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Evaluating a community-based program within multi-ethnic communities: examining the outreach and engagement program of MECCA

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EVALUATING A COMMUNITY-BASED PROGRAM WITHIN MULTI-ETHNIC COMMUNITIES: EXAMINING THE OUTREACH AND ENGAGEMENT PROGRAM OF MECCA

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TABLE OF CONTENTS

Page

LIST OF TABLES

Page

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ABSTRACT

The present study includes a program evaluation to assess the extent to which a community-based multiethnic program, specifically the Outreach & Engagement (O&E) Program of the Multi-Ethnic Collaborative of Community Agencies (MECCA) adhered to Community-Based Participatory Research (CBPR) principles as intended in its development and implementation. A post-reflection discussion, which included questions that were guided by the Community-Based Participatory Research Evidence-Based Curriculum, with the O&E Program Evaluator determined the extent to which each CBPR principle was fulfilled. Thematic findings from the post-reflection discussion highlighted many strengths, as well as areas of improvement within the research-community partnerships. MECCA's O&E Program proved to successfully apply and incorporate CBPR principles within a county-funded framework, as well as demonstrated ways to simultaneously serve and collaborate with a multitude of multi-ethnic communities. Additional research is needed with applying CBPR principles simultaneously with various multiethnic communities and its' potential influence on the development, implementation, and evaluation of CBPR programs.

KEYWORDS**:** *community-based participatory research, CBPR principles, program evaluation, multicultural communities, MECCA, post-reflection discussion*

Introduction

Multi-Ethnic Collaborative of Community Agencies

The Multi-Ethnic Collaborative of Community Agencies (MECCA) in Orange County, California, consists of six ethnic and linguistically-isolated community mental health agencies. The six agencies serve different communities, specifically the Spanish-speaking, Arabic-speaking, Korean-speaking, Farsi-speaking, and Vietnamese-speaking communities. The collaborative agencies include ABRAZAR, ACCESS California Services (ACCESS), Korean Community Services (KCS), Omid Multicultural Institute for Development (OMID), Orange County Children's Therapeutic Art Center (OCCTAC), and Vietnamese Community of Orange County Inc. (VNCOC). The MECCA coalition was developed in 2010, in response to the Mental Health Services Act (2004), which initiated a necessary focus on prevention, early intervention, and provision of services to support community mental health programs. The collaborative of agencies unified to provide resources to communities with a long history of being underserved and neglected of culturally responsive services.

Across the MECCA coalition, two county-funded programs were conducted: the Early Intervention Program for Older Adults (EISOA) and the Outreach and Engagement Program (O&E). The O&E program officially ended in October of 2015. Both programs focus on the provision of culturally-responsive resources by community staff members to serve and empower community members to achieve their goals. The Outreach and Engagement Program, which will be the primary focus of this study, strived to decrease the stigma associated with mental health and prevent mental health difficulties through referring and linking members with culturally-responsive services and agencies. Staff also engaged community members through agency-

specific and MECCA workshops and services to prevent mental health difficulties in a manner that was culturally-congruent and meaningful to the communities.

The O&E program offered a variety of different services, including mental health, medical, legal, and social services. The mental health services provided by the O&E Program included both individual and group interventions (i.e., psychoeducational, support, skill-building, case management) that focused on normalizing difficulties that many members within these cultural communities experienced, as well as providing psychoeducation and skills that would be utilized and meaningful within their lives. Although there was some overlap of group topics across MECCA, the group topics were generally specific to the communities being served. Examples of groups or classes included: learning English, cooking, playing musical instruments, sewing, dance, and other skills-based activities.

Rationale and Importance

The nation's fastest growing populations are ethnic populations, currently comprising 36.6% of the U.S. population (U.S. Census Bureau, 2012a). Diverse communities are projected to increase annually and by 2043, it is expected that the U.S. will become a majority-minority nation with the absence of a majority group (U.S. Census Bureau, 2012b). By 2060, it is projected that multi-ethnic individuals will comprise 57% of the population (U.S. Census Bureau, 2012b), which indicates a pertinent need for culturally diverse community services and intentional focus on expanding awareness of the varying needs of multi-ethnic community members.

Due to the prevalence of mental health issues and potentially aversive impact on ethnic communities, it is imperative to understand how to appropriately reach this growing population, fulfill their needs as specified by them, decrease the stigma associated with mental health

treatment, and utilize culturally congruent methods of alleviating their distress. Researchers and clinicians can positively impact the lives of community members through their relationships and provision of culturally responsive services. Additionally, community and social engagement can improve the well-being of many community members that are experiencing physical and emotional symptomatology (Park, 2009).

Prior to the provision of services, researchers have to be cognizant of different factors, such as treatment accessibility and individual client factors, that may impact a community member's approach and willingness to receive treatment (Appel & Oldak, 2007). Research supports that older adults from ethnic communities are less inclined than their Caucasian counterparts to endorse mental health symptoms or receive treatment (Sorkin, Pham, & Ngo-Metzger, 2009); thus, such findings highlight the need to promote mental health awareness and culturally responsive coping resources to the younger generation of ethnic communities. This will likely decrease mental health stigma and increase the community member's sense of trust in the mental health care services throughout their lives (Munson et al., 2011). There can be different factors that have contributed to the stigma and barriers associated with mental health services for younger adults, including: lack of awareness of mental health symptoms and available services, fear of psychotherapy, and low self-esteem in one's ability to feel better through treatment (Pepin, Segal, & Coolidge, 2009; Vanheusden et al., 2008). However, through surrounding young adults with mental health support, they are more likely to seek services and ultimately prevent serious mental and medical health consequences throughout their communities (Gulliver, Griffiths, & Christensen, 2010; Munson et al., 2011).

Stigma Associated with Mental Health

Many multicultural communities have greater stigma towards mental health, which encompasses discrimination and shame towards mental health services and consumers of mental health (Corrigan, Druss, & Perlick, 2014; Knifton et al., 2010; Rastogi, Massey-Hastings, & Wieling, 2012). The different levels of stigma, including internalized, social, and structural, impact an individual's comfort and willingness to access mental health resources (Link & Phelan, 2001). Internalized stigma is shame that occurs within an individual out of fear of anticipated discrimination (Link & Phelan, 2001). Social stigma can result from interaction with family members, friends, and fellow community members. Structural stigma can also occur in which discrimination is infiltrated in the media, cultural values, and legal system (Link & Phelan, 2001).

Due to the prevalence of mental health stigma in ethnic communities, there is a significant decrease in the number of individuals that seek necessary services and their experience of the provided services (Dow, 2011; Lam et al., 2009; Shah & Beinecke, 2009). Additionally, the number of individuals that seek services is considerably less than the number of individuals that need mental health services due to mental health stigma or agency-specific limits on the volume of individuals that can be served (Chang, Kwan, & Sevig, 2013; Gary, 2005; Henderson, Evans-Lacko, & Thornicroft, 2013). In many cases, stigma is depicted as fear of being looked down upon and consequently not accepted within one's community. For instance, Latino and Asian-American communities strive to avoid shame and maintain a positive image within their respective communities through adhering to cultural and familial expectations of "saving face" (Jimenez, Bartels, Cardenas, & Alegria, 2013, p. 1066). In order to accurately understand the manner in which stigma is manifested in different communities, as well as

intervene with culturally-responsive techniques, a community approach and partnership should be utilized (Knifton et al., 2010).

Specific Aims

This study intended to add to the current literature in three ways. The first objective was to provide literature on the participatory action research framework and need for evaluating community programs within this model. The second objective was to examine the need and prevalence of outreach programs. The third objective was to conduct a program evaluation to evaluate the extent to which MECCA's programs, specifically the O&E program, adhered to Community-Based Participatory Research (CBPR) principles as intended in its development and implementation.

Traditional versus Community-Based Frameworks

Traditionally, many research frameworks include a researcher from an academic organization entering a community and conducting research as he/she fits. Mertens (2009) states that researchers who typically evaluate the viability of programs are not members of the communities served nor experience the direct benefits of the research programs (as cited in Robinson, Fisher, & Strike, 2014); instead, researchers engage with communities through participating in "helicopter" research (Bilodeau et al., 2009, p. 193), which solely benefits the researcher and neglects community members. Researchers generally use traditional approaches and measures from an adapted top-down approach that are then superficially modified for cultural considerations (Blume & Lovato, 2010). Community members are typically only recipients of program services and do not partake in consultation, development, and evaluation of services and programs (Kidd & Kral, 2005; Robinson et al., 2014). However, research with multicultural communities has illustrated the unique intricacies of working with specific

communities and the need for researchers to be exposed to a comprehensive and unadulterated understanding of community-specific mental health issues and culturally-tailored and responsive interventions (Bilodeau et al., 2009; Bogart & Uyeda, 2009; Morisky et al., 2010). Inclusive, non-traditional approaches to evaluation strive to empower targeted members and collaborate with them during all stages of project implementation and evaluation (Bogart & Uyeda, 2009; Kidd & Kral, 2005; Mendez-Luck et al., 2011; Robinson et al., 2014). Through such collaboration, community members are positioned in roles of power and greater equality exists between academic institutions and community members (Robinson et al., 2014). In an effort to understand the subjective realities of community members, there is a significant need for researchers to collaborate with community members from the beginning of the research process and utilize the cultural community values as the infrastructure of the overall process (Blume & Lovato, 2010; D'Alonzo, 2010; Glassman & Erdem, 2014). It is important to understand the subjective experiences of the individual and "human action as it exists" (Glassman & Erdem, 2014, p. 214), which with the growing ethnic communities and cultures requires culturally unique and diversified approaches and perspectives (Baiardi, Brush, & Lapides, 2010).

Researchers may benefit from such collaboration through utilization of Participatory Action Research (PAR), which is the "creation of context in which knowledge development and change might occur" (Kidd & Kral, 2005, p. 187) through the reciprocal sharing of participant and researcher values during the research process (Bogart & Uyeda, 2009). Rhodes et al. (2007) posited that when culturally appropriate treatments do not exist, "traditional 'outside-expert'" (p. 3) approaches to research and practice often result in ineffective interventions (as cited in Morisky et al., 2010). In various fields of study, when compared to traditional frameworks, community-based participatory research has been shown to lead to more effective interventions,

culturally appropriate delivery and experience of services, and increased community capacity (Bogart & Uyeda, 2009; Morisky et al., 2010). This process flourishes on the flexibility of researchers and participants in being open to differing perspectives, beliefs, manners to serve and relate to the community, while simultaneously staying committed to the shared vision and community-specific values and issues (Bogart & Uyeda, 2009; Kidd & Kral, 2005; Viguer, Rodrigo, & Sole, 2013). Additionally, it is important to meet community members where they are within the context of their lives, understand their subjective realities, and bear witness to their experiences, while simultaneously collaborating with them in effecting positive change within their lives. Community-based participatory research protects community members from being the subjects of a researcher's study, but rather ensures that they are co-leaders and experts in shedding light on meaningful community-specific issues that are being studied.

Conducting community-based participatory research. Community-based participatory research, which is founded on relational and cultural involvement throughout the research process, necessitates an overall paradigm shift from traditional research frameworks. The relationships established serve as the backbone of the framework and research is conducted *with* communities, rather than *on* communities (Bazzano et al., 2009; Bogart & Uyeda, 2009; Dalal, Skeete, Yeo, Lucas, & Rosenthal, 2009; Morisky et al., 2010). The community-based participatory researcher is consistently working towards the needs of the community members even prior to the start of the research study, including a pre-research period, research project phase and collaboration with the community, and post-research considerations. This is a process that is driven by the research team's desire to serve the communities that they are collaborating with and engage in a process of mutual appreciation of multiple perspectives, co-learning, equal participation, and strengthening existing strengths through the research process (D'Alonzo, 2010;

Morisky et al., 2010; Pastor-Montero et al., 2012). Unlike traditional researchers, community-based participatory researchers demonstrate their investment and dedication to the community through interacting with community members, researching community-decided questions, and advocating for community-specific needs and issues (D'Alonzo, 2010; Morisky et al., 2010). Throughout the stages of this model, particularly within the pre-research period, equality and empowerment of all members, strengthening of relationships with community stakeholders, and quality of relationships (i.e., levels of intimacy and trust) are all highlighted as variables corresponding to the viability of the program (D'Alonzo, 2010; Dietz et al., 2012; Glassman & Erdem, 2014; Morisky et al., 2010; Pastor-Montero et al., 2012). Each stakeholder provides a valuable perspective on distinct areas of the research and through the knowledge generated from this relational process, individuals are better informed on how to interact with one another and meet community needs. This unremitting process "requires a…cyclical process of discovery and realization" (Glassman & Erdem, 2014, p. 209) that benefits all stakeholders (Morisky et al., 2010). Within this framework, appropriate time and investment in the pre-research period are critical factors in the overall success of the project as they significantly determine how well the researchers and community members can work together to draw attention to community needs, realize how best to serve community needs, and effect positive and lasting change within the community (D'Alonzo, 2010; Hsu, Wang, Chen, Chang, & Wang, 2010; Morisky et al., 2010). Unlike traditional research frameworks through which the research process is driven by the beliefs and needs of the Principal Investigator (PI), community-based participatory action research is driven by the needs and beliefs of community members and allows for research to be implemented into action (Bilodeau et al., 2009; D'Alzono, 2010). Within this framework, community engagement and collaboration are necessary to understand the impact of the research

on the community (Ahmed & Palermo, 2010; D'Alonzo, 2010). Thus, during this beginning and fundamental stage, it is essential that the researcher select a community-advisory board that includes prominent community leaders that serve as the backbone for the direction of the current and future research (D'Alonzo, 2010; Morisky et al., 2010).

Researchers respect community members as the true experts on their lives, as well as view themselves as facilitators and empowering-agents in the process of change (D'Alonzo, 2010). Within this strength-focused orientation is a prominent focus on community-specific needs and shared processes of learning, as well as an openness and flexibility towards understanding, growth, and action (D'Alonzo, 2010; Glassman & Erdem, 2014; Kidd & Krol, 2005; Pastor-Montero et al., 2012; Ponder-Brookins et al., 2014; Thomas, Donovan, & Sigo, 2010). The community determines the problem area, how best to intervene to benefit the community, and establishes boundaries of the areas and community truths that can be evaluated. This deep understanding of the community partner is a byproduct of the relationships, level of communication, and transparency throughout the research process. Due to the collaborative nature of the research framework and reduced power differentials between academic researchers and community members, designed interventions are consequentially more culturally congruent and meet the needs of various stakeholders involved in the research (Morisky et al., 2010).

In order to ensure full involvement of community members and reliable discovery of information through the data, it is essential that community members are involved in deciding through a culturally competent and aware manner the type of research that will be conducted and how it will be evaluated (D'Alonzo, 2010; Oscos-Sanchez, Lesser, & Kelly, 2008). These research methods will depend on the goals of the community members and evaluation methods that they regard as acceptable and appropriate. Community members must be comfortable with

the study design and data collection methods (e.g., qualitative, quantitative, mixed methods) (D'Alonzo, 2010). Additionally, prior to the data collection phase, researchers and community members should thoroughly discuss the process of data collection, identify the administrator(s), and empower staff to administer, score, and interpret measures. A detailed and sincere discussion of cultural and ethical issues that may be experienced should be addressed and effective coping reviewed (D'Alonzo, 2010).

Within this framework, after measures have been administered and research conducted, researchers remain in contact with community members and engage in a reflective process to better understand areas of strength, relative weaknesses, potential future modifications, and overall evaluation of the process (D'Alonzo, 2010; Glassman & Erdem, 2014). Glassman and Erdem (2014) noted that there are "not any preconceived ideas that lead to this transformation, but education that engenders an action, research, and reflection cycle" (p. 219). Researchers have stressed the importance of learning and new discovery that requires a consistent, cyclical process of reflection and openness to experience (D'Alonzo, 2010; Kidd & Kral, 2005; Macaulay & Nutting, 2006; Pastor-Montero et al., 2012). Glassman and Erdem (2014) stated "researchers need to always be working from the perspective that they may not actually understand what they think they understand" (p. 209) and should consistently collaborate and consult with the community, apply and test interventions, and modify as necessary (Glassman & Erdem, 2014). Similarly, D'Alonzo (2010) conceptualized participatory action research as "dancing the mambo," (p. 288) such that with every step forward knowledge is gained and with every step backward active reflection is facilitated. Researchers take a step back, modify their approach, and refocus on the well-being of the community members. It is important to note the needs of communities are likely to change throughout the course of the researcher-community

partnership. To such a degree, interventions also change as needs change and are consistently modified to fulfill the real-life needs of the members (D'Alonzo, 2010; Glassman & Erdem, 2014).

Program evaluation. Evaluation is a tool that allows for a depiction of the impact that a program may be having on individuals, as well as provides a blueprint to improve current or future programs (Baron-Epel, 2003). A program evaluation provides information about challenging areas in the development and implementation of programs, ways to overcome barriers and challenges, and programmatic strengths (Chyung, Wisniewski, Inderbitzen, & Campbell, 2013). Program evaluations are generally focused on intervention outcomes to identify programmatic success within a given time-period (Hsu, Wang, Chen, Chang, & Wang, 2010), while benefits of community engagement are generally not acknowledged nor appreciated (Ahmed & Palermo, 2010). Although the numerical results gained provide context to the number of interventions delivered and utilized, they discount other programmatic impacts and do not provide an accurate and comprehensive description of the results.

With a focus on reducing health inequalities, researchers strive to deliver culturally responsive services "that focus on risk reduction, vulnerability reduction, and promotion and protection of human rights" (Flaskerud, 2007b, p. 432). Culturally responsive services and cultural competence are learned through community engagement and partnership; thus, calling forth for community-based participatory research that relies on open communication, health promotion, and interaction with the communities served (Flaskerud, 2007b; Letcher & Perlow, 2009). Rather than viewing the community as the setting in which the research takes place in, community-based participatory research views the community as a "unit of identity" (Macaulay & Nutting, 2006, p. 4) that yields increased relevance to members and overall greater ecological

validity (Macaulay & Nutting, 2006). Similarly, Blume and Lovato (2010) stated that "the community is as much a client in the therapeutic relationship as the individual" (p. 192) and it is important to "increase collective efficacy in the context of the community" (p. 193) to maximize the opportunity for positive change. One must understand the community, attune to the community experience, and provide treatment under the leadership of the community in order to provide culturally-responsive treatment. Within community psychology, program evaluation is similar to other types of research in that researchers collaborate with community members and leaders to encourage program modification and improvement to satisfy all stakeholders (Patel et al., 2009; Wolff, 2014). Although inclusive participatory methods of evaluation are infrequently used, they are beneficial in endorsing community engagement and improving programs to benefit individuals as they deem fit (Robinson et al., 2014).

Community-based participatory research (CBPR) evaluations have proved to be efficacious with a myriad of programs and contexts focusing on a variety of complex health and developmental challenges, such as parenting programs in the Latino population, HIV risk reduction among heterosexual Black men, facilitating factors and barriers in implementing a trauma focused program after a natural disaster, and interventions for child sexual abuse (Allen et al., 2013; Kataoka et al., 2009; Reid, Reddock, & Nickenig, 2014; Wilson et al., 2014). In a study by Hsu et al. (2010), they state that many health programs have shifted their strong focus on program outcomes to program process, which accounts for the quality and extent of community partnerships. As community partnerships are growing in the fields of health research, there has been an improvement in the quality of research conducted and greater clinical applicability of data into real community change (Ahmed & Palermo, 2010; McKinney et al., 2014).

Similarly, in a study by Robinson et al. (2014), they discuss the infrequency by which participants are included in program evaluations, specifically those from more vulnerable populations. They specifically discuss the meager literature surrounding the experience of individuals with cognitive disabilities (Robinson et al., 2014) in evaluation, both as program evaluators and informed, proactive participants. The study discusses the importance of utilizing those from the target population, such as an evaluator with a "cognitive disability" (Robinson, Fisher, & Strike, 2014, p. 499) to empower individuals and demonstrate to both the population and overall community the strengths of the individuals and population. Additionally, the unique lived experiences of individuals involved in the research and evaluation are valuable and participants may resonate more with evaluators and stakeholders with similar life experiences. Researchers who worked one-on-one with the participants and asked the research questions received distinct information depending on their nature of involvement in the target community and if they were an insider or outsider within the community. Thus, in the study, one of the main researchers who himself had a cognitive impairment noted that he was able to receive deeper responses from participants when they identified with him. The responses of the participants were impacted by the researcher's experience and level of identification within the target community. Through utilizing an inclusive approach to evaluation, it encourages and allows for equal opportunities and decision-making across all phases of evaluation and overall systemic positive change for marginalized populations. It is especially important to collaborate with community members as the evaluator's understanding of the community and sociocultural reality will impact how the evaluation is conducted, knowledge generated, and obtained. Additionally, the unique experiences of the evaluators will inform the process of evaluation, measures utilized, and method of analysis (Robinson et al., 2014).

In a study by McKinney et al. (2014), a community-based nutrition curriculum and program, NuFit, was adapted for Latino and African-American adolescents in Chicago. The study combined community-based participatory research and peer education to create the curriculum. Through the involvement of community stakeholders and adolescents, the study yielded more critical guidance and unique perspectives from those the curriculum served. This allowed for cultural and group relevance, as well as viability of the curriculum. NuFit was consistently modified based on the experiences of the peer educators. Students in the intervention group improved in nutrition and fitness behaviors, as well as attitudes toward nutrition and fitness. The input of the parents, peers, and adolescents involved in the study aided in the adaptation, implementation, and evaluation process and highlighted areas of need for the adolescent population. Through collaborating with adolescents, the study was able to learn about more sociocultural implications that impacted adolescents and the need to focus on community and parental involvement in addressing obesity rates in adolescents. Through the knowledge obtained from the study, modifications to the curriculum can be implemented to improve health rates and eventually lead to greater improvement in school-based initiatives (McKinney et al., 2014).

In a study by Shetgiri et al. (2009), researchers demonstrated the benefits of conducting community-based participatory research and discussed lessons learned that could be applied to existing CBPR programs. Shetgiri et al. (2009) reached out to Latino adolescents (11-17 years) in the Los Angeles area, their parents, and community representatives from local organizations to determine their individual and possible culturally influenced definitions of youth success, barriers to success, and facilitators of success. Thus, in an effort to further understand the depth of culturally-specific risk and protective factors, this learning experience entailed a collaborative

process of answering and defining experiences and instances that are relevant to the Latino adolescent population to address their needs and positively impact the community. Researchers and the community learned how these specific Latino adolescents understand and experience success, risk and resilience factors to success, and the similarities and discrepancies between their views and those of their parents and local representatives. Researchers have applied the knowledge obtained to effect meaningful change within the community. For example, only through understanding the community-needs and conducting qualitative interviews to understand their experience of this particular topic were researchers able to ascertain how to improve the community's resources and lead to community action. From the knowledge gained through this study, community leaders have collaborated with community agencies and academic institutions to create mentoring, parenting, and school-based resiliency promotion programs. This study on community-academic partnership promoted culturally-appropriate support of Latino adolescents and encouraged consistent evaluation of community-academic programs (Shetgiri et al., 2009).

Need and prevalence for outreach programs. Many specialized fields of study around the world, such as medical and mental health, have utilized outreach programs to engage cultural communities that they traditionally would not have access to because of varying factors (Elissen, Van Raak, Derckx, & Vrijhoef, 2013; Khampahakdy-Brown, Jones, Nilsson, Russel, & Klevens, 2006). Ng and McQuistion (2004) defined outreach to be a treatment method for engaging isolated and underserved populations (as cited in Elissen et al., 2013). Outreach aims to achieve many goals, such as prevention of distinct issues, raising awareness, and reaching individuals that typically would not be accessible (Mier, Boone, & Shropshire, 2009). For underserved and isolated communities, there are numerous barriers to accessing resources; therefore, many organizations utilize a myriad of outreach interventions to connect with these communities.

Some barriers that may exist include a lack of awareness of available resources, stigma associated with associating one's self to a medical or mental health issue, individual and community consequences, and lack of available linguistically and culturally responsive services (Khampahakdy-Brown et al., 2006). For mental health treatment and services, outreach often includes a psychoeducational component to promote awareness of mental health, decrease mental health stigma, and overcome additional barriers to accessing mental health treatment for many underserved populations, including: refugees, homeless individuals, persons living with HIV/AIDS, students, veterans, and multicultural communities impacted by natural disasters (Eilssen et al., 2013; Khampahakdy-Brown et al., 2006; Matthieu, Gardiner, Ziegemeier, & Buxton, 2014; Mier et al., 2009; Rajabiun, Cabral, Tobias, & Relf, 2007; Rosen, Greene, Young, & Norris, 2010).

Although many community agencies provide psychoeducational interventions to those individuals requesting them, a challenge for many community agencies is the manner in which to connect and reach multi-ethnic community members prior to their decision and often last-resort of visiting a community-based agency for support. Khampahakdy-Brown et al. (2006) recommend being more "mobile and creative in reaching out... helping them receive the services they need rather than expecting them to come to us" (p. 45). Many workshops are targeting more general topics, such as domestic violence of women, rather than the intricacies apparent in domestic violence in different ethnic groups. In an effort to target a broader population and avoid cultural mishaps, individual and cultural challenges have at times been neglected (Khampahakdy-Brown et al., 2006). As Rosen et al. (2010) stated, individuals respond to different situations uniquely dependent on the impact of various variables within their lives, such as ethnicity and language. Subsequently, influenced by these various variables, individuals then

experience and receive outreach interventions differently. There is a paucity of literature on how to target a myriad of cultural communities in culturally- responsive and meaningful ways. Interventions and programs that are more specifically tailored to the targeted communities are able to reach more individuals and effect lasting change in their lives (Rosen et al., 2010). There are a variety of interventions often offered by agencies to aid individuals including psychoeducation workshops, therapy or counseling, advocacy and case management, home visits, one-on-one in person meetings, and support; however, these interventions are beneficial when they are modified to meet the cultural needs of community members. Thus, in order to be experienced as impactful and valuable, agencies need to understand the interventions within the context of the lives of the individuals they serve. Due to the great number of barriers and stressors that an individual experiences, their experience or need of interventions, such as therapy, may be different. For example, members from underserved populations with highly stressful life experiences are more prone to benefit from solution-focused therapies, rather than insight-oriented approaches (Khampahakdy-Brown et al., 2006). Another component that many agencies are starting to consider and some currently use is providing "bicultural-bilingual" (Khampahakdy-Brown et al., 2006, p. 42) services to these communities. However, there is very little understanding regarding how these two aspects are operationalized, measured, and guaranteed within the community, and more research is necessary to understand the quality and ethics of these approaches.

Ethical challenges & culturally responsive framework. Within the mental health field, psychologists are guided by a code of ethics to protect their clients and participants in research. According to the American Psychological Association's Ethical Principles & Code of Conduct (American Psychological Association, 2010), psychologists are committed to the principles of

Beneficence and Nonmaleficence, Fidelity and Responsibility, Integrity, Justice, and Respect for People's Rights and Dignity (American Psychological Association, 2010). In working with multicultural communities, it is necessary to take extra steps to ensure that clinical work and research projects are ethical in nature, as well as protect the participants and clients involved from both clinical and cultural standpoints. These extra steps often positively impact the quality of the interaction; thus, research will be implemented through interacting with members from a place of acceptance and attunement, use of diverse methods to understand others, and ultimately empowering them to take ownership of their lives (Ponterotto, 2014). If researchers attempt to serve communities from traditional and longstanding frameworks, it becomes increasingly necessary to reevaluate what it means to provide culturally-responsive care, how researchers can expand their understanding of cultural communities through collaborating with them, and how various interventions must be changed to meet the growing multicultural communities (Blume & Lovato, 2010; Flaskerud, 2007a). Gallardo, Johnson, Parham, and Carter (2009) stressed the importance of having culturally-responsive care as the foundation for the work that clinicians do with patients and the importance of increasing our understanding and knowledge about cultural variables that impact all stages of clinical work and research. In engaging with individuals as cultural beings, it is important to consider potential challenges and ethical practices, while simultaneously conceptualizing, interacting, and serving individuals in a culturally responsive way.

Trimble, Scharrón-del Río, and Casillas (2014) suggest the focus of ethical research practice calls for the application of responsible and respectful research practices, which requires trusting relationships with communities, validation of the experiences of community members, and empowering community members. Many ethnic communities have been historically

disempowered either in their country of origin or in the United States. Concordantly, when conducting community-based participatory research, researchers need to expand their expectations and understanding of ethical and culturally responsive care.

Researchers should be flexible in their style of interaction and engagement with research participants, and individualize them based on the individual characteristics and cultural values. It is essential to check-in with participants throughout all aspects of the research (D'Alonzo, 2010; Dietz et al., 2012; Glassman & Erdem, 2014; Morisky et al., 2010; Pastor-Montero et al., 2012) to ensure the ethical nature and adherence to the CBPR framework. For instance, in many cultures, it is a sign of disrespect for researchers to communicate via methods other than in-person visits with community members (D'Alonzo, 2010). Community members are voluntarily contributing to the research experience and willingly providing valuable information that would otherwise be unavailable; thus, researcher appreciation, flexibility, patience, and understanding of community-specific cultural values are fundamental to the success of the partnership and adherence to ethics. As a researcher, who is typically an "outsider" (p. 286) to the community, one needs to remain committed to the process, accept that the process will likely take additional time, and that it may entail challenges that may not be encountered in traditional research frameworks (D'Alonzo, 2010). Blume and Lovato (2010) discuss how individuals from ethnic communities respond differently than their Westernized counterparts to various concepts, such as time. Ethnic communities prefer more thoughtful processes and intention-driven goals, rather than experiencing a sense of urgency in fulfilling goals. Thus, when working with ethnic communities, it is necessary to have a comprehensive understanding of community approaches and concepts. In the process of expanding understanding, the relationship gains both ethical merit and harmonious balance within the experience and relational style.

Mikesell, Bromley, and Khodyakov (2013) included a comprehensive list of strategies provided by Macaulay et al. (1998) to ensure ethical community-based participatory research, such as: engaging community members at all stages of the research, facilitating open and genuine communication about the process, needs, and research protocols, developing community-advisory boards to aid in culturally responsive care and understanding, and developing community review boards to ensure that community needs are at the forefront of the research and are being targeted. One of the most unique aspects of successful community work is the strong reflective stance of all the stakeholders involved and cyclical, dynamic process throughout the collaborations (Glassman & Erdem, 2004; Kidd & Kral, 2005; Macaulay & Nutting, 2006; Pastor-Montero et al., 2012). Furthermore, Macaulay et al. (1998) encouraged cultural humility to promote ethical engagement, which is described as genuine consideration and appreciation of the individuals involved, negotiating funding procedures with a fundamental understanding of the cultural and community needs, and focusing on the research design (as cited in Mikesell et al., 2013).

Approach

This study aimed to conduct a program evaluation to evaluate the extent to which the O&E program adhered to Community-Based Participatory Research (CBPR) principles, as intended in the development and implementation of MECCA and its' programs. Although the O&E program is not running anymore (2012-2015), reflection on past outcomes and community partnerships is valuable in understanding the strengths and areas of improvement for effectively working and serving multicultural communities. Community-Based Participatory Research is an approach to research that is founded on collaboration and equal involvement between the research-community partners (Flicker, Travers, Guta, McDonald, & Meagher, 2007). The CBPR

approach recognizes and appreciates the unique strengths of each partner and involves all members in the different phases of research (Horowitz, Robinson, & Seifer, 2009). More specifically, it aims to provide an ethical and culturally responsive engagement between community-academic partnerships in which community members are equally involved at the three levels of research: (a) Input: communities decide research ideas and projects, (b) Process: communities are involved throughout data collection, analysis, and interpretation phases, and (c) Outcome: communities utilize the knowledge gained for action within the communities (Flicker et al., 2007). Thus, the CBPR approach promotes inclusive involvement and authentic sensitivity to the concerns of community members and empowers them in determining the manner in which these concerns will be recognized and findings disseminated.

According to Israel, Eng, Schulz, and Parker (2012), CBPR is founded on nine guiding principles that are established for collaborations to aspire to, but the extent to which they are fulfilled is different by the specific collaborations. It is believed that the greater adherence and incorporation of all the CPBR principles will promote improved programmatic outcomes, address community and partnership concerns, and eventually lead to systemic change (Ponder-Brookins et al., 2014). A CBPR approach involves a process of gaining knowledge about community health through partnerships in an effort to encourage action and social change within the community, improve community health outcomes, and eliminate health disparities (Flicker et al., 2007). This study examined the principles that the research team adhered to in the development and implementation of the program, as well as areas that could have been further incorporated throughout the process. The CBPR principles are provided in Table 1 (Belansky, Cutforth, Chavez, Waters, & Bartlett-Horch, 2011; Israel et al., 2012) and descriptive information for each principle is provided in Appendix 1.1 (Israel et al., 1998; Israel et al., 2012).

Table 1

Community-Based Participatory Research Principles

1. Community as a unit of identity.
2. Builds on strengths and resources within the community.
3. Facilitates a collaborative and equitable partnership in all phases of research.
4. Fosters co-learning and capacity building among all partners.
5. Balances between knowledge generation and intervention for the mutual benefit of all partners.
6. Focuses on the local relevance of public health problems, addresses social inequalities, and attends to the multiple influential factors on health and well-being.
7. Cyclical and iterative process.
8. Shared commitment to disseminating project findings to all partners.
9. Process and commitment to sustainability.

Note. Adapted from "Methods in Community-Based Participatory Research for Health, Second Edition," by B. A. Israel, E. Eng, A. J. Schulz, and E. A. Parker, 2012, p. 8-11.Copyright 2012 by John Wiley & Sons, Inc.

Methodology

Qualitative methods are often used in community-based research due to their exploratory nature and ability to gather information from participants that is culturally relevant and congruent (Gill, Stewart, Treasure, & Chadwick, 2008). A program evaluation through discussion with the Program Evaluator, a key informant, allows for knowledge generation and understanding with one who is well versed in the focused research area. Key informants can provide greater understanding of the relationships between organization and community, as well as a unique perspective on the legal, social, and/or financial aspects of the partnership and organization. Key informants often provide information that is specific to their experiences

within their positions, as well as have a general understanding of the systemic picture and collaborative relationships within the organization (Marshall, 1996). The rationale for collecting qualitative data was to provide rich qualitative information about the program and its adherence to CBPR principles, as well as to contextualize the programmatic outcomes.

For the purposes of this program evaluation, the O&E Program Evaluator was identified to share his programmatic experiences as both a member of the MECCA Executive Board and Research Team. The Program Evaluator is also the Dissertation Chair. The Program Evaluator, who is a Latino male clinical psychologist in his 40s, and an active member in the development and management of MECCA, as well as the collection, analysis, and dissemination of data. He was the focus of this program evaluation because of his involvement in the design, implementation, and management of the O&E program.

With the CBPR approach, there is a significant focus on reflection and modification throughout the implementation and development of CBPR partnerships. Additionally, a principle of CBPR, *Principle 7: Cyclical and Iterative Process* (Belansky et al., 2011; Israel et al., 2012), is focused on continuous reflection and modification to promote collaborative, outcome, and systemic improvements. Thus, in an effort to understand the degree to which CBPR principles were included within the work, researchers and community members are encouraged to regularly engage in a process of reflection prior, during, and post community engagement. For this study, a post-reflection discussion with the Program Evaluator focused on a set of predetermined areas of interests and adherence to each principle area, while also encouraged room and flexibility in delving into different topics that arose from discussion of these reflection questions (Willig, 2013). The questions were categorized based on specific concepts in order to gather comprehensive and organized information, as well as provide the Program Evaluator the

opportunity to reflect on all the areas that were found to be relevant in each CBPR principle. The post-reflection discussion was audio-recorded and analyzed after the discussion for both content and meaning (Willig, 2013).

A post-reflection discussion was conducted with the Program Evaluator in his private office in a university setting over the course of one day. During the discussion, specific categories were evaluated through the questions associated with the seven categories of interest (Table 2). For each category, there are specific questions that were organized to gather the information specific to that unit, and to allow for flexibility for an overall discussion and reflection of the Program Evaluator's perceptions on how the program fulfilled specific components of the categories and CBPR principles. Two members of the research team, who were involved in the initial data collection process during the fiscal years of 2012-2013 and 2013-2014, separately listened to the recordings and documented the post-reflection specific themes. The Program Evaluator of this dissertation is one of the members of the original research team, who was involved in the data collection in the aforementioned fiscal years. The two members of the research team then discussed the themes reviewed separately until consensus was reached. The third member of the research team, who was not involved in the aforementioned data collection process, audited the themes generated through consensus building. The internal audit consisted of the third researcher independently listening to the recordings, documenting the post-reflection specific themes, and comparing the themes with those initially identified by the two researchers.

Instrumentation

The Community-Based Participatory Research evidence-based curriculum (The Examining Community-Institutional Partnerships for Prevention Research Group, 2006) was

developed as a skill-building and evaluative tool to help community-institutional partnerships develop and maintain CBPR partnerships, as well as to assess the extent to which CBPR principles were adhered to within CBPR partnerships. The curriculum includes 7 units (Table 2), which were identified as integral components in CBPR through a three-year collaborative project focused on the development and evaluation of CBPR projects and partnerships (Seifer, 2006).

In order to develop the post-reflection discussion guide, the aforementioned research team reviewed information about the CBPR approach and the specific aims of the CBPR curriculum. Information that was included in each curriculum unit was assessed and gathered through the utilization of open-ended questions.

Table 2

Areas of Focus for the Post-Reflection Discussion

Curriculum Units	Reflection Questions
CBPR-Getting Grounded	Were CBPR principles reviewed at the outset? Were community members introduced to the CBPR principles? Were they informed of the differences between CBPR and traditional research? Were the tangible benefits and challenges discussed?
Developing a CBPR Partnership- Getting Started	How were partners identified and selected? How was the Program Evaluator determined? What did the initial selection process look like? As agencies/members were added, was it collectively decided that the member/agency was an appropriate match for the group? How were operating norms established to ensure power sharing? How was an infrastructure created for carrying out the research process?

(continued)

Curriculum Units	Reflection Questions
Developing a CBPR Partnership- Creating the "Glue"	How were the values of the ethnic agencies/MECCA collaborative included in the development and management of research? Were ethical considerations related to conducting research with MECCA reviewed within the research group? Were research challenges reviewed? What are the strengths and resources in the community? Were key cultural and historical dimensions discussed? Who needs to be involved in order to ensure community voice? To what extent did that occur? How were major health problems in the communities identified?
Trust & Communication in a CBPR Partnership- Spreading the "Glue" and Having it Stick	How was trust developed and maintained? How would you describe the partnership between researchers-community? How could the partnership been improved? What were some challenges? How were they dealt with?
Show me the Money- Securing and Distributing Funds	How were funding sources identified? How was it decided how funds would be distributed? Did the funding source understand the CBPR framework? How did the funding impact the overall implementation and process of the CBPR program, if it did? Did this impact the researcher-community partnership? Who was included in the grant writing process? How was the research design decided? How were data collection methods decided? How was the manner of administration of methods decided? Were the measures translated in the language of the community members? How was it demonstrated that the measures were culturally appropriate?

(continued)

Curriculum Units	Reflection Questions
Disseminating the Results of CBPR	How was data understood? Were partners involved in contextualizing the information and making sense of the data? Were the results disseminated back into the community? Were the findings applied to changes in programmatic interventions and/or policy changes? Was information shared with community members? If so, how did you determine what was most important to share with the community and the manner in which to share with the community? Were the results published? Were multiple individuals involved as co-authors? Were written policies developed as to how the dissemination would be handled at the outset? Did the knowledge lead to community action? Were the "lessons learned" from the partnership disseminated to the communities and/or the broader psychology community?
	How often was there an internal evaluation/check-in? What did the evaluations look like? Were decisions and evaluations documented? Was sustainability defined for the group? Was a sustainability plan developed and/or implemented? How did the group decide on which activities to pursue/continue? Were the goals of the partnership reviewed and revised, as needed? When is it appropriate to end a CBPR partnership? Has that been discussed?

Results

Researchers utilized the CBPR Curriculum program evaluation template (Table 2) and gained information that was later organized into the main themes. The following six themes were derived from the reflection questions subsumed within each CBPR curriculum unit and identified

through the post-reflection analysis amongst the research team. Although the thematic areas were likely influenced by the information gained from all the CBPR curriculum units, for the purposes of this section, the CBPR curriculum units that were specifically associated with the thematic areas are identified per each theme. Sample questions specific to each unit and which derived information for each thematic area are included below; however, refer to Table 2 for a comprehensive list of reflection questions asked per each CBPR unit during the post-reflection discussion. The thematic areas embody the key information provided by Dr. Gallardo and specifically his experience of the MECCA O&E program as related to one or more of the curriculum units. The identified themes reflect important elements of the development and implementation of the O&E program.

CBPR Curriculum Units associated with *Partnership & Collaboration*

The theme, Partnership & Collaboration, was identified from information derived specifically from four CBPR curriculum units, including: (a) [1]Trust & Communication in a CBPR Partnership- Spreading the "Glue" and Having it Stick, (b) Show Me the Money-Securing and Distributing Funds, (c) Disseminating the Results of CBPR, and (d) Unpacking Sustainability in CBPR Partnerships. Sample questions that were asked per unit include: (a)[2] Can you describe how the partnership between researchers and community members worked? How were the challenges dealt with between researchers and communities? (b) How was the data collection method decided? How was it decided how to administer the measures? (c) How was data understood? and (d) When is it appropriate to end a CBPR partnership? Has that been discussed?

[1] The CBPR curriculum units are arbitrarily numbered for organizational purposes throughout the Results Section.
[2] Sample questions from the specific numbered CBPR curriculum units asked during the discussion.

Partnership and collaboration. Partnership and collaboration were described as an alliance built on trust, community advocacy, and shared decision-making at various stages of the development, implementation, and evaluation phases. The process of establishing the MECCA collective, community membership, and implementation of the county-funded programs was an unexpected process that was triggered by genuine care and devotion to meeting community-specific needs, as well as a lack of available resources for various ethnic communities. The stakeholders included MECCA board members, executive directors, community members and staff, research team, and county funders. The Program Evaluator reported that he did not explicitly discuss the CBPR model with the various stakeholders because of initial time constraints in organizing the program. Collaborators reportedly functioned from a "humanistic" stance, one that is described as genuine care about the individuals and communities, and desire to learn and collaborate with community agencies to empower the communities being served. There is a common thread of conducting research with communities and in the benefit of the community members and needs. Collaborators understood the importance of serving community-specific needs, and engaged in equal partnership across various levels of collaboration (except with county-funders). County-funders worked from a deductive "top-down" approach, in which their priority was on demonstrating the program success through traditional measures that had been validated when utilized with the dominant culture. County-funders evaluated program success by monthly and annual outcomes gathered through county-required measures. The Program Evaluator advocated to the county on behalf of MECCA around limitations of county requirements and assessment expectations, as well as the need to develop and utilize measures that made sense to staff members and communities. The county has become increasingly more open and accepting of these modifications and/or new methods of assessments; however, the

Program Evaluator and other stakeholders need to adhere to county requirements in order to continue to receive funding. There is a tiered involvement in place with some activities and decision-making, such as with the grant writing process. The Program Evaluator was involved from the beginning and then Board Members and Executive Directors contributed to the process. Non-research members were only selectively involved in contextualizing the programmatic data for county-required evaluations when additional feedback was needed to understand outcome discrepancies or answer county-specific questions. The data gathered has not been disseminated for community purposes and utilized mainly for county-funding purposes. Stakeholders consistently engaged in an open channel of communication about programmatic processes and outcomes, exchanged information about community needs and quality of services provided to fulfill them, and made appropriate modifications to improve delivery of services, interactions between all stakeholders, and overall programmatic effectiveness. Stakeholders assumed that as long as the programs existed, the CBPR partnerships would continue; however, this was never discussed amongst partners.

The MECCA Board is comprised of members from different ethnic communities, who have united to be a strong advocating force for various ethnic communities. As they have worked to overcome barriers in receiving services for communities, they have also been challenged by their interactions with one another. They have individually and collectively experienced cultural and interpersonal mishaps when engaging with one another. The Program Evaluator stated that cultural trainings would be helpful to foster the individual relationships of members, as well as cross-cultural engagement across communities. There have been limited opportunities for agencies to foster relationships. The Program Evaluator reported that meetings on humanistic and ethical considerations, especially with how to join a different community or engage with

members from other cultural backgrounds, have been found to be beneficial in the development and implementation of the O&E Program.

CBPR Curriculum Units associated with *County-Funded Challenges*

The theme, *County-Funded Challenges*, was identified from information derived specifically from three CBPR curriculum units, including: (a) Show me the Money-Securing and Distributing Funds, (b) Developing a CBPR Partnership- Creating the "Glue," and (c) Unpacking Sustainability in CBPR Partnerships. Sample questions that were asked per unit include: (a) Did the funding source understand the CBPR framework? How did the funding impact the overall implementation and process of the CBPR program, if it did? Were the measures translated in the language of the community members? How was it demonstrated that the measures were culturally appropriate? (b) What are the strengths and resources in the community? How did we determine the major health problems that have impacted the communities? and (c) Was a sustainability plan developed and/or implemented? Was sustainability defined for the group?

County-funded challenges. The MECCA agencies have experienced county-funded challenges and limitations, specifically related to the time allotted for program development & implementation, utility and distribution of funding, and the data collection process. MECCA received county funding that required MECCA to follow the county's requirements and timelines in the development and implementation of the programs. The short period of time prior to implementation placed pressure on community staff members, agencies, and researchers to fulfill the demands placed by county, while also providing culturally responsive care to communities. Community agencies were not provided the time to reflect on programmatic goals specific to their agencies or the overall implementation process prior to implementing the county-funded programs.

Community agencies were in need of county funding for survival, particularly to be able to support human and non-human resources necessary to serve their communities. Thus, all six agencies implemented county-funded programs regardless of their need or goodness of fit between agencies and programs. As non-profits, the community agencies depended on their county funders to be able to continue to serve community members. In an effort to keep their doors open to community members, agencies implemented county-funded programs and modified them to address their specific community needs. Additionally, within the MECCA collective, Executive Directors utilized an equality model in that they equally distributed funding across all agencies, in order to reduce possible tension amongst partners. This inadvertently placed more pressure on those agencies that were able to appropriately implement the programs, as well as had the available resources, to take on more of the responsibility in demonstrating the positive impact of the funding to the county. The Program Evaluator shared a belief that an equity model would have likely allowed for better use of county funding for respective agencies and led to higher outcomes for county purposes.

Additionally, there was initially a mismatch between county goals and community-based resources to meet the specified goals. The Program Evaluator advocated to the county for the needs of community members, as well as the manner in which program services would be assessed. It was a difficult balance between advocating for community needs, while also staying within the requirements of the county and meeting expectations to ensure continued county funding. County funding was the sole source of funding for many of the agencies and thus the continued funding was necessary for the survival of the specific community agencies, as well as the MECCA collective. A sustainability plan had not been decided on prior to or during program

development and implementation, but rather sustainability was described as meeting county's requirements to have resources and funding available for continued program implementation.

There was also a discrepancy between daily community experiences and the feasibility of meeting county requests. The county required the administration and collection of data measurements in a manner that was inconsistent to the culture of the communities being served. There were many questions on measures that were not culturally sensitive to the needs of members and many times were not answered. The county also required the administration of measures during a community member's initial visit with the agency; however, this was found to be insensitive to the community member's initial level of comfort and inappropriate to cultural and interpersonal values. Additionally, there were limited staff and resources, which impacted the staff's ability to regularly and appropriately administer the measures. There were explicit discussions about measures and frequency of administrations with staff to determine the cultural appropriateness to the communities being served. Challenges were reviewed and modified as identified and the research team advocated for changes to the county. Community agencies advocated for having measures in the respective languages of their communities. Community staff members and county translated measures. The measures were not back translated into the respective language due to limited funding, staff availability, and time constraints.

The county has demonstrated an interest in serving the needs of underserved communities; however, county funding has traditionally been granted to agencies predominantly serving Caucasian populations. The implementation and data requirements that the county had prescribed were not translatable to working with ethnic and linguistically-isolated communities; thus, greater flexibility from the county was needed to be able to appropriately meet the goal of serving underserved communities and meeting outcome requirements. County stakeholders were

focused on quantitative outcomes to determine the impact of the program for the various communities and initially demonstrated inflexibility in the manner that they understood programmatic success. The Program Evaluator described a consistent desire to advocate for the community members and educate county officials on the challenges of effectively and sensitively working with community agencies, as well as ways to overcome such barriers. Through the Program Evaluator's longstanding history of discussions with staff and county officials, the county has increased awareness of community-based difficulties with already developed programs and data collection processes, as well as the need to be flexible in order to appropriately serve the needs of communities.

CBPR Curriculum Units associated with *Evaluation*

The theme, *Evaluation,* and subthemes, *Check-In Process* & *Lessons Learned*, were identified from information derived specifically from three CBPR curriculum units, including: (a) Unpacking Sustainability in CBPR Partnerships, (b) Show me the Money- Securing and Distributing Funds, and (c) Trust & Communication in a CBPR Partnership- Spreading the "Glue" and Having it Stick. Sample questions that were asked per unit include: (a) How often was there an internal evaluation/check-in? What did the evaluations look like? (b) How were data collection methods decided? How was it demonstrated that the measures were culturally appropriate? and (c) What were some challenges within the partnership?

Evaluation. Programmatic evaluations consisted of yearly, informal discussions with the Executive Directors and staff prior to the start of the new fiscal year. The evaluative discussions covered the challenges faced during the previous year, lessons learned from programmatic outcomes, program implementation strengths and areas of growth, and review of the data collection processes. Programmatic revisions were made prior to each fiscal year. The

evaluations were tailored to the discussion of necessary revisions that needed to occur because of county-demands or improvement of delivery of services. The evaluations often occurred as a result of specific external demands and need for revisions, or internal difficulties of meeting the county-funded demands within the last year. The Program Evaluator shared that time and preparation for the upcoming fiscal years was a challenge due to evaluations that needed to be completed for county purposes, as well as limited availability of the different stakeholders to meet and discuss all relevant topics within a short period of time. There has not been a sole person or MECCA member that has been assigned the task of documentation of meetings and evaluative discussions. Discussions were inconsistently documented by different members and kept in their possession. There was not a shared file for all members to have access to the documentations.

Check-in process. Check-ins occurred consistently and informally with Executive Directors, agency staff, and researchers. The information discussed during the informal check-ins was dependent on the issues occurring within the agencies and relevant for the staff, board, and participants at that time. Initially, at the start of the programs, check-ins occurred more frequently across all stakeholders. Agency staff did more formal check-ins during staff meetings, during which they discussed participant struggles as related to data administrations and collection, as well as quality of services provided to participants. This information was documented for the purposes of informing Executive Directors, but was not archived for review. Board Members initially would check-in as a group during monthly board meetings; however, since January 2016, the Board Meetings occur once every three months. The check-ins that occurred during the Board Meetings were documented in the Board Meeting Minutes. There is not a specific area where all the Board Meeting Minutes are archived nor is there a specific

person that has been responsible for consistently documenting the content of the meetings. The research team facilitated check-ins with staff about two to three times per year. Researchers attended the staff meetings and provided didactics on assessments, evaluation and administration frequency of measures, and the CBPR framework. There was dialogue regarding the changes implemented, as well as time for staff to provide feedback on measures and the data collection process. Instruction was also provided regarding implementation of measures and understanding of results. The information gained from the staff informed the research team's decision to look for measures that were culturally appropriate and useful to the communities being served. The research team would modify questions or change measures to more accurately capture the needs and experiences of community members. The feedback was inconsistently documented and not stored in a shared archive available to the research team. PowerPoint presentations that were used as a template for the check-ins with staff were saved and available for review and use by the research team.

Lessons learned. There were informal, annual discussions of lessons learned with the MECCA Board. The discussions focused on how to respond to the challenges and modifications needed from external factors (ex. county) and learned strategies for overcoming such challenges. There was a lack of structure regarding the specific ideas focused on and discussions were influenced by the information shared by the Executive Directors. The Program Evaluator described the benefit of allotting an amount of time in the future to have formal discussions of lessons learned, in order to have a comprehensive and structured review of the various factors associated with the development and implementation of the identified programs. Additionally, the Program Evaluator shared that up until this point, MECCA's stance to evaluation has been reactive to external factors and demands. There is a greater desire to be more intentional about

the evaluative process in order to proactively assess programmatic goals and embed structured evaluations in various meetings. The Program Evaluator stated that a more reflective and structured stance would be helpful in consistently improving the programs, as well as providing the space to identify new projects that would be beneficial for the MECCA collective to participate in. However, no changes have been made to the structure or quality of the annual discussions on lessons learned.

CBPR Curriculum Units associated with *Discussion & Implementation from CBPR Model*

The theme, *Discussion & Implementation from CBPR Model***,** and subtheme, *Sharing Information*, was identified from information derived from all seven of the CBPR curriculum units. The seven CBPR curriculum units include: (a) CBPR- Getting Grounded, (b) Developing a CBPR Partnership- Getting Started, (c) Developing a CBPR Partnership- Creating the "Glue," (d) Trust & Communication in a CBPR Partnership- Spreading the "Glue" and Having it Stick, (e) Show me the Money- Securing and Distributing Funds, (f) Disseminating the Results of CBPR, and (g) Unpacking Sustainability in CBPR Partnerships. Sample questions that were asked per unit include: (a) Were CBPR principles reviewed at the outset? Were community members informed of the differences between CBPR and traditional research?, (b) How was the Program Evaluator determined?, (c) Were ethical considerations related to conducting research with MECCA reviewed within the research group? What are the strengths and resources in the community? Were research challenges reviewed?, (d) How would you describe the partnership between researchers-community?, (e) How was the manner of administration of methods decided?, (f) Were partners involved in contextualizing the information and making sense of the data? Were the results disseminated back into the community? Were the findings applied to

changes in programmatic interventions and/or policy changes?, and (g) How did the group decide on which activities to pursue/continue?

Discussion and implementation from CBPR model. MECCA was granted county funds shortly after its inception, which was used to develop and implement county-proposed programs. It was described as an unexpected process in which partners joined together to gather the necessary resources to implement the programs within the specified time. The Program Evaluator was chosen by the Executive Directors to oversee the implementation and development of the programs, as well as the data collection process. The Program Evaluator entered the collective with a CBPR mindset and past history of working with ethnic communities. Identification and implementation of programs did not initially occur from a CBPR framework since the MECCA programs were already identified and created from county funding. Thus, the programs were modified and adapted with CBPR principles, with hopes of creating culturally-responsive and collaborative partnerships with the communities.

Staff and community stakeholders were overwhelmed with the need to implement the programs with limited resources and time. The Program Evaluator shared that the MECCA collective was "running before walking" due to the internal and external demands to execute the programs. Thus, they did not have the flexibility to engage in a thoughtful and intentional process that would be necessary when working from a CBPR framework. Staff was introduced to MECCA's research and partnership philosophy (i.e., CBPR framework) during initial staff meetings prior to the fiscal years. This CBPR review included the partnership's stance towards engagement and evaluation, rather than explicit review of each CBPR principle. The staff meetings also heavily focused on the administration of measures and implementation processes of the specific programs. Staff regularly experienced the CBPR values through the Program

Evaluator's stance of openness and collaborative manner of engagement with them, as well as discussions regarding the importance of equal partnership. The manner in which Executive Directors and the Program Evaluator developed and maintained their professional relationships and partnerships manifested the spirit of the CBPR framework. With the direction of the Executive Directors and inherent value placed on working with communities, the agencies and programs developed with a strong foundation in CBPR values.

MECCA's desire to respectfully enter communities and work with communities allowed for streamlined rapport- building and trust with staff and other community stakeholders. Staff were presented with a general overview of the similarities and differences between traditional and community-based participatory research during the annual meetings. Stakeholders engaged in discussion about the CBPR model and the manner to appropriately enter and work with different cultural communities. Stakeholders did not review *ethical considerations* as per the CBPR model when working with linguistically and ethnically-isolated communities; however, there was a strong and continued focus on *humanistic* considerations, which captures the core of ethical considerations when working with all individuals, including linguistically and ethnically-isolated individuals. Humanistic considerations is honoring and respecting both the differences and similarities of all individuals as cultural beings and engaging with individuals and communities in a manner that is culturally-responsive. It is being able to connect with the qualities and strengths inherent in all individuals and serving and empowering them in a manner that will translate readily within their daily lives. The benefits of a CBPR framework were discussed amongst staff in reference to MECCA, particularly related to how collaboration, shared learning, and empowerment could benefit multicultural communities. The Program Evaluator emphasized the need to recognize and serve the needs of the communities. During

these meetings, staff shared their input on measures and reviewed challenges with administering and utilizing measures in a manner that would be helpful for community members. The nature of the dialogues was revolved around interacting with members in a culturally-responsive manner in order to most appropriately meet their needs.

Verbal discussions about explicitly the CBPR model did not occur with the county. Written proposals to the county referenced the CBPR framework and logic models. Challenges with working with communities were verbally and in written form discussed with county, as modifications to processes or measures were needed. Modifications to the data collection process was informed by the information shared by staff and challenges experienced. The frequency of administration times was revised based on feedback from staff, as well as a discussion with community members and county. Staff also advocated for their communities and shared a desire to provide a more descriptive and accurate representation of the communities themselves and the impact that the county-funded services were having within their lives. Thus, after the first year of the programs, the feedback from staff led to a greater focus on community strengths and assets, as well as ways to more holistically capture these inherent resources. The research team worked with community stakeholders in developing qualitative and individualized forms to capture the specific goals of community participants and the manner in which they achieved them (i.e., Wellness Plans). The challenges that the staff disclosed were validated and adaptations were made to improve the staff's quality of experiences when working within the communities, as well as the overall benefits to community members. Thus, ways to modify the data protocol were consistently reviewed, while being mindful of county-requirements. The MECCA collaborative focused on the benefits of the county-funded programs for the MECCA collective, rather than specific benefits for each community.

Sharing information. Staff was provided with information about the need for data collection. There was a focus on external, county-requested quantitative evaluations, rather than in-house evaluations to assess programmatic outcomes and CBPR processes. Staff were not involved in contextualizing data gained through the data collection process, unless additional information was requested by county to understand the data. Community members did not have access to the agency-specific or MECCA collective data nor received data interpretations or findings. Data findings were not disseminated to the MECCA communities nor published on a greater scale. The research team has prepared a manuscript to be published in the future, which focuses on the lessons learned from the establishment and collaboration of the different ethnic communities in MECCA. The findings from the aforementioned manuscript, as well as county outcomes, have not been utilized as a way to bring policy change to improve health outcomes within the Orange County community; findings have started the conversation with stakeholders regarding the importance of improving health outcomes and providing culturally-responsive care to all.

CBPR Curriculum Units associated with *Process of Building MECCA and its Programs*

The theme, *Process of Building MECCA and its Programs,* was identified from information derived specifically from four CBPR curriculum units, including: (a) Developing a CBPR Partnership- Getting Started, (b) Developing a CBPR Partnership: Creating the "Glue," (c) Trust & Communication in a CBPR Partnership- Spreading the "Glue" and Having it Stick, and (d) Show Me the Money- Securing and Distributing Funds. Sample questions that were asked per unit include: (a) How were partners identified and selected? What did the initial selection process look like? How was an infrastructure created for carrying out the research process?, (b) How were the values of the ethnic agencies/MECCA collaborative included in the development and

management of research? How were community major health problems identified?, (c) How were the challenges dealt with between researchers-communities? How could the partnership been improved?, and (d) How did the funding impact the overall implementation and process of the CBPR program, if it did? Did this impact the research-community partnership?

Process of building MECCA and its programs. A community member that knew the Executive Directors of VNCOC, KCS, OCCTAC and Dr. Gallardo approached all members to bring together agencies and resources to serve the growing population of underserved, ethnically and linguistically isolated communities in Orange County, California. The Executive Directors of ACCESS and ABRAZAR were then approached by the Executive Directors of the aforementioned agencies and Dr. Gallardo, and invited to participate in the collaborative. OMID was founded and funded by MECCA, in response to the need to reach and provide culturally-responsive services to the growing Farsi-speaking population in Orange County, California.

The Board of Directors, which is comprised of 50% community members, is responsible for determining partner selections, should a community-based agency be identified or approach MECCA to join the collective. Since MECCA's inception in 2010, agencies that have collaborated with MECCA have been agencies that have approached MECCA. The coalition of MECCA has not reached out to agencies and the majority of the Executive Board has to agree on the inclusion of any new partner in the collective. The Board reviews the community-based organizations and its principles to determine its alignment with the MECCA collective values. The MECCA coalition would like to target hard-to-reach communities and areas where there is a need for social and mental health services. The Program Evaluator shared MECCA's desire to reach the African American community, which is not represented within the current MECCA coalition, as it is a community that would benefit from the services provided. The MECCA

coalition is dedicated to finding partners that demonstrate genuine care and commitment to serving all individuals, as well as demonstrate the provision of ethical, culturally-responsive, and accessible services to linguistically and ethnically-isolated communities.

Around the inception of MECCA, the coalition received county funding to implement two county funded programs. Dr. Miguel Gallardo's position as the Program Evaluator was an organic decision for the Executive Board, due to being one of the founding members of MECCA, a university professor and skilled in community data collection and analysis, and a trusted person that was accepted by the multiethnic community. Dr. Gallardo selected graduate students as Research Assistants to assist with data collection, organization of data protocol, and staff trainings related to research. The research team was comprised of the Program Evaluator and two research assistants.

The building of MECCA and the implementation of its' programs was described as a reactive process, during which the MECCA coalition responded to county and community needs and requests as they occurred. Planning prior to the implementation process did not occur. The MECCA coalition and Executive Board did not engage in a discussion related to discussing the specific needs of each community and community-based agencies, but rather focused on the needs of the MECCA coalition that could be fulfilled by the county-funded programs. The funding opportunities were the driving force in determining the community-needs that would be fulfilled. The theme of "running before walking" was referenced as a description of how the MECCA coalition and county-funded programs developed. Challenges were dealt with as they were discovered in the implementation and data collection process; thus, stakeholders were learning in real-time how to effectively work with one another in fulfilling county requirements and providing meaningful, culturally-responsive services to consumers. Through the passage of

time and overcoming of barriers and challenges in implementing county-funded programs, MECCA has learned more about working within a multicultural coalition. Specifically, MECCA has experienced greater stability and consistency in the processes of engagement and quality of services delivered across these cultural communities. The MECCA coalition has currently arrived at a space where it can engage in a more reflective and intentional practice in selecting opportunities and program partnerships that meet its needs and areas of interest. There is currently a greater focus on intentionally determining community-specific needs and subsequently looking for grants and external funds that would fulfill the pre-determined needs. This stance towards program development allows for programs to be developed from the needs voiced by communities, rather than solely in response to the funding available.

CBPR Curriculum Units associated with *MECCA Collaborative*

The theme, *MECCA Collaborative*, and subthemes, *Strengths* and *Areas of Improvement*, were identified from information derived specifically from two CBPR curriculum units, including: (a) Developing a CBPR Partnership- Creating the "Glue" and (b) Trust & Communication in a CBPR Partnership- Spreading the "Glue" and Having it Stick. Sample questions that were asked per unit include: (a) What are the strengths and resources in the community? Who needs to be involved in order to ensure community voice? and (b) How was trust developed and maintained? How could the partnership been improved?

MECCA collaborative. The multicultural coalition includes many strengths and areas of improvement that are further discussed below.

Strengths. Each ethnically and linguistically isolated community has been described as being resourceful and resilient in collectively overcoming and persevering obstacles related to living in the United States, particularly around immigration histories, acculturation experiences,

and psychological distress. These shared cultural experiences across the communities have allowed staff and other community members to better understand and support one another. Community members embody strength and resilience in their willingness and deliberate focus on overcoming barriers to meeting their individual and collective needs. Staff have demonstrated dedication to improving the quality of lives of others, as well as empowering others to advocate for their own needs. The hopeful stance and proactive actions of the individual communities has manifested further strength and vitality across all levels of the collective partnerships. There is a lasting focus on serving and compassionately connecting with individuals within the context of their lives. Executive Directors and their respective agencies genuinely care for their partners and utilize their commitment to helping others as a means to be able to impact positive change across the MECCA collective.

The collaborative was described as a strength within itself as it has unified ethnic community agencies that have well-established histories of being accepted and trusted by their community members. This unification has provided a platform for MECCA to help others within the multicultural community on a larger scale. The individual community agencies are the direct service providers to their respective communities and have keen insight into the needs of their members. Each community agency is embedded within the community and has been built from community needs and supported by culturally and linguistically-responsive community members. Thus, through MECCA's collaboration with these specific agencies and providers, MECCA is able to connect and reach many underserved and hard-to-reach individuals and communities. Through a multiethnic collaboration, MECCA has a stronger presence and more power in being able to advocate for additional support and services both for individual agencies and across the collective. MECCA is also more likely than a single community agency to receive

financial support from external and varied entities through its representation of many different cultures, ethnicities, and languages. The individual agencies within MECCA also have a stronger and noticeable presence within their communities, as they are able to advocate and receive the necessary resources to satisfy their collective needs.

MECCA honors the individual community agencies, while promoting cross-cultural dialogue and interaction between the agencies. The cross-cultural interactions have increased opportunities at both the individual agency and greater MECCA collective levels, specifically through strengthened capacities and utilization of resources to serve both levels of the collaborative. The relationships of staff with community members is built on trust and reciprocity through which staff organically and respectfully enter and interact with their respective communities. Each Executive Director is a member of the community that they serve. They are identified as a point of contact for their communities through their proficiency in their respective languages and representation of their interests. Executive Directors have the chance to learn about the distinct needs and services available at each agency and refer and link community members to the appropriate agencies. The collective is comprised of at least one agency that is serving one of the threshold languages in Orange County, California, and all the threshold languages are accounted for within the MECCA collective. MECCA brings linguistic and ethnic diversity through the makeup of staff, community members served, and type and quality of services provided to the Orange County community, as well as to the greater non-profit and profit world.

Areas of improvement. The Program Evaluator discussed some of the challenges associated with the establishment of MECCA and unification of different ethnic communities. He shared an initial experience of cultural misunderstandings amongst the Executive Directors

due to limited familiarity with the different ethnic communities and culturally specific values. The Program Evaluator described a need for educational and competence-based cultural trainings about the various ethnic communities of the Executive Directors. There was also an expressed need for in-depth discussions with the Executive Directors and staff to discuss and reflect upon the cultural differences that may be experienced within the multicultural collective, as well as within the communities. Additionally, the check-in process with Executive Directors and staff is an area that can be further improved through increasing the frequency of the meetings and implementing more structure. The county would also benefit from additional training regarding the different ethnic communities, their needs, and the CBPR framework, in order to promote greater understanding and flexibility with fulfilling county requirements as a multi-ethnic coalition.

Discussion

This section will focus on assessing the areas in which the Outreach & Engagement Program adhered to each CBPR principle, as well as areas that would benefit from additional attention. It is important to note that the CBPR principles are intended to guide the research and partnership process and serve as "ideals" to fulfill within the partnership. CBPR principles should be assessed on a continuum and influenced by the context and experience of each partnership; thus, CBPR partnerships will look differently and incorporate each principle to varying extents. There will always be room for modifications and improvements within CBPR partnerships and evaluation allows for these process and outcome improvements to be consistently made (Israel et al., 1998; Israel et al., 2012).

Each principle and the manner in which MECCA incorporated and utilized each principle will be assessed below. For a description of the CBPR principles, refer to Appendix 1.1.

Recognizes Community as a Unit of Identity

In CBPR projects, communities are clearly identified, which has been the case within the development and implementation of MECCA's O&E program. The MECCA coalition is identified as a collaborative that serves underserved and marginalized communities that would benefit from social and mental health services in Orange County, California. MECCA is comprised of six communities that have been identified based on their ethnic and linguistic identities, as well as their specific geographical location in Orange County, California. MECCA recognized these communities as having distinct, yet similar factors that influenced the daily experiences of community members and communal health; these factors greatly inform the collaboration and partnership. Furthermore, the specific ethnic communities were described to share common values and experiences, including collectivistic cultures, immigration histories, acculturation experiences, and psychological distress. The community-based agencies and their Executive Directors, as well as staff and community members, represent the communities being served. A significant strength of the MECCA coalition is the inclusion of community members within the Executive Board as it allows for a better understanding of the day to day experiences of community members on both an individual and communal level. Ideally, MECCA and its' programs would benefit from including community members throughout all phases of the development and implementation of its programs. Through my participation in the research collection process and reflection on the last few years of the O&E program, it is important for Executive Directors and community members to assess the extent to which this will be feasible and make small, yet meaningful changes towards including community members throughout the research phases.

Since MECCA is a coalition that is founded on six different ethnic and linguistically-isolated community agencies, there is a need to focus on both the individual communities and greater multicultural collective. It appears that initially within the implementation process, the needs of the MECCA coalition were more heavily focused on because of funding and need to financially survive as a coalition. Since there is a back and forth between MECCA's desire and abilities to meet the individual community and collective needs, it would benefit from agreeing on an explicit definition for their community and determine if they will focus more heavily on each individual community, the collective, or both.

Builds on Strengths and Resources within the Community

The MECCA coalition strived to integrate the individual community members and communal strengths and skills in the development and implementation of its programs. The community-based agencies within MECCA are community-embedded agencies that have had a longstanding history of serving their respective communities through direct contact with their community members and communities. The community-based agencies, staff, and Executive Directors, are respected and trusted by community members and have keen insight into the needs of their communities and the manner in which to most effectively and sensitively fulfill them. Thus, the inclusion of existent community-based agencies and utilized supports within MECCA has allowed for these agencies to continue serving their communities, while strengthening their resources through opportunities given through their partnership within MECCA.

As far as the implementation of programs, MECCA and its respective agencies were initially focused on the needs of the county and limited in their abilities to modify the research instruments or data collection processes with input from community members. Researchers were informed of county requirements and provided agency staff with pre-determined measures to

assess for programmatic outcomes. This process did not utilize communal resources and strengths, but rather utilized standardized assessments that were aligned with traditional research and did not include community input; thus, the measurement outcomes were not culturally appropriate or sensitive to culturally-specific issues and demonstrated decreased reliability and validity. However, within the first few months of the O&E program, the research team conducted a needs assessment with staff and Executive Directors and learned of the community challenges in fulfilling county measures and requirements. The staff and Executive Directors also provided feedback on ways to more accurately and sensitively capture the impact of the program on individuals and communities through the development of a new measure (i.e., Wellness Plans). From early on, this process of learning from community members, advocating for their needs to county, and making modifications (as necessary) paved the way for the incorporation of community strengths and employment of resources that have had a history of effectively fulfilling community needs. Community input was vital to the development of instruments and assessment of measurement utility. The Wellness Plans capture the individualized goals of community members and allow for staff to use existent and culturally-appropriate support to fulfill their goals. Staff have referred and linked community members to services that are embedded within their communities, which has contributed to increased awareness and utilization of community resources and strengths. With time, MECCA has demonstrated greater commitment in involving community input and building on the strengths of community members. This is an area that can continue to be strengthened through modifying how the data is gathered, such that it is meaningful, appropriate, and feasible within the community.

However, through reflection on the research team's manner of engagement with the community staff members, there was a distinct focus on supporting and empowering each

individual. This was demonstrated through the quality of discussions with staff members, genuine curiosity to learn from them about their communities and perspectives on the research processes, and consistent encouragement for feedback on ways to improve research interaction with the communities. As community members were encouraged and appreciated for bringing more of themselves and their cultural values within the research-staff relationships, they likely also enhanced and exercised their inherent strengths.

Facilitates a Collaborative, Equitable Involvement of All Partners in All Phases of the Research, Involving an Empowering and Power-Sharing Process that Attends to Social Inequalities

Staff and Executive Directors were informed of the Program Evaluator's desire to maintain equal partnerships and involvement through his collaborative and open manner of engagement. The staff was informed of this principle, as well as how it is an integral component of the research framework. The Program Evaluator provided an open and power-sharing environment via open-ended questions, genuine curiosity, and encouragement and appreciation of community input. The manner in which the Program Evaluator interacted with staff within and outside of meetings contributed to a collaborative relationship between the research team and community. However, a deeper look into the potential power dynamics between the various relationships within the research team and across agencies would provide additional insight into the implicit impact of various factors on the relationship dynamics. The influence of gender, age, formal education, social class, and ethnicity could have been influencing factors on the extent to which members within the partnership felt comfortable in equally sharing their perspectives. A review of the CBPR principles and power-sharing processes would have benefitted all partners through explicit orientation to the CBPR framework and membership roles.

Additionally, community partners were not involved within all phases of the research process, particularly the data analysis, interpretation, and dissemination. Due to county requirements and time constraints, MECCA struggled in appropriately including community members in interpreting the findings within their sociocultural contexts and understanding the meaning of their findings in reference to their community experiences. Community members were not involved in contextualizing the data, with the exception of incidents when the research team and county were unable to understand the outcomes and needed additional information and assistance. MECCA needs to place a stronger focus on incorporating representatives from each community agency in the data interpretation stage, as well as conveying the findings to their respective communities and staff in a manner that is helpful and understandable. This is an essential principle of the CBPR framework that the MECCA coalition has to further incorporate in its partnerships. Community members will be empowered by the knowledge and likely more motivated to engage in their research processes as they are included in each component of the research. Additionally, it will empower them to take ownership of the research process and exercise increased confidence and participation within the partnership. Although it is evident for the aforementioned reasons that the intentional inclusion of this principle will benefit MECCA and its' partners, the county-demands have made it difficult for MECCA to engage in mutually beneficial and reflective CBPR practices. Thus, it is important that MECCA collaborate with county to determine ways that it can have additional time or receive support to appropriately engage with community members during the research phases in order to successfully and meaningfully fulfill this principle.

Overall, The MECCA coalition has not disseminated its findings to the greater CBPR or psychology field. MECCA has a wealth of information, lessons learned, and experiences that

would benefit the greater community. This information will provide community agencies and academic-research institutions with insight and awareness of ways to effectively and sensitively engage with community-based agencies and exercise the CBPR principles.

Integrates Knowledge and Intervention/Action for Mutual Benefit of All Partners

The community agencies and research team expressed interest in collaborating with one another to conduct research and fulfill communal needs. Research engagement proved to be mutually beneficial to both the researchers and communities for many different reasons; however, the extent to which it benefitted each member of the partnership varied. Researchers have had the opportunity to learn about various areas, including: community-based agencies, available community resources, culturally-specific values and norms, and benefits of community involvement in the research process and delivery of interventions. Additionally, community partners have received some support in the identification and fulfillment of their communal needs through participating within the research process and receiving county- funding. The research process has provided an avenue for county and other stakeholders to learn about the growing needs of the communities and collaborate with them in fulfilling their needs.

Although the research demonstrated to be beneficial to both the research team and community partners, it is important to note that community partners did not explicitly endorse interest in participating in the O&E Program nor did all the agencies need the services or have the resources to appropriately implement the O&E Program. Community involvement in the O&E Program was influenced by the unexpected process in which county-funding became available, which led to the implementation of the O&E Program; thus, the implementation was more demonstrative of a “reactive” process to the funding, rather than a reflective and intentional process that focused on the needs of each community. As a new coalition, there was

understandably a greater focus on how to continue to receive county-funding to financially survive as an organization. The Program Evaluator and Executive Board consistently modified and adapted the O&E Program to promote greater utility for the communities, which naturally improved county outcomes. As the O&E Program continued, there was a better balance between knowledge generation and application of interventions for the mutual benefit of both the researchers and community partners. The MECCA coalition has demonstrated a consistent desire to serve community members and has taken additional steps to ensure that all county-funded programs and opportunities, including the O&E program, have been meaningful and supportive of the communities being served. Thus, the intentional focus on community members has not wavered; the Program Evaluator and Executive Board overcame many barriers to serve communities to the extent that was possible within the limitations placed by county-demands and time and resource constraints. However, as mentioned by the Program Evaluator, this is an area of continued growth for MECCA. The coalition would benefit from engaging in a more reflective practice in identifying the specific needs of individual communities and the greater collective, as well as agreeing on the specific methods through which the needs will be fulfilled to ensure mutual and equal benefit to all members of the partnership.

Fosters Co-Learning and Capacity Building Among All Partners

The relationships between community and research members are built on a sincere desire to learn from one another through sharing different areas of expertise or perspectives. The research team has learned from community members about how to appropriately engage with members in a manner that is culturally-responsive, as well as ways to appropriately measure levels of change and assess outcomes. Community members have shared their struggles with conducting research within the community, as well as the strengths and resiliencies of their

community members; thus, the research team has been provided with a unique window into the day-to-day lives of the community members and learned how to more effectively advocate to county for communal needs and services. Community members have also learned from the research team about the benefits of conducting research for communities, didactics on assessments (i.e., implementation and interpretation), and information regarding the CBPR framework. The research team should spend additional time providing an overview of the research stages, as well as detailed information about each CBPR principle and ways that each member of the partnership can learn from one another.

The Program Evaluator spent time providing information to the county about the various cultural communities, as well as provided written references of the CBPR framework. Although the county has increased understanding and flexibility in working with MECCA and community agencies, the county would benefit from additional, more structured and explicit information about the CBPR model and its application with the various cultural communities being served within MECCA. This will increase the county's awareness of community values and histories, needs and appropriate services, and the manner in which the CBPR framework can be advantageous, ethical, and culturally sensitive in serving these communities. It is likely though that the Program Evaluator and community stakeholders will have to continue advocating to county for the various cultural communities and sharing challenges as they occur, in order to continue to expand the county's awareness and appreciation for culturally-specific presentations, values and experiences, and challenges.

Involves a Cyclical and Iterative Process

CBPR involves an iterative process, in which all stages of the research and partnership are consistently re-visited and modified as necessary. This is an area of continued growth for

MECCA. The Program Evaluator and research team conducted informal and formal check-ins and needs assessments with the Executive Directors and staff, but primarily focused on areas related to research (i.e., challenges in measure administration, desired changes). As mentioned, the programmatic evaluations consisted of discussions with the Executive Directors and staff prior to the start of the new fiscal year; however, additional check-ins were only added as needed due to external demands by county or internal difficulties in sensitively working with the communities. Since a specific member was not identified to consistently document and store the discussed information, most of the evaluative information is not available for review. Although MECCA has demonstrated to successfully exercise an aspect of this principle through informal discussions with staff, more formalized and consistent dialogue did not occur regarding research and non-research areas. MECCA did not demonstrate a consistent, cyclical, and informative process in the identification of community issues, interpretation of data, impact of findings on action and policy changes, dissemination of results, action changes, and determination of sustainability. Additionally, the lack of structure likely interfered with MECCA's ability to consistently utilize the lessons learned from the evaluations to impact more lasting change within the partnerships and organizations. Although there is one manuscript in preparation regarding the lessons learned from the research-community partnership, this information has not been re-visited nor disseminated to the communities or greater CBPR field.

Additionally, an area of growth for the MECCA coalition is the cyclical process necessary with partnership development and functioning. The MECCA coalition will benefit from spending adequate time to learn about each cultural community and the personal and cultural qualities of the Executive Directors. The increased time for reflection will allow for deeper understanding of interpersonal and cultural dynamics, as well as subsequently improved

collaboration amongst the Executive Directors and agencies. Additionally, there have not been reviews conducted on the role of each community-based agency within the MECCA coalition and partnership. Regular check-ins with MECCA partners about research and partnership processes and outcomes will ensure CBPR stability and programmatic and partnership success. Although this CBPR principle emphasizes MECCA's areas of growth, it also highlights the inherent difficulties in fulfilling this principle due to limited resources, time constraints, and inconsistencies between county- demands and daily community experiences. MECCA will likely be able to fulfill this principle with additional time and flexibility, continued experience with CBPR program implementation, and inclusion of the aforementioned principle-specific recommendations.

Focuses on the Local Relevance of Public Health Problems and on Ecological Perspectives that Attend to the Multiple Determinants of Health

Due to the initial time constraints and county-funded requirements, the MECCA coalition was not able to appropriately attend to the community health concerns that accounted for individual, immediate, and greater familial and community contexts. Although MECCA has demonstrated via qualitative and quantitative outcomes to provide beneficial and necessary services to community members, it did not provide programs or services that were initially requested nor needed within the communities. However, MECCA has demonstrated significant skill in fulfilling the community needs it can, while meeting county-funded requirements. Although the O&E program was not initially requested by community members, it successfully fulfilled many community needs and provided meaningful, culturally-responsive services that would otherwise not be available. Additionally, the various determinants of health (i.e., social, economic, historical, and cultural) were believed to be important to the Executive Directors and

Program Evaluator, but were not always focused on due to differing resources and focuses amongst the agencies. When available, the resources were not always easily translated into appropriate interventions and outcomes due to the focus on meeting county deadlines and needs. A holistic focus on health and fulfillment of locally relevant needs is an area of growth for MECCA, as it will provide necessary and more comprehensive services to the communities. As the Program Evaluator described, there is a deliberate aim to focus more heavily on health concerns derived from community members.

Disseminates Findings and Knowledge Gained by All Partners

MECCA has provided many meaningful, culturally-responsive services and gathered a considerable amount of data annually from the services provided through the county-funded programs; however, the data has only been submitted to county to fulfill outcome requirements. Thus, community stakeholders have not been informed of the findings nor involved in the organization of the workbooks for county. Staff and Executive Directors have only been involved to contextualize the data, when there are additional questions regarding the data from the county. The nature of the current research-community partnership, as well as county-demands and time constraints, has not allowed for consistent consultations and collaborations with one another regarding the findings. Thus, this CBPR principle has not been met and is a significant area of growth for MECCA. The dissemination of findings to the community-based agencies and greater psychology field is essential, as it will enhance awareness about community-specific work and findings, culturally-responsive services, and CBPR collaborations within a multicultural coalition.

Involves Long-Term Commitment by All Partners and Commitment to Sustainability

The Program Evaluator discussed the importance of maintaining strong relationships across the community-based agencies and MECCA Board. Executive Directors and staff have built relationships on genuine trust, warmth, and dedication to their communities, as well as commitment to the mission and values of MECCA. Although Executive Directors and each individual community-based agency has demonstrated commitment to meeting the goals of county, as well as collaborating on the needs of the greater multicultural communities, a sustainability plan has not been developed. The Program Evaluator described that due to the early challenges with program implementation, sustainability had been viewed as fulfilling county requirements in order to continue county-funding, rather than an explicit, more comprehensive description of sustainability within the relationships and coalition. For the future, additional reflection on the meaning and process of sustainability for MECCA will be advantageous to each individual agency and the coalition. A sustainability plan will guide and protect the partnership through honoring the relationships and adhering to a pre-determined guideline for separation.

Reflection on the Process of Conducting CBPR with Multi-Ethnic Communities

Although the thematic findings and review of each CBPR principle provide valuable information about the collaborative process within a multiethnic coalition, it does not capture many of the nuanced, more relational, qualitative components of the MECCA partnerships. Thus, it can be incomplete and dismissive to the work that the specific communities have conducted. As a member of the initial research team and current Principal Investigator, I believe that the quality of relationships across the agencies has not been captured due to the more narrowed focus on each principle. The work of MECCA, success of O&E, and the individuals impacted

cannot be captured without understanding the quality and depth of the connections between the individual community-based agencies, greater MECCA coalition, and with community and county officials. There is a palpable and genuine affection towards one another, one that has birthed the partnerships and allowed for their continued collaborations, as well as provided each member of the partnership a lens into the worldview of the other. The staff was instrumental in understanding the community and cultural perspectives, as well as advocating for the needs of their members and alerting researchers to important areas of focus. As other CBPR researchers have found, the commitment and proactive engagement of the staff was essential to the quality of partnerships and CBPR success (Johnson-Shelton, Moreno-Black, Evers, & Zwink, 2015). The relationships within MECCA were founded on trust that allowed for community members to share their often vulnerable experiences with an understanding that the information would be used to help them. Additionally, staff were usually ethnically and linguistically-matched to the community members they served, which likely promoted a positive impact on community members that may not have been appropriately captured in the CBPR evaluation process. Without an accurate window into the experiences of community members, researchers cannot effectively help members and the data will likely be invalid (Khan, 2015); thus, MECCA's deliberate attention to having long-lasting relationships with the various multi-ethnic communities was one of the primary focuses during the implementation of the O&E Program. This focus formed a strong foundation on which MECCA could more intentionally concentrate on the incorporation of all the CBPR principles. Without these relationships across the board, it is unlikely that MECCA and its partners would have been able to conduct the collaborative work that they did and are continuing to do within multi-ethnic communities. Authentic partnerships, which have a reciprocal and mutually beneficial learning process amongst members, promote the

translation of research findings into practical changes in the lives of community members (Schittdiel, Grumbach, & Selby, 2010). Community-based programs will benefit from fostering relationships not only at the beginning of the research process, but reinforcing the importance of continually attending to community-academic relationships during and after research collaborations (Wilson, Coleman, Floyd, & Donenberg, 2015) to experience its powerful impacts. Without the strong partnerships across MECCA, it is unlikely that MECCA would have had the unique opportunity to intimately work with the various multi-ethnic communities and effect meaningful change.

Additionally, with respect to each individual CBPR principle, it is important to note that the research team's intention was to understand, connect, and empower community members in advocating for their needs. The intentional decision to directly or indirectly collaborate with community members naturally shifted the stance through which community members were perceived and the manner in which they were involved. Although there are many areas of growth, MECCA has an essential transformative ingredient- genuine curiosity and concern for the welfare of others- that cannot be learned and which is felt through the indelible imprints from experiences of services provided to deserving individuals. The O&E Program Evaluator was transparent with community members about his privileges and research expertise, while also being authentic about his commitment to learn from the communities in order to appropriately serve them. Walker and Carrion (2015) discuss their lessons learned from implementing a CBPR healthcare program and note the importance of transparency in identifying one's motives for engagement in the research, in order to contextualize one's intentions and decision-making perspectives, as well as promote collaboration. The sincere desire to understand and collaborate within the partnership is the essence of CBPR and MECCA. In thinking about generalizing the

experiences in developing and implementing MECCA's O&E program to other community-based programs, intentionality, transparency, and collaboration are key elements in approaching program development within ethnic or multiethnic communities. Additionally, through MECCA's experience, the CBPR principles can be included once these underlying elements are consistently exercised.

In thinking about the feasibility in implementing all aspects of the CBPR framework with hard-to-reach, underserved communities, the CBPR principles should serve as ideals to strive for, rather than areas that must be satisfied. The principles are secondary, especially when working with underserved communities, to the unwavering commitment and dedication to the collective wellbeing and relationships amongst stakeholders. In thinking about the MECCA O&E Program, it was initiated by county, which is often seen as contradictory to the CBPR framework since it was not initially derived from community needs (Johnson-Shelton et al., 2015); however, with the guidance of the Program Evaluator, this approach still successfully integrated the communities and adhered to the essential sentiment of empowerment and collaboration through the medium of relationships. The MECCA O&E Program was successful in serving communities and utilizing a county-provided opportunity to its benefit. Additionally, MECCA demonstrates to other community-based programs how to utilize CBPR partnerships and principles within traditional research protocols through shifting the research focus to community members and deepening the positive impact on communities (Johnson-Shelton et al., 2015). This is an important skill as it is more likely that CBPR principles will be incorporated with traditional practices until CBPR is more accepted by the greater psychology field, academic institutions, and various other stakeholders.

Furthermore, the available CBPR literature focuses on the inclusion of CBPR principles, research, or evaluations with singular identified communities; however, there is a lack of research on the development, implementation, or evaluation of CBPR processes within a multi-ethnic collective or agency. Thus, without information to guide the processes of negotiating cross-cultural challenges with ethnically and linguistically- isolated communities, it was likely more challenging for the MECCA O&E Program to implement and evaluate its' program. The greater challenges were likely related to the need for stakeholders to learn how to serve a diverse composition of community-based agencies, while simultaneously collaborating in a culturally responsive manner with one another. Applying CBPR principles with differing cultural communities was also difficult due to the differences in contextual backgrounds that made it harder to understand and satisfy one another's needs (Schmittdiel, Grumbach, & Selby, 2010). Additionally, some stakeholders could not communicate with one another due to language barriers; thus, this was an additional factor that impacted the extent to which partners collaborated with one another. Thus, these factors likely influenced the process in which the CBPR principles were implemented, as they required for the stakeholders and research team to consistently and fluidly adapt to distinct cultural contexts and manners of engagement. Furthermore, the consistent adherence to CBPR principles will be more viable when the funder(s) understand the empowering and consumer-centered process and are intentional in incorporating aspects of CBPR in all components of the research. MECCA worked hard to overcome county-funded challenges and increase awareness of CBPR, while improving the health of the communities.

Additionally, one of the strengths of the O&E Program was that it was run by staff that were community members from the respective communities they served. The priority was on

empowering staff to take initiative in working with community members and administering research measures as they saw fit, which meant less emphasis was placed on providing staff with feedback on areas for improvement. This likely impacted the quality of the data collection process. Spending time in the community to identify the respective community's communal areas (e.g., spiritual centers, primary care clinics) would be beneficial, as it would help identify leading voices in that community. The identified individuals can engage in one-on-one meetings with the research team to individually help them in understanding research measures, implementation, and documentation within a collaborative framework.

Overall, the MECCA O&E Program has proved to be a resilient, culturally-centered program that has overcome many challenges, while simultaneously paving the way for collaborating with a multitude of multi-ethnic communities. With the rich experiences and intimate academic-community partnerships that are existent across MECCA, it is only with time and experience that MECCA will continue to surpass obstacles and serve as an exemplar in appropriately including multi-ethnic community members in all stages of the research. With the trusting relationships and inclusion of CBPR partnerships, there will be a significant improvement in community care and health (Schmittdiel et al., 2010).

Final Thoughts

The findings from this post-reflection discussion and analysis will be shared with the MECCA Executive Board and staff members prior to the July 2017 fiscal year. The research team will allocate sufficient time to discuss and receive feedback regarding the thematic findings. Although the Outreach and Engagement Program ended in September 2015, the findings will inform the implementation and modification of MECCA's current and future programs and partnerships. Additionally, the thematic findings highlight both strengths and areas

of improvement within the partnerships and extent of CBPR adherence. The thematic findings reinforce that the academic-community relationships allowed for stakeholders that would traditionally not collaborate to be able to effect positive change in academic and community experiences. Overall, the thematic findings provide lessons learned from the development and implementation of MECCA's O&E Program, as well as serve as a guide for future programs.

Limitations & Future Research

This study has some limitations. First, the program evaluation is based on the qualitative information gathered from only one key informant. Although the research team believed that the key informant provided rich and detailed information from his various roles within the partnership, the study would have benefitted from discussions with other stakeholders to capture the varying experiences and disclosures; however, due to time and systemic constraints, it was difficult to include other stakeholders. Additionally, the key informant's experience and responses were likely impacted by his close relationship with the research and program processes. Secondly, the author of this study is one of the members of the Outreach & Engagement research team; thus, her intimate connection with the data collection and analysis likely allowed for greater understanding of the process, potentially biased her understanding or lessons learned from the discussion with the Program Evaluator, as well as influenced her writing of the findings. Future research should include both internal and external auditors throughout the programmatic evaluative process, in order to minimize biases. Thirdly, the methodology utilized qualitative research and thematic analysis that was influenced by the understanding and perspectives of the research team. The research team included two members that were part of the O&E data collection and one member that did not interact with the data or staff during the collection process. All three members of the research team are female doctoral

students with different ethnic backgrounds and cultural experiences, as well as an expressed interest in multicultural studies. It is likely that their demographics, interests, and personal and professional experiences with cultural communities may have impacted their understanding and importance given to specific areas of the reflection discussion. Future research should include greater diversity within the research team, as well as additional members that do not have experience with the program development and original data collection processes. The questions included for each unit of the CBPR curriculum, which was used as a discussion guide, were based on the unit-specific learning objectives and the research team's interpretation of the focus areas within each unit. Inclusion of both qualitative and quantitative program evaluation assessments would provide a more comprehensive assessment of CBPR adherence and limit potential biases in the interpretation of data. Future studies should include a balanced evaluation on adherence to CBPR principles and context of partnerships. Finally, there was a lack of research on how to assess CBPR principles when implemented with various multiethnic communities at one time; thus, additional research is needed with multiple cultural communities and its' impact on the implementation and evaluation of CBPR programs.

REFERENCES

Ahari, S. S., Habibzadeh, S., Yousefi, M., Amani, F., & Abdi, R. (2012). Community based needs assessment in an urban area: A participatory action research project. *BMC Public Health, 12,* 161. doi: 10.1186/1471-2458-12-161

Ahmed, S. M. & Palermo, A. S. (2010). Community engagement in research: Frameworks for education and peer review, *American Journal of Public Health*, 100(8), 1380-1387. https://doi.org/10.2105/AJPH.2009.178137

Appel, P. W. & Oldak, R. (2007). A Preliminary comparison of major kinds of obstacles to enrolling in substance abuse treatment (AOD) reported by injecting street outreach clients and other stakeholders. *The American Journal of Drug and Alcohol Abuse*, *33*(5), 699-705. doi: 10.1080/00952990701522641

Baiardi, J. M., Brush, B. L., & Lapides, S. (2010). Common issues, different approaches: Strategies for community-academic partnership development, *Nursing Inquiry,* 17(4), 289-296. https://doi.org/10.1111/j.1440-1800.2010.00509.x

Baron-Epel, O. (2003). Consumer-oriented evaluation of health education services*, Patient Education and Counseling, 49,* 139-147. http://dx.doi.org/10.1016/S0738-3991(02)00073-3.

Bazzano, A. T., Zeldin, A. S., Diab, I. R. S., Garro, N. M., Allevato, N. A., Lehrer, D., & WRC Project Oversight Team (2009). The healthy lifestyle change program: A pilot of a community-based health promotion intervention for adults with developmental disabilities. *American Journal of Preventive Medicine, (37)*6S1, S201-S208. doi: 10.1016/j.amepre.2009.08.005

Belansky, E. S., Cutforth, N., Chavez, R. A., Waters, E., Bartlett-Horch, K. (2011). An adapted version of Intervention Mapping (AIM) is a tool for conducting community-based participatory research. *Health Promotion Practice*, 12(3), 440-455. https://doi.org/10.1177/1524839909334620

Bilodeau, R., Gilmore, J., Jones, L., Palmisano, G., Banks, T., Tinney, B, & Lucas, G. I. (2009). Putting the "community" into community-based participatory research: A commentary. *American Journal of Preventive Medicine, (37)*6S1, S192-S194. doi:10.1016/j.amepre.2009.08.019

Bledsoe, K. L., & Graham, J. A. (2005). The use of multiple evaluation approaches in program evaluation. *American Journal of Evaluation, 28,* 302-319 doi:10.1177/1098214005278749

Blume, A. W., & Lovato, L. V. (2010). Empowering the Disempowered : Harm Reduction with racial / ethnic minority clients, *66*(2), 189–201. doi:10.1002/jclp

Bogart, L.M., & Uyeda, K. (2009). Community-based participatory research: Partnering with communities for effective and sustainable behavioral health interventions. *Health Psychology, (28)*4, 391-393. https://doi.org/10.1037/a0016387

Cheng, H. L., Kwan, K. L. & Sevig, T. (2013). Racial and ethnic minority college students' stigma associated with seeking psychological help: Examining psychocultural correlates, *Journal of Counseling Psychology*, 60(1), 98-111. https://doi.org/10.1037/a0031169

Chyung, S.Y., Wisniewski, A., Inderbitzen, B., & Campbell, D. (2013). An improvement-and accountability-oriented program evaluation: An evaluation of the adventure scouts program. *Performance Improvement Quarterly,* 26(3), 87-115. https://doi.org/10.1002/piq.21155

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, *15*(20), 37-70. doi: 10.1177/1529100614531398

The Examining Community-Institutional Partnerships for Prevention Research Group. (2006) Developing and sustaining community-based participatory research partnerships: A skill-building curriculum. Retrieved from http://www.cbprcurriculum.info.

Dalal, M., Skeete, R., Yeo, H. L., Lucas, G. I., & Rosenthal, M. S. (2009). A physician team's experiences in community-based participatory research: Insights into effective group collaborations, *American Journal of Preventive Medicine*, 2009, 37(6S1). doi: 10.1016/j.amepre.2009.09.036

Dietz, N. A., Hooper, M. W., Byrne, M. M., Messiah, A., Baker, E. A., Parker, D.,… Kobetz, E.(2012). Developing a smoking cessation intervention within a community-based participatory research framework. *Journal of Smoking Cessation*, *7*(02), 89–95. doi:10.1017/jsc.2012.17

Dow, H. D. (2011). Migrants' mental health perceptions and barriers to receiving mental health services. *Home Health Care Management, 23,* 176-185. doi: 10.1177/1084822310390876

D'Alonzo, K. T. (2010). Getting started in CBPR: Lessons in building community partnerships for new researchers. *Nursing Inquiry*, *17*(4), 282–8. doi:10.1111/j.1440-1800.2010.00510.x

Elissen, A. M., Van Raak, A. J., Derckx, E. W., & Vrijhoef, H. J. (2013). Improving homeless persons' utilisation of primary care: Lessons to be learned from an outreach programme in The Netherlands. *International Journal of Social Welfare*, *22*(1), 80–89. doi:10.1111/j.1468-2397.2011.00840.x

Flaskerud, J. H. (2007a). Cultural competence: What is it? *Issues in Mental Health Nursing*, 28, 121-123. doi: 10.1080/01612840600998154

Flaskerud, J. H. (2007b). Cultural competence: What effect on reducing health disparities? *Issues in Mental Health Nursing,* 28, 431-434. doi: 10.1080/01612840701246628.

Flicker, S., Travers, R., Guta, A., McDonald, S., & Meagher, A. (2007). Ethical dilemmas in community-based participatory research: Recommendations for institutional review boards, *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 84(4), 478-493. doi: 10.1007/s11524-007-9165-7.

Gallardo, M. E., Johnson, J., Parham, T. A., & Carter, J. A. (2009). Ethics and multiculturalism: Advancing cultural and clinical responsiveness. *Professional Psychology: Research and Practice*, *40*(5), 425–435. doi:10.1037/a0016871

Gary, F. A. (2005). Stigma: Barriers to mental health care among ethnic minorities. *Issues in Mental Health Nursing, 26,* 979-999. https://doi.org/10.1080/01612840500280638

Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: Interviews and focus groups. *British Dental Journal*, 204, 291-295. https://doi.org/10.1038/bdj.2008.192

Glassman, M. & Erdem, G. (2014). Participatory action research and its Meanings : Vivencia, praxis, conscientization. *Adult Education Quarterly 64*(3), 206-221. https://doi.org/10.1177/0741713614523667

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry, 10,* 113. doi:10.1186/1471-244X-10-113

Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental illness stigma, help seeking, and public health programs. *American Journal of Public Health, 103*(5),777-780.Retrieved from http://search.proquest.com/docview/1349240725?accountid=458

Horowitz, C. R., Robinson, M., & Seifer, S. (2009). Community-based participatory research from the margin to the mainstream: Are researchers prepared?. *Circulation*, 119(19), 2633-2642. https://doi.org/10.1161/CIRCULATIONAHA.107.729863

Hsu, H. C., Wang, C. H., Chen, Y. C., Chang, M. C., & Wang, J. (2010). Evaluation of a community-based aging intervention program. *Educational Gerontology*, 36, 547-572, doi: 10.1080/03601270903237713

Israel, B. A., Schulz, A., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*, 19, 173-202, doi: 10.1146/annurev.publhealth.19.1.173.

Israel, B. A., Eng, E., Schulz, A., Parker, E. A., & Satcher, D. (2012). *Methods in community-based participatory research for health*. San Francisco, CA: Jossey-Bass.

Jimenez, D. E., Bartels, S. J., Cardenas, V., & Alegría, M. (2013). Stigmatizing attitudes toward mental illness among racial/ethnic older adults in primary care. *International Journal of Geriatric Psychiatry*, *28*(10), 1061–8. doi:10.1002/gps.3928

Johnson-Shelton, D., Moreno-Black, G., Evers, C., & Zwink, N. (2015). A community-based participatory research approach for preventing childhood obesity: The communities and

schools together project. *Program Community Health Partnership*, 9(3), 351-361. https://doi.org/10.1353/cpr.2015.0056

Kataoka, S. H., Nadeem, E., Wong, M., Langley, A. K., Jaycox, L. H., Stein, B. D., & Young, P. (2009). Improving disaster mental health care in schools, A community-partnered approach. *American Journal of Preventive Medicine, (37)*6S1, S225-S229, doi:10.1016/j.amepre.2009.08.002

Khamphakdy-Brown, S., Jones, L. N., Nilsson, J. E., Russell, E. B., & Klevens, C. L. (2006). The empowerment program : An application of an outreach program for refugee and immigrant women, *28*(1), 38–47. doi:http://dx.doi.org/10.17744/mehc.28.1.fmc2j3jw5xx1cvbf

Khan, C.T. (2015). Kombis, brothels, and violence against women: Building global health partnerships to address women's health empowerment. 2015). In *Partnerships for Mental Health: Narratives of Community and Academic Collaboration.* (pp. 69-75). Springer International Publishing. doi: 10.1007/978-3-319-18884-3_5

Kidd, S. A. & Kral, M. J. (2005). Practicing participatory action research. *Journal of Counseling Psychology*, 52(*2),* 187-195, doi: 10.1037/0022-0167.52.2.187

Knifton, L., Gervais, M., Newbigging, K., Mirza, N., Quinn, N., Wilson, N., & Hunkins-Hutchison, E. (2010). Community conversation: Addressing mental health stigma with ethnic minority communities. *Social Psychiatry and Psychiatric Epidemiology*, *45*(4), 497–504. doi:10.1007/s00127-009-0095-4.

Lam, C. S., Tsang, H. W. H., Corrigan, P. W., Lee, Y. T., Angell, B., Shi, K. & Larson, J. E. (2010). Chinese lay theory and mental illness stigma: Implications for research and practices. *Journal of Rehabilitation, 76*, 35-40.
Retrieved from EBSCOhost. (Accession No. 48316136).

Letcher, A. S. & Perlow, K. M. (2009). Community-based participatory research shows how a community initiative creates networks to improve well-being. *American Journal of Preventive medicine, (37)*6S1, S292-S299, doi:10.1016/j.amepre.2009.08.008

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology,* 27(1), 363-385. https://doi.org/10.1146/annurev.soc.27.1.363

Macaulay, A. C., Cross, E. J., Delormier, T., Potvin, L., Paradis, G., & McComber, A. (as cited in Mikesell, L., Bromley, E., & Khodyakov, D., 2013) (1998). Developing a Code of Research Ethics for research with a Native community in Canada: A report from the Kahnawake Schools Diabetes Prevention Project. *Int J Circumpolar Health*. *57*(1),38-40. doi: 10.2105/AJPH.2013.301605

Macaulay, A. C., Delormier, T., McComber, A. M., Cross, E. J., Potvin, L. P., Paradis, G.,…Desrosiers, S. (1998). Participatory research with native community of Kahnawake creates innovative Code of Research Ethics. *Can J Public Health*. *89*(2), 05-108.
Retrieved from PubMed (PMID: 9583251).

Macaulay, A. C. & Nutting, P. A. (2006). Moving the frontiers forward: Incorporating community-based participatory research into practice-based research networks. *Annuals of Family Medicine,* 4(1), 4-7, doi: 10.1370/afm.509

Marshall, M. N. (1996). The key informant technique. Oxford University Press, 13(1), 92-97. https://doi.org/10.1093/fampra/13.1.92

Matthieu, M. M., Gardiner, G., Ziegemeier, E., & Buxton, M. (2014). Using a service sector segmented approach to identify community stakeholders who can improve access to suicide prevention services for veterans. *Military Medicine*, *179*(4), 388–95. doi:10.7205/MILMED-D-13-00306

McKinney, C., Bishop, V., Cabrera, K., Medina, R., Takawira, D., Donate, N.,…Guevara, B. (2014). NuFit: Nutrition and fitness CBPR program evaluation. *Journal of Prevention & Intervention in the Community,* 42, 112- 124, doi: 10.1080/10852352.2014.881180

Mendez-Luck, C. A., Trejo, L., Miranda, J., Jimenez, E., Quiter, E. S., & Mangione, C. M. (2011). *The Gerontologist*, *(51)*S1k, S94-S105, doi: 10.1093/gerant/gnq076

Mertens, D. M. (2009). Transformative research and evaluation. New York, NY: The Guilford Press.

Mier, S., Boone, M., & Shropshire, S. (2009). Community consultation and intervention: Supporting students who do not access counseling services. *Journal of College Student Psychotherapy*, *23*(1), 16–29. doi:10.1080/87568220802367602

Mikesell, L., Bromley, E., & Khodyakov, D. (2013). Ethical community-engaged research: A literature review. *American Journal of Public Health*, *103*(12), e7–e14. doi:10.2105/AJPH.2013.301605

Morisky, D. E., Malow, R. M., Tiglao, T. V., Lyu, S. Y., Vissman, A. T., & Rhodes, S. D. (2010). Reducing sexual risk among Filipina female bar workers: Effects of a CBPR-developed structural and network intervention. *AIDS Education and Prevention, (22)*4, 371-385. https://doi.org/10.1521/aeap.2010.22.4.371

Munson, M. R., Scott, L. D., Smalling, S. E., Kim, H., & Floersch, J. E. (2011). Former system youth with mental health needs: Routes to adult mental health care, insight, emotions, and mistrust. *Children and Youth Services Review, 33,* 2261-2226. http://dx.doi.org/10.1016/j.childyouth.2011.07.015.

NG, A. T. & McQuistion H. L. (2004). Outreach to the homeless: Craft, science, and future implications. *Journal of Psychiatric Practice 10*(2), 95-105. https://doi.org/10.1097/00131746-200403000-00004

Oscos-Sanchez, M. A., Lesser, J., & Kelly, P. (2008). Cultural competence column. Flaskerud, J. (Ed.), *Issues in Mental Health Nursing,* 29, 197-200 doi: 10.1080/01612840701792258

Park, N. S. (2009). The relationship of social engagement to psychological well-being of older adults in assisted living facilities. *Journal of Applied Gerontolog*y, 28(4), 461-481. https://doi.org/10.1177/0733464808328606

Pastor-Montero, S. M., Romero-Sánchez, J. M., Paramio-Cuevas, J. C., Hueso-Montoro, C., Paloma-Castro, O., Lillo-Crespo, M.,… Frandsen, A. J. (2012). Tackling perinatal loss, a participatory action research approach: Research protocol. *Journal of Advanced Nursing*, *68*(11), 2578–85. doi:10.1111/j.1365-2648.2012.06015.x

Patel, A. I., Bogart, L. M., Uyeda, K. E., Martinez, H., Knizewski, R., Ryan, G. W., & Schuster, M. A. (2009). School site visits for community-based participatory research on healthy eating. *American Journal of Preventive Medicine, (37)*6S1, S300-S306 doi: 10.1016/j.amepre.2009.08.009

Pepin, R., Segal, D. L., & Coolidge, F. L. (2009). Intrinsic and extrinsic barriers to mental health care among community-dwelling younger and older adults. *Aging & Mental Health*, *13*(5), 769–77. doi:10.1080/13607860902918231

Ponder-Brookins, P., Witt, J., Steward, J., Greenwell, D., Chew, G. L., Samuel, Y., … Brown, M. J. (2014). Incorporating community- based participatory research principles into environmental health research : Challenges and lessons learned from a housing pilot study, *Journal of Environmental Health*, *76*(10), 8–18, Retrieved from PubMed (PMID: 24988659).

Ponterotto, J. G. (2013). Qualitative research in multicultural psychology: Philosophical underpinnings, popular approaches, and ethical considerations. *Qualitative Psychology, 1(S),* 19-32, doi: 10.1037/2326-3598.1.S.19

Rastogi, M., Massey-Hastings, N., & Wieling, E. (2012). Barriers to seeking mental health services in the Latino/a community: A qualitative analysis. *Journal of Systemic Therapies*, *31*(4), 1-17. doi:10.1521/jsyt.2012.31.4.1

Rajabiun, S., Cabral, H., Tobias, C., & Relf, M. (2007). Program design and evaluation strategies for the special projects of national significance outreach initiative. *AIDS Patient Care and STDs*, *21 Suppl 1*, S9–19. doi:10.1089/apc.2007.9991

Reid, S. D., Reddock, R., & Nickenig, T. (2014). Breaking the silence of child sexual abuse in the Caribbean: A community-based action research intervention model. *Journal of Child Sexual Abuse,* 23, 256-277, doi: 10.1080/10538712.2014.888118

Rhodes, S. D., Eng, E., Hergenratber, K. C, Rem- nitz, I. M., Arceo, R., Montano, J., & Alegria-Ortega, J. (2007). Exploring Latino men's HIV risk using community-based participatory research. *American Journal of Health Behavior, 31,*146-158. https://doi.org/10.5993/AJHB.31.2.4

Robinson, S., Fisher, K. R., & Strike, R. (2014). Participatory and inclusive approaches to disability program evaluation. *Australian Social Work, (67)*4, 495-508 doi: 10.1080/0312407X.2014,902979

Rosen, C. S., Greene, C. J., Young, H. E., & Norris, F. H. (2005). Tailoring Disaster Mental Health Services to Diverse Needs: An analysis of 36 crisis counseling projects, *Health & Social Work*, 211-221, http://dx.doi.org.lib.pepperdine.edu/10.1093/hsw/35.3.211

Schmittdiel, J. A., Grumbach, K., & Selby, J. V. (2010). Systems-based participatory research in health care: An approach for sustainable translational research and quality improvement. *Analysis of Family Medicine*, 8(3), 256-259. https://doi.org/10.1370/afm.1117

Seifer, S. D. (2006). Building and sustaining community-institutional partnerships for prevention research: Findings from a national collaborative. *Journal of Urban Health. https://doi.org/10.1007/s11524-006-9113-y*

Shah, A., & Beinecke, R. H. (2009). Global mental health needs, services, barriers, and challenges. *International Journal of Mental Health, 38,* 14-29. doi: 10.2753/IMH0020-7411380102

Shetgiri, R., Katoka, S. H., Ryan, G. W., Askew, L. M., Chung, P. J., & Schuster, M. A. (2009). Risk and resilience in Latinos: A community-based participatory research study. *American Journal of Preventive Medicine, (37)*6S1, S217-S224 doi: 10.1016/j.amepre.2009.08.001

Sorkin, D. H., Pham, E., Ngo-Metzger, Q. (2009). Racial and ethnic differences in the mental health needs and access to care of older adults in California, *Journal of the American Geriatrics Society*, 57(12), pp. 2311-2317. https://doi.org/10.1111/j.1532-5415.2009.02473x

The Examining Community-Institutional Partnerships for Prevention Research Group (2006). *Developing and Sustaining Community-Based Participatory Research Partnerships: A Skill-Building Curriculum.* www.cbprcurriculum.info

Thomas, L. R., Donovan, D. M., & Sigo, R. L. W. (2010). Identifying community needs and resources in a Native Community: A research partnership in the pacific northwest. *International Journal of Mental Health Addiction,* 8, 362-373 doi:10.1007/s11469-009-9233-1

Trimble, J. E., Scharrón-del Río, M., Casillas, D. M. (2014). Ethical matters and contentions in the principled conduct of research with ethnocultural communities. In F. T. L. Leong, L. Comas-Díaz, H. Nagayama , C. Gordon , V. C. McLoyd, & J. E. Trimble (Eds.), *APA handbook of multicultural psychology*, *Vol. 1: Theory and research* (pp. 59-82). Washington, DC: American Psychological Association. doi: 10.1037/14189-004

U.S. Census Bureau. (2012a). Most children younger than age 1 are Minorities, Census Bureau Reports. Retrieved from: http://www.census.gov/newsroom/releases/archives/population/cb12-90.html

U.S. Census Bureau. (2012b). U.S. Census Bureau projections show a slower growing, older, more diverse nation a half century from now. Retrieved from: http://www.census.gov/newsroom/releases/archives/population/cb12-243.html

Vanheusden, K., Mulder, C. L., van der Ende, C., van Lenthe, F.J., Mackenbach, J. P. Verhulst, F. C. (2008). Young adults face major barriers to seeking help from mental health services, *Patient Education and Counseling, 73*, 97-104, http://dx.doi.org/10.1016/j.pec.2008.05.006.

Viguer, P., Rodrigo, M. F., & Sole, N. (2013). The family debate on values and living together: A community-based approach through participatory action research, *Journal of Community Psychology*, 41(8), 944-958. https://doi.org/10.1002/jcop.21582

Walker, S. E. and Carrion, V. G. (2015). The center for youth wellness: A community-based approach to holistic health care in San Francisco. In *Partnerships for Mental Health: Narratives of Community and Academic Collaboration.* (pp. 37-50). Springer International Publishing. doi: 10.1007/978-3-319-18884-3_3

Wilson, H. W., Coleman, G. J., Floyd, B. R., & Donenberg, G. R. (2015). Building relationships with at-risk populations: A community engagement approach for longitudinal research. In *Partnerships for Mental Health: Narratives of Community and Academic Collaboration.* (pp. 19-35). Springer International Publishing. doi: 10.1007/978-3-319-18884-3_2

Wilson, T. E., Fraser-White, M., Williams, K. M., Pinto, A., Agbetor, F., Camilien, B.,… Joseph, M. A. (2014). Barbershop talk with brothers: Using community-based participatory research to develop and pilot test a program to reduce HIV risk among black heterosexual men. *AIDS Education and Prevention, (26)*5, 383-397. https://doi.org/10.1521/aeap.2014.26.5.383

Willig, C. (2013). *Introducing Qualitative Research in Psychology,* (3rd ed.). New York, NY: McGraw-Hill House.

Wolff, T. (2014). Community psychology practice: Expanding the impact of psychology's work. *American Psychologist*, 803-813, doi: 10.1037/a0037426.

APPENDIX A

Extended Review of the Literature

Author/Year	Research Questions/Objectives	Sample	Instrumentation	Research Approach/Design	Major Findings
Ahari, Habibzadeh, Yousefi, Amani, & Abdi (2012). Community based needs assessment in an urban area: A participatory action research project, *BMC Public Health* , *12* , 161. doi:10.1186/1471-2458-12-161	The study utilized participatory action research as a method for community assessment to assess the health problems within the Iranian community. The study aimed to: "1) demonstrate how health related needs could be assessed through a PAR approach to community participation in an urban community inside a developing country; and 2) encourage community groups and non-state organizations to collaborate to conduct health-related research" The goal as to determine the primary needs of the community through meeting with community members, in order to provide appropriate interventions.	The community stakeholders involved in the development and implementation of the study included N=12 Steering Committee members, who were local community members, that had been elected to participate in the design and data collection/analysis. N = 600 Iranian households decided based on cluster random sampling using the Community Development Center (CDC) database of Ardabil, Iran. N = 600 Households were interviewed, 15% of the households in Ardabil, Iran	The Steering Committee selected a 60 yes/no item questionnaire that assessed the local health of the community members, as well as their demographics. Thirty face-to-face interviews were also conducted and repeated after a period of 14 days to assess instrument reliability (r = 0.76).	A community needs assessment was conducted, in accordance with the PAR model. The Steering Committee consisted of local community members, who facilitated the methods design and data analysis of the study. The Steering Committee elected representatives from the 12 areas within the neighborhood, who subsequently attended questionnaire and data analysis workshops. There were three group discussions held in each area within the 12 areas of the neighborhood, during which representatives asked community members "what is the most important problem in your community's health?" Community members were informed of the PAR model and that information would be utilized to provide appropriate and necessary interventions. Mixed Methods Data Analysis: Surveys, Focused Group Discussions, and face-to-face interviews Assessment areas: seriousness, urgency, solvability, and financial burden of the problems to produce more results throughout the neighborhood.	With regards to the PAR model, the study found: to serve and collaborate with the communities, one must establish relationships of empowerment, trusting relationships with leaders within the community, and involvement in health research to encourage greater community member participation. 1) Relationships of empowerment: researchers help community members identify and find out their own problems and needs. 2) Community participation was found to be achieved through: -Acknowledging the role of people in designing and conducting studies Providing trainings in research methods and analysis to community members -Building trusting relationships and empowering members -Using the community's viewpoint as guidance -Creating a sense of responsibility in the community -Involving a non-state organization in the research as a bridge between the community and the state -Communicating research results with participants in public forums (i.e., discussions) and newspaper articles. Through the PAR model, researchers were able to identify the problems as identified by the community members to be able to provide interventions and support.
Ahmed, S. M. & Palermo, A. S. (2010). Community engagement in research: Frameworks for education and peer review, *American Journal of Public Health* , *100* (8), 1380-1387.	The National Institutes of Health (NIH) Director's Council of Public Representatives (COPR) aim was to provide 1) the definitions and principles of community engagement and ways to increase level of engagement, 2) guidelines to educate researchers and lay public on community engagement, and 3) criteria and guidance that peer-review panels can use to assess the level of community engagement.	N/A	Review of the literature and meetings with experts in the different focuses of community engagement (sample # not provided)	Literature Review	Framework for education on community engagement in research: Based on 5 principles and the 13 values described in the framework. The 5 principles include: -Definition and scope of community engagement in research -Strong community-academic partnership -Equitable power and responsibility -Capacity building -Effective dissemination plan Framework for peer review of community engagement proposals: There are different points, but the goal through the different points is to provide information to the researchers and community members of how to engage in research and the need for reviewers to be familiar with the principles of community engagement.
Appel, P. W. & Oldak, R. (2007). A Preliminary Comparison of Major Kinds of Obstacles to Enrolling in Substance Abuse Treatment (AOD) Reported by Injecting Street Outreach Clients and Other Stakeholders. *The American Journal of Drug and Alcohol Abuse,* *33* (5), 699-705. doi: 10.1080/00952990701522641	To identify barriers to engaging in substance abuse treatment for heroin users.	N = 144 Outreach clients N = 55 Outreach program and staff N = 11 Agency managers and officials	Use of four-factor classification of treatment enrollment barriers: 1) individual client issues (IC) 2) access to treatment (TAX) 3) Availability of treatment (AVL) 4) Acceptability of clients	Use of four-factor classification of treatment enrollment barriers: 1) individual client issues (IC) 2) access to treatment (TAX) 3) Availability of treatment (AVL) 4) Acceptability of clients	Most common obstacle category was access to treatment
Arabian, S., Cabral, H., Tobias, C., & Relf, M. (2007). Program design and evaluation strategies for the special projects of national significance outreach initiative. *AIDS Patient Care and STDs,* 21 Suppl 1, S9–19. doi:10.1089/apc.2007.9991	To evaluate outcomes from national significance outreach initiative	N = 10 sites and 1133 study participants	quantitative evaluation; client interviews, medical record data, and program contact information Measures: sociodemographic and health care utilization, barriers to care (i.e., established for study), HIV stigma as a barrier for care, support services (non-medical needs adapted from HIV Cost and Services utilization Study and the Measurement Group needs assessment survey), outreach program contacts (# of contacts), retention qualitative study: 7/10 sites participated in interviews that covered experience testing HIV positive and seeking first HIV treatment, past experience with HIV medical care, current experience with HIV medical care, future plans with living with HIV, and role of programmatic interventions.	nonrandomized, longitudinal study	This study discusses the study design and methods used to implement and evaluate the large multisite initiative. Some of the strengths/limitations are discussed below: 1) different interventions used across the sites 2) the study design lacked comparison groups 3)lack of construct validity of survey items 4) sampling approach for the study (purposive)

Baiardi, J. M., Brush, B. L., & Lapides, S. (2010). Common issues, different approaches: strategies for community-academic partnership development, *Nursing Inquiry, 17* (4), 289-296.	To describe the process of development and implementation of a collaborative partnership. The researchers describe their use of the CBPR framework at all stages of the research (i.e, including data collection and analysis), outcomes of collaborative research efforts, and lessons learned.	N/A	N/A	CBPR Framework	Described the process of working from a CBPR framework. Lessons Learned: - The need to recognize the power differentials/hierarchy that can occur within an organization, rather than just between academic-community partners. - Bring up group dynamics directly and allow members to provide their individualized goals for participation in the group. -Individual efforts are essential to the group's overall success. -Mindful about the impact of grants on partnerships and utilizing partnership experiences to inform grant proposals and research developments.
Baron-Epel, O. (2003). Consumer-oriented evaluation of health education services, *Patient Education and Counseling, 49,* 139-147. http://dx.doi.org/10.1016/S0738-3991(02)00073-3	To evaluate the extent to which the presence of formal health education units in health plans impacts a consumers reported health education.	*N* = Four Israeli health plans that insure all Israel residents (semi-structured interviews) *N* = 793 Respondents to questionnaire/ surveys	Semi-Structured Interview: Interviews were conducted with the national coordinators from each of the four Israeli health plans. Interview consisted of questions related to job description, how health issues are handled, priorities, administrative issues and personal variables. -Questionnaire: With Israeli respondents that addressed their perception of their health, lifestyle behaviors, pattern of visits to the medical team, counseling on lifestyle issues, and additional questions. Counseling on lifestyle issues was measured using three stages: Assessment, Advice, and Assistance, in order to comprehensively evaluate the content of the counseling. - The goal is to assess the consumer's perception of the health care interventions provided.	Mixed Methods	The results did not demonstrate significant differences between the plans (with/without health units); thus, the study suggests that in order to capture the consumer's perspective of the interventions, there need to be more effective ways to assess the quality and quantity of health education.
Bazzano, A. T., Zeldin, A. S., Diab, I. R. S., Garro, N. M., Allevato, N. A., Lehrer, D., & WRC Project Oversight Team (2009). The healthy lifestyle change program: A pilot of a community-based health promotion intervention for adults with developmental disabilities. *American Journal of Preventive Medicine* , (37)6S1, S201-S208	The introduction focuses on the limited interventions available for individuals with developmental disabilities, who also have concerns with wellness and obesity. Additionally, the focus of this study is on utilizing a CBPR framework and methods to work "with" community members that have developmental disabilities and learn how to appropriately serve them. - The Healthy Lifestyle Change Program was developed to assess the extent to which it helped in improving the wellness of those with developmental disabilities.	*N* = 431 Community-Dwelling adults (aged18-65 years), who were overweight (BMI>25) with another risk factor for diabetes or metabolic syndrome, and received services from a community agency.	The program and intervention was developed from a CBPR framework. The Healthy Lifestyle Change Program (HLCP) intervention was designed by the team. The program included peer mentors, with the belief that they could better understand the struggles of individuals with developmental disabilities. The HLCP included twice-weekly, 2 hour sessions conducted over 7 months at community locations. Topics focused on: general health care, nutrition, physical fitness, chronic conditions, medications, and behavioral modification. Outcomes were assessed at the baseline and at the end of the program (7 months). In addition, additional measures were administered, including: health knowledge questionnaires, Beck Depression Inventory-II.	A CBPR framework and methodology, in which members of the population met weekly with academic advisors to discuss the development, implementation, and dissemination of the study to the larger community. The design used a pre/post test outcomes evaluation	The HLCP evaluation demonstrated positive outcomes of weight loss, improved nutrition, increased physical activity (55% reported exercise 3x a week to 75% post-program), increased confidence in their ability to access health care. There was no significant change in mean life satisfaction, but 59% reported improved life satisfaction. Outcomes: 2/3rds of participants (29/44) lost or maintained weight (tracked via weight and abdominal girth).Median weight loss was 7 lbs. The program has continued and disseminated its findings to others.
Belansky, E. S., Cutforth, N., Chavez, R. A., Waters, E., Bartlett-Horch, K. (2011). An adapted version of Intervention Mapping (AIM) is a tool for conducting community-based participatory research. *Health Promotion Practice, 12* (3), 440-455. https://doi.org/10.1177/1524839909334620	This study uses a CBPR framework to apply an adapted version of Intervention Mapping (AIM) to help students increase physical activity and healthy eating.	*N* = 5 schools 3-4 participants from each school Total of 16 semi structured interviews conducted with individuals that had a leadership position within the school (i.e., principal), as well as involved in the planning process of AIM.	This study uses AIM, which is Intervention Mapping to aid for public health intervention. Intervention Mapping is a planning process to aid for public health and policy changes. Intervention Mapping includes: -acknowledgement of links between individuals and their physical and sociocultural environments -use of behavioral theory to guide intervention strategies - planning for evaluation, adoption, and sustainability	Data Analysis Methods: Qualitative Interviews 16 semi-structured interviews were conducted	Findings demonstrate that the implementation and application of AIM was aligned with 7 of 9 CBPR principles. Areas of growth regarding CBPR principles: -The concerns of the research advisory board and stakeholders at the school were not the same -the CBPR process did not focus on empowering the task force to continue to project post the completion of the AIM process Task Force Feedback: a) shortening the process for the task force b) building leadership roles/capacity building with members in the task force to promote continuing the process post study without relying on outside facilitators c) working on program notebook prior to implementation, to strengthen program implementation and sustainability.

Bilodeau, R., Gilmore, J., Jones, L., Palmisano, G., Banks, T., Tinney, B,, & Lucas, G. I. (2009). Putting the "community" into community-based participatory research: A commentary. *American Journal of Preventive Medicine,* (37)6S1, S192-S194. doi:10.1016/j.amepre.2009.08.019	To share perspectives on community-academic research partnerships and provide recommendations to strengthen the relationships between community health partners and university researchers to improve the benefits for all stakeholders.	UCLA, University of Michigan, University of Pennsylvania, and Yale University training Robert Wood Johnson Foundation (RWJF) Clinical Scholars in CBPR	CBPR Framework	Commentary	Benefits of Academic-Community Based Research Partnerships -Benefits to Community Partners: Exposure to unique clinical and research expertise, enhancing the credibility of our work, building capacities for EBP, Foundation for Reciprocal Relationships -Benefits for university researchers doing CBPR: Providing new understanding of complex health issues, experience in translating research intro practice -Challenges of CBPR: Investment of time, stakeholder involvement is multi-layered, balancing available time with goals of the project, balancing commitments to service provision with research project needs, sustainability of efforts, negotiating access to data generated by research, and universities' skepticism about CBPR.
Bledsoe, K. L., & Graham, J. A. (2005). The use of multiple evaluation approaches in program evaluation. *American Journal of Evaluation, 28* , 302-319 doi:10.1177/1098214005278749	Review of evaluation methods, as well as benefits of using multiple evaluation approaches in community work. -Use of a program evaluation that used different components of various evaluation approaches to examine a community-based family literacy program.	A program (Fun with Books) is an interactive family literacy program that uses children's literature and music to support school readiness.	Program Evaluations: Empowerment Evaluation: a participatory evaluation that incorporates the perspectives of all stakeholders and allows for all stakeholders to identify and define their program needs and the evaluation methods. Theory-Driven Evaluation: combination of both social science theory and stakeholder program logic model to define the goals of the program, the manner in which it fulfills the goals, and how much each goal and objective can impact the overall impact. Consumer-Based Evaluation: Incorporating the consumers if the design and implementation of the program (including evaluation procedures and questions) Inclusive Evaluation: Including both traditional stakeholders (such as academic researchers and funders), as well as those stakeholders that have been traditionally excluded from the research process (i.e., consumers, groups)	Review of Evaluation Literature: particularly theory-driven, consumer-based, empowerment, inclusive, and use-focused evaluations.	The findings found that the use of multiple evaluation approaches allowed for developing programmatic recommendations and taking care of specific areas of the program. 1) Theory-Driven Approach: was the most useful in identifying what the program intended to do through the use of scientifically based strategies and logic models. 2) Empowerment Approach: was useful in helping all the stakeholders understand the goals and objectives of the program, rather than solely focusing on those of the research/evaluation team. 3) Inclusive Approach: encouraged the high-level stakeholders to exercise cultural sensitivity through including the perspectives and needs of those that the program served. Regarding the program implementation, it was recommended that there be an extension of the program length, more structured and formalized ways of testing consumers, identify the target population more accurately. Recommendations for future evaluations: -Include all stakeholders in the ongoing evaluation process -Develop an evaluation team -Use other similar programs as a point of reference to follow in how they are conducting their program and evaluating it.
Blevins, D., Morton, B., & McGovern, R. (2008). Evaluating a community-based participatory research project for elderly mental healthcare in rural America, *Clinical Interventions in Aging* , *3* , 535-545.	To explore the collaborative nature of partners in a mental health program and to assess the (Naylor Method) effectiveness of a method for assessing the collaborative process (includes 6 domains).	$N = 16$ collaborative partners	Semi-structured interviews (questions related to identification of need, definition of actual research activities, use of resources, evaluation methods, indicators success, and sustainability)	CBPR/Qualitative interviews	Evaluating CBPR through the interview data: -the categories of participation and collaboration are intertwined in each domain -model does not assess for the level of collaboration between partners -model does not assess the level of readiness necessary for collaborative relationships -domains should be more distinguished to do a more effective assessment.
Blume, A. W., & Lovato, L. V. (2010). Empowering the Disempowered : Harm Reduction with racial / ethnic minority clients, *66* (2), 189–201. doi:10.1002/jclp	To use a harm-reduction CBPR model with clients from ethnic communities to better serve individuals via a case study.	N/A	Case Study	Harm-Reduction Therapy	The authors use the case study to present how to use harm-reduction strategies, while support from the communities to understand the cause of the individual's distress and ways to use the community values (use of healer) to help one improve their mood. -Both the community and the individual collaborate to find healing for the individual and through the process the community has increased self-capacity. -Harm Reduction strategies are empirically supported and by collaborating with the community, one is acting in accordance with scientific evidence and community guidance.

Bogart, L. M. & Uyeda, K. (2009). Community-based participatory research: Partnering with communities for effective and sustainable behavioral health interventions. *Health Psychology, 4* (28), 391-393	Advancing health psychology through debunking myths about CBPR and discuss the benefits of using CBPR	Randomized controlled trial of a school-based adolescent obesity prevention intervention (Students for Nutrition and Exercise). -Community partner is a large school district	CBPR Principles; using Resnicow et al.'s (2009) research, as well as their own study to discuss the benefits of their research	Randomized controlled trial, & commentary	Myth 1: Every Study should include all elements of CBPR- Researchers should engage in a discussion with community partners about the type of CBPR needed to fulfill their goals Myth 2: CBPR leads to compromised and weak research methodologies- Although internal validity may be sacrificed (i.e., not all schools are the same), it can increase external validity and generalizability of results to the real setting; the findings can be translated into real interventions for communities. Also, some research questions would never be thought of without being learned from the communities. Myth 3: CBPR helps community members more than researchers-CBPR helps researchers understand the needs of the communities and thus to develop culturally-sensitive interventions to more effectively help them. Without CBPR principles, the studies would lack ecological validity. It is important to focus on the shared goals of both parties and bring greater awareness to them.
Braun, K. L., Nguyen, T. T., Tanjasiri, S. P., Campbell, J., Heiney, S. P., Brandt, H. M., Smith, S. A., et al. (2012). Operationalization of community-based participatory research principles: Assessment of the national concern institute's community network programs. *American Journal of Public Health* , *102* (6).	To review CBPR literature and use of CBPR measurement tools.	N = 25 Community Network Programs (CNPs)	27-item questionnaire for CNPs to self-assess their operationalization of 9 CBPR principles	Literature Review, self-assessment	Review of the 9 CBPR principles - CNPs performed well in: recognizing the community as a unit of identity, assessing and building on community strengths, facilitating colearning, embracing iterative processes, and achieving a balance between data generation and intervention -Variability between shared power and resources with their communities, and sustainability
D'Alonzo, K. T. (2010). Getting started in CBPR: Lessons in building community partnerships for new researchers. *Nursing Inquiry, 17* (4), 282–8. doi:10.1111/j.1440-1800.2010.00510.x	To share lessons learned and the competencies needed by new researchers who are using CBPR and steps in establishing, maintaining, and sustaining academic-community partnerships.	Review of the author's experience with different CBPR projects involving groups of Latino immigrants in two New Jersey communities.	N/A	Reflection, Review of existing literature	Competencies for "Pre-Research" Period: -Community engagement -Community Advisory Board -Outreach -Community's Role in Problem Identification -Research Project-Methodological Issues -Flexibility & Patience -Insider vs. Outsider -Commitment and training issues Post-Research Issues- Timing Concerns for Tenure Track Faculty -Community Empowerment
Dalal, M., Skeete, R.,Yeo, H. L., Lucas, G.I., & Rosenthal, M.S. (2009). A physician team's experiences in community-based participatory research: Insights into effective group collaborations, *American Journal of Preventive Medicine* , *2009,* 37(6S1).	From the perspective of physician-researchers, to describe experiences in intragroup (between postdoc fellows) and intergroup (fellows/community) collaborations while conducting a CBPR project.	N = 7 Fellows engaged in a 18-month CBPR project -The CBPR project is focused on improving the health of individuals within New Haven -280 Community leaders were surveyed -30 structured interviews with key-informants	Survey (name not provided) -Structured Interviews (no additional information provided)	no information was provided on the Survey analysis -Structured Interviews were transcribed, coded, and analyzed, and findings were confirmed by community members (no additional information was provided)	Seven CBPR principles applied to both the intergroup and intragroup relationships: 1) Building Trust 2) Shared interest 3) Power-Sharing 4) Fostering Co-learning and capacity building 5) Building on Existing Strengths 6) Employing an Interactive Process 7) Balance between research and action for the mutual benefit of all partners Relationships are at the core of CBPR -As the fellow cohort developed strong relationships, their interpersonal relationships mirrored the development of the fellow-community relationships
Dietz, N. A., Hooper, M. W., Byrne, M. M., Messiah, A., Baker, E. A., Parker, D.,… Kobetz, E.(2012). Developing a smoking cessation intervention within a community-based participatory research framework. *Journal of Smoking Cessation*, *7* (02), 89–95. doi:10.1017/jsc.2012.17	To use a CBPR approach of collaboration between community and academic stakeholders to identify a community intervention for smoking cessation that would be beneficial. The article provides support for CBPR interventions.	N = 39 African American Participants within a total of four focus groups. The participants were comprised of former and current smokers aged 18 years and older Two of the focus groups included current smokers (N = 21) and two focus groups included former smokers (N = 21)	Focus Groups Semi-structured interviews (60 minutes) with open-ended questions created by the university researchers and community board members. Topics included: tobacco use/cessation, heath sequences, attitudes and beliefs, smoking behaviors. The focus groups were led by a health psychology student of African American descent. Interviews were audio-recorded and transcribed by an outside transcriber.	CBPR framework Spatial modeling technique to identify an area that has higher than expected incident rates of tobacco-associated cancers Focus groups stratified by gender to identify if smoking cessation intervention (peer support groups) will be accepted within the community	Themes related to smoking cessation: 1) smoking cessation treatment as a support group is preferred to other formats (i.e., individual counseling, educational videos) 2) There are also barriers to using support groups (i.e., accessibility, difficulty relating to the leader, feeling group leader was judgmental, sense of abandonment due to the group termination) Smoking cessation intervention via support groups is currently being piloted by group leaders (former smokers) and is supported by community efforts.

Dow, H. D. (2011). Migrants' mental health perceptions and barriers to receiving mental health services. *Home Health Care Management, 23,* 176-185. doi:10.1177/1084822310390876	The article focuses on the different perceptions that individuals from various ethnic communities have regarding mental health	N/A	Literature Review	N/A	Individuals have many different perceptions of mental illness. The manner in which they experience their symptoms, disclose them, and make treatment decisions are related to cultural values about sickness. It has been found that one's cultural beliefs impacts their likelihood to seek services. -Family can be a source of support or stress in the process of acculturation and can impact help-seeking experiences. - importance of a culturally appropriate and sensitive assessment. Barriers to receiving mental health services: -Disconnect between the client's cultural and western counseling style -Differences in communication patterns between counselor and client -Misdiagnosis of minority clients and ineffective treatment that makes individuals perceive mental health treatment as ineffective -language barriers and lack of trained staff -impact of client's background and SES -lack of insurance coverage -stigma of mental health and differences in help-seeking behaviors (bad rep if mental health diagnosis, mistrust in seeking help, lack of ties/negative role of dominant community, pride as a barrier to treatment)
Elissen, A. M., Van Raak, A. J., Derckx, E. W., & Vrijhoef, H. J. (2013). Improving homeless persons' utilisation of primary care: lessons to be learned from an outreach programme in The Netherlands. *International Journal of Social Welfare, 22* (1), 80–89. doi:10.1111/j.1468-2397.2011.00840.x	To provide lessons learned from an outreach programme for the homeless in the Netherlands	Outreach Program (January-December 2008) N = 210 homeless participants within the program Interviews conducted with: N = 5 primary care providers N = 5 shelter employees N = 18 homeless participants	Semi-structured interviews with three different stakeholders within the program (i.e., primary care providers, employees, and homeless participants).	Case Study	Adapting the program to meet the lifestyle and needs of the homeless population. The program and providers focused mostly on the physical issues, rather than mental health issues. Providers would benefit from coming out of their area of expertise and attending to the holistic needs of the consumers. To reduce the barriers to service use, consultations among providers was used (i.e., change in consultation times, new locations, and the scope of the program was broadened to allow homeless individuals to relate)
Flicker, S., Travers, R., Guta, A., McDonald, S., & Meagher, A. (2007). Ethical dilemmas in community-based participatory research: Recommendations for institutional review boards, *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 84* (4), 478-493.	Assess the extent to which IRB and Research Ethics Boards (REBs) reflected CBPR principles and frameworks.	Convenience sample of N = 30 members from US-based Association of Schools and Public Health	Template developed to assess CBPR and collective experience	Content Analysis of forms and guidelines used by institutional review boards (IRBs) and research ethics boards (REBs)	Findings showed that guidelines did not take into the CBPR framework. They often focused on risk against the individual, rather than the community. -These ethics may be putting communities at risk by not incorporating standards that account for CBPR. Recommendations for ethical review: - IRBs/REBs engaged in reviewing CBPR grants should be provided with basic training in CBPR principles -they should mandate that CBPR projects should mandate signed reference of understanding of the principles of CBPR -they should require CBPR projects to document the process by which decisions were made and the process of consultation with communities.
Gallardo, M. E., Johnson, J., Parham, T. A., & Carter, J. A. (2009). Ethics and multiculturalism: Advancing cultural and clinical responsiveness. *Professional Psychology: Research and Practice, 40* (5), 425–435. doi:10.1037/a0016871	To discuss how conflicts may arise when putting culturally responsive care in practice (fulfilling ethical implications and being culturally responsive)	N/A	Commentary	N/A	Discussion of cultural responsiveness and the manner it presents within the therapeutic relationship -Discussion of ethical implications of one's current practice -Struggles with fulfilling ethical practices and cultural responsivity
Gary, F. A. (2005). Stigma: Barriers to mental health care among ethnic minorities. *Issues in Mental Health Nursing, 26,* 979-999.	To review the stigma of mental illness experienced by four ethnic minority groups in the U.S.	N/A	N/A	Literature Review	Prejudice: Negative stereotypes about people Discrimination: When expressing negative stereotypes in action Double Action: involvement in ethnic minority membership and experiencing the barriers of being associated with mental health Stigma (Discussion of public stigma, family and courtesy stigma, self-stigma)
Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: interviews and focus groups. *British Dental Journal, 204,* 291-295.	To review the most common methods of data collection used in qualitative research (interviews and focus groups).	N/A	Literature Review	N/A	Qualitative Research Interviews: -Three fundamental types of research interviews (structured, semi-structured, and unstructured) Focused groups are used for generating information from the experiences of individuals.
Glassman, M. & Erdem, G. (2014). Participatory action research and its Meanings : Vivencia, praxis, conscientization. *Adult Education Quarterly 64* (3), 206-221.	To review the origin of Participatory Action Research and how it's development is related to the sociopolitical context, as well as provide information about its' history.	N/A	N/A	Literature Review	The cycle of PAR: Action -> Research -> Reflection -> Transformation/Action -Problem solving "with" the communities -Political background, nonhierchical dynamic, and recurring/cyclical process

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry, 10,* 113. doi:10.1186/1471-244X-10-113	To summarize reported barriers and facilitators of help-seeking for mental health issues in young people.	N/A	Systemic Review of Literature	Thematic Analysis on 22 published studies (15 qualitative, 7 quantitative) of perceived barriers/facilitators identified through PubMed, PsycInfo, & the Cochrane database.	Strategies for improving help seeking should focused on improving mental health literacy, reducing stigma, and accounting for one's desire for self-reliance. Facilitator themes: positive past experiences with help seeking, social support, confidentiality and trust, positive relationships with service staff, education and awareness, perceiving the problem as serious, ease of expressing emotion and openness, positive attitudes seeking help. Barrier Themes: Perceived public and self-stigmatizing attitudes, lack of accessibility, self-reliance, confidentiality and trust, difficulty identifying the symptoms of mental illness, concern about characteristics of provider, fear or stress about the act of help-seeking, and knowledge about mental health services.
Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental illness stigma, help seeking, and public health programs. *American Journal of Public Health, 103* (5),777-780.	To assess if large-scale anti-stigma campaigns could lead to increased levels of help seeking and understand the roles that stigma and discrimination contribute to the treatment gap.	Provision of the "Time to Change" anti-stigma campaign in the UK in 2012 -Did not provide specific sample	Anti-stigma programs that include multiple components aimed at specific groups of individuals at the larger and smaller, community levels. Community Attitudes Toward the Mentally Ill scale Mental Health Knowledge Schedule Attitudes to Mental Illness Scale	Multivariable logistic regression: examined the relationship between campaign awareness and help seeking	The major findings included: no relationship between campaign awareness and intended help seeking. -Positive relationship with help seeking and identifying as female -Negative relationship for the age category 25-34 and help seeking -Additional information is needed regarding initial and subsequent actions post-campaign participation
Horowitz, C. R., Robinson, M., & Seifer, S. (2009). Community-based participatory research from the margin to the mainstream: are researchers prepared?. *Circulation, 119* (19), 2633- 2642.	Literature review to support the use of CBPR for decreasing health disparities	N/A	CBPR Model	Literature Review	CBPR is a new approach that can potentially help in ways that current approaches it. -Need for insider perspective -Opportunity for new partnerships -Chance to build trust, generate ideas Team-Building -Building a partnership -Developing a structure, rules of operation, shared decision-making -Mutually select study selection -Fundings and ethics review; collaborative process -Research conduct and analysis; stakeholders are involved throughout all phases Disseminate Findings -Community Input -Local Dissemination -Translate Findings into practice Challenges Crossing Cultures Balancing scientific rigor and community acceptability
Hsu, H. C., Wang, C. H., Chen, Y. C., Chang, M. C., & Wang, J. (2010). Evaluation of a community-based aging intervention program. *Educational Gerontology, 36,* 547-572, doi:10.1080/03601270903237713	To evaluate the outcome and process of a CBPR aging intervention program for the elderly in Taiwan.	Participants in the research project (Successful Ageing for the Elderly in Taiwan) from 2004-2006 Included participants from six different areas to capture different lifestyles. *N*=720 people (age 65+)	Measures: Track behavior (regular exercise and dietary behavior), health outcomes (activities of daily living, elderly functional index, and depressive symptoms via the Center for Epidemiologic Studies Depression Scale)	Chi-square test to assess differences in characteristics across the three groups of individuals that received the community intervention (i.e., participants in the intervention communities, nonparticipants in the intervention communities, and residents in the control communities).	The results indicated that the intervention participants endorsed increased exercise and less problematic dietary issues. -The intervention did not prove to impact the physical functioning or depressive symptomatology significantly.
Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Ann. Rev. Public Health, 19, 173-202*	To provide a review of key CBPR principles, rationale for using CBPR, and discussion of challenges/benefits of use of this program.	N/A	N/A	Literature Review	1. Recognizes community as a unit of identify. 2. Builds on strengths and resources within the community. 3. Facilitates collaborative partnerships in all phases of the research. 4. Integrates knowledge and action for mutual benefit. 5. Promotes co-learning and empowering process that attends to social inequalities. 6. Involves a cyclical and iterative process. 7. Addresses health from both positive and ecological perspectives. 8. Disseminates findings and knowledge gained to all partners. Provision of literature for the benefits of CBPR Partnership-Related issues: challenges, lack of trust and respect, inequitable distribution of power and control, conflicts associated with differences in perspectives and etc., conflicts over funding, conflicts associated with different emphases on tasks, time-consuming process, who represents the community and how Facilitating Factors: jointly developed operating norms, identification of common goals, democratic leadership, presence of community organizer, involvement of staff, research role, prior history of

Jimenez, D. E., Bartels, S. J., Cardenas, V., & Alegría, M. (2013). Stigmatizing attitudes toward mental illness among racial/ethnic older adults in primary care. *International Journal of Geriatric Psychiatry, 28* (10), 1061–8. doi:10.1002/gps.3928	Study examines the extent to which race/ethnicity is associated with differences in perceived stigma of mental illness and perceived stigma for different mental health treatment.	*N* = 1247 non-Latino Whites *N* = 536 African Americans *N* = 112 Asian-Americans *N* = 303 Latinos Patients were recruited from six VA's, three community health centers, and two hospital centers.	SAMOSA Mental Health and Alcohol Abuse Stigma Assessment Questionnaire developed for the study to assess shame or stigma related to mental health issues (no psychometric information is available)	One-way analysis of variance (ANOVA) to assess racial/ethnic group differences on sociodemographic variables -x2 test for categorical variables	Results: SES differences and immigration characteristics of the different ethnic communities -Perceived Stigma: No significant difference was observed between African Americans and non-Latino Whites; African Americans endorsed greater comfort in disclosing such information to their primary care. -Asian-Americans: endorsed greater shame related to mental health issues and illness than non-Latino Whites -Latinos expressed greater shame or embarrassment of having a mental illness or alcohol abuse problem than non-Latino Whites -A greater proportion of Latinos than non-Latino Whites felt that others would perceive them differently. -Latinos expressed greater comfort in discussing mental health issues with PCP's than non-Latino Whites.
Johnson-Shelton, D., Moreno-Black, G., Evers, C., & Zwink, N. (2015). A community-based participatory research approach for preventing childhood obesity: The communities and schools together project. Program Community Health Partnership, 9(3), 351-361.	To discuss a community based program and the lessons learned through implementation of the CBPR model.	Schools, community organizations, and researchers	N/A	CBPR framework	Lessons Learned: 1. Overlapping goals can lead to community capacity building 2. Partnership activities can enhance the projects 3. Engagement of key personnel is essential 4. Participation of organizations impact the nature of the partnership/work 5. Complex issues require coordination by researchers
Kataoka, S. H., Nadeem, E., Wong, M., Langley, A. K., Jaycox, L. H., Stein, B. D., & Young, P. (2009). Improving disaster mental health care in schools, A community-partnered approach. American Journal of Preventive Medicine, (37)6S1, S225-S229, doi:10.1016/j.amepre.2009.08.002	To assess the benefits of post-disaster mental health services within school for a period of 10 months.	*N* =9 focus groups (consisting of 39 school-based mental health counselors and 5 program administrators) 10 men, 35 women	2 Day clinical training regarding a youth trauma intervention	CBPR framework (the Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) that was developed within the CBPR framework) Content analysis to explore content within the focus groups. Qualitative data analysis software	Child and family mental health needs: families needed substantial needs for crisis intervention services and mental health counseling directly/indirectly related to the hurricane -Need for mental health services that were not focused on the hurricane Clinician factors: need for greater self-care for clinicians School/Community Organizational factors: the role of organizational structure in delivering services in schools. Difference between when there is a system in place to support counselors versus systems that do not have those support systems in place. Policy-Level Factors: Theme of lack of funding to support students in areas that were not affected. There was a need for more funding to support the communities.
Khamphakdy-Brown, S., Jones, L. N., Nilsson, J. E., Russell, E. B., & Klevens, C. L. (2006). The empowerment program : An application of an outreach program for refugee and immigrant women, 28(1), 38–47.	To provide information on the application an outreach program for refugee and immigrant women in a Midwestern city, as well as reviewing common challenges	N/A	Outreach program	Case study	common challenges: pre-migration experiences, post-migration stressors (i.e., limited English-speaking skills, unemployment), difficulties with adjusting to a new culture. Barriers to mental health service delivery: limited understanding/awareness of mhs, lack of transportation, limited English, unemployment, financial difficulties, etc. Empowerment program: outreach program to address barriers to traditional Western mental health interventions for refugee women. The staff is bilingual and bicultural that serve positions to advocate for community members. Case study Three major recommendations for other providers: increase mobility to reach women and provide services, increase psychoeducational information rather than more traditional approaches, and utilize bicultural-bilingual advocates.

Kidd, S. A. & Kral, M. J. (2005). Practicing participatory action research. Journal of Counseling Psychology, (52)2, 187-195, doi: 10.1037/0022-0167.52.2.187	To provide a definition of PAR, as well as review of the historical background, roles involved, and benefits and challenges of the research.	N/A	N/A	Literature Review	The PAR process of reflective action is the method within itself. -Difficulties can arise from the intimacy of the relationships -Benefits through the application to the daily lives of community members Findings: -The Attitude of Participation and Becoming Involved -Participation, Action, and the Generation of Knowledge Critique: Keeping a critical awareness in the face of ambiguity -disagreement and constraint -"Good" PAR- related to ways to improve validity -The Rewards
Knifton, L., Gervais, M., Newbigging, K., Mirza, N., Quinn, N., Wilson, N., & Hunkins-Hutchison, E. (2010). Community conversation: Addressing mental health stigma with ethnic minority communities. Social Psychiatry and Psychiatric Epidemiology, 45(4), 497–504. doi:10.1007/s00127-009-0095-4.	Study focuses on mental health anti-stigma interventions for consumers from Black and Ethnic Minority (BME) communities. More specifically, it aims to: 1) evaluate the acceptability and practicability of a community development workshop program. 2) explore attitudes towards mental health problems amongst BME communities 3) assess the impact of workshops upon participants 4) Review the value of different types of evaluations with target communities.	Participants were members of existing BME community groups Academic researchers worked with the community organizations within a CBPR model to ensure cultural responsiveness of workshop. *N*=26 workshops were delivered to 257 participants over a 9-week period. -246 participants completed the evaluations Ethnic participants included: Chinese, Indian, or Pakistani	"Community Conversation" (90 minute mental health and stigma supportive workshop) designed to provide information about mental health and stigma. -Pre/Post workshop questionnaires -Pre-questionnaires identified demographics replaced in post-group questionnaires by open questions on workshop acceptability and changes in knowledge/attitudes, beliefs, and behavioral intent as a result of the workshop. The questions were open-ended responses.	Statistical Package for Social Scientists -Qualitative data were systematically coded in order to identify key themes regarding knowledge, attitudes, and behavior towards mental health.	At baseline, over 50% participants expressed stigmatizing responses in relations to public protection, talking with someone with a mental health difficulty, and contribution to communities. There was most stigma around dangerousness, social distance, capability, secrecy and shame and equal rights. -Workshop impact: Less stigma was reported post-workshop. -91% they would make a change post workshop -Community conversation workshops engaged participants and reduced stigma. -Recognition that mental health problems are common, reduced secrecy, increased desire to support those with mental health difficulties and decreased desire for social distance, reduced blame, and greater openness. -The only aspect that worsened was attitudes in relation to returning to work due to workplace stigma.
Lam, C. S., Tsang, H. W. H., Corrigan, P. W., Lee, Y. T., Angell, B., Shi, K. & Larson, J. E.(2010). Chinese lay theory and mental illness stigma: Implications for research and practices. *Journal of Rehabilitation, 76,* 35-40.	To discuss the theories of mental illness in Chinese culture and how it can contribute to the stigma associated with individuals with mental illness.	N/A	N/A	Literature Review	Chinese Lay Theory and Stigma of Mental Illness: - "face": related to reputations -Family stigma: Mental illness can impact the whole family and lead to a loss of familial reputation. -Public Stigma: Research supports that individuals within the community experience more stigma related to returning to the community. -Self stigma: occurs when the person internalizes and accepts the stigma as justified. -Review of implications for research and practices: the four dimensions of mental disorders (i.e., pathologizing, moralizing, medicalizing, and psychologizing)
Letcher, A. S. & Perlow, K. M. (2009). Community-based participatory research shows how a community initiative creates networks to improve well-being. *American Journal of Preventive medicine*, (37)6S1, S292-S299, doi:10.1016/j.amepre.2009.08.008	This study focuses on how diverse individuals engage in a supportive network to optimize health and proposes a theoretical model of community-building for health promotion.	Purposeful sample *N*=28 members	Qualitative Study In-depth interviews exploring the experience of members within the CBPR program (i.e., Community Exchange) that was guided by a guideline influenced by the preparatory workshops.	CBPR model, case study, themes were generated via grounded theory	Four primary themes related to participation in the CBPR program: -motivation for participation -reciprocity -personal and community growth -health promotion and improved well-being These themes were combined to develop a model of how participation in the service exchange program leads to building a community. The model goes from Exchange-> relationship-> personal growth -> collective growth-> community * dynamic, non-linear process
Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27* (1), 363-385.	Provision of research on stigma	N/A	N/A	N/A	Defining stigma in relationships Component 1- on distinguishing and labeling differences Component 2-on associating human differences with negative attributes/stereotypes Component 3-on separating "us" from "them" Component 4- Status Loss and Discrimination (due to being labeled; Individual and structural discrimination)

Macaulay, A. C., Delormier,T., Mc Comber, A. M. et al. (1998). Participatory research with native community of Kahnawake creates innovative Code of Research Ethics. *Can J Public Health. 89* (2), 05-108.	To use a CBPR program to improve healthy eating and increase physical activity in elementary school children.	Community near Montreal, Canada (*N* =2200 inhabitants)	One mile run/walk test, Weight, Behavioral Assessments via 51 item self-report food frequency questionnaire and self-report physical activity questionnaire (questionnaires adapted from the Quebec Heart Health Demonstration Project), proximal impact evaluation: self-administered self-efficacy and perceived parental support questionnaires	mixed longitudinal and cross-sectional design, process evaluation	CBPR: Development of a curriculum: Developing personal skills- curriculum that includes 10, 45-minute lessons per grade -Strengthening community action through active community problem resolution -Creating supportive environments -health public policy: active advocacy for school nutrition policy The experimental and comparison communities were similar -Active lifestyles is impacted by the extent of tv watching and physical activity.
Macaulay, A. C. & Nutting, P. A. (2006). Moving the frontiers forward: Incorporating community-based participatory research into practice-based research networks. *Annuals of Family Medicine*, (4)*1* , 4-7, doi: 10.1370/afm.509	Hypothesis: incorporating CBPR principles with practice-based research networks (PBRNs) will strengthen the field of family medicine and decrease health disparities and increase outcomes	N/A	N/A	Editorial Commentary	Review of literature Case Examples Recommendations: recommend that the partners develop written guiding principles to protect the communities and individual stakeholders. The inclusion and process of creating the guidelines can strengthen the partnership and the proposed research. Although there are many challenges, the inclusion of CBPR will be beneficial to the implementation and dissemination of findings.
Marshall, M. N. (1996). The key informant technique. *Oxford University Press, 13* (1), 92-97.	To examine the role of the key informant technique and discuss the potential benefits of its inclusion in research	The number of key informants were not included. -Describe the professional relationship between general practitioner and their role with patients.	Interviews conducted were between 30-40 minutes and they were conducted by the author. -Some were conducted via telephone and others were face-to-face. -Interviews were audio-taped and transcribed by the author.	Qualitative Research; thematic analysis of the transcripts	Derived key themes: -the positive features of the current relationship, the negative features of the current relationship, possible ways of improving the relationship, and visions about the future.
Matthieu, M. M., Gardiner, G., Ziegemeier, E., & Buxton, M. (2014). Using a service sector segmented approach to identify community stakeholders who can improve access to suicide prevention services for veterans. *Military Medicine, 179* (4), 388–95. doi:10.7205/MILMED-D-13-00306	To provide a framework for outreach that uses a service sector segmented approach for Veterans to improve community-based suicide prevention services.	*N* = 70 VA and community-based providers * Identified using a two-step purposive, snowball sampling process	Semi-structured interview and self-report survey Interview focused on the provider's perspective of the need of Veterans for mental health and suicide prevention services, the referral process to attain those services, and the barriers encountered in accessing mental health services. Self-report survey: 1) organizational assessment, provider demographics, individual-level factors, exposure to suicide, and awareness of suicide prevention resources.	Mixed-Methods study/Data Analysis in SPSS for univariate and bivariate analysis	Results: statistically significant differences in the percentage of Veterans served across each service sector. There were similar rates of referral for suicide across the sectors. There is a need to expand outreach efforts beyond the traditional locations of mental health and in sectors that are often visited by Veterans.
Mendez-Luck, C. A., Trejo, L., Miranda, J., Jimenez, E., Quiter, E. S., & Mangione, C. M. (2011). *The Gerontologist,* (51)S1k, S94-S105, doi:10.1093/geront/gnq076	To describe the recruitment strategies (successes and challenges) and costs associated with the 2 community-based research with a Mexican-origin/Spanish-speaking population.	*N* = 154, female family caregivers of Mexican descent	Qualitative Interviews and quantitative surveys to examine caregiving constructs among women of Mexican origin	Case Study, CBPR framework (i.e., specifically 2 principles focused on developing and sustaining equitable partnerships)	Recruitment Approaches: -Six main recruitment approaches: public event in community, community-based organization (CBO) sponsored recruitment, flyer into study, in-person/contact in community, participant of another UCLA study, and personal referrals. -Of the recruitment strategies that were most successful were the collaborative result of the researchers and CBOs. -Organizational Referrals: snowball sampling at the CBO level. The highest number of referrals came from organizational referrals. Costs Associated with conducting studies in a community setting: -Nonfinancial and financial costs
Mier, S., Boone, M., & Shropshire, S. (2009). Community consultation and intervention: supporting students who do not access counseling services. *Journal of College Student Psychotherapy, 23* (1), 16–29. doi:10.1080/87568220802367602	To provide different ways to provide "outreach" or supportive services to students that would not traditionally seek services.	N/A	N/A	Reflection, Review of Existing Literature	Outreach -Consultation with staff/faculty about study -Crisis intervention: counselor takes immediate action -Student Support: Meeting with students in-person at locations other than the counseling center, to help those that would not typically come into the counseling center -Counseling -Advocacy: in order to eliminate possible environmental stressors and improve psychological well-being -Case Management

Mikesell, L., Bromley, E., & Khodyakov, D. (2013). Ethical community-engaged research: a literature review. *American Journal of Public Health*, *103* (12), e7–e14. doi:10.2105/AJPH.2013.301605	To provide a foundation for conducting ethical CBPR.	N/A	N/A	Literature Review (thematic, CBPR in health research)	Almost all the articles suggest that CBPR ethics should focus on the well-being of the community, rather than just participants. Community autonomy: respect for community needs and interests Ethical components of CBPR: community collaboration, community significance, community return, and community control Ways to ensure ethical CBPR: engage community, prioritize transparency, develop community advisory boards, engage IRBs about CBPR, develop community review boards, promote professional/ethical development, carefully consider study personnel, change funding priorities, and emphasize rigorous research design.
Morisky, D. E., Malow, R. M., Tiglao, T. V., Lyu, S.Y., Vissman, A.T., & Rhodes, S.D. (2010). Reducing sexual risk among Filipina female bar workers: Effects of a CBPR-developed structural and network intervention. *AIDS Education and Prevention, 4* (22), 371-385.	To assess the effect of three interventions that were developed through a CBPR partnership, in order to reduce sexual risk among Filipina female bar workers (FBWs).	*N* =911 FBW study participants	Needs assessment, in-depth interviews with key community informants. Interviews were conducted by individuals in the CBPR partnership Behavioral outcomes was assessed through HIV and STI testing and receiving results and psychoeducation about condom use.	CBPR, chi-square tests for categorical variables and F tests for continuous variables Multivariable logistic regression model using generalized linear mixed modeling	Intervention selection was defined by three partnership-defined priorities: reduce the sexual risk of FBW, reach large number of FBW, and facilitate sustainability within communities. Interventions: a peer-educator intervention, a manager-training intervention, and a combination peer educator and manager training intervention. Interview findings also informed the development of a questionnaire The FBWs in the intervention group had significantly higher awareness of HIV knowledge than the control group. Additionally, more FBWs in the combined peer-educator and manager training condition attended regular meetings and were informed of the importance of condom use and regulations of these meetings compared to the control group. They were also most likely to attend an HIV prevention class and reported that the class increased their consistent condom use. Those in the intervention group were more likely to engage in HIV prevention related activities than those in the control group.
Munson, M. R., Scott, L. D., Smalling, S. E., Kim, H., & Floersch, J. E. (2011). Former system youth with mental health needs: routes to adult mental health care, insight, emotions, and mistrust. *Children and Youth Services Review, 33,* 2261-2226. http://dx.doi.org/10.1016/j.childyouth.2011.07.015	The purpose is to explore the mental health service use experiences among former system youth with childhood histories of mental disorders, use of publicly-funded mental health services, and use of additional public systems of care.	*N* =60 (aged 18-25) participants(purposive sampling) that were former system youth who had experienced a unique transition to adulthood, either due to being given a mood disorder diagnosis, using Medicaid-funded mental health services, and using at least one additional public system of care.	Qualitative, in-depth semi-structured face to face interviews The interview focused on 6 core questions on mental health service use experiences -The Service Assessment for Children and Adolescents (SACA) measured lifetime history of mental health service use Center for Epidemiological Studies Depression Scale- assess level of depression at the time of interview Child Trauma Questionnaire- assesses physical abuse and neglect	Multi-phase analytic process	Themes generated: -families of mental health service users -routes to adult mental health services -facilitators of access and engagement in mental health service utilization -physicians, professionals, family were key individuals of reconnection to adult mental health services -loss of facilitators of the process: becoming a parent -Emotion and Mistrust
Okazaki, S., Kassem, A. M., & Tu, M.-C. (2014). Addressing Asian American mental health disparities: Putting community-based research principles to work. *Asian American Journal of Psychology, 5* (1), 4–12. doi:10.1037/a0032675	To provide research on mental health disparities for Asian Americans, as well as to discuss CBPR principles in addressing mental health disparities research.	N/A	N/A	CBPR framework	Mental health disparities and Asian Americans: -Prevalence rates -Access to care Factors sustaining disparities: structural factors (i.e., "model minority" stereotype), cultural factors (i.e., cognitive, affective, and value orientation barriers) CBPR Framework: review of principles Challenges of CBPR: funding, training, difficulties in addressing challenges with westernized interventions.
Oscos-Sanchez, M. A., Lesser, J., & Kelly, P. (2008). Cultural competence column. Flaskerud, J. (Ed.), *Issues in Mental Health Nursing, 29,* 197-200, doi:10.1080/01612840701792258	To discuss CBPR	N/A	N/A	Commentary	Review of CBPR framework and implications regarding cultural competence
Park, N. S. (2009). The relationship of social engagement to psychological well-being of older adults in assisted living facilities. *Journal of Applied Gerontology, 28* (4), 461-481.	To explore social engagement and its relationship to the psychological well-being of older adults in assisted living facilities.	*N* = 82	Interviews	Hierarchical Regression models	Higher life satisfaction was associated with reciprocity, social activity participation. Perceived social support was not related to improved psychological well-being. Higher perceived support was associated with higher life satisfaction and decreased negative mood symptoms.

Pastor-Montero, S. M., Romero-Sánchez, J. M., Paramio-Cuevas, J. C., Hueso-Montoro, C., Paloma-Castro, O., Lillo-Crespo, M.,… Frandsen, A. J. (2012). Tackling perinatal loss, a participatory action research approach: Research protocol. *Journal of Advanced Nursing*, *68* (11), 2578–85. doi:10.1111/j.1365-2648.2012.06015.x	To demonstrate how PAR can improve the care provided to parents that have experienced perinatal loss.	N = 30 (maximum), professionals that work in the Mother and Child Unit for patients ata tertiary level public hospital in SPAIN	Qualitative interventions as related to each stage will be implemented (review major findings)	PAR (outreach and awareness, induction, interaction, implementation, and systematization).	The study is being proposed. Outreach and awareness (e.g., strategies include discussion about the study proposal, group session, joint discussion) Induction: (e.g., strategies include joint strategy planning, focus groups, relationship map, brainstorming) Interaction (e.g., strategies include joint reflection, presentation of cases, role-playing) Implementation (e.g., strategies include discussion about the evaluation indicators, relationship maps, joint discussion) Systematization (e.g., strategies include discussion about positive and negative aspects of the intervention, focus groups)
Patel, A. I., Bogart, L .M., Uyeda, K. E., Martinez, H., Knizewski, R., Ryan, G. W., & Schuster, M. A. (2009). School site visits for community-based participatory research on healthy eating. *American Journal of Preventive Medicine,* (37)6S1, S300-S306, doi: 10.1016/j.amepre.2009.08.009	To demonstrate the effectiveness and utility of a CBPR framework, specifically site visits, in the development of an intervention to implement obesity-related policies in LAUSD middle schools.	N = 4 LAUSD middle schools CBPR partnership between UCLA/RAND Center for Adolescent Health Promotion with three community advisory boards and main community partner, LAUSD	Researchers and community partners developed the site visit protocol (i.e., included observations, mapping and listing activities)	CBPR framework Data analysis: inductive coding used to identify themes via observation checklists, school documents, and handwritten notes	Role of site visit observations in translating policy into practice in the school food environment: Cafeteria improvement motion component 1) increase participation in the National School Lunch Program (NSLP)->Policy: develop a comprehensive program to market cafe meals to students Intervention: larger signs of available options so that students are aware of food items 2) facilitate students' ability to make healthier choices Policy: fresh fruits and vegetables are available throughout the meal period Intervention: have presliced (since sliced are thrown out) fruits available for students 3) Elicit student and parent input to improve NSLP Policy: offer free drinking water to students Intervention: Free water is available in the cafeteria **Site visits allowed for an understanding of how policy changes will be implemented and will look like within the real school setting
Pepin, R., Segal, D. L., & Coolidge, F. L. (2009). Intrinsic and extrinsic barriers to mental health care among community-dwelling younger and older adults. *Aging & Mental Health*, *13* (5), 769–77. doi:10.1080/13607860902918231	To examine intrinsic and extrinsic barriers to mental health care among younger and older adults	N = 76 (age: 23) N = 88 (age: 71) Total: 164 participants divided in groups by age	Barriers to Mental Health Services Scale (BMHSS)-56 item self report measure that examines 10 barriers to the utilization of mental health services (i.e., help-seeking attitudes, stigma, knowledge and fear of psychotherapy, belief about inability to find a psychotherapist, belief that depressive symptoms are normal, insurance and payment concerns, ageism, concerns about psychotherapist's qualifications, physician referral, and transportation concerns).	two-way ANOVAs conducted to examine the effects of age group and gender, and its effects on BMHSS total score, intrinsic barriers, extrinsic barriers, and the 10 subscales. Simple correlations were also conducted between ethnicity and the 10 subscales, as well extent of relationships between years of education, instinct scale, extrinsic scale, and 10 subscales.	Younger Group: -Intrinsic barriers: knowledge and fear of psychotherapy, belief about inability to find a psychotherapist, and help seeking. Extrinsic barriers: insurance and payment concerns, physician referrals, and concerns about psychotherapist's qualifications. Men found stigma to be a more significant concern than women, while women found finding a psychotherapist to be a more significant barrier. Older adults endorsed these intrinsic barriers (highest): belief about inability to find a psychotherapist, help seeking, and knowledge and fear of psychotherapy. Of the extrinsic barriers, these were more endorsed: insurance and payment issues, concerns about psychotherapist's qualifications, and transportation issues.
Ponder-Brookins, P., Witt, J., Steward, J., Greenwell, D., Chew, G. L., Samuel, Y., Kennedy, C., and Brown, M. J. (2014). Incorporating community- based participatory research principles into environmental health research : Challenges and lessons learned from a housing pilot study, *Journal of Environmental Health*, *76* (10), 8–18.	Use of CBPR principles in a pilot study and provision of the lessons learned and challenges from the implementation of a CBPR study.	Non-probability convenience sample drawn from two urban senior citizen independent living housing complexes in Atlanta, Georgia. N = 74 participants recruited N = 34 from research project N = 40 from control	N/A	CBPR framework	Results were impacted by the 9 CBPR principles. -Results disseminated via town halls. Lessons learned to increase community participation: -defining the community through incorporating al stakeholders in the decision of who is impacted by the decisions -determining methods to ensure power sharing among all partners -acknowledging the effect of funding dynamics on CBPR approach -building long-term research-community relationships that benefit all involved
Ponterotto, J. G. (2013). Qualitative research in multicultural psychology: Philosophical underpinnings, popular approaches, and ethical considerations. *Qualitative Psychology*, *1* (S), 19-32, doi:10.1037/2326-3598.1.S.19	To review the current status of qualitative research in psychology (i.e., consensual qualitative research, grounded theory, and participatory action research)	N/A	N/A	Literature Review	Qualitative inquiry approach: Consensual qualitative research (CQR), Grounded theory (GT), and Participatory action research (PAR) Competencies for ethical qualitative research with culturally diverse communities

Rastogi, M., Massey-Hastings, N., & Wieling, E. (2012). Barriers to seeking mental health services in the Latino/a community: A qualitative analysis. *Journal of Systemic Therapies, 31* (4), 1-17. doi:10.1521/jsyt.2012.31.4.1	To explore how Latino community members perceive mental health services, barriers to mental health, and recommendations.	*N* = 18	Five focus groups, one individual interview, questionnaire	Purposive and non-random sample, Constant comparison	Three domains: issues of access to MHS for Latinos, barriers that prevent Latinos from utilizing mHS, and solutions offered by participants to facilitate utilization of MHS. Issues of access: presenting problems (i.e., f, client needs, provider characteristics barriers: individual, barriers at the family level, sociocultural, legal concerns, difficulties obtaining services Participant proposed solutions: increasing awareness and information, improving access to mental health, provider characteristics, and supporting other Latinos in seeking help.
Reid, S. D., Reddock, R., & Nickenig, T. (2014). Breaking the silence of child sexual abuse in the Caribbean: A community-based action research intervention model. *Journal of Child Sexual Abuse, 23*, 256-277, doi:10.1080/10538712.2014.888118	To demonstrate the use of a community based model in child sexual abuse.	*N* = 13 villages	Notes, pre/post-intervention evaluation questionnaires, pre and post intervention discussion, focus groups, structured interviews	CBPR	Quantitative Findings: increased awareness of community resources Qualitative findings: increased knowledge of child sexual abuse through the community activities Project Outcomes and outputs: Increased knowledge, capacity building, and motivation to act
Robinson, S., Fisher, K.R., & Strike, R. (2014). Participatory and inclusive approaches to disability program evaluation. *Australian Social Work, 4* (67), 495-508, doi:10.1080/0312407X.2014,902979	To assess the extent to which participatory and inclusive approaches include individuals with cognitive disabilities in their evaluation.	N/A Case study on a Resident Support Program	Weaver and Cousins' framework for measuring the depth and quality of inclusive evaluation. The dimensions of the framework are: Control of technical decision making, diversity among stakeholders selected for participation, power relations among participating stakeholders, manageability of evaluation implementation, and depth of participation.	Weaver and Cousins' framework	Review of each component of the framework -The article wanted to assess the extent to which the inclusive evaluation practice impacted utility, social justice, and inclusive practice. 1) The program changed in response to the evaluation-> now more streamlined and responsive to needs. 2) Social justice-> contributed to the decrease of social inequalities as it focused on the people and brought attention to their voices and needs. 3) Inclusive practice- there was a limited ability to engage individuals with cognitive disabilities in all points of the evaluation design and dissemination of findings.
Rosen, C. S., Greene, C. J., Young, H. E., & Norris, F. H. (2005). Tailoring Disaster Mental Health Services to Diverse Needs: An analysis of 36 crisis counseling projects, *Health & Social Work,* 211-221.	To examine archival data from 36 crisis counseling projects to assess the extent to which interventions/services were tailored to the needs of the communities, as well as the actual impact of the services provided.	N=36 Crisis counseling projects over a five year period	Program evaluation informed by a logic model (examines program outputs, resources available, and program activities)	Retrospective Evaluation of Crisis Counseling Projects (CCPs) Descriptive statistics on programs that tailored interventions Correlation and linear regression	Tailoring of activities: 2/3rds of projects reported tailoring of interventions Variables associated with greater tailoring of activities: in communities where the population consisted of 30% or more of ethnic/racial minority groups. Reach to members of minority groups: the rate at which projects tailored their interventions was related to the extent to which they sought minority groups Those that tailored their interventions more were more likely to serve more clients
Seifer, S. D. (2006). Building and sustaining community-institutional partnerships for prevention research: Findings from a national collaborative. *Journal of Urban Health.*	To report on a three-year project that included 10 community-institutional partnerships and provide information about their common characteristics of successful partnerships, as well as recommendations for strengthening emerging and established partnerships.	*N*=10 community-institutional partnerships	Guiding Questions (copied as listed): 1) What is meant by "successful community-institutional partnerships for prevention research?" 2) What are the factors that contribute to successful community-institutional partnerships for prevention research? 3) What are the barriers that interfere with successful community-institutional partnerships for prevention research? 4) What ideas, recommendations, and strategies can build the capacity of communities, institutions, and funding agencies to engage in successful community-institutional partnerships for prevention research?	The methods varied by partner and they used different approaches to answer the four guiding questions. Each member of the partnership answered these questions, reviewed their responses, and convened to discuss their responses and develop a mutual conceptual framework for understanding partnerships. Thus, this discussion was taped and transcribed (qualitative data analysis) and analyzed for themes. A descriptive narrative was written for each theme.	Common characteristics of successful community-institutional partnerships for prevention research: 1. Trusting relationship; 2. Equitable processes and procedures: 3. Diverse membership; 4. Tangible benefits to all partners; 5. Balance between partnership process, activities, and outcomes:6. Significant community involvement in scientifically sound research; 7. Supportive organizational policies and reward structures; 8. Leadership at multiple levels; 9. Culturally competent and appropriately skilled staff and researchers; 10. Collaborative dissemination; 11. Ongoing partnership assessment, improvement, and celebration; 12. Sustainable impact; 13. Funding agency requirements, definitions, timelines, are often not conducive to CBPR; 14. Lack of funding and funding mechanisms that specifically support community involvement; 15. unequal distribution of resources that often occurs between institutional and community partners in another frequent tension.
Shah, A., & Beinecke, R. H. (2009). Global mental health needs, services, barriers, and challenges. *International Journal of Mental Health, 38* , 14-29. doi:10.2753/IMH0020-7411380102	Review of the direct and indirect burden of mental health problems, limited resources, barriers, and challenges	N/A	N/A	Literature Review	Mental health issues impact the individual and leave a burden of mental problems on the families, communities, and countries. Limited Resources: insufficient funding for mental health services, mental health resources centralized in near cities, difficulties in integrating mental health care in primary care services. Policy, Plan, and program: to improve mental health and reduce the negative impact of mental health issues on all stakeholders. Others barriers to care: stigma, human rights and legislation, mental health law and policy, poverty, effects of war, and migration.

Shetgiri, R., Katoka, S .H., Ryan, G. W., Askew, L. M., Chung, P. J., & Schuster, M. A. (2009). Risk and resilience in Latinos: A community-based participatory research study. *American Journal of Preventive Medicine*, (37)6S1, S217-S224, doi: 10.1016/j.amepre.2009.08.001	A CBPR partnership examined perceptions of resilience among Latino adolescents (aged 11-17) in Los Angeles	*N*=20 Latino young individuals *N*=10 parents *N*= representatives from community-based organizations	Semi-Structured qualitative interviews, demographic questionnaires Youth interviews: 45 minutes, open-ended questions Example: What do you think it means to be successful? -Parental interview: 45 minutes, open-ended questions about definitions of youth success and perceptions of risk and protective factors -Community based interviews: 45 minutes, perceptions of success and risk and protective factors, and what they believed their role was in helping adolescents be successful	Interviews were audiotaped and transcribed Content-Analysis and Grounded Theory, CBPR framework	Participants endorsed protective factors: self, family, and community factors Parents endorsed children's individual desire and familial support All stakeholders viewed peers as potential barriers rather than potential sources of support for participants All stakeholders agreed that a successful person overcame problems and fulfilled goals. Barriers to success: YOUTH Self-Perceived:- Fear related to environment; Family- influence, lack of caring; Peers: peer pressure; Community- violence and low expectations PARENT Self-Perceived: fear, stigma; family-influence, lack of caring; peer pressure, violence, low expectations CBO Rep Self-perceived fear, stigma; family: influence, lack of caring; peer pressure; violence, low expectations Facilitators of success: Individual (education, goal-directed, self-motivated) Family (involvement and high expectations) Community (support, teachers, programs, role models)
Simmons, V. N., Klasko, L. B., Fleming, K., Koskan, A. M., Jackson, N. T., Noel-Thomas, S.,… Tampa Bay Community Cancer Network Community Partners (2015). *Evaluation and Program Planning*, *52*, 19-26.	To describe the implementation and outcomes of the participatory evaluation of community/academic partnership.	*N* = 23	Mixed methods: Semi-structured interviews and questionnaire, rating scales	cross-sectional, mixed-methods CBPR evaluation	Results: -Community partner cancer education/training needs (identified multiple areas of training to increase the capacity of the partnership) Partner perspectives on the partnerships' adherence to CBPR: Respondents rated the partnerships' adherence to CBPR was high. -Describing TBCCN (community center) and organizational role within community center: described as "collaboration" or "partnership" and belief that they shared mutual benefits. -Community partners' expectations of TBCCN and benefits: Belief that the organization met their expectations Lessons Learned: integrating community representative as liaisons, recognizing partners as bringing unique experiences, sustainability of the network is powered through the partnership, community feedback is valuable and contributes to the sustainability
Sorkin, D. H., Pham, E., Ngo-Metzger, Q. (2009). Racial and ethnic differences in the mental health needs and access to care of older adults in California, *Journal of the American Geriatrics Society* , *57* (12), 2311-2317.	To examine the racial and ethnic differences in the prevalence rates of psychological distress and need and use of mental health services.	*N* = 16, 974 people aged 55+ *N* = 13, 974 non-Hispanic Whites *N* = 719 African Americans *N* = 1,215 Asians *N* = 1,066 Latinos	Survey: CHIS is a random-digit dial (RDD) telephone survey Interviewing one sample adult in each household Interviews were conducted in English, Spanish, Mandarin, Cantonese, Vietnamese, and Korean. -The questionnaire was reviewed for cultural adaptations	SAS Callable SUDAAN Release 8.0.2 to account for complex sampling Bivariate and multivariate analyses	African Americans, Asians, and Latinos were more likely to report mental distress than whites. With those with mental distress, fewer minorities than whites reported accessing mental health services. -Older Asian-American adults with symptoms indicative of serious mental illness were less likely to report a need for help than other groups. -Ethnic communities were less likely to report accessing mental health services than non-Hispanic whites. -Older age was associated with less disclosed need for help and access to mental health services.
Thomas, L. R., Donovan, D. M., & Sigo, R. L. W. (2010). Identifying community needs and resources in a Native Community: A research partnership in the pacific northwest. *International Journal of Mental Health Addiction*, *8* , 362-373, doi:10.1007/s11469-009-9233-1.	To provide a case study to demonstrate how to use a CBPR/TPR (tribally based community research) approach	The Healing of the Canoe is a research partnership between the Suquamish Tribe and an academic organization that is using a CBPR/TPR approach	Interviews with stakeholders, adherence to models, and focus groups	CBPR/TPR approaches and frameworks	Results: Identification of issues of concerns, community strengths and asserts, the community as the expert partner, and CBPR/TPR principles and giving back to the community. Lessons Learned from the community-academic collaboration

Vanheusden, K., Mulder, C.L., van der Ende, C., van Lenthe, F.J., Mackenbach, J.P. Verhulst, F.C. (2008). Young adults face major barriers to seeking help from mental health services, *Patient Education and Counseling, 73* , 97-104, http://dx.doi.org/10.1016/j.pec.2008.05.006.	The study examines barriers-to-care in young adults (ages 19-32 in Netherlands) with serious internalizing or externalizing problems, who do not seek mental health/professional help.	Cross-sectional population-based survey conducted with 35 municipalities that were randomly selected. The total sample *N* =3338 young adults who participated in the postal survey, then *N* =2258 participated in the study. Of the total, the study focuses on the number of young adults with clinical levels of internalizing/externalizing problems (*N* =364).	The Adult Self-Report (ASR):a questionnaire used to assess internalizing and externalizing problems Use of mental health services: assessed by question "Have you consulted one of the following persons or agencies because of mental health problems or alcohol or drug problems in the past 12 months?" Included available mental health options Problem-Recognition: was assessed by "Did you have mental health problems during the past 12 months?" Other barriers-to-care: For participants that admitted to a mental health issue, but did not seek professional help. They were provided with the Barriers-to-Care Checklist.	Logistic Regression analysis, Latent Class Analysis, Multivariate logistic regression analysis	There were 364 young adults with clinical levels of internalizing/externalizing problems and 1879 young adults with normal ASR scores -The female sex predicted an increased likelihood of admitting problems, while externalizing problems reported a decreased likelihood of reporting. -From the brief checklist, themes of "perceived problems as self-limiting," and "perceived help-seeking negatively" were endorsed amongst the barriers.
Viguer, P., Rodrigo, M. F., & Sole, N. (2013). The family debate on values and living together: A community-based approach through participatory action research, *Journal of Community Psychology* , *41* (8), 944-958.	A CBPR intervention in the form of Family debate about Values and Living Together (FDVL), who's objectives are carrying out reflection and dialogue about living together, determine family's visions of its values, and involve family in transforming and improving its reality.	*N* =2321 families across 16 towns in Spain	Family debate about values and living together (FDVL) booklet Family post debate questionnaire for parents end of project evaluation questionnaire	CBPR framework	Families consider these values very important: honesty, peace, effort, success, tolerance, dialogue, obedience, helping others, respect, and freedom. -With regard to child rearing practice, high importance placed on emotion and spending time with children. With regard to values in the classroom are cooperative and favor integration. Post-intervention results: all stakeholders shared the importance of continuing to work on these matters both at home and in the community. Collaboration between community and university was rated very positively.
Wilson, T. E., Fraser-White, M., Williams, K. M., Pinto, A., Agbetor, F., Camilien, B., Henny, K., Browne, R. C., Gousse, Y., Taylor, T., Brown, H., Taylor, R., & Joseph, M. A. (2014). Barbershop talk with brothers: Using community-based participatory research to develop and pilot test a program to reduce HIV risk among black heterosexual men. AIDS Education and Prevention, (26)5, 383-397	To describe the process for development of the Barbershop Talk with Brothers (BTWB) CBPR program and evaluation.	*N* =80 men completed a baseline assessment of the pilot of the program *N* =78 men completed the program *N* =71 complete a 3-month assessment	Intervention Mapping process (within CBPR) - Participants completed audio computer-assisted self-interviews (ACASI) in barbershops. Of those men, some were selected to engage in focus groups and individual interviews. - Formative data collection: barbershop observations and barber focus groups, brief behavioral risk assessments, and focus groups and individual interviews.	CBPR, Qualitative data from the interviews were transcribed, underwent thematic analysis, and coded.	Pre/Post Assessment measures indicate key behavioral outcomes: attitude and self-efficacy toward consistent condom use improved (greater confidence about its importance), perceptions of community empowerment increased, HIV stigma decreased through reaching and educating heterosexual Black men about HIV prevention in communities. There were no significant differences in HIV stigma. Themes related to the qualitative data included: low information about low HIV transmission, low perceived HIV risk, higher emotional attachment with a partner, impulsive decision making, and difficulties with discussing safer sex options.
Wolff, T. (2014). Community psychology practice: Expanding the impact of psychology's work. American Psychologist, 803-813, doi: 10.1037/a0037426	To provide an overview of community psychology (definition, history, principles)	N/A	N/A	Literature Review	Community psychology believes that change needs to happen on the level of the community and the change occurs by strengthening community capacity to address community-identified goals. Major Components: -Prevention -Social and systems change -Community members lead the decision making -Multidisciplinary approach (stakeholders within the community) Community Psychology Practice Competencies: ecological perspectives, empowerment, sociocultural and cross-cultural competence, community inclusion, ethical/reflective practice, program development, prevention and health promotion, community leadership, small and large group processes, resource development, consultation and organizational development, collaboration and coalition development, community development, community organizing, public policy analysis, community education

APPENDIX B

CBPR Principles and Detailed Descriptions

CBPR Principle	**Expansion of each principle from review of Israel et al. (1998) and Israel, Eng, & Schulz (2012)**
Recognizes community as a unit of identity	Units of identity are socially constructed dimensions of identity. Community is characterized by a sense of emotional connection and identification to shared values, experiences, and norms, as well as an emotional connection to one another. A community can be a specific geographic location or transcend physical parameters and include a shared identity, one that includes common values and experiences (e.g., ethnicity, religion). CBPR partnerships recognize and work with communities as units of identity to be able to promote greater public vitality across the unit, as well as to strengthen the sense of community through collective engagement (Israel et al., 1998; Israel, Eng, & Schulz, 2012).
Builds on strengths and resources within the community	This principle is focused on building on the inherent strengths and resources of the community, in order to help resolve their community-identified needs. CBPR aims to continue to utilize and enhance the inherent individual and communal strengths and resources (i.e., skills of individuals, type of relationships, networks, community supports) to promote greater collaboration, support, and resiliency in improving their communal health. CBPR identifies and further expands already existent social structures and utilized supports (i.e., religious support, networks of relationships) to better community public health (Israel et al., 1998; Israel, Eng, & Schulz, 2012).
Facilitates a collaborative, equitable involvement of all partners in all phases of the research, involving an empowering and power-sharing process that attends to social inequalities	All partners engage in a shared process of learning and making decisions throughout all stages of the research. The stages of research include: identification of the problem, data collection and analysis, interpretation of results, and dissemination of the results and action strategies to effect community change. Research and academic partners are cognizant of the history of social and hierarchical inequalities within traditional research and strive to address and rectify these inequalities

	by having trusting and equal relationships with community members. Researchers are also aware that a history of inequalities can impact the community members perception of the researchers, research being conducted, and their role within the partnership; thus, it is essential that stakeholders explicitly address these concerns by providing a safe space for community members to openly communicate, share information and power, and be appreciated for their knowledge. The ideal relationships and partnerships are founded on open communication, shared-decision making, trust, and mutual respect, as well as primary focus on community needs (Israel et al., 1998; Israel, Eng, & Schulz, 2012).
Integrates knowledge and intervention/action for mutual benefit of all partners	CBPR strives to disseminate findings to the scientific literature and broaden the understanding of health across different communities, as well as translate research findings to community changes or action strategies to address the needs of the communities. There is a commitment that all partners will benefit from the gained information; thus, researchers learn more about a specific community, while community members experience the benefits of these findings within their communities (Israel et al., 1998; Israel, Eng, & Schulz, 2012).
Fosters co-learning and capacity building among all partners	This principle is founded on the notion that all members possess and can share power, skills, knowledge, and experiences that can benefit the collective. The partnership is based on reciprocal exchange amongst all partners. There is an appreciation of the different areas of expertise and perspectives that each stakeholder possesses and can contribute in the collective learning process. For instance, academic researchers learn from community members in how to appropriately interact and engage their communities, as well as provide them with more culturally syntonic services. Communities can learn from researchers about the different phases of research (Israel et al., 1998; Israel, Eng, & Schulz, 2012).

Involves a cyclical and iterative process	CBPR includes an iterative process, in which all stages of the research are consistently re-visited to ensure that the research is focused on the needs of the community and modified as necessary. CBPR focuses on partnership development, community assessment, identification of community problems, development of research methodology, data collection and analysis, interpretation of data, impact on action and policy changes, dissemination of results, action changes (if appropriate), identification of lessons learned, and determination of sustainability. From each step, information is gained about the processes and outcomes from the partnership and ways to improve them (Israel et al., 1998; Israel, Eng, & Schulz, 2012).
Focuses on the local relevance of public health problems and on ecological perspectives that attend to the multiple determinants of health	CBPR aims to address community and public health concerns from an ecological approach that accounts for individual, immediate context, and greater familial and community contexts, as well as accounts for physical, mental, and social well-being and health. CBPR includes an interdisciplinary perspective of the connection between the biomedical, social, economic, financial, historical, and political components of health (Israel et al., 1998; Israel, Eng, & Schulz, 2012).
Disseminates findings and knowledge gained by all partners	This principle highlights the importance of disseminating research findings to all partners in a manner and with language that is understandable, meaningful, and respectful to all partners. The results and findings should also inform necessary action interventions (as appropriate). Additionally, all partners should be involved in the greater dissemination of findings within the field, as well as researchers should make attempts to consult and receive permission from participations prior to submission of manuscripts for publication. Participants should also be acknowledged and appreciated for their contributions and made co-authors on publications, as appropriate (Israel et al., 1998; Israel, Eng, & Schulz, 2012).

Involves long-term commitment by all partners and commitment to sustainability	CBPR partnerships are founded on a long-term commitment to the different partners and their needs, as well as built on genuine trust and respect. Although stakeholders may decide to end their partnerships, they remain committed to the relationships and sustain a strong foundation to return and utilize in the future, should they decide. At the core of the CBPR process is the relationships, importance of the partnerships, and need to consistently evaluate the CBPR partnerships to ensure that they are working most effectively (Israel et al., 1998; Israel, Eng, & Schulz, 2012).

APPENDIX C

Certificate of Completion

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Sheva Assar** successfully completed the NIH Web-based training course “Protecting Human Research Participants”.

Date of completion: 01/06/2013 Certification Number: 1070716

APPENDIX D

IRB Approval Letter

Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: July 06, 2016

Protocol Investigator
Name: Sheva Assar Protocol #: 16-05-267
Project Title: Evaluating a Community-Based Program within Multi-ethnic Communities: Examining the Outreach and Engagement Program of MECCA
School: Graduate School of Education and Psychology

Dear Sheva Assar:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chairperson

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives