Replicating the Family Connections Program: Lessons Learned

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Culturally Competent Practice With Cambodian and Korean Families in Los Angeles: Results From a 5-Year Replication Project of Family Connections

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Introduction

Asian Pacific Counseling and Treatment Centers (APCTC)[1] is the oldest (established in 1977) and largest operator of mental health centers serving the Asian and Pacific Islander (API) communities in Los Angeles (LA) County, providing high quality, culturally competent mental health services to children, adolescents, adults and senior adults, and families. With multi-disciplinary teams, APCTC functions as a multilingual, multicultural provider with a full range of mental health programs and services. Implementing the Family Connections (FC) Program within this established mental health service delivery system was deemed an appropriate fit — one that would improve understanding of how to prevent child maltreatment within Asian communities. Of particular interest was the opportunity to implement culturally appropriate interventions for Cambodian families, a Southeast Asian sub-group, and Korean families, an East Asian sub-group.

FC was selected for several reasons to advance the prevention of child maltreatment within two very different Asian sub-groups. Most important was the flexibility of the nine practice principles (see page 5). In addition, the intensive staff training and cultural competency values were felt to be beneficial for the target populations.

The purpose of this article is to present three culturally competent practices specific to Cambodian and Korean sub-groups in the context of implementing FC: (1) "Buy-in" from the target population; (2) tailored service delivery protocols; and (3) cultural adaptations to FC for Cambodian refugee and Korean immigrant population groups. This discussion is presented to build on the utility of FC among culturally diverse populations.

Background: Cambodian and Korean Family Characteristics

Cambodian refugee and Korean immigrant families vary greatly in terms of immigration history, traditions, and current status in the United States. Members of the Cambodian population were refugees in this country, fleeing the brutal Pol Pot regime starting in 1975 (Chang, Rhee, & Berthold, 2008). The Korean population started immigrating to this country in the 1960s and more heavily in the 1980s (Kim & Cain, 2008). Their main incentive for immigration was economic opportunities (Shin & Shin, 1999). These immigration patterns have led to very different family issues and service needs.

LA County is home to 11% of all API children (Children Now, 2001), and California is home to 37% of all child maltreatment cases nationwide for children who are Asian (not Pacific Islander) (U.S. Department of Health & Human Services, 2009). Experts believe that the numbers are significantly underreported due to family loyalty and filial piety, and also the shared cultural values among the people who have contacts with these families. Many API groups find it shameful to talk about or share problems with those outside the family, and believe that they should solve problems by themselves. Close-knit ethnic enclaves reinforce these customs. Currently, 840 children who have ethnicity listed as Asian or Pacific Islander are receiving services from the LA County Department of Children and Family Services (DCFS). Interestingly, over 40.4% (twice the general population average of 20.8%) of these services are voluntary or non-court-mandated (Nguyen, 2008), possibly indicating a small crack in the community's historic "wall of silence." The growing understanding of maltreated children who are API provides compelling evidence supporting the need for child welfare prevention and intervention programs in this geographic area and other such growing communities nationwide.

[1]APCTC is a division of Special Service for Groups, a private, nonprofit human services provider in California.

Cambodian Families

In LA County, the Cambodian population numbers 28,226 persons or 2.5% of the total Asian population. Significantly, however, 31% of child maltreatment cases investigated by the Asian Pacific Unit of DCFS involve Cambodian families (Nguyen, 2008). Treatment need among the Cambodian community is especially urgent as a result of the trauma many refugees endured in their home country under the Pol Pot Khmer Rouge regime (1975-1979), during which 1 to 3 million people died of starvation, disease, or mass executions. Many Cambodian refugees remain traumatized; more than 62% of the community suffers from post-traumatic stress disorder, and 51% have a major depressive disorder (Marshall, Schell, Elliott, Berthold, & Chun, 2005). Such staggering numbers indicate a great need for intervention.

Treatment need among the Cambodian community is especially urgent as a result of the trauma many refugees endured in their home country under the Pol Pot Khmer Rouge regime.

However, there are multiple obstacles to serving this group. Cambodian families have a very high rate of linguistic isolation; 57% of all Cambodian households in LA County are without a person 14 or older who is able to speak English "very well" (APALC, 2004). The high rate of language isolation could be a result of a considerably low level of educational attainment; 56% of Cambodian adults aged 25 and older have not completed high school (APALC, 2004). In addition, Cambodians have a remarkably high poverty rate, with 68% below 200% of the federal poverty line (APALC, 2004). Poverty is well established as a risk factor for child maltreatment and overall child well-being (Thomas, Leicht, Hughes, Madigan, & Dowell, 2003; Sedlak & Broadhurst, 1996; Slack, Holl, McDaniel, Yoo, & Bolger, 2004).

Korean Families

The Korean population in LA County has grown by 28% from 1990 to 2000, representing 16.4% of LA County's Asian population (APALC, 2004; U.S. Census Bureau, 2000). Currently, 14.9% of the API child maltreatment cases investigated by the county are Korean (Nguyen, 2008). In LA County, 59% of Korean households are linguistically isolated (APALC, 2004). While Asians are more likely to be foreign-born (66%) than other ethnic groups (APALC, 2004), at 77%, Koreans are almost double the norm (U.S. Census Bureau, 2000). Such a rapidly expanding immigrant community typically experiences a high need for services and resources — but faces significant barriers to accessing them.

More than one third (36%) of Koreans in LA County live below 200% of the poverty level (APALC, 2004), even though there is a well-accepted stereotype of business proliferation and growth. There have been increasing reports of Korean domestic violence in the media, especially in the wake of a series of high-profile deadly family rampages in 2006 (Gable, 2006; Hayasaki, 2006) and the Virginia Tech massacre perpetrated by a disturbed Korean student in 2007. A report by the Asian and Pacific Islander Institute on Domestic Violence (2005) indicated that 30% of Koreans surveyed reported witnessing their fathers regularly hit their mothers, while 80% reported being hit regularly as children. These and other indicators showcase a growing risk for child well-being in this rapidly growing immigrant group.

Needs at Intake for Families Served

To implement FC with the target population, 74 Cambodian and Korean families were recruited to receive services. Descriptive information about these families that was collected during the intake process is presented. All families met the eligibility criteria for enrollment, which included: living in LA County; the parent or caregiver was a recent Cambodian or Korean immigrant; the family in need of services had at least one child who was between 5 and 11 and lived in the home; the family was stable and willing to accept services; and there was no current DCFS

Table 1. Demographic Characteristics for Cambodian and Korean Families at Intake (*N* = 74).

Demographic Characteristic	Cambodian Families (*n* = 39)	Korean Families (*n* = 35)
Parent/caregiver average age	41.7 yrs (standard deviation or sd =8.4)	41.6 yrs (sd=7.9)
Target child average age	8.2 yrs (sd=2.1)	8.5 yrs (sd=1.9)
Parent/Caregiver gender		
Female	92.3% (36)	100% (35)
Male	7.7% (3)	--
Target child gender		
Female	35.9% (14)	40.0% (14)
Male	64.1% (25)	60.0% (21)
Parent/Caregiver marital status		
Married (living together)	38.5% (15)	82.4% (28)
Separated/divorced/widowed	46.1% (18)	17.6% (6)
Never married	15.4% (6)	--
Parent/Caregiver employment		
Unemployed	84.6% (33)	58.8% (20)
Part-time employment	10.3% (4)	11.8% (4)
Full-time employment	5.1% (2)	29.4% (10)
Parent/Caregiver highest education completed		
Less than high school	69.2% (27)	--
High school	17.9% (7)	11.8% (4)
Some college/graduated	10.3% (4)	76.4% (26)
Some graduate school/graduated	2.6% (1)	11.7% (4)
Living arrangements		
House/Apt. owned	2.6% (1)	32.4% (11)
House/Apt. rented	69.2% (27)	64.7% (22)
Public housing/Section 8	17.9% (7)	2.9% (1)
Share house/apt. w/friend, relative	10.2% (4)	--
Family annual income		
$9,999 and less	18.9% (7)	11.8% (4)
$10,000 - $19,999	54.0% (20)	17.6% (6)
$20,000 - $29,999	13.5% (5)	32.3% (11)
$30,000 - $39,999	8.1% (3)	5.9% (2)
$40,000 - $49,999	--	14.7% (5)
$50,000 or more	5.4% (2)	17.6% (6)

involvement. Just over half of families were Cambodian (52.7%) and just under half were Korean (47.3%). Demographics for the Cambodian and Korean families are shown in Table 1.

For Cambodian families, almost all caregivers were female (92.3%). The average age of the caregiver was 42 years old, and the average age of the child was 8 years old. About two thirds of Cambodian families included a boy who was the identified child (64.1%). The largest percentage of Cambodian caregivers represented those who were separated, divorced, or widowed (46.1%), followed by those who were married (38.5%). More than two thirds of caregivers were unemployed (84.6%). A significant portion of Cambodian caregivers had less than a high school education (69.2%). More than two thirds lived in a rented house or apartment (69.2%). The most common income group was $10,000 to $19,999 per year (54.0%).

For Korean families, all caregivers were female, with an average age of 42 years old. The average

Table 2. Rank Ordering by Percent of Cambodian and Korean Families Receiving Public Assistance/ Participating in Social Welfare Programs at Intake (*N* = 74).

Cambodian Families (*n* = 39)		Korean Families (*n* = 35)	
% (n)	**Rank ordering**	**% (n)**	**Rank ordering**
59.0 (23)	(1) Food Stamps	17.1 (6)	(1) Medicaid
43.6 (17)	(2) Temporary Assistance for Needy Families (TANF)	5.7 (2)	(2) Food Stamps
33.3 (13)	(3) Medicaid	5.7 (2)	(2) Social Security
23.1 (9)	(4) Supplemental Security Income (SSI)	5.7 (2)	(2) SSI
12.8 (5)	(5) Women, Infants and Children (WIC)	2.9 (1)	(3) TANF
2.6 (1)	(6) Social Security	2.9 (1)	(3) WIC
--	(7) Unemployment	--	(4) Unemployment
--	(7) General assistance	--	(4) General assistance

Table 3. Rank Ordering of Risk Factors Experienced by 30% or More of Cambodian and Korean Families at Intake (*N* = 74).

Cambodian Families (*n* = 39)		Korean Families (*n* = 35)	
% (n)	**Rank ordering**	**% (n)**	**Rank ordering**
100 (39)	(1) Over-employed/newly employed/unemployed	82.9 (29)	(1) Over-employed/newly employed/unemployed
76.9 (30)	(2) Caregiver mental health problem	82.9 (29)	(1) Child behavior/mental health problem
48.7 (19)	(3) Isolation	40.0 (14)	(2) Inadequate nurturing
38.5 (15)	(4) Inadequate nutrition	37.1 (13)	(3) Permitting other maladaptive behavior
35.9 (14)	(5) Inadequate nurturing	31.4 (11)	(4) Delay in obtaining mental health care
33.3 (13)	(6) More than 3 children in the home		

age of the child was 8 years old. Boys were the identified child for 60% of families. Almost all caregivers were married (82.4%). About two thirds were unemployed (58.8%), with about one third employed full-time (29.4%). Most Korean caregivers had gone to college or graduated from college (76.4%) or attended or graduated from graduate school (11.7%). About two thirds lived in a rented house or apartment (64.7%). The most common income group was $20,000 to $29,999 per year (32.3%).

Table 2 presents data on the percentage of families that reported receiving public assistance and social welfare programs at intake. A rank ordering is also presented based on the total percentage of families receiving each benefit. Of immediate note is that in the case of Cambodian families, almost two thirds reported receiving Food Stamps (59% or 23 families), with almost half receiving Temporary Assistance for Needy Families (TANF) (43.6% or 17 families), and one third receiving Medicaid (33.3% or 13 families). Only a small number of Korean families reported receiving any of these types of government assistance, with the largest percentage reporting receipt of Medicaid (17.1% or 6 families). For the remainder of the assistance categories, only one or two Korean families reported receiving these at intake.

Table 3 presents the most prevalent risk factors that were experienced by 30% or more of Cambodian or Korean families. Over-employment (working excess hours), being newly employed, and unemployment were the most common risk factors for both Cambodian (100%) and Korean (82.9%) families. For Cambodian families, risk factors were caregiver-focused (caregiver mental health problems, isolation, and inadequate nurturing), related to basic needs (inadequate nutrition), and family-focused (more than three children in the home). For Korean families, risk factors were child-focused (e.g., child behavior/mental health problems, permitting maladaptive behaviors, delay in obtaining mental health care) and caregiver-focused (inadequate nurturing).

Table 4 presents the average scores for the standardized assessments conducted at intake. A general indicator of need is suggested when the average scores are in a problem or clinical range. For Cambodian families, areas of need were indicated for caregivers in several areas, including social support, depression, post-traumatic stress disorder (PTSD) symptoms, parenting skills (including inappropriate development expectations, lack of empathy, corporal punishment, role reversal, and power independence), parenting stress, and interactions between caregivers. No problems with children were in the clinical range. For Korean families, caregiver needs were also indicated in several areas, including social support, depression, PTSD symptoms, parenting (including empathy skills, use of corporal punishment, role reversal, and power independence), parenting stress, and caregiver/child interactions. Korean parents scored their children in the borderline problem range on the Child Behavior Checklist (CBCL).

Lessons Learned: Implications for Practice

In this section, we present the lessons learned in three main practice areas significant to culturally competent practice — "buy in" of Cambodian and Korean families, service delivery protocols, and cultural adaptations of FC — as well as the implications for frontline social workers, supervisors, and administrators.

'Buy-in' of Cambodian and Korean Families

Implications for Children's Social Workers, Supervisors, and Administrators

Community-based recruitment strategies. At the outset of FC implementation, outreach and participant recruitment took longer than expected, necessitating staff to intensify outreach efforts. For Cambodian families, one productive recruitment strategy included outreach to

Table 4. Areas of Need as Indicated by Mental Health Assessment Average Scores at Intake for Cambodian and Korean Families (*N* = 74).

Assessment	Cambodian Families (*n* = 39)		Korean Families (*n* = 35)	
Support Function Scales	Mean (M)=46.2 (standard deviation or sd = 13.6)	Moderate need	M=46.8 (sd=15.8)	Moderate need
Center for Epidemiologic Studies Depression Scale (CES-D)	24.6 (sd=10.7)	Clinical range >16	M=20.6 (sd=11.2)	Clinical range >16
Post-Traumatic Stress Disorder Symptom Checklist – Civilian Version (PCL-C)	M=44.1 (sd=16.2)	Clinical range >28 to 50	M=38.6 (sd=15.1)	Clinical range >28 to 50
Adult-Adolescent Parenting Inventory II (AAPI), Form A sten scores				
Inappropriate developmental expectations	M=2.6 (sd=1.1)	High risk	M=5.0 (sd=2.0)	Normal
Lack of empathy	M=1.3 (sd=.65)	High risk	M=2.8 (sd=1.5)	High risk
Corporal punishment	M=3.0 (sd=1.1)	High risk	M=3.6 (sd=1.3)	High risk
Role reversal	M=1.6 (sd=1.2)	High risk	M=2.8 (sd=1.5)	High risk
Power independence	M=1.6 (sd=1.2)	High risk	M=2.8 (sd=1.5)	High risk
Parenting Stress Index (PSI) – Short Form				
Total stress percentile	M=91.4 (sd=9.9)	Clinical range >90	M=96.8 (sd=4.1)	Clinical range >90
Child Behavior Checklist (CBCL) (1991) for Ages 4 to 18				
Internalizing behaviors	M=55.4(sd=8.4)	Normal <60	M=58.1 (sd=10.0)	Normal <60
Externalizing behaviors	M=49.8 (sd=7.6)	Normal <60	M=54.8 (sd=10.7)	Normal <60
Total problems	M=54.3 (sd=8.9)	Normal <60	M=61.3 (sd=10.9)	Borderline 60-63
Family Assessment Form (FAF)				
Section A: living conditions	M=2.7 (sd=.53)	Adequate	M=1.9 (sd=.48	Adequate
Section B: financial	M=2.7 (sd=.59)	Adequate	M=1.9 (sd=.49)	Adequate
Section C: supports to caregivers	M=2.6 (sd=.64)	Adequate	M=2.3 (sd=.65)	Adequate
Section D: caregiver/child interactions	M=2.5 (sd=.64)	Adequate	M=3.0 (sd=.77)	Problems
Section E: developmental stimulation	M=2.9 (sd=.62)	Adequate	M=2.5 (sd=.71)	Adequate
Section F: interactions between caregivers	M=3.1 (sd=1.2)	Problems	M=2.7 (sd=1.0)	Adequate
Section G: caregiver history	M=2.7 (sd=.87)	Adequate	M=2.1 (sd=.59)	Adequate
Section H: caregiver personal characteristics	M=2.4 (sd=.50)	Adequate	M=2.1 (sd=.48)	Adequate

well-known community-based organizations. Once recruited, the provision of assistance with basic needs (food, employment, and housing), as supplied through the case management portion of FC, was identified as a compelling draw for most Cambodian families. For Korean families, a similar strategy of partnering with local community-based organizations or faith-based networks did not draw in families as hoped. Maximizing children's educational attainment was identified as the major draw to many of the Korean families whose members agreed to participate in FC. The most common source of referrals for both groups was self-referrals (46.2% of Cambodian referrals and 28.6% of Korean referrals), which often followed small group community presentations.

Maximizing children's educational attainment was identified as the major draw to many of the Korean families whose members agreed to participate in FC.

Staff "matching" by language/culture. While APCTC staff were extensively trained to provide culturally appropriate services, specific client "matching by ethnic sub-group" was not always possible. The main reason was a shortage of Cambodian professionals (i.e., therapists) both regionally and nationally — likely a direct result of their refugee history, which included the near-termination of almost all educated professionals and paraprofessionals during the Khmer Rouge regime in the late 1970s. As a result of this shortage, Korean therapists were used for Cambodian families, but worked in close collaboration with Cambodian outreach workers/case managers who were able to build trusting relationships with Cambodian families. To have at least one member of the FC team "match" the client appeared to facilitate the provision of case management services, but may not have been sufficient to address more substantive emotional and psychological issues such as depression and PTSD. All bilingual and bicultural staff were either immigrants themselves or had parents who were immigrants or refugees.

Outreach and engagement. As noted, outreach and participant recruitment took longer than anticipated. Based on existing research and staff feedback, several factors were probably at work. First, child maltreatment is considered shameful behavior. As such, a broad community-based outreach approach (e.g., one that relied on churches) did not necessarily lead to community buy-in. Smaller parent (peer-based) groups were more receptive, as these groups were more willing to acknowledge problems (or potential problems) among peers. Different API sub-groups have different priorities, as evidenced by the clear differences between Cambodian and Korean groups. It behooves other providers looking to implement FC to use not only existing community-based organization networks and linkages, but create avenues for smaller, more intimate settings such as parent groups and neighborhood associations.

Service Delivery Protocols

Implications for Child Welfare Workers

The individualized approach of FC allowed for the incorporation of cultural nuances and styles by trained staff.

Greeting style. Bowing is the act of lowering the torso and head as a social gesture in direction to acknowledge another person. For many Southeast Asian groups, including Cambodians, pressing the hands together similar to a prayer may be done at the same time as bowing without any physical contact. However, depending on different emotions, including humility, sincerity, or

deference, physical contact (hand or arm shaking) may also accompany bowing. Respectfully nodding the head is acceptable — especially if familiarity has already been established. Bowing as part of the general greeting was uniformly observed by all staff throughout the project.

Use of culturally appropriate title. Bilingual staff commonly used culturally appropriate titles loosely translated as "uncle" or "aunt" for all Cambodian adult household members. This denoted respect and acceptance. With Cambodian families, men were greeted as "bong-pros" (uncle) and the women as "bong-srey" (aunt). Staff reported that over time, the use of titles became more informal and at times playful. Staff often reported that they felt fully accepted by the families and were treated as if they were part of extended family networks. For English-speaking staff who interacted with Cambodian parents, use of "Mr." or "Mrs." was appropriate initially, but as rapport developed, the English-speaking workers shifted to using "Uncle [First Name]" or "Aunt [First Name]." For Korean parents, greetings were more formal. "Mr." and "Mrs." were appropriate throughout service provision. Use of "Mom" and "Dad" as a third-person reference (i.e., when talking with a child) was also acceptable for both ethnicities in the context of parenting issues, but the more formal "Mother" and "Father" were often more comfortable for Korean families.

Food or other tokens of hospitality. Food is used within all Asian (and other) cultures in very specific ways. It is a token of respect and good manners to bring food or snacks. Arriving empty-handed would not have been commented upon, but would have been noticed. Promotional items (e.g., mugs) were also much appreciated. Providing staff a flexible budget to pick and choose the most appropriate items seemed to increase harmony among staff and clients.

Client choice for service delivery. The location of FC services was based on client choice, but most were provided in clients' homes. Services were sometimes provided at one of the APCTC clinics located throughout LA County. Repeated visits to a family's home firmly established the helping alliance, a core component of FC (see the Introduction in this issue). Overall, families appreciated the opportunity to decide where services would be provided.

Implications for Child Welfare Supervisors and Administrators

Staff cultural competency. As noted, Korean therapists worked with Cambodian families, but in close collaboration with Cambodian outreach workers/case managers who were able to build trusting relationships with the families. Under these circumstances, it was important that the supervisor encouraged the necessary teamwork by providing ongoing opportunities for the two staff to regularly communicate about the family. While staff-client "matching" is ideal, sharing a language with at least one team member was adequate. The integration of cultural norms (titles of respect for elders and adults, bowing, food, and tokens of appreciation) increased trust-building between all staff and families. Further, the use of cultural norms and establishment of the helping attitude among staff (another training requirement of FC) were welcomed and successful. Cultural competence, one of the nine FC practice principles, was reviewed throughout the project. Direct service staff reported that they accepted and respected cultural differences between the families and themselves by using empathy, by noticing the differences, and by noting the uniqueness of each family. They also reported that they engaged in ongoing cultural self-assessment by being positive about their own cultures and interested in other cultures, and by engaging in conversations on cultural issues outside of work with friends and colleagues. The

project supervisor used weekly team meetings, individual supervision sessions, and chart reviews to encourage the development of cultural competence.

Goal-setting differences between ethnic groups. As noticed throughout the project and discussed in staff focus groups, the targeted outcomes of service plan goals were very different for Cambodian and Korean families. Cambodian families identified goals that focused strongly on short-term, basic needs, including housing and food. It is reasonable to assume that Cambodians remain particularly impacted by their refugee experiences and therefore prioritize basic needs (food, shelter) over any other considerations. This is also in keeping with lower socio-economic status and high poverty levels among Cambodian families participating in the study — for families facing these challenges, basic needs take center stage. Korean families were more likely to identify educational and career goals for children, and seek long-term economic family and community stability. Children's educational attainment was consistently highlighted as a primary concern. While sample sizes were too small for comparison, these significant differences raise the question of how refugee versus immigrant status impacted various levels of family and community dynamics.

Cultural Adaptations of FC

Implications for Child Welfare Supervisors and Administrators

Translation of "Family Connections." Language nuances and translatability vary from culture to culture. The initial interpretation of a program name is important to potential clients, so considerable time was spent to assure that an appropriate translation was used. While the word "connections" is easily recognized as a term denoting familial and social networks, it does not translate well into either Cambodian or Korean languages. A process similar to a back-translation was used to assure that the program name was translated well. Staff who were fluent in each language, who were also fluent in English, and who understood FC came up with these translations. The translations were then shared with other staff who were fluent in both English and either Khmer (the language spoken in Cambodia) or Korean. Once it was decided that the translation worked in Khmer or Korean, the phrase was translated back to English. After much discussion, the name Caring for Our Families (CFOF) was selected to better represent the philosophical principles of FC.

Empowerment and strengths-based approaches. Empowerment and strengths-based approaches are integral to FC and contributed to its selection for implementation. However, based on staff observation, these are not always familiar or comfortable concepts to Asian communities and, in particular, to refugee sub-groups. Even with repeated discussions and sessions, families struggled with these concepts. As opposed to embracing a family-driven process, most Cambodian families preferred for staff to define and identify goals (short- and long-term) as well as the methods and activities required to accomplish those goals.

Many families appeared to be confused or embarrassed by staff's efforts to empower them to do things on their own rather than relying on staff to do things for them. This appears to be in keeping with the Cambodian refugee experience and common anomie — a state of hopelessness, helplessness, and feeling disconnected from society (Mozingo, 2009). In particular, for Cambodian refugees, staff felt 3 or 6 months of services (the two experimental groups) was too short to significantly empower families. Staff reported a lesser degree of resistance to empowerment and strengths-based approaches from Korean families, but still recognized the need to continually reinforce and reassure

families that their choices were "not wrong." It was typical that Korean families were very reticent during the initial trust-building phase and tried to pinpoint staff recommendations rather than their own. Once trust was established, however, Korean families were much more willing to self-identify goals, needs, and approaches, especially within the context of their children's educational attainment. As part of procedure, staff maintained both a respectful and deferential demeanor. Staff reported that the tendency for both groups to try to avoid taking the lead in service planning was not a dichotomy in the staff-client relationship, but more of a culture-influenced response to avoid appearing "demanding" or "needy."

Integration of FC within a traditional mental health agency. For a traditional mental health agency whose priority is to stabilize and provide intensive treatment to severely mentally ill clients, a comprehensive prevention strategy targeting at-risk families may seem out of keeping with the agency's primary intervention and stabilization mission. Further, a comprehensive prevention model such as FC (while service-rich) comes with a correspondingly high per-client cost. This is a difficult program design to maintain, especially during leaner economic times and/or when treatment dollars are more restrictive (both of these situations are currently the norm).

Also, a mental health provider may have more difficulty in outreach and recruitment than a traditional community-based organization. Negative stereotypes relating to mental illness remain an unfortunate part of our society, necessitating additional effort to recruit clients into a prevention program such as FC. Staff unanimously agreed that FC could be a tremendous asset for a family with one or more members already receiving mental health services.

Conclusions and Discussion

This FC replication study provided valuable evidence that sub-populations within the broader "Asian" category are distinct and unique, requiring careful review and assessment of outreach or "buy-in" strategies, service delivery protocols, and cultural adaptations of the underlying philosophy and theories guiding practice. Understanding and navigating the "community" face as well as the "private" face for both Cambodian and Korean families was key to successful outreach, especially as it relates to sensitive topics such as child maltreatment and mental health. Partnering with community-based classes was found to be an effective outreach strategy for both Cambodian and Korean families, along with hiring staff whose language and culture matched those of the families.

While our sample sizes for Korean and Cambodian families are not large enough to make broad generalizations, staff's collective observations and anecdotal evidence revealed the critical need for culturally and linguistically appropriate service delivery models that consider greeting style, use of appropriate titles, consideration of how to handle tokens of hospitality, and client choice for the location of service delivery. Examination of goal-setting activities highlighted that Cambodian families exhibited very different demographic characteristics related to poverty and child risk than Korean families, and this impacted the goals they wished to pursue. As stated by Chang, Rhee, and Berthold (2008): "Unlike other Asian groups (e.g., Chinese, Filipino, Korean) who voluntarily immigrated to the United States with the aims of economic success…many Cambodians were forced to leave their homeland…to avoid war, executions, or labor camps under the Khmer Rouge regime" (p. 142). Some of the differences observed in this replication project may be related to refugee versus immigrant status, and are cause for thought regarding the ongoing impact of refugee experiences on future generations. For Korean families, the increasing incidence of violence, especially among Korean American youth, and strong parental expectations, must be taken into consideration for any practical application of prevention modalities (Kim & Cain, 2008; Ngo & Le, 2007).

Cultural adaptations specifically related to the underlying philosophy of FC were also considered. Adaptations to implementing an empowerment and strengths-based approach were important to consider in the context of Cambodian refugee and Korean immigrant populations. More work needs to be done to determine whether such practice theories are appropriate for these populations. The organizational context of implementing FC within an existing mental health program was also considered, with the competing interests of prevention versus intervention services brought to the forefront. Finally, cost and available resources must be taken into consideration for broad implementation of FC, especially for API populations still struggling with the "model minority" myth (the assumption of success despite marginalization) and corresponding shortages of prevention, treatment, and intervention practices and funding.

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