OR alcohol OR tobacco OR suicide

Results were restricted to peer-reviewed articles published in English, from 2014 through 2019 that were not book reviews or dissertations.

The following Resource Registries were also used:

- SAMHSA's Cultural Competence Resources located at https://www.samhsa.gov/capt/tools-learning-resources/resources-related-cultural-competence
- SAMHSA's Evidence-Based Practice Resource Center located at https://www.samhsa.gov/ebp-resource-center
- The Athena Forum located at http://www.theathenaforum.org
- Blueprints – http://www.blueprintsprograms.com/allPrograms.php
- FindYouthInfo.gov located at http://youth.gov/evidence-innovation/program-directory
- Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide (operated by CrimeSolutions.gov) located at http://www.ojjdp.gov/mpg

- RAND Corp. Promising Practices Network on Children, Families and Communities located at http://www.promisingpraNOctices.net/programs.asp
- U.S. Department of Education: What Works Clearinghouse located at http://ies.ed.gov/ncee/wwc

Other key websites include the following:

- SAMHSA located at https://www.samhsa.gov/
- National Institutes of Health located at https://www.nih.gov/
- National Council on Behavioral Health located at https://www.thenationalcouncil.org/
- Google Scholar located at https://scholar.google.com/

These registries and websites have less sophisticated search features than academic databases and the search was restricted to identifying entries that contained the search term:

- Cultural competen*

Within such entries, referenced articles published in English, from 2014 through 2019 that were not book reviews or dissertations were identified. Due to the volume of search results from key websites, only the first 300 entries from each search were reviewed. Additionally, due to the nature of this search, entries that were clearly irrelevant to the topic were excluded at this initial point.

These searches resulted in a total of 134 identified articles, reduced to 124 articles—after excluding duplicates. Article abstracts and executive summaries underwent an initial review to determine relevance. Articles were excluded if they were not based in the U.S.,

Given the variegated nature of the construct, we adopt the term sociocultural competence to represent the individual, social, and cultural factors that shape development.

– Pamela Garner, 2014

not focused on prevention, not focused on improving cultural competency, had no process or outcome evaluation or meta-analysis and systematic review of prior research—academic journal articles only, or were opinion pieces or commentaries. This review resulted in 26 academic journal articles and 13 government-published resources that still merited potential inclusion.

Academic journal articles underwent a full-text review using the same exclusion criteria, which resulted in four additional articles being excluded. Information was collected from each of the remaining 22 articles to create the records found in Section VI and is summarized in Section V. As all other articles that still merited potential inclusion were previous SAMHSA publications, article full texts were assessed using both the same exclusion criteria and to determine whether they provided any unique information not presented in one of the other SAMHSA resources. This resulted in four resources that merited inclusion, which are provided and discussed in Sections III and IV.

III. SAMHSA Resources for Improving Cultural Competence

As with all behavioral topics, SAMHSA has created numerous products addressing cultural competency that interested stakeholders may find relevant and helpful. Four of the most relevant products that this review identified are:

1. The webpage explainer, Cultural Competence and Strategic Prevention Framework located at https://www.samhsa.gov/capt/applying-strategic-prevention-framework/cultural-competence/cultural-competence-spf

2. The 2-page tip sheet, Tips for Ensuring a Culturally Competent Collaboration located at https://www.samhsa.gov/capt/sites/default/files/tipsforensuringaculturallycompetentcollaboration_508compliant.pdf

3. The 44-page toolkit, Increasing Cultural Competence to Reduce Behavioral Health Disparities located at https://www.samhsa.gov/capt/sites/default/files/resources/increasing-cultural-competence-reduce-behavioral-hd.pdf

   ◼ The 341-page Treatment Improvement Protocol (TIP) #59 Improving Cultural Competence located at https://store.samhsa.gov/system/files/sma14-4849.pdf

These four products were selected for inclusion because they offer varying levels of detail on

what cultural competence means and how prevention organizations and other behavioral health stakeholders can improve their cultural competence and reduce health disparities. The Toolkit and TIP also provide worksheets and tools for organizations to use in assessing their cultural competence and in planning for improvements.

Prevention stakeholders interested in using these or other products to assist in their efforts to improve their cultural competence should remember these key lessons from the products:

◼ Establish definitions for all terms first to eliminate confusion.

Identify and use a planning process, such as the Strategic Prevention Framework, to guide improvement efforts.

◼ Include people from diverse cultural groups in all aspects of the process.

◼ Use a collaborative approach that includes additional stakeholders and feedback opportunities.

◼ Be consistent in applying new cultural competency standards and fully integrate them into stakeholder work.

IV. Summary of SAMHSA Recommendations on Culturally Competent Language

In the products identified in Section III, SAMHSA offers numerous messaging guidelines for prevention organizations seeking to improve their cultural competence. The Tip Sheet (i.e., Tips for Ensuring a Culturally Competent Collaboration) recommends that in presentations and meetings, preventionists:

- make sure that all printed, digital, and audiovisual materials reflect the culture, preferred language, and background of the populations they are meant to serve

- connect with culturally relevant organizations to be outreach ambassadors

- invite a member from the community to co-present

In the Toolkit (i.e., Increasing Cultural Competence to Reduce Behavioral Health Disparities), SAMHSA recommends using the National Culturally and Linguistically Appropriate Services (CLAS) Standards for developing culturally competent services and care, including the four Standards (page 21) organized around the theme of communication and language assistance, which are:

- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

In TIP #59 (i.e., Improving Cultural Competence), SAMHSA summarizes its guidelines for developing culturally competent communication with the following seven points (page 12):

1. Frame issues in culturally relevant ways.

2. Allow for complexity of issues based on cultural context.

3. Make allowances for variations in the use of personal space.

4. Be respectful of culturally specific meanings of touch (e.g., hugging).

5. Explore culturally based experiences of power and powerlessness.

6. Adjust communication styles to the client's culture.

7. Interpret emotional expressions in light of the client's culture.

TIP #59 (i.e., Improving Cultural Competence), also recommends using the RESPECT mnemonic to reinforce culturally competent and responsive behaviors (page 44):

- **Respect** — Understand how respect is shown within given cultural groups. Counselors demonstrate this attitude through verbal and nonverbal communications.

- **Explanatory Model** — Devote time in treatment to understanding how clients perceive their presenting problems. What are their views about their own substance abuse or mental symptoms? How do they explain the origin of current problems? How similar or different is the counselor's perspective?

- **Sociocultural Context** — Recognize how class, race, ethnicity, gender, education, socioeconomic status, sexual and gender orientation, immigrant status, community, family, gender roles, and so forth affect care.
- **Power** — Acknowledge the power differential between clients and counselors.
- **Empathy** — Express, verbally and nonverbally, the significance of each client's concerns so that he or she feels understood by the counselor.
- **Concerns and Fears** — Elicit clients' concerns and apprehensions regarding help-seeking behavior and initiation of treatment.
- **Therapeutic Alliance/Trust** — Commit to behaviors that enhance the therapeutic relationship; recognize that trust is not inherent but must be earned by counselors.

While there are gaps and controversy around the relationship between substance use and ethnicity and culture, current evidence suggests that culture, beliefs, attitudes, and values held by ethnic and racial groups may affect both the risk and the treatment of substance use.

– Eden Hernandez Robles, 2016

V. Summary of Findings From Academic Research

The Summary of Findings From Academic Research section provides a descriptive summary of findings from the academic journal articles identified through this document's literature review. Additional information from each article, organized by article, is found in Section VI of this document. The published articles described here shed light on key considerations for organizations seeking to improve their cultural competence, including the importance of collaboration and grounding efforts in a conceptual framework.

First, it is important to note that research identifying specific best practices for implementing and evaluating cultural competency improvement strategies has not kept pace with the increased understanding of the importance of cultural competence. More research, with more rigorous methodologies, is needed to better serve the minority populations most at risk of experiencing negative behavioral health disparities. Stakeholders interested in improving their cultural competence should be aware of these research limitations as they move forward with their efforts.

Few evidence-based, culturally grounded prevention programs exist and research cites a lack of training, guidelines, and experience with cultural minority clients among service providers (Chu, 2017; Okamoto, 2014). Existing research primarily outlines process- and outcome-related barriers and successes of prevention efforts targeting alcohol and drug use, tobacco use, suicide, and HIV among cultural minorities.

Additionally, these outcome evaluations have yielded mixed results; demonstrating effectiveness, but often limited by weak study designs, small sample sizes, and the absence of an appropriate comparison group.

Research has found that minority groups disproportionately experience harmful behavioral health outcomes relative to their non-minority counterparts (Valenti et al., 2017; Clifford et al., 2015; Ford et al., 2015). In recognition of this disparity, recipients of SAMHSA's Strategic Prevention Framework State Incentives Grants (SPF SIG) are encouraged to increase the cultural competency of their substance abuse prevention programming among other objectives (Orwin et al., 2014). To achieve this across the over 2,200 interventions launched through SPF SIG, Communities of Practice (CoP) are often utilized as a tool to collaborate, share information, and problem-solve across community sectors toward a shared goal (Anderson et al., 2014).

In addition to multi-sector collaboration, the literature highlights collaboration with populations of interest as a necessary procedural element in implementing culturally competent programs. For example, Scott and colleagues held monthly discussions with tribal coordinators to ensure that their evaluation was culturally grounded and informed by Indigenous evaluation models (2017). Additionally, linguistic equivalence, comprehensibility, and cultural appropriateness, as informed by members of the target community, are cited as important considerations in the development of program components and evaluation criteria (Gonzalez & Tricket, 2014). Gonzalez and Tricket describe a collaborative process which led to the discarding of old evaluation measures and using new,

culturally informed measures (2014). Similarly, Okamoto and colleagues cite community engagement and investment as particularly important for grounding prevention efforts in the communal norms and values of the target population (2014).

An example of a collaborative effort involving academic and community partners is the Lumbee Rite of Passage (LROP), a model for implementing a suicide prevention program for Native American youth in North Carolina (Langdon et al., 2016). The program evaluation was developed with consistent collaboration between academic research partners and an advisory board of Lumbee community members to ensure that the research process was culturally responsive and respectful to the community. The evaluation found that participants with regular LROP attendance showed a decrease in thoughts of suicide and an increase in protective factors (Langdon et al., 2016). Additionally, researchers developed a conceptual model which incorporated key elements such as context (i.e., socioeconomic, cultural, and geographic), equitable partnerships, and using a culturally tailored and appropriate research design and outcome evaluation.

Applying a conceptual model, (Langdon, 2016), is another common procedural step for culturally competent prevention programming. The development and application of a conceptual framework can help ensure that the process of developing a new program or adapting an existing one is systematic and grounded in research and theory. For example, Garner and colleagues constructed a multi-level model which illustrates the interaction among sociocultural elements (i.e., home and neighborhood context, child sociocultural characteristics, and

Treatment for alcohol and other drug misuse have conventionally followed a non-Indigenous approach and have proven to be less effective and even harmful to Indigenous peoples.

– Jessica Liddell, 2017

school context) and children's social emotional competence (2014). The explanatory model reveals how these elements may moderate outcomes for children and considers the cultural, linguistic, and social elements of the target population. Wang and colleagues similarly offer a conceptual framework for ensuring deep, structural-level cultural adaptation for their alcohol use prevention efforts targeting Chinese-American families (2014). Extending beyond language and imagery, the intervention sought to incorporate the worldview and values of Chinese-American participants into the program. The framework incorporates macro-level theory and a review of literature to incorporate culturally based constructs into the intervention.

In addition to outlining important procedural elements, the research also reports barriers specific to evaluating a culturally competent prevention program that are often inherent when working with a minority population. These include a lack of national or historical data for some populations, having too small of a sample size to conduct a rigorous evaluation, and difficulty creating a safe space for the target population to be honest and share their experiences with sensitive prevention topics

(Valenti et al., 2017). Similarly, one evaluation cited a lack of Native staff to work with Native patients as a challenge in applying culturally based prevention models (Croff et al., 2014). As a result, culturally competent prevention interventions are often based on a less established and rigorous body of evidence, which can result in a larger investment of time and resources on the part of program developers compared to interventions which do not take cultural competency into consideration (Okamoto, 2014; Clifford et al., 2015).

When few tailored, evidence-based interventions designed and evaluated for a population of interest are available, adaptation of other, existing interventions becomes a more cost-effective and viable option. The balance between implementing interventions with fidelity and achieving a more appropriate cultural fit for minority populations was also cited in the literature as a program and evaluation challenge. Marsiglia and colleagues discuss this balance and developed a model to guide adaptation efforts that were culturally competent while still maintaining core elements of the intervention (2014).

In the face of evaluation challenges, the evidence is mixed regarding the efficacy of culturally competent prevention efforts. Through a systematic review, Bloom suggests that adapting existing prevention interventions, or developing new interventions, to become culturally competent for minority groups has been found to improve outcomes (2016). Additionally, a systematic review of interventions designed to improve cultural competence in health care for Native Americans and Indigenous Australians found statistically significant improvements in numerous key areas. These interventions included knowledge and awareness regarding health care for Indigenous populations, preparedness and confidence in working with Indigenous populations, increased adherence to delivery of health services among Indigenous health workers, and Indigenous patient satisfaction (Clifford et al., 2015).

However, a summary of evidence across 10 meta-analyses demonstrated mixed results, with some finding that culturally tailored treatment enhanced effectiveness for ethnically diverse groups, while others suggested that there was little benefit when compared to standard treatment effectiveness (Huey et al., 2014). Similar findings were reported by Lee and colleagues who found that although tobacco cessation curricula tailored to the LGBT population showed evidence of effectiveness, no rigorous outcome evaluations existed at the time of the systematic review (2014).

Research suggests that due to minority stressors and issues of acculturation and identity, suicide prevention should also be conducted in a culturally competent manner. Shadick and Akhter describe their methods in developing a multicultural suicide prevention kit for seven different student groups, including Latinos. While the program's counseling center saw a 12% increase in the number of minority students referred to the counseling center, compared to a 3% overall increase, the study could not confirm whether that was due to the prevention kit. Ford and colleagues similarly focus on the Latino community and suicide prevention. Through focus groups with community leaders and youth, they identified specific risk factors for depression and suicide and specific cultural factors that were important to prevention programs. These risk factors included cultural and familial

In an ever-changing cultural landscape, there is a renewed need to examine social work education and the interventions social workers implement with cultural diverse communities.

– Flavio Marsiglia, 2015

discouragement in expressing emotions, the importance of seeking professional help, and the importance of educators being Latino (2015). Meanwhile, Wexler and colleagues reviewed suicide prevention among rural Indigenous Alaskan communities, with their research suggesting that current prevention models, which emphasize increasing referrals to mental health services, have been ineffective. Instead, they suggest strengthening local support networks to ensure community members are better able to reach out to persons-in-need before a crisis (2015).

A systematic review of substance use prevention for Latino adolescents revealed positive, albeit small, effects on substance use outcomes immediately post-intervention, and somewhat larger effects at follow up (Hernandez et al., 2016). Another systematic review of substance use prevention programs, these tailored for Indigenous youth, found that only some of the

14 articles included reported a high number of abstinent days, that participants maintained their resistance strategies, or that alcohol and drug use outcomes were noticeably or statistically different when compared to a control group. Several studies also reported increases in connections to Indigenous community or identity (Liddell & Burnette, 2017).

Lastly, regarding HIV Prevention, Perez and colleagues employed a systematic review of culturally sensitive interventions to screen and treat Latino men who have sex with men. While all 10 relevant records incorporated surface-level cultural features, such as bilingual study recruitment, deep structural-level cultural features were lacking. While interventions often noted the importance of cultural considerations, rarely was it described how these factors were incorporated into intervention activities.

VI. Cultural Competence Articles and Citations

The Cultural Competence Articles and Citations section provides records that summarize key extracted information from each of the 23 peer-reviewed, academic research articles that met the literature review's inclusion criteria. The records are organized into four groups, based on target population:

1. Youth-focused articles
2. Adult and community-wide articles
3. LGBT-focused articles
4. Process articles that do not have a specific population of focus

Articles within each group are presented alphabetically by lead author, have a new title describing the article's relevance to cultural competency, and provide the following information:

- **Citation** – The article citation
- **Description** – A summary of the key background information from the article
- **Population** – What population was the focus of the article
- **Setting** – Where the study or research described by the article occurred
- **Evaluation Design** – How the article authors collected information or evaluated outcomes
- **Evaluation Outcomes** – What the article found related to the effectiveness of cultural competency

Readers interested in learning more are encouraged to use the article citations to obtain full-text versions. Additional information on cultural competency is also available through SAMHSA at the URLS included in Section III.

Adaptation at the deep structure addresses core values, beliefs, norms, and worldviews of the targeted cultural group to provide context and give saliency to the problem.

– Meme Wang-Schweig, 2014

Adapting Prevention Interventions to Focus on Family Relationships

Citation	Bloom, A. W. (2016). Advances in Substance Abuse Prevention and Treatment Interventions Among Racial, Ethnic, and Sexual Minority Populations. *Alcohol Research: Current Reviews*, 38(1), 47–54.
Description	Systematic reviews have identified increased success among prevention interventions that adapted to have a greater focus on family relationships, in response to the importance that many minority cultures place on the family rather than individuals. Family-orientated interventions focus on interdependence and work together to resolve members' problems and issues and attempt to improve family communication and prevention strategies such as parental monitoring.
Population	Additionally, while evaluations are still being conducted, initial results are promising for adapting prevention interventions to focus on minority community relationships, particularly among American Indian/Alaska Native communities.
Settings	Minority youth
Evaluation Design	Various
Evaluation Outcome(s)	• Adapting existing prevention interventions, or developing new interventions, to become culturally competent for minority groups has been found to improve outcomes.

Focus Groups Informing Depression/Suicide Prevention among Latino Youth in Chicago

Citation	Ford-Paz, R. E., Reinhard, C., Kuebbeler, A., Contreras, R., & Sánchez, B. (2015). Culturally Tailored Depression/Suicide Prevention in Latino Youth: Community Perspectives. *The Journal of Behavioral Health Services & Research*, 42(4), 519–533. doi:10.1007/s11414-013-9368-5
Description	While evidence-based depression/suicide treatment exists, it is underutilized by Latino youth who are at elevated risk for depression and suicide compared to other ethnic groups. Following meetings with community partners and stakeholders in Chicago, depression/suicide prevention was identified as a topic of mutual concern. Two focus groups of youth and youth-involved Latino community leaders were conducted to address risk factors for depression/suicide, limitations of existing prevention programming, cultural factors important to prevention programs and the "ideal" program.

The nine community leader focus group participants consisted of youth program organizers, pediatricians, and school personnel, among other affiliations. The nine adolescents were youth council members, health leaders at local agencies, and volunteers with the police among other affiliations. Open-ended questions on various topics were posed to the two groups. |
Population	Latino adolescents and adult Latino community leaders
Settings	The Latino community in Chicago
Evaluation Design	Focus groups involving adult Latino community leaders as well as Latino youth were conducted to extract reoccurring themes to inform a culturally tailored depression/suicide prevention program for the young Latino community in Chicago.
Evaluation Outcome(s)	Three overarching themes were extracted from the focus-group transcripts:

1. Utilizing a multipronged approach – Specifically, focus groups advocated for combining multiple strategies (e.g., public awareness campaigns, educational outreach, youth development activities, skill-building activities) to reach different subpopulations and ensure long-term sustainability.

2. Raising awareness about depression in culturally meaningful ways – For example, applying information that highlights Latino-specific risk factors, such as cultural and familial discouragement in expressing emotions and seeking professional help. Emphasis was placed on educators being people with whom Latino youth and families can identify.

3. Promoting Latino youth's social connection and cultural enrichment activities, instead of relying on individual-level interventions that emphasize self-help. This approach helps to buffer feelings of social isolation, discrimination, and acculturation stress while addressing the stigma of seeking help. |

Sociocultural Considerations in Social Emotional Learning Programs for Children

Citation	Garner, P. W., Mahatmya, D., Brown, E. L., & Vesely, C. K. (2014). Promoting Desirable Outcomes Among Culturally and Ethnically Diverse Children in Social Emotional Learning Programs: a Multilevel Heuristic Model. *Educational Psychology Review*, 26(1), 165–189. doi:10.1007/s10648-014-9253-7
Description	A substantial body of research supports the association between social emotional competence and academic competence in children. Paired with the increased prevalence of social emotional problems among children in the school setting, numerous social emotional learning (SEL) interventions have been developed. The 2013 Collaborative for Academic, Social, and Emotional Learning (CASEL) Guide evaluates classroom-based SEL programs to identify well-designed, high-quality, and evidence-based interventions. The efficacies of these highly regarded SEL programs across various cultural subgroups are discussed.
	The authors construct a multilevel model which illustrates the interaction among sociocultural elements—specifically home and neighborhood context, child sociocultural characteristics, and school context—and children's social emotional competence. The explanatory model reveals how these elements may moderate outcomes for children. Limitations of SEL evaluation research are discussed, such as the small number of interventions that have been the subject of a systematic effort to consider the cultural, linguistic, and social elements of their target population. Additionally, the development of standardized measures for scoring the quality of sociocultural adaptations to SEL programs would benefit future research in this area.
Population	Preschool and elementary school-aged children
Settings	Classroom
Evaluation Design	Findings specific to sociocultural background were extracted from studies presented in the widely disseminated 2013 CASEL Guide to explore how future SEL research might better address sociocultural factors.
Evaluation Outcome(s)	• Only 4 of the 23 interventions identified in the 2013 CASEL Guide adopted a rich, sociocultural approach by including practices that embraced the cultural beliefs and practices of the target population.
	• These programs shared the following elements: (1) compatible and sensitive to characteristics of the target population; (2) consider issues of measurement equivalence, language, and consider multiple domains of development in choosing outcome measures; (3) consider dosage and timing; and (4) emphasize formal training for teachers in applying sociocultural competence in the classroom.

Collaborative Measure Development in Two Alaska Native Communities

Citation	Gonzalez, J., & Trickett, E. J. (2014). Collaborative Measurement Development as a Tool in CBPR: Measurement Development and Adaptation within the Cultures of Communities. *American Journal of Community Psychology*, 54(1), 112–124. doi:10.1007/s10464-014-9655-1
Description	Limited research is available regarding the processes of creating or adapting measures for research with Alaska Natives and American Indians. This study describes the collaborative process of measurement development and provides a technical description of the final measurement model used to inform a suicide and alcohol abuse prevention project targeting two Yup'ik Alaska Native youth communities. Members of the development team included Yup'ik community co-research staff and university-based faculty and staff. An oversight committee of respected and well-known community leaders was also established (i.e., The Yup'ik Regional Coordinating Council [YRCC]) to provide guidance and coordinate efforts between the two communities. Scales were reviewed at the item level to establish: (1) linguistic equivalence, (2) comprehensibility, and (3) cultural relevance/appropriateness of original items which were rewritten for use by adolescents. The community differences evident between the two populations are discussed, though they shared a common cultural history.
Population	Yup'ik Alaska Native youth
Settings	Two rural Yup'ik communities
Evaluation Design	A community-based participatory research (CBPR) design was utilized over a 3-year period.
Evaluation Outcome(s)	• Through discussion with community partners and the YRCC, some original measures were discarded, and new measures created resulting in a considerably different model from the original. For example, asking youth about trauma and suicidal ideation was too culturally inappropriate. After much discussion, the trauma measure was removed. • In Native communities, cultural practices encompass the format for gathering information, how data gatherers introduce themselves and the task, confidentiality, and attention to respectful behavior and topics. • The authors emphasize honoring differences between Native communities. While *population* refers to the Yup'ik Alaska Natives as a whole and a shared history, *community* refers to the local expression of this shared history. • The "culture of the community" and the "culture of science" were at times at odds during the measure development process.

Culturally Adapted Substance Use Interventions for Latino Adolescents: A Meta-Analysis

Citation	Hernandez Robles, E., Maynard, B. R., Salas-Wright, C. P., & Todic, J. (2016). Culturally Adapted Substance Use Interventions for Latino Adolescents: A Systematic Review and Meta-Analysis. *Research on Social Work Practice*, 28(7), 789–801. doi:10.1177/1049731516676601
Description	Adults who meet the criteria for substance dependence frequently report substance initiation occurring at early adolescence, underscoring the importance of intervention efforts. Additionally, research supports that Latino adolescents are more likely than other ethnic groups to use a variety of substances. A systematic review and meta-analysis were conducted to synthesize effects across 10 studies of 12,546 Latino adolescents who participated in interventions intended to prevent or reduce substance use.
Population	Latino adolescents
Settings	Most of the interventions were conducted in a school setting while others were provided in a combination of settings (e.g., school, community-based organization, and home settings). Three of the studies did not report a setting.
Evaluation Design	Campbell Collaboration systematic review procedures were used for all aspects of the search, retrieval, selection, and coding process. To be included, studies must have been conducted or reported between January 1990 and March 2014. The search strategy consisted of 14 electronic databases and research registries, 6 relevant websites, reference harvesting of prior reviews, and included studies and personal contacts with researchers and research centers. Outcomes of interest in this review were substance use-related behavioral outcomes, including alcohol, nicotine, or illicit drug use as measured by self-report, parent report, or other report (e.g., teacher, clinician), and standardized scales. After applying exclusionary criteria, a total of 10 studies were identified for inclusion, consisting of 7 randomized controlled trials and 3 quasi-experimental design studies. Two coders independently screened and extracted data from all studies and complete agreement between the coders was achieved through discussion of any discrepancies. Two meta-analyses were performed to synthesize effects on substance use outcomes—one for studies reporting effects at post-test and one for studies reporting effects at a follow-up time point (i.e., between 2 and 24 months).
Evaluation Outcome(s)	• The results suggest positive, yet small effects on substance use outcomes at post-test (g=. 06) and slightly larger effects at follow up (g=. 26). .

An Academic-Community Partnership for Developing Suicide Prevention Programming for Lumbee American Indian Youth

Citation	Langdon, S. E., Golden, S. L., Arnold, E. M., Maynor, R. F., Bryant, A., Freeman, V. K., & Bell, R. A. (2016). Lessons Learned From a Community-Based Participatory Research Mental Health Promotion Program for American Indian Youth. *Health Promotion Practice*, 17(3), 457–463. doi:10.1177/1524839916636568
Description	Statewide data indicate that American Indians in North Carolina have significant health and economic disparities. The Lumbee Rite of Passage (LROP) is an academic-community partnership and prevention model for developing and implementing a suicide prevention program for Lumbee American Indian youth in North Carolina. The main objectives of the LROP were to: (1) understand knowledge and perceptions of existing mental health resources; and (2) develop, implement, and evaluate a cultural enrichment program as a means of suicide prevention.
Population	Lumbee American Indian youth (11–18 years) in North Carolina
Settings	Community-based
Evaluation Design	A community-based participatory research approach was utilized. Four focus groups were held with Lumbee youth and interviews were held with professionals working in mental health and/or with youth. Extracted themes were used to design and implement a 6-month culturally informed suicide prevention program. A community advisory board (CAB) was also developed to guide the research process and to ensure that the process is responsive to and respectful of communities. Four main concepts characterized the LROP model: (1) Contexts (i.e., socioeconomic, cultural, geographic, etc.); (2) Group Dynamics/Equitable Partnerships; (3) Intervention/ Research (i.e., culturally tailored, appropriate research design); and (4) Outcomes.
Evaluation Outcome(s)	• **Contexts** – Interviews revealed stigma surrounding seeking treatment and a conflict between beliefs about mental illness and Christianity. Rather than specifically targeting suicide, leaders used drumming, dancing, singing, and beadwork to enhance enculturation, provide social support, and improve self-esteem as a means of suicide prevention • **Group Dynamics/Equitable Partnerships** – The authors describe the crucial involvement of Lumbee investigators and field coordinators as well as Lumbee youth in the CAB which brought trust in programming. Leadership turnover was cited as a challenge • **Intervention/Research** – Using data collected from focus groups and interviews to inform the enhanced intervention was key. The study team used this information to provide appropriate resources to participants and to help providers understand factors that affect care seeking and cultural nuances for providing culturally tailored care. • **Outcomes** – Significant findings are limited due to the small sample size and lack of randomization. Participants with regular attendance showed a decrease in suicidal ideation and an increase in protective factors. An evaluation data supported program was used by the tribe to support the continuing need for youth-focused programs.

A Systematic Review of Alcohol and Other Drug Use and Misuse for Indigenous Youth in the United States

Citation	Liddell, J., & Burnette, C. E. (2017). Culturally-Informed Interventions for Substance Abuse Among Indigenous Youth in the United States: A Review. *Journal of Evidence-Based Social Work*, 14(5), 329–359. doi:10.1080/23761407.2017.1335631
Description	Alcohol and other drug (AOD) use and misuse are pressing health concerns among Indigenous populations and are considered the largest contributing factor to increased mortality among Indigenous peoples. A systematic review was employed to investigate the current state of empirically backed and culturally tailored substance abuse prevention and intervention programs for Indigenous youth—18 or younger—in the United States.
Population	Indigenous youth in the U.S.
Settings	Settings included schools, community centers, alcohol and drug inpatient sites, and community events
Evaluation Design	The systematic review included peer-reviewed empirical research focusing on AOD abuse prevention programs that are culturally informed and aimed at Indigenous youth, ages 9–18, published between 1988 and 2016. Inclusion criteria included articles that were peer-reviewed, incorporated a culturally informed intervention, provided outcomes evaluating the intervention, addressed AOD, and were aimed at Indigenous youth in the United States. A total of 14 articles met the inclusion criteria. Quantitative research methods were the most commonly employed (n = 12) with only two studies reporting using qualitative methods exclusively (n = 2). Many studies did not utilize a randomized control trial format or involve a true comparison group (n = 10). The 14 articles were then analyzed in terms of the cultural intervention itself (i.e., primary population, intervention, core tenants, focus of intervention, intervention goals, location, intervention location, and program length) and their evaluation approach.
Evaluation Outcome(s)	• Some evaluations reported a high number of abstinent days that participants were able to maintain their "resistance strategies," or that AOD use outcomes were noticeably or statistically different when compared to a control group. Several studies reported increases in connections to Indigenous community or identity. • At a minimum, interventions referenced using culturally informed examples in their curriculum while others described developing culturally informed video vignettes or participating in a variety of culturally informed activities, for example incorporating a traditional medicine man. • Involving the community in intervention implementation was described by several programs (n = 5) as was including family members (n = 3). The use of Indigenous stories and legends was a technique mentioned by several authors (n = 6). Several studies also mentioned talking circles as a method related to sharing stories and valuing shared history (n=3).

Implementing Culturally Grounded Drug Prevention Interventions for Indigenous Youth

Citation	Okamoto, S. K., Helm, S., Pel, S., McClain, L. L., Hill, A. P., & Hayashida, J. K. P. (2014). Developing empirically based, culturally grounded drug prevention interventions for indigenous youth populations. *The Journal of Behavioral Health Services & Research*, 41(1), 8–19. doi:10.1007/s11414-012-9304-0
Description	The majority of prevention science research has focused on the cultural adaptation of prevention interventions. An alternative approach, however, involves structuring an intervention from the "ground up" based on the values, beliefs, and worldviews of the target population. Culturally grounded programs, as opposed to culturally adapted programs, place the culture of the participant at the center of the intervention. The relevance of a culturally grounded approach to drug prevention development for Indigenous youth populations is discussed. A case example is provided of a multiyear project funded by the National Institute on Drug Abuse (NIDA) involving drug use prevention among Native Hawaiians. The program applies a culturally grounded as opposed to a culturally adapted approach. Various challenges and opportunities inherent in the approach are explored.
Population	Indigenous youth populations (e.g. , American Indian, Alaskan Native, and Native Hawaiian youth)
Settings	School-based
Evaluation Design	A non-systematic overview of the literature surrounding culturally grounded interventions for indigenous youth is employed in addition to a case study.
Evaluation Outcome(s)	• Very few evidence-based, culturally grounded prevention programs specific to Indigenous youth exist, though there are unique Indigenous phenomena that don't have a parallel in Western culture, making adaptation of existing prevention interventions difficult. • Community engagement and investment is especially important for culturally grounded drug prevention efforts because it ensures that tribal and communal norms and values are represented. • A case example of Promoting Social Competence and Resilience of Native Hawaiian Youth (PSCR) is provided. This was a multiyear, interdisciplinary (i.e., social work, psychology, sociology, and computer sciences), pre-prevention study funded by NIDA which examined the social and cultural contexts of substance use for rural Native Hawaiian youth. Since the intervention was based on a less established body of literature compared to many adapted interventions, the process involved significantly more time and resources, to create prevention components and ground them in the social and cultural context of Native Hawaiian youth.

Development of A Suicide Prevention Kit For Diverse College Students

Citation	Shadick, R., & Akhter, S. (2014). Suicide prevention with diverse college students. *Journal of College Student Psychotherapy*, 28(2), 117–131. doi:10.1080/87568225. 2014. 883877
Description	There appears to be differences in suicide ideation and behavior across diverse groups of students. This article details the process used to develop a multicultural suicide prevention kit. The kit is a platform-based customizable group of prevention materials. It includes an MS PowerPoint presentation, fact sheets, brochures, posters, public service announcements, role plays, self-study quizzes, and bibliographies. The kit is tailored to seven different student groups. The rationale for approaching suicide prevention in a culturally competent manner is discussed and methods used to gain culture-specific phenomena that impact the mental health of diverse students are presented.
Population	American college students
Settings	College campus
Evaluation Design	Focus groups were facilitated by counseling center staff to elicit information from 60 active and high-profile students (e.g., student leaders from diversity-oriented clubs and organizations, resident assistants, and peer educators of diverse backgrounds) to learn about diverse students' needs in treating depression and suicide. Asian, African, Caribbean, Latino, Muslim, LGB, White, International, and students with disabilities were represented. Additional assessment instruments, validated measures, and recommendations from the literature informed the kit. The development of the kit focused on identifying and addressing person-specific suicide risk factors (e.g., academic pressure, drug and alcohol use, and sexual assault).
Evaluation Outcome(s)	• Feedback from over 50 training workshops as well as regional and national meetings indicated that 100% of people found the information in the training and the kit useful, over 95% of participants indicated that they feel more confident in handling students with a mental health crisis, and at least 80% used the information to provide help to suicidal students. • The counseling center saw a 12% increase in the number of minority students referred to the counseling center, compared to a 3% overall increase during the same time period. However, it is not possible to tie that increase to the kit training.

Reducing Early-Adolescent Antisocial Behavior for Diverse Ethnic Groups

Citation	Smith, J. D., Knoble, N. B., Zerr, A. A., Dishion, T. J., & Stormshak, E. A. (2014). Family Check-Up Effects Across Diverse Ethnic Groups: Reducing Early-Adolescence Antisocial Behavior by Reducing Family Conflict. *Journal of Clinical Child & Adolescent Psychology*, 43(3), 400–414. doi:10.1080/15374416. 2014. 888670
Description	Evidence suggests that ethnic minority youth are at greater risk for negative mental health outcomes because of barriers to services (e.g., stigma and economic resources, and a lack of available culturally relevant services). Therefore, culturally sensitive family interventions are a public health imperative. The Family Check-Up (FCU) involves a home-based ecological assessment comprised of brief developmentally appropriate interaction tasks that assess family functioning and caregiving domains (e.g., parental monitoring, effective limit setting, child-caregiver relationship quality). A variety of parent, teacher, and youth self-report measures were also collected as part of the assessment. The extent to which the intervention is effective for improving youth adjustment and parent-child interactions for diverse cultural groups is evaluated.
Population	Families with early-adolescent children
Settings	Middle schools
Evaluation Design	A sample of 1,193 families was drawn from 2` large-scale randomized prevention trials conducted in diverse urban middle schools. Three groups were established based on youth self-identification of ethnicity (i.e., European American, African American, and Hispanic). Group differences are examined in a hypothesized mediating effect of family conflict on later antisocial behavior.
Evaluation Outcome(s)	• Path analysis revealed that youth in the intervention group reported significantly less antisocial behavior over a 2-year period. Moreover, youth-reported reductions in family conflict at 12 months were an intervening effect. Ethnicity did not moderate the relationship.

Applying a Conceptual Framework to Guide Structural Level Cultural Adaptation to Alcohol Use Prevention Efforts

Citation	Wang-Schweig, M., Kviz, F. J., Altfeld, S. J., Miller, A. M., & Miller, B. A. (2014). Building a conceptual framework to culturally adapt health promotion and prevention programs at the deep structural level. *Health Promotion Practice*, 15(4), 575–584. doi:10.1177/1524839913518176
Description	Cultural adaptation of prevention programs should be guided by the development of and adherence to a conceptual framework. A family-based intervention, Guiding Good Choices (GGC) for Chinese American families addresses risk and protective precursors for preventing alcohol use through developing parenting practices that increase positive parent-child bonding. The program targets parents of children between ages 9 and 14. The authors describe how a conceptual framework was used to inform cultural adaptation of the program on a deep structural level which upholds worldview, norms, beliefs, and values. Lastly, a summary of the preliminary evidence for the program's effectiveness is offered.
Population	Chinese-American parents and their children
Settings	Elementary schools in Chicago's Chinatown
Evaluation Design	Data were collected from 191 Chinese American parent-child dyads through self-administered questionnaires distributed to students in 6th through 8th grades and their parents.
Evaluation Outcome(s)	• A conceptual framework is offered to guide the process of cultural adaptation on a deep structural level, specifically adaptations that honor worldview, norms, beliefs and values that: (1) examine the original theory underlying the intervention to determine constructs relevant to the program's core components; (2) use a macro-level theory to identify and select key constructs most likely to be culturally dependent, (3) review the literature to specify how culture might influence these constructs; and lastly (4) incorporate culturally based constructs and their relationships to the core constructs into the intervention. • Preliminary evaluation findings revealed that a child's perceived bonding with his/her parent served as a protective factor against alcohol use among adolescents. Additionally, positive parenting practices were inversely related to intergenerational cultural dissonance, revealing that as parents engaged in these practices to a greater degree, children perceived less acculturation-based conflict.

Identifying Barriers to Culturally Competent Suicide-Risk Assessment

Citation	Chu, J. P., Poon, G., Kwok, K. K., Leino, A. E., Goldblum, P., & Bongar, B. (2017). An assessment of training in and practice of culturally competent suicide assessment. *Training and Education in Professional Psychology*, 11(2), 69–77. doi:10.1037/tep0000147
Description	Researchers and experts have suggested a lack of training and practice related to culturally competent suicide-risk assessment (SRA); however, this suggestion has primarily been based on "conjecture" and anecdotal data. This study surveyed 161 doctoral-level psychologists to obtain specific, qualitative, and quantitative data on the availability and quality of existing culturally competent SRA.
Population	Cultural minority populations
Settings	Office-based mental health service providers
Evaluation Design	Doctoral-level clinical psychologists were randomly selected from online American Psychology Association directories and offered to participate in an online survey on SRA topics. Responses were organized on Likert Scales and underwent quantitative analysis.
Evaluation Outcome(s)	Participants reported a lack of availability and types of culturally competent SRA training. The following four key barriers to the provision of culturally competent SRA were identified: 1. Lack of training 2. Lack of awareness 3. Lack of experience with cultural minority clients 4. Lack of practice guidelines

Systematic Review to Improve Indigenous Health Care

Citation	Clifford, A., McCalman, J., Bainbridge, R., & Tsey, K. (2015). Interventions to improve cultural competency in health care for Indigenous peoples of Australia, New Zealand, Canada and the USA: a systematic review. *International Journal for Quality in Health Care*, 27(2), 89–98. doi:10.1093/intqhc/mzv010
Description	Health disparities between Indigenous and non-Indigenous peoples are well established. A systematic review process was employed to identify published evaluations of interventions designed to improve cultural competence in health care for Indigenous populations in Australia, New Zealand, Canada and the U.S.
	There were three main categories of interventions across studies: (1) education and/or training of health professionals or health students; (2) culturally specific/tailored health programs or resources for Indigenous people; and (3) interventions which increased Indigenous involvement in health care delivery to Indigenous people. Key study characteristics, methodological quality, and outcomes of these interventions were extracted to determine which have demonstrated effectiveness in improving cultural competence.
Population	Indigenous peoples of Australia, New Zealand, Canada and the U.S.
Settings	Settings varied across studies; community health centers, civic organizations, hospitals, universities, pharmacies, and dental clinics were represented in the sample
Evaluation Design	Sixteen intervention studies were retained for final review through a systemic database search of literature published between 2002 and 2013. Data was extracted related to intervention type and components, study population and setting, sample size, study design, outcomes measured, and intervention effectiveness. Methodological quality was assessed using criteria such as selection bias, study design, confounders, and data collection, among others.
Evaluation Outcome(s)	• Of the 16 studies identified, 11 evaluated interventions in the U.S.—including Native American, Native Hawaiian, and Native Alaskan populations—5 studies targeted Indigenous Australians, and no study targeted the Maori peoples of New Zealand or First Nation peoples of Canada.
	• Main positive outcomes reported were statistically significant improvements in knowledge and awareness regarding health care for Indigenous populations, preparedness and confidence in working with Indigenous populations, increased adherence to delivery of health services among Indigenous health workers, and Indigenous patient satisfaction.
	• Few published evaluations of interventions were identified, and the methodological quality of studies was less than ideal with only two studies applying randomization and nine using a validated measure.

Provider Versus State Perspectives on Treating American Indian and Alaska Native Patients with Substance Use Disorders

Citation	Croff, R. L., Rieckmann, T. R., & Spence, J. D. (2014). Provider and state perspectives on implementing cultural-based models of care for American Indian and Alaska native patients with substance use disorders. *The Journal of Behavioral Health Services & Research*, 41(1), 64–79. doi:10.1007/s11414-013-9322-6
Description	American Indian and Alaska Native (AI/AN) experience disproportionate rates of substance use disorders. Findings from interviews with 22 program directors of community-based substance abuse treatment centers and 18 representatives from Single State Authorities (SSAs) on substance abuse are discussed. The study aimed to identify and evaluate provider and state perspectives on needed infrastructure, policies, and resources to improve the quality of care for AI/AN individuals with substance use disorders. Topics included funding, selection of practices, and state policies, organization including data systems and monitoring outcomes, and clinical efforts such as trainings, and the application of cultural-based practices and/or evidence-based practices.
Population	American Indians/Alaska Natives
Settings	Single state agencies on substance abuse and community-based substance abuse treatment centers
Evaluation Design	A qualitative approach was applied, and data was collected over 1-year (i.e., 2010–2011) through semi-structured, open-ended qualitative interviews with SSAs and program directors of substance abuse treatment centers that serve AI/AN populations.
Evaluation Outcome(s)	• Both respondent groups emphasized the critical role of culturally relevant care in individual and community healing. • Lack of Native staff to work with Native patients was cited as a challenge in applying cultural-based models of care. • Gaps in state-tribal collaborations, staff-based tensions, a widening generational divide, and blurred consensus of "tradition" impact service delivery. • While many SSAs acknowledged the need for cultural awareness, treatment providers expressed this most adamantly.

Preponderance of Evidence Surrounding Evidence-Based Care for Ethnically Diverse Populations

Citation	Tilley, Jr., S. J. H., J. L., Jones, E. O., & Smith, C. A. (2014). The Contribution of Cultural Competence to Evidence-Based Care for Ethnically Diverse Populations. *Annual Review of Clinical Psychology*, 10(1), 305–338. doi:10.1146/annurev-clinpsy-032813-153729
Description	There is limited research on the relevance of evidence-based treatments (EBTs) on culturally diverse populations. The effects of psychotherapy with ethnic minorities was explored, specifically the role of cultural competence when implementing EBTs. Three questions are addressed: (1) does psychotherapy work with ethnic minorities; (2) do psychotherapy effects differ by ethnicity; and (3) does cultural tailoring enhance treatment effects? The review summarizes the evidence available on these topics.
Population	African Americans, Latinos, Asian Americans
Settings	Clinical
Evaluation Design	Evidence is summarized from a database of over 300 randomized trials of mental health treatments that: (1) include predominantly ethnic minority participants; (2) assess how client ethnicity affects treatment outcomes; or (3) evaluate separate treatment effects for ethnic minority participants. The process in not systematic.
Evaluation Outcome(s)	• Approximately 60–70% of randomized trials or meta-analyses that examined ethnic differences found no significant moderator effects suggesting that psychotherapies appear to work equally well for Whites and ethnic minorities; the authors do not provide the total number of studies evaluated. • Four meta-analyses that compared outcomes across two or more ethnic minority groups generally found no ethnic differences in treatment outcomes, although one meta-analysis (Smith et al., 2011) showed that Asian Americans benefited more from psychotherapy than did African Americans, Latinos, and Native Americans. • Ten meta-analyses evaluating culturally tailored interventions for ethnic minorities (i.e., youth and adult) found mixed results; some suggest cultural tailoring can enhance treatment effectiveness for ethnically diverse groups while others suggest that some forms of cultural tailoring may provide little benefit compared to standard treatments and may reduce treatment effectiveness. • Culturally adapted treatments are clearly effective with ethnic minorities when compared to conventional control groups, however, it is not clear if culturally adapted interventions are more effective when compared to non-adapted interventions.

A Collaborative, Participatory Evaluation of Tribal Tobacco Policy and Education

Citation	Scott, S., D'Silva, J., Hernandez, C., Villaluz, N. T., Martinez, J., & Matter, C. (2017). The Tribal Tobacco Education and Policy Initiative: Findings From a Collaborative, Participatory Evaluation. *Health Promotion Practice*, 18(4), 545–553. doi:10.1177/1524839916672632
Description	American Indians have the highest rates of commercial tobacco use among racial and ethnic groups. Despite substantial evidence on effective approaches to reduce tobacco use among the general population, limited research is available on how sovereign Tribal Nations are addressing this issue. A participatory evaluation was conducted from 2010 to 2013 in four Minnesota Tribal Nations. The evaluation sought to answer the following questions: (1) what types of activities facilitate tobacco-related policy and norm changes in tribal communities; (2) how do these approaches compare to approaches used in nontribal settings; and (3) can this work bring about community-generated change that helps restore tobacco tradition while reducing commercial tobacco use? An evaluation framework was developed through a collaborative process to ensure that it is culturally grounded and informed by Indigenous evaluation models.
Population	American Indians in Minnesota
Settings	Tribal communities
Evaluation Design	Data was collected using a mixed-methods design. The primary data source was a web-based data collection tool, the Tribal Tobacco Story (TTS). Completed by tribal coordinators, TTS is a multisite advocacy evaluation method designed to gather data on major activities, strategies, and indicators for tobacco cessation. Monthly discussions with tribal coordinators were held to validate, clarify, and reflect on TTS entries and solicit details for coding. Additional qualitative data was collected at listening sessions during which the previous year of TTS entries were reviewed and discussed.
Evaluation Outcome(s)	• The following activities facilitated tobacco-related changes in tribal communities; creating smoke-free policies (56%), restoring the idea of tobacco as a sacred "first medicine" (22%), building support within the community (15%), creating smoke-free businesses (5%), and reducing industry marketing (2%). • Unlike non-tribal populations, Tribal Nations do not seek outside support from advocacy groups but rely on their own citizens to ask for and create change within their own communities. • Coordinators were successful in generating support for policy change by conducting culturally relevant education, engaging tribal members, and relationship building. This resulted in norm changes, practices toward restoring traditional tobacco, informal policies, and tribal resolutions to advance smoke-free policies.

A Culturally Aligned Suicide Prevention Alternative for Indigenous Alaskans

Citation	Wexler, L., White, J., & Trainor, B. (2015). Why an alternative to suicide prevention gatekeeper training is needed for rural Indigenous communities: presenting an empowering community storytelling approach. *Critical Public Health*, 25(2), 205–217. doi:10.1080/09581596. 2014. 904039
Description	Gatekeeper training, though the most common approach to youth suicide prevention, may have limited effects in Indigenous communities. Based on work undertaken with Indigenous leaders in rural Alaska, a culturally grounded, practical alternative is offered. Gatekeeper trainings coalesce around key content such as teaching about suicide prevalence, risk factors, and warning signs; and encouraging participants to refer those at risk to mental health services. However, recent national evaluations indicate that participants acquire information and skills, but do not often apply them, believing the practices are not aligned with local cultural and social expectations. The Collaborations for At-Risk (youth) Engagement and Support (CARES) Model does not aim to increase referral to mental health services but instead strengthens the local support network so that community members are better able to reach out to persons-in-need before a crisis. A comparison of the two models, Gatekeeping and CARES, are outlined.
Population	Rural Indigenous communities in Alaska
Settings	Community-based
Evaluation Design	A non-systematic overview of the literature specific to Indigenous youth suicide prevention strategies
Evaluation Outcome(s)	The following critiques of the Gatekeeper Model are presented and compared to the culturally informed elements of the CARE Model: • Where the CARE Model starts with stories of support and "reaching out", the Gatekeeper model starts with general suicide-related statistics. • The CARE Model establishes expertise within the group whereas the Gatekeeper Model assumes that expertise lies with the facilitator. • Lessons presented through the CARE Model are grounded in stories offered by participants while the Gatekeeper Model offers information out of context related to risk and protective factors and signs of distress. • The CARE Model emphasizes personal commitment and social action whereas the Gatekeeper Model emphasizes crisis intervention.

Systematic Review of Tobacco Use Cessation Interventions Tailored for LGBT Individuals	
Citation	Lee, J. G. L., Matthews, A. K., McCullen, C. A., & Melvin, C. L. (2014). Promotion of Tobacco Use Cessation for Lesbian, Gay, Bisexual, and Transgender People: A Systematic Review. *American Journal of Preventive Medicine,* 47(6), 823–831. doi. org/10.1016/j.amepre.2014.07.051
Description	Lesbian, gay, bisexual, and transgender (LGBT) people are at increased risk for the adverse effects of tobacco given their high prevalence of use compared to heterosexuals. Specifically, in the U.S., LGBT adult smoking prevalence is 68% higher than that of heterosexuals. A systematic review was conducted of both gray and peer-reviewed literature describing clinical, community, and policy interventions in addition to knowledge, attitudes, and behaviors regarding tobacco use cessation among LGBT individuals.
Population	LGBT
Settings	Health centers and community-based organizations—domestic and international
Evaluation Design	A systematic review process was employed utilizing eight electronic databases of articles from 1987 to 2014. Authors and researchers were also contacted to identify gray literature. Interventions were defined to include pharmacotherapy, clinical approaches, behavioral counseling, media campaigns, and public policy. Two authors independently reviewed each title, abstract, and, as necessary, full-text article to code for inclusion and exclusion. Coding differences were resolved through discussion. Study characteristics were extracted including study design, population, date, intervention description, number of participants, attrition, outcomes, and funding. In total, 29 peer-reviewed and 22 gray literature citations were included.
Evaluation Outcome(s)	• Group cessation curricula tailored for LGBT populations were found feasible to implement and showed evidence of effectiveness, however, no rigorous outcome evaluations exist. • The available evidence suggests that non-tailored clinical treatments work as well for LGBT and non-LGBT populations. Yet, LGBT-specific barriers may exist to accessing cessation services. • LGBT cultural competency trainings emphasize information on disparities, causes of smoking in LGBT communities, and use of culturally appropriate language. Suggested strategies covered three domains: (1) understanding barriers; (2) creating a welcoming environment; and (3) providing culturally relevant materials such as a quick guide tailored to LGBT populations with specific statistics, imagery, and suggestions for dealing with stressors specific to LGBT populations.

HIV Prevention Interventions for Latino Men Who Have Sex With Men: A Systematic Review

Citation	Perez, A., Santamaria, E. K., & Operario, D. (2018). A Systematic Review of Behavioral Interventions to Reduce Condomless Sex and Increase HIV Testing for Latino MSM. *Journal of Immigrant and Minority Health*, 20(5), 1261–1276. doi:10.1007/s10903-017-0682-5
Description	HIV continues to disproportionately affect specific groups, including Latinos and men who have sex with men (MSM). Increased rates of HIV testing have the potential to reduce rates of transmission. Therefore, culturally sensitive efforts to screen and treat Latino MSM diagnosed with HIV are needed. This article aims to: (1) identify interventions designed to reduce condomless sex and/or increase HIV testing among Latino MSM and summarize effects across studies; and (2) describe program characteristics and the incorporation of cultural factors into HIV interventions for Latino MSM. In addition, methodological rigors of studies included in this review are evaluated.
Population	Latino men who have sex with men
Settings	Community-based
Evaluation Design	A systematic review process was employed across four electronic databases. After screening 1,777 unique records, 10 relevant interventions were included which analyzed data from a total of 2,871 Latino MSM. Data were extracted by a single coder who pulled details regarding study location, design, population, aims, intervention characteristics, and results. The studies were deductively coded for specific cultural factors (i.e., machismo [masculine pride], familismo [family closeness], collectivism [importance of community], sexual silence [remaining silent about one's sexuality] among others).
Evaluation Outcome(s)	• Four studies reported reductions in condomless anal intercourse while one reported reduction in number of sexual partners. All studies incorporated surface structure cultural features such as bilingual study recruitment. Incorporation of deep structure cultural features was lacking. • One intervention received a strong methodological quality rating, six received a moderate rating, and three received a weak rating. • Information about cultural factors was sparse. Intervention studies often noted the importance of cultural considerations, and eight described cultural components in ways consistent with the deductive codes, but they rarely describe how these were incorporated into intervention activities. • The most common cultural components of included interventions were *machismo* and *sexual silence*.

Service to Science Evaluation Training and Technical Assistance for LGBTQ-Serving Prevention Organizations

Citation	Valenti, M., Campetti, R., Schoenborn, N., Quinlan, K., & Dash, K. (2017). Building evaluation capacity of local substance abuse prevention programs serving LGBQ populations. *Evaluation and Program Planning*, 63, 101–108. doi:10.1016/j.evalprogplan.2017.04.003
Description	Community-based organizations (CBOs) offering prevention programming to LGBTQ populations are historically under-funded and under-supported, including lacking the capacity to implement rigorous evaluation protocols. From FY2010–FY2014, SAMHSA funded nine organizations through the Service-to-Science Initiative to receive rigorous, customized training and technical assistance (T/TA) on developing and improving evaluation efforts to better serve LGBTQ populations. Organizations also received an evaluation coach who provided 40 hours of additional T/TA and $30,000 to implement evaluation improvements
	The nine participating organizations offered a wide-range of prevention services designed for LGBTQ populations, including programs to build skills, mitigate sexual minority stress, offer peer support, and provide safe spaces. However, four of the organizations had never evaluated their efforts to determine their effectiveness and cultural competency, and the other five indicated they were still in their formative stages. Through the T/TA and the accompanying initial evaluation, the organizations learned how to develop logic models and establish specific goals, identify the success and cultural competence of specific interventions, and establish plans for adjusting services.
Population	LGBTQ populations—primarily youth
Settings	Community-based organizations
Evaluation Design	Each participating program received a qualitative, case study analysis to identify what types of evaluation T/TA programs received, evaluation enhancements programs implemented, and challenges programs encountered. This included an analysis of archival and administrative data and phone interviews.
Evaluation Outcome(s)	The case study analysis found that organizations: • received T/TA on understanding and developing logic models • worked with trainers to discuss and understand the conceptual underpinnings behind specific interventions, developed program theories of change, and identified additional T/TA needs • developed data collection protocols appropriate for their LGBTQ populations • cited lack of data and challenges with obtaining data (i.e., confidentiality and consent issues) as major barriers to prior evaluation efforts

PROCESS-FOCUSED ARTICLES

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Using Communities of Practice to Support Cultural Competence

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<td>Citation</td>
<td>Anderson-Carpenter, K. D., Watson-Thompson, J., Jones, M., & Chaney, L. (2014). Using Communities of Practice to Support Implementation of Evidence-Based Prevention Strategies. Journal of Community Practice, 22(1–2), 176–188. doi:10.1080/10705422. 2014. 901268</td>
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Communities of Practice (CoP) are a mechanism for allowing individuals and organizations between and across community sectors (e.g., schools, families, youth-serving organizations, government agencies, law enforcement, local businesses, faith-based organizations, etc.) to improve prevention programming collaboration and cultural competence. CoP can be structured in a variety of ways; however, key elements include project leadership—including facilitators and advocates/champions—identified objectives, clear measures, and technological supports as appropriate (e.g., software to meet virtually). Through CoP, participants learn how to better address issues of common interest and support shared goals and objectives of similar stakeholders.

SAMHSA supports the use of CoP through Strategic Prevention Framework (SPF) grants, which encourage awardees to collaborate with key stakeholders throughout the SPF process. This study described how the Kansas SPF used CoPs to improve prevention efforts from 2009 to 2012.

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<td>Population</td>
<td>Universal and selective populations</td>
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<td>Settings</td>
<td>Fourteen diverse communities in Kansas</td>
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<td>Evaluation Design</td>
<td>Qualitative process evaluation of SPF sub-grantees in Kansas</td>
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<td>Evaluation Outcome(s)</td>
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Through the Kansas CoP:

- sixty-eight percent of program changes were multi-sector collaborations (e.g., child welfare agencies working with family courts to ensure families attend parenting courses)
- all sectors reported implementing community practice changes and new evidence-based prevention strategies
- participants used technological supports to share information (e.g., evaluation findings, implementation resources, and training videos on relevant topics—including cultural competence)

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Applying Adaptation Protocols in a Practice Setting: An Overview and Case Study

Citation	Marsiglia, F. F., & Booth, J. M. (2014). Cultural Adaptation of Interventions in Real Practice Settings. *Research on Social Work Practice*, 25(4), 423–432. doi:10.1177/1049731514535989
Description	Culturally and contextually tailored prevention interventions with strong evidence supporting their effectiveness should be implemented when possible and appropriate. However, in the absence of an evidence-based intervention designed and tested for the population of interest, adaptation can be more viable and cost-effective. An overview of common challenges and opportunities related to cultural adaptation of behavioral interventions are presented along with a step-by-step outline of an adaptation protocol for practitioners to use as a guide in their adaptation efforts. A case study is presented where a systematic approach to adaptation was successfully applied.
Population	Not specified
Settings	Not specified
Evaluation Design	Through a non-systematic review of the literature, the authors discuss a general approach to guide cultural adaptation efforts as well as provide a more detailed outline of a cultural adaptation protocol. A case study is also presented.
Evaluation Outcome(s)	• The conflict between implementing evidence-based interventions with fidelity versus adapting them to achieve a better cultural fit is discussed. • Three steps involved in all adaptation models are outlined: (1) determining that cultural adaptation of an intervention should be pursued; (2) identifying mismatches between the original intervention and the client's culture; and lastly, (3) testing/evaluating changes that have been made to rectify these disparities. • The Centers for Disease Control and Prevention (CDC) approach to intervention adaptation is outlined starting with the selection of an empirically backed intervention based on the initial assessment of the targeted population and ending with pilot testing to ensure that the effects of the original intervention are maintained after changes have been applied. The approach strongly discourages adaptors to change the deep structures of the intervention. • The case study explores the process involved in the successful adaptation of a substance abuse prevention program which while maintaining its core elements, changed its content and structure to be more culturally relevant to Native American youth.

Prevention Infrastructure in States Receiving Strategic Prevention Framework Incentive Grants

Citation	Orwin, R. G., Stein-Seroussi, A., Edwards, J. M., Landy, A. L., & Flewelling, R. L. (2014). Effects of the Strategic Prevention Framework State Incentives Grant (SPF SIG) on state prevention infrastructure in 26 states. *The Journal of Primary Prevention*, 35(3), 163–180. doi:10.1007/s10935-014-0342-7
Description	The Strategic Prevention Framework State Incentive Grant (SPF SIG) program is a national public health initiative sponsored by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention. The 26 state grantees used a data-driven planning model to allocate resources to 450 communities, which launched over 2,200 interventions to target substance abuse prevention. An additional goal was to build prevention capacity and infrastructure at the state and community levels, specifically across the following infrastructure domains: strategic planning; data systems; workforce development; the use of evidence-based programs, policies, and practices; evaluation and monitoring; and cultural competence. This paper addresses whether the state infrastructure goal was achieved and what contextual and implementation factors were associated with success.
Population	Not specified
Settings	State and community level
Evaluation Design	Two rounds of structured interviews were conducted with state agencies using an instrument developed to quantitatively assess the components of states' substance abuse prevention infrastructure. Supplemental interviews were conducted to assess implementation of the strategic prevention framework. All responses were coded and scored. Additionally, state strategic plans were reviewed and coded to assess the strength of the linkage states made between needs assessment results and decisions about substance use-related prevention priorities.
Evaluation Outcome(s)	• Overall, the SPF SIG program met its goal of increasing prevention infrastructure across multiple domains, though the mediating effects of implementation were evident only in the evaluation/monitoring domain. • Across the six domains, states scored highest on data systems and lowest on strategic planning. Positive associations were found among the domains, indicating that states with higher capacity on one domain generally have higher capacity on others as well. • The cultural competence domain was weakly correlated with the other domains. Rather than being treated as a separate domain, questions targeting cultural competence were embedded in the Round 2 interviews on the use of evidence-based programs, policies, and practices; strategic planning; and workforce development.

VII. Definitions and Additional References

A. DEFINITIONS

This appendix includes definitions of key terms relevant to culture competence used by the published articles identified through this literature review.

Cultural Competency Term	Definition	Reference
Cultural Adaptation	Modifying an intervention to be culturally appropriate to a specific population. Adaption can be surface-level, for example translating materials to a client's native language, or it can be at a structural-level, upholding the worldview and values of the population, for example, incorporating a population or community's value of family into the design of an intervention.	**Wang-Schweig et al., 2014**
Linguistic Equivalence	Considering language, grammatical construction, syntax, and local word choices to ensure clarity of meaning when delivering services to a given population. Note that the use of metaphors and turns of phrase might hinder program delivery.	**Gonzalez & Tricket, 2014**
Implicit Cultural Bias	Cultural biases that perpetuate stereotypes and prejudices often expressed automatically and without awareness. Implicit cultural bias can harm prevention efforts and undermine treatment outcomes.	**Blume et al., 2016**
Culturally Grounded	A program is culturally grounded when it is developed from the "ground up" with attention to the cultural values, practices, and beliefs of the target population. This is in opposition to adaption, wherein program components are modified from their original version.	**Okamoto et al., 2014**

Cultural Competency Term	Definition	Reference
Cross-Sector Collaboration	When individuals representing different community sectors exchange information and resources to improve program efforts. For example, health care professionals might collaborate with schools to administer a prevention strategy targeting youth in the community. Cultural competency efforts that utilize cross-sector collaboration can broaden the impact of an intervention.	**Anderson et al., 2014**
Multipronged Approach	Combining multiple strategies simultaneously to reach different subpopulations or address multiple risk factors, such as combining public awareness campaigns, educational outreach, and skill-building activities.	**Ford et al., 2013**
Community Advisory Board	A Board of individuals from the community who can support and guide program development and implementation. Members of the program's target population should be represented on the Board to provide feedback on the cultural appropriateness.	**Langdon et al., 2016**
Conceptual Framework	A multistep model guiding the development of a program, strategy, organization, etc. In the context of culture competence, a basic conceptual framework might include steps such as: (1) use a theory to identify and select key constructs most likely to be culturally dependent; (2) review the literature to determine how culture might influence these constructs; and (3) incorporate culturally based constructs and their relationships into developing the intervention.	**Wang-Schweig et al., 2014**

B. ADDITIONAL REFERENCES

Three additional references were cited in the Introduction section, beyond those identified through the literature review (see Section VI for those citations):

Burlew, K., et al. (2012). Increasing Ethnic Minority Participation in Substance Abuse Clinical Trials: Lessons Learned in the National Institute on Drug Abuse's Clinical Trials Network. *Cultural Diversity and Ethnic Minority Psychology*, 17(4), 345–356.

SAMHSA. (2014). *Improving Cultural Competence. Treatment Improvement Protocol* 59. Retrieved from https://store. samhsa. gov/system/files/sma14-4849. pdf

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