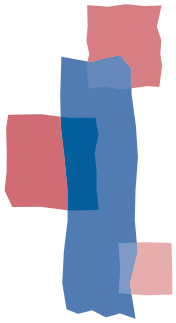

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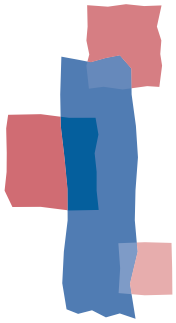

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Substance Abuse and Mental Health Services Administration

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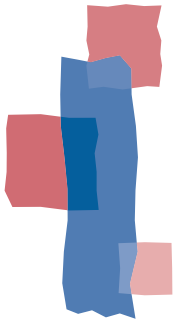

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This booklet provides an overview of activities associated with implementing evidence-based practices (EBPs) and enhancing the cultural competence of EBPs. This booklet is particularly relevant to mental health authorities and agency staff who develop and manage EBP programs.

# Interventions for Disruptive Behavior Disorders

For references, see the booklet, *The Evidence*.

This KIT is part of a series of Evidence-Based Practices KITs created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

This booklet is part of the Interventions for Disruptive Behavior Disorders KIT, which includes six booklets:

**How to Use the Evidence-Based Practices KITs**

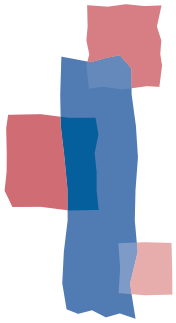
**Characteristics and Needs of Children with Disruptive Behavior Disorders and their Families**

**Selecting Evidence-Based Practices for Children with Disruptive Behavior Disorders to Address Unmet Needs: Factors to Consider in Decisionmaking**

**Implementation Considerations**

**Evidence-Based and Promising Practices**

**Medication Management**



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## Introduction

A broad range of activities are essential to successfully implement an Evidence-Based Practice (EBP). These activities help build support for the EBP, integrate the EBP into agency policies and procedures, train staff agency-wide on basic EBP principles, and allow for ongoing monitoring and evaluation of the program. Practitioner training in how to deliver an EBP is only one aspect of EBP implementation.

This booklet introduces the general range of activities involved in successfully implementing EBPs. For more information about implementing specific EBPs, see Evidence-Based and Promising Practices in this KIT, which contains detailed, EBP-specific information on such activities as staffing, training, financing, and fidelity measuring.

## Build Support for Change: Five Steps for Consensus Building

Within a system, change affects different stakeholders differently. When changing the mental health system, mental health agencies should expect varied reactions from staff, community members, providers, and families and youth.

Since misunderstanding EBPs can stand in the way of your efforts to implement EBPs, proactively building a consensus to change the system or implement EBPs in the community is an essential component of success. This can be done through a five-step process (see Figure 1).

**Figure 1: Five Steps for Consensus Building**

**To start implementing your EBP:**

1. Identify key stakeholders who will be affected by implementing the EBP.
2. Invite potential champions from each stakeholder group to participate in an EBP advisory committee.
3. Ask the committee to advise you during the process.
4. Build an action plan.
5. Actively involve committee members in such ongoing activities as the following:

- Participating in EBP basic training;
- Providing basic information about the EBP to their stakeholder groups;
- Advising you during all phases of the implementation process; and
- Participating in an ongoing evaluation of the EBP.

### Step 1 Identify key stakeholders who will be affected by implementing the EBP.

Stakeholders may include provider agency personnel at all levels, mental health authority staff, family organizations, family members, youth, researchers, policymakers, and funders. Consensus building should also involve a broad array of community agencies in education, child welfare, juvenile justice, and health care.

### Step 2 Invite potential champions from each stakeholder group to participate in an EBP advisory committee.

According to agencies who have successfully implemented EBPs, identifying ongoing champions and forming an advisory committee are critical activities for success. Although you may feel that creating an advisory committee slows the process, it soon becomes apparent that any amount of time used to build stakeholder support is worth the effort.

EBPs have little hope for success if the community fails to recognize that they are needed, affordable, worth the effort, and congruent with community values and the agency's practice philosophy. Mental health authorities and agency administrators must convey to key stakeholders a clear vision and a commitment to implementing the EBP.

By forming an advisory committee of potential champions from each stakeholder group, you will be able to disseminate information broadly

within the community. You should plan to build committee members' knowledge in the EBP and then ask them to hold informational meetings or to disseminate information regularly to their stakeholder groups.

### Step 3 Ask the committee to advise you during the process.

In addition to having them conduct community education activities, ask committee members to advise you during all phases of the implementation process. This is why the advisory committee should be instituted and members educated about the EBP early in the planning process. Community members may help assess how ready the community and the agency are to implement the EBP and its activities. Once the EBP is in place, committee members can keep EBP staff informed of relevant community trends that may have an impact on providing the evidence-based services.

EBP advisory committees are crucial for sustaining the EBP over time. When EBP staff turn over, or other well-trained staff leave and must be replaced, or when funding streams or program requirements change, community alliances are essential to maintain the EBP. A well-established committee can champion the EBP through changes.

### Step 4 Build an action plan.

Once key stakeholders basically understand the EBP, have your advisory committee develop an action plan for implementation. Action plans outline activities and strategies involved in developing the EBP program, including the following:

- Integrating the EBP principles into mental health authority and agency policies and procedures;
- Outlining initial and ongoing training plans for internal and external stakeholders;
- Designing procedures to monitor and evaluate the EBP regularly; and
- Base the activities in your action plan on the needs of the population you serve, your community, and your organization.

### Step 5 Actively involve committee members in ongoing activities.

Committee members can help you with such tasks as deciding which outcomes you should emphasize. They can help you evaluate and integrate continuous quality improvements and engage in other essential activities.

## Integrate the EBP into Policies, Procedures, and Financing

### Examine policies and procedures

Mental health authorities and agencies that have successfully implemented EBPs highlight the importance of integrating the EBP into policies and procedures. For example, you will immediately face decisions about staffing the EBP program.

Mental health authorities can support the implementation process by integrating staffing criteria into regulations. Agency administrators should select an EBP program leader and practitioners based on mental health authority regulations and qualifications that the EBP requires. New EBP position descriptions should be integrated into the agency's human resource policies.

Agency administrators and mental health authorities should also review administrative policies and procedures to ensure that they are compatible with EBP principles. For example, you may need to modify admission and discharge assessment, treatment planning, or service-delivery procedures. Make sure policies and procedures include information about how to identify children and adolescents who are most likely to benefit from the EBP and how to integrate inclusion and exclusion criteria into referral mechanisms.

Examine policies and procedures early in the process. Integrating EBP principles into policies and procedures will build the foundation of the EBP program and will ensure that the program is sustainable. While most changes will occur in the planning stages, monitoring and evaluating the program regularly will allow you to periodically assess the need for more changes.

Assessment instruments can help identify strengths and areas of infrastructure that may need reinforcement to support implementing and disseminating EBPs. Examples of assessment instruments that can be used to help integrate EBPs into policies and procedures are presented in Figure 2.

## Figure 2: Assessments for Integrating EBPs into Service Systems

The **State Health Authority Yardstick (SHAY)** (Finnerty, Rapp, Lynde, & Goldman, 2005) was developed by the New York State Department of Mental Health to assess state infrastructure to support EBPs. It was developed in collaboration with the SAMHSA-CMHS-funded National EBP Implementation Project. Corresponding directly to the infrastructure domains, the areas measured on the SHAY include:

- Planning for EBP implementation
- Financing (adequacy, startup, conversion)
- Training (ongoing consultation and technical support, quality, infrastructure/sustainability)
- Leadership (state commissioner and EBP leader)
- Policy and regulations of the State Mental Health Authority (SMHA) and Non-SMHA agencies related to EBP program standards
- Quality improvement (client outcomes, stakeholder support)

The **Organizational Readiness for Change** (Lehman, Greener, & Simpson, 2002) instrument was developed for use in substance abuse treatment organizations to assess the readiness of an organization to implement EBPs. This tool also affords opportunities for use in children's mental health service provider organizations. There are two versions—one for directors and another for staff—which assess 18 domains in the following areas:

- Motivational readiness (perceived need for improvement, training needs, pressure for change)
- Institutional resources (office, staffing, training, resources, computer access, electronic communication)
- Staff attributes (value placed on professional growth, efficacy, willingness and ability to influence co-workers, adaptability)
- Organizational climate (clarity of mission and goals, staff cohesiveness, staff autonomy, openness of communication, level of stress, openness to change)

Measures are available at **http://www.ibr.tcu.edu/pubs/datacoll/commtrt.html#Form-ORC**.

The **Evidence-based Practice Attitude Scale** (Aarons, 2004) was designed to assess mental health provider attitudes toward adopting evidence-based practices. This brief measure assesses four dimensions related to the following:

- Appeal of evidence-based practices
- Likelihood of adopting given requirements to do so
- Openness to new practices
- Perceived divergence of EBPs from usual practices

## Identify funding issues

Identifying and addressing financial barriers is critical because specific costs are associated with starting new EBP programs and sustaining them. Identify short- and long-term funding mechanisms for EBP services, including federal, state. Private foundation funds are also important. You can use your EBP advisory committee to project startup costs by identifying the following:

- Time for meeting with stakeholders that is not reimbursed;
- Time for staff while in training;
- Costs associated with reducing productivity requirements to account for time spent planning;
- Travel to visit other model EBP programs; and
- Costs for needed technology (cell phones and computers) or other one-time expenses accrued during the initial implementation effort.

You should also identify funding mechanisms for ongoing EBP services and the support of continuous quality improvement efforts, including ongoing training, supervision, technical assistance, fidelity, and outcomes monitoring. In addition, you may need to revise rules for reimbursement that are driven by service definitions and criteria. This may require interagency meetings at the federal, state, and local levels. Resources that will help you plan for financing issues are presented in Figure 3.

**Figure 3: Resources for Exploring Financing Options**

- A Self Assessment and Planning Guide: Developing a Comprehensive Financing Plan (Armstrong et al., 2006).

  This guide was developed to increase understanding of financing structures and strategies to support effective systems of care. It was designed to guide service systems and individual communities in assessing their current financing structures and strategies and to prioritize a strategic financing plan for moving forward. It provides a means for projecting possible outcomes that are to be achieved and strategies for achieving those outcomes.

- Public Financing of Home and Community Services for Children and Youth with Serious Emotional Disturbance: Selected State Strategies (Ireys et al., 2006).

  This monograph, sponsored by the U.S. Department of Health and Human Services, provides information about sources of federal funding for child mental health services and profiles state approaches to financing home and community based services, including various Medicaid options.

## Understand Medicaid

Medicaid is an essential resource for funding many EBP programs, and understanding how it works is essential for agencies planning to adopt an EBP. Medicaid is a federal-state partnership. The federal government develops regulations based on federal statutory requirements. State Medicaid agencies have the responsibility to implement the program in their state.

The federal statute holds the Medicaid state agency and the Medicaid director responsible for all aspects of the program. While Medicaid state agencies may collaborate and contract with other public and private agencies, including mental health agencies, the Medicaid director is held accountable for all activities.

Medicaid now funds more than half of public mental health services administered by states and could account for two-thirds of such spending by 2017 (Buck, 2003). Accordingly, Medicaid is the single largest source of funding for public mental health services for children, youth, and their families.

### Medicaid eligibility

Medicaid provides access to health coverage for low-income women and their children and for people with disabilities and others who have high medical costs. To qualify, all these individuals must have low or moderate incomes, but Medicaid eligibility is also linked to age, with specific eligibility categories for elderly people as well as children.

Since Medicaid is a means-tested program, it has extensive rules on income and resources. In addition, individuals must fit into one of the eligibility categories established by federal law and meet other criteria, such as residency requirements and citizenship or immigration status. Children are the largest age group covered under Medicaid and represent about half of all beneficiaries.

### Medicaid-covered services

The Medicaid benefits or services package is broad. More than 30 services listed in Medicaid Statute Section 1902(a) are either optional or mandatory. If they are mandatory, states must provide these services. In addition, states may choose to cover certain optional services.

In both cases, Federal Financial Participation (FFP) is available as a match from the federal government to the states for services provided. A number of broad-based services that are covered are extremely important for maintaining an adequate mental health care system and that in fact are the basis for the entire health care system. In the following material, Medicaid services that are important for mental health service delivery are discussed and defined.

## Physician services

These are services provided by psychiatrists; primary care physicians such as pediatricians, family practitioners, and internal medicine physicians; and specialists, including those in neurology, obstetrics and gynecology (OB-GYN), and surgery.

Services that are important for children and youth can include screening for mental health issues and physical examinations to rule out physical health problems that can mimic mental health issues, such as hyperthyroidism and Attention Deficit Hyperactivity Disorder (ADHD).[1] Neurological issues such as temporal lobe seizures can mimic mental health issues and should be considered. Payment for these services is covered under Medicaid for eligible individuals.

Psychiatry services for therapy and medication monitoring are common reasons for providing mental health services. Medicaid expenditures for physician services are second only to those for pharmaceuticals for all age groups. See Medicaid statute 1905(a)(5)(A) and (B) and regulation 42CFR440.50.

## Inpatient hospital services

These services include general hospitals and specialty hospitals such as mental health and children's acute care hospitals. The acute care hospitals can provide a full range of services: medical, surgical, obstetrics, and inpatient mental health; but not for Institutions for Mental Disease (IMD).

For children and youth, this inpatient care can also include long-term mental health hospitalization. See Medicaid statute 1905(a)(1) and regulation 42CFR440.20.

## Federally Qualified Health Centers (FQHC)

These facilities provide comprehensive ambulatory, community-based services in medically underserved areas. Services include adult medicine, pediatrics, OB-GYN, pharmacy, laboratory and radiology, and mental health services by referral.

Case management is provided. A number of FQHCs provide co-located physical and mental health services. An example is the FQHC in Greenwood, North Carolina. Federal Medicaid payment regulations require enhanced reimbursement rates to cover the cost of providing comprehensive health and, where applicable, mental health services. See Medicaid statute 1905(a)(2)(C) and 1905(L)(1) and (2) and regulation 42CFR491.1-491.11.

## Rural health clinic

These facilities provide health services in rural and medically underserved areas. Services may or may not be as comprehensive as those offered through FQHCs. See Medicaid statute 1905(L)(1) and (2) and 1905(I)(1) and regulations 42CFR440.20(b) and (c).

## Laboratory and X-ray services

These are often used as part of a comprehensive assessment of children and youth. Laboratory services may be used to ensure that the use of psychotropic medications is safe and that the liver, blood, and kidney functions are adequate to metabolize these medications. They can also be used to rule out physical health diseases that can mimic mental health issues (for example, hyperthyroidism). See Medicaid statute 1905 (a)(3). Various mechanisms for financing services through Medicaid are presented in Figure 4.

[1] Some states consider ADHD as a mental health condition.

## Figure 4: Range of Medicaid Financing Mechanisms for Home and Community-Based Services for Children and Youth

### Clinic Option

States can provide non-hospital-based community services, but only in community clinics and under the direction of a medical doctor.

- Services typically include traditional counseling, psychotherapy, and medication management.
- Not typically used to expand home and community-based services because of the limitation in setting.

### Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

- As part of regular screening for physical and mental health conditions of Medicaid eligible children under 21 years of age, states are required to provide services that are federally authorized by Medicaid, but not necessarily covered in a State Medicaid Plan.
- States have not been using proactively to expand home and community-based services.

### Managed Care Waivers 1915 (b) and Demonstration Waivers 1115

- Managed care mechanism "carved" out from the regular state plan that limits choice of provider under Medicaid.
- Managed care entity can use funding streams beyond Medicaid.
- 1915 waivers are approved for 2 years and states can renew.
- Demonstration waivers (1115) allow states to innovate through expanding eligibility or services, not typically covered by Medicaid, or to test innovative service delivery systems.

### Medicaid 1915 (c) Home and Community-Based Services Waivers

- States can expand Medicaid coverage of community-based services, not otherwise covered, for a designated number of individuals as an alternative to institutional care (that is, hospital).
- States can expand Medicaid eligibility to populations, not otherwise eligible for Medicaid (for example, uninsured).

### Rehabilitation Option

- Rehabilitation service defined as "any medical or remedial services (provided in a facility, home, or other setting) recommended by a physician or other licensed practitioner…for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."
- Services can include:
  - Restoration and maintenance of daily living skills;
  - Training in social skills;
  - Development of appropriate social networks;
  - Recreational services that are therapeutic in nature; and
  - Telephone counseling services.
- Wide variation in services provided by states under the Rehabilitation Option. Some states cover:
  - Psychological assessment;
  - Crisis intervention;
  - Individual, group, family therapy;
  - Day treatment;
  - Home-based services;
  - Behavioral management skills training;
  - Therapeutic foster care;
  - Family preservations services;
  - Care coordination; and
  - Help in medication compliance.

### TEFRA Katie Beckett Provision

States can expand Medicaid eligibility to children with disabilities by waiving parental income for children who are living at home but who would otherwise be eligible for Medicaid-funded institutional care.

(Summarized from Ireys, Pires, & Lee, 2006)

## Figure 4a: What Do State Medicaid Plans Cover?

- Varies from state to state.
- See Medicaid Plan for your state.
- For summary of clinic services covered by Medicaid in your state in 2004, see: **http://www.kff.org/medicaid/benefits/service.jsp?gr=off&nt=on&so=0&tg=0&yr=2&cat=12&sv=5**.

### Guidance

- Include State Medicaid agency, other healthcare funders, and managed care organizations in discussions early.
- Read more about the various mechanisms described above.
- In preparing to work with State Medicaid agency:
  - Clearly define the EBP being considered.
  - Identify components of the EBP (match what is already covered).
  - Describe qualifications of practitioners.
  - Describe the dose and duration of the service.
  - Present cost-effectiveness data, if available (See Washington State Institute for Public Policy report on Benefits and Costs of Prevention and Early Intervention Programs for Youth at: **http://www.wsipp.wa.gov/pub.asp?Docid=04-07-3901**).

### References

Ireys, H.T., Pires, S., & Lee, M. (2006). Public financing of home and community services for children and youth with serious emotional disturbances: Selected state strategies. (2006). Washington, DC: Office of Disability, Aging and Long Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Center for Medicare and Medicaid Services.(2005). Medicaid support of evidence-based practices in mental health programs. Available at: **http://www.cms.hhs.gov/PromisingPractices/Downloads/EBP_Basics.pdf**.

## State and program examples of Medicaid funding

States that are actively trying to expand coverage for intensive home and community-based services typically use a combination of Medicaid financing options in addition to other mechanisms, including contracting with care management entities for high-risk populations and using blended or braided funds from other agencies, including Medicaid (Ireys et al., 2006). See Figure 5 for an illustration of Michigan's Home- and Community-Based Waiver Program.

Other examples of state programs include the following:

- Five states with home and community-based waivers (IN, KS, NY, VT, and WI) cover parent/family/home education, support, and training (Ireys et al., 2006).
- Two states with home- and community-based waivers (VT & WI) cover therapeutic foster care (Ireys et al., 2006).

Multisystemic Therapy Services, the disseminators of MST, developed a position statement on Medicaid funding for MST that outlines strengths and weaknesses of Medicaid as a funding source. To find the document, go to: **http://www.mstservices.com/userauth/Medicaid%20Standards.htm**.

The website also contains information on each state's position on funding MST with Medicaid dollars. For states that do fund MST with Medicaid (for example, Arizona, California, Indiana), between 40 and 60 percent of a model program budget is covered.

## Figure 5: Illustration of Michigan's 1915[c] Home and Community-Based Waiver

The Home and Community-Based waiver, (1915[c] waiver), for children with serious emotional disturbance (SED) is administered by the Michigan Department of Community Health (MDCH) and funded with federal Medicaid dollars matched by local resources including the state general funds allocated to the Michigan Community Mental Health Services (CMHSP) program.

The waiver is designed to provide in-home services and supports to children under age 18 with SED who meet the criteria for admission to a state inpatient psychiatric hospital and who are at risk of hospitalization if waiver services are not provided. The waiver is limited to children residing in counties that that have been pre-approved through the waiver. Under Medicaid statutory and regulatory requirements, all matching funds must be local funds.

Examples of local funds used in this waiver are CMHSP general revenue funds, local child care funds. However, Title IV-E Foster Care (SSA 45CFR Parts 1355, 1356, 1357) funds cannot be used as match as they are federal funds. To ensure that all matching funds are local, CMHSP must document the type and source of funds used to meet the match obligation. The documentation is provided in both the individual child's budget and in the written agreement between the State agencies: CMHSP and MDCH.

Eligibility criteria for the program include the following. The child must:

- Be at risk of hospitalization in the state psychiatric facility,
- Demonstrate serious functional limitations. The criteria will be identified using the Child and Adolescent Functional Assessment Scale (CAFAS®),
- Be under 18 years old,
- Be financially eligible for Medicaid when viewed as a family of one (that is, Katie Beckett option) or otherwise eligible for Medicaid, and
- Be in need of and receive at least one waiver service per month.

Birth and adoptive families must choose these services as an alternative to hospitalization, participate in developing the plan of service, allow services to be provided in the home setting, and provide care and supervision beyond the services authorized in the waiver.

The services that are provided use the "Wraparound" as a framework for providing and coordinating services that are family-centered. It will also include the services that are traditionally provided such as physician services, medication management, family therapy, i.e., functional family therapy.

Functional family therapy can be provided in the community and in the home. If the family members are Medicaid eligible then the services can be provided through Medicaid.

### Reference

Michigan Department of Community Health, SED Waiver, *A Home and Community-Based Waiver for Children with Serious Emotional Disturbance, A Technical Assistance Manual*, May 2007, taken from **http://michigan.gov /documents/mdch/SED_Waiver_TA_Manual_5-9-07_FINAL_196150_7.pdf**).

## Train All Levels of Staff in the Agency

One of the next steps in implementing your EBP is to develop a training plan. You may gauge the amount of training needed by assessing the readiness of your community. If a community is uninformed about the EBP and is unaware of the existing need, you may have to conduct a wide range of educational activities. If a community already understands the EBP and knows how it may address problems that community members want to solve, you may need fewer educational activities.

Agency administrators who have successfully implemented EBPs highlight the importance of providing basic training on the EBP to all levels of staff throughout the agency. Educating and engaging staff will ensure support for the EBP. In the long run, if they are well trained, EBP staff will have an easier time obtaining referrals, collaborating with staff from other service programs, and facilitating a continuum of care.

You can help train key stakeholder groups if you first train members of your EBP advisory committee and then ask them to disseminate information about the purpose and benefits of the EBP.

Ongoing inservice training is an efficient way to provide background information, the EBP practice philosophy and values, and the basic rationale for EBP service components in a comfortable training environment. Consider including members of your advisory committee in decisions about the frequency and content of basic EBP training.

### Offer more intensive training to program leaders and practitioners

While staff at all levels in the agency should receive basic EBP training, the EBP program leader and practitioners will require more intensive training. To help practitioners integrate EBP principles into their daily practice, offer comprehensive skills training to those who provide EBP services. For information about training requirements and resources for the EBPs covered in this KIT, see *Evidence-Based and Promising Practices*.

Although most skills that practitioners need may be introduced through formal training, research and experience show that the most effective way to teach EBP skills is through supervision, on-the-job consultation, and coaching (Fixsen et al., 2005).

In many mental health agencies, turnover is high. This means that a single training will not be sustained unless the new expectations are incorporated into ongoing training efforts for new employees. Early in the process, mental health authorities and agency administrators must decide how to do the following:

- Identify internal and external stakeholders who will receive basic training;
- Determine how often basic training will be offered;
- Identify who will provide the training;
- Identify EBP staff and advisory group members who will receive comprehensive skills training;
- Determine the training format for ongoing training to EBP staff;
- Determine whether EBP staff may visit a model EBP program; and
- Determine how consultation and coaching will be provided.

Many agencies have found it useful for EBP program leaders and practitioners to become familiar with the structure and processes of the practice by visiting agencies that have successfully implemented the EBP.

## Monitor and Evaluate Regularly

Key stakeholders who implement EBPs may find themselves asking two questions:

- Has the EBP been implemented as planned?
- Has the EBP resulted in the expected outcomes?

Asking these two questions and using the answers to improve your EBP program are critical components for ensuring the success of your EBP program.

- To answer the first question, collect process measures, which capture how services are provided.
- To answer the second question, collect outcome measures, which capture the program's results.

As you prepare to implement an EBP, it is strongly recommended that you develop a quality assurance system using both process and outcome measures to monitor and improve the program's quality from the start through its mature development.

### Why you should collect process measures

Process measures give agency staff an objective, structured way to gain feedback about program development and about how services are provided. Experience suggests that this is an excellent method to diagnose program weaknesses and to clarify strengths.

Process measures also give mental health authorities a comparative framework in which to evaluate statewide implementation of an EBP. They allow mental health authorities to identify statewide trends and outliers. Once EBP programs reach high fidelity, ongoing monitoring allows agency staff to test local innovations while ensuring that EBP programs do not drift from core EBP principles. (See Figure 6.)

## Figure 6: What Does Fidelity Mean?

Sometimes an evidence-based practice does not produce expected outcomes because it is not being implemented according to the model (the model is the version of the intervention that research found to be effective). A practice is not implemented well or "according to the model" when critical features or components of the intervention are not included in the version of the EBP being implemented. Research has shown the EBP to be effective if key components of the intervention are in place. When these components are absent, the version of the EBP being implemented is no longer "true to the model." It lacks fidelity.

Fidelity refers to the degree that the version of the EBP being implemented is "true to the model." If most of the key components are present, the implemented version has high fidelity; if most are absent, it has low fidelity.

Fidelity scales are used to measure the degree to which the critical components of an EBP are present. The reason such scales are important is that they are like a thermometer—they tell you if the EBP is being implemented as it should be or if adjustments need to be made. Often, if an intervention is not producing desired outcomes, a clinician will recommend an alternative. Before switching interventions, it helps to make sure that the intervention was properly designed and administered. Fidelity scales indicate any modifications that are needed. In this sense, fidelity measures are a gauge of the quality of services that consumers and family members receive.

For many interventions, fidelity scales do not exist. In this situation, standards and clinical guidelines are used to assure quality instead of fidelity measures.

## Why you should collect outcome measures

While process measures capture how services are provided, outcome measures capture the program's results. Every mental health service intervention—whether considered treatment or rehabilitation—has both immediate and long-term client goals. In addition, children and families have goals for themselves, which they hope to attain by receiving mental health services. These goals translate into outcomes and the outcomes translate into specific measures.

Some outcomes result directly from an intervention, such as staying in school. Others are indirect, such as improving a family's quality of life as a result of the child being able to stay in school. Some outcomes are concrete and observable, such as the number of days attending school in a month. Others are subjective and private, such as being satisfied with EBP services.

Family and child outcomes are the bottom-line for mental health services, which is analogous to the role of profit in business. No successful businessperson would assume that the business was profitable just because the enterprise produced a number of widgets or because employees worked hard. Productivity does not necessarily lead to profit.

## Assessing child and family outcomes

A review of the most frequently identified client outcomes assessed across the EBPs contained in this KIT included reduction of disruptive behavior, improved family functioning, the reduction of delinquent behavior, and improved parenting skills (Zubritsky et al., 2007). Table 1 summarizes the instruments for measuring these types of outcomes and information about how these materials can be acquired.

## Table 1: Measurement Instruments for Assessing Child and Family Outcomes

| Instrument | Age Range | Outcomes Assessed | # of Items | Informant | Reference/Publisher |
|---|---|---|---|---|---|
| **Child Behavioral Symptoms** | | | | | |
| **Behavioral Assessment System for Children (BASC-2)** | 2–21 | Aggression, conduct problems | 100–160 | Parent, teacher, child (8–21) | 2nd Ed: Reynolds & Kamphaus, 2004* http://ags.pearsonassessments.com |
| **Achenbach System of Empirically Based Assessment** | 1.5–18 | Aggressive behavior | 99–118 | Parent, teacher, child (11–18) | Achenbach & Rescorla, 2000, 2001* http://www.aseba.org http://www.assess.nelson.com |
| **Early Childhood Inventory-4 & Children's Symptom Inventory-4** | 3–18 | Oppositional behavior, oppositional defiant disorder, conduct disorder | 108 | Parent, teacher, child (12–18) | Sprafkin & Gadow, 1996* Gadow & Sprafkin, 1995* http://www.checkmateplus.com |
| **Conners' Rating Scales: Long & Short Form** | 3–17 | Oppositional behavior | 27–80 | Parent, teacher, child (12–18) | Conners, 1997* http://www.pearsonassessments.com |
| **Revised Behavior Problem Checklist** | 5–18 | Conduct disorder | 89 | Parent & teacher | Quay & Peterson, 1996* |
| **Eyberg Child Behavior Inventory (ECBI)** | 2–16 | Conduct disorder, oppositional defiant disorder | 36 | Parent | Eyberg, 1999** |
| **Strengths and Difficulties Questionnaire (SDQ)** | 3–16 | Strengths & difficulties | 25 | Parent, teacher, child (11–16) | Goodman, 1997 Goodman, Meltzer, Bailey, 1989 http://www.sdqinfo.org http://www.routledge.com |
| **Peabody Treatment Progress Battery: Symptoms & Functioning Severity Scale** | 11–18 | Global measure of severity of symptoms of conduct disorder and oppositional defiant disorder | 33 | Youth, adult, caregiver, and clinician | Bickman et al., 2007 http://peabody.vanderbilt.edu/ptpb |
| **Child Functioning** | | | | | |
| **Child and Adolescent Needs and Strengths- Mental Health (CANS-MH)** | 4–21 | Oppositional behavior, antisocial behavior | 41 | Clinicians | Lyons, 1999** http://www.buddinpraed.org/cans/ |
| **The Child and Adolescent Functioning Scale (CAFAS)** | 5–18 | Aggression, conduct disorder, oppositional defiant disorder, behavioral non-compliance | 165 | Clinicians | Hodges, 2000, 2004 http://www.CAFAS.com |
| **Parent/Family Assessment** | | | | | |
| **Dyadic Parent-Child Interaction Coding System III** | 3–6 | Quality of parent-child social interactions | | Structured observation of parent-child interaction | Eyberg, Nelson, Duke, Boggs, 2005 http://pcit.phhp.ufl.edu/Measures.htm |
| **Behavioral Coding System** | | Quality of parent-child interactions | | Structured observation of parent-child interaction | Forehand & McMahon, 1981 McMahon & Forehand, 2003, (p. 58). |
| **Caregiver Wish List** | 3–18 | Caregiver's parenting skills and child's behavioral compliance | 67 | Caregiver, parent | Hodges, 2002 http://www.CAFAS.com |
| **Parenting Scale** | 1.5–4 | Parenting skills | 30 | Parent | Arnold, O'Leary, Wolff, & Acker,1993 |

*In McMahon, R., & Frick, P. (2005). Evidence-based assessment of conduct problems. *Journal of Clinical Child and Adolescent Psychology, 34* (3), 477-505.

** In Grisso, T., & Underwood, L. (2003). *Screening and assessing mental health and substance use disorders among youth in the juvenile justice system: Research and Program Brief*. Delmar, NY: National Center for Mental Health and Juvenile Justice.

Additional sources for measurement instruments include the following:

Maruish, M. (Ed.). (2004). *The Use of Psychological Testing for Treatment Planning and Outcome Assessments: Instruments for Children and Adolescents* (3rd ed.). Mahwah, NK: Lawrence Erlbaum Associates, Inc.

Rush, A. J., First, M. B., & Blacker, D. (Eds.) (2008.) *Handbook of Psychiatric Measures, Second Edition*. Arlington, VA: American Psychiatric Publishing, Inc.

Children develop within microcultures of families and neighborhoods that are influenced by larger macrocultures characterized by particular languages, traditions, social structures, economies, values, and attitudes. A concern about assessment measures is their generalizability to multiethnic cultures. Achenbach & Rescorla (2007) point to the need for multicultural research to develop and test assessment instruments for use with children from multiple cultures.

## Address Cultural Competence and EBPs

You can improve the quality of your EBP program if you ensure that it is culturally competent—that is, it adapts to meet the needs of families from diverse cultures. It is important, however, to ensure that you are informed about culture and cultural competence and issues associated with these concepts.

### Cultural competence defined

*Cultural competence* is an approach to delivering services that assumes that services are more effective when they are provided within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served.

The U.S. Surgeon General has defined *Cultural competence* in the most general terms as:

> ...the delivery of services responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, beliefs, and values.

In most cases, cultural competence refers to sets of guiding principles developed to increase the ability of mental health providers, agencies, or systems to meet the needs of diverse communities, including racial and ethnic minorities.

While families, providers, policymakers, and administrators have long acknowledged the intrinsic value of cultural competence, sufficient research has not yet been dedicated to identifying its key ingredients. Therefore, the field still struggles to define cultural competence, put it into operation, and measure it in a manner that is generally accepted by researchers and practitioners alike.

The word *competence* is somewhat misleading in that it implies that a set of criteria has been developed for use in evaluating a program. This set of criteria, however, has not yet been completely identified; cultural competence is still under-researched. In this context, competence means that the responsibility to tailor care to different cultural groups belongs to the system, not to the consumers of services. Every provider or administrator who is involved in delivering care at every level—from mental health authorities to clinical supervisors and practitioners—bears responsibility for making their programs accessible, appropriate, appealing, and effective for the diverse communities they serve. Many providers do this as a matter of course within their practice.

## What culture is and how it affects care

Broadly defined, a *culture* is a common heritage or set of beliefs, norms, and values that a group of people shares. People who are placed—either by census categories or by identifying themselves—into the same racial or ethnic group are often assumed to share the same culture. However, this can be misleading.

A great diversity exists within each broad category. Individuals may identify with a given racial or ethnic culture to varying degrees. Others may identify with multiple cultures, including those associated with their religion, profession, sexual orientation, region, or disability status.

Culture is dynamic, changing continually, and influenced both by people's beliefs and the demands of their environment. Immigrants from different parts of the world arrive in the United States with their own cultures but gradually begin to adapt and develop new, hybrid cultures that allow them to function in the dominant culture. This process is called *acculturation*. Even groups that have been in the United States for many generations may share beliefs and practices that maintain influences from multiple cultures. This complexity necessitates an individualized approach to understanding culture and cultural identity in the context of mental health services.

People's culture influences many aspects of care, starting with whether they think care is even needed. Culture influences the concerns that people bring to the clinical setting, the language they use to express those concerns, and the coping styles they adopt.

Culture affects family structure, living arrangements, and the degree of support that people receive during difficult times. Culture also influences help-seeking behavior, whether people begin with a primary care doctor, a mental health program, a minister, spiritual advisor, or community elder. Finally, culture affects whether people attach a stigma to mental health problems and how much trust they place in providers.

The professional culture of agencies, administrators, and practitioners influences how care is organized and delivered. Cultural influences affect the manner in which practitioners ask questions or how they interact with families. Culture also affects equally important aspects of care that may be less overt, such as the following:

- The operating hours of an agency;
- The importance that staff attaches to reaching out to family members and community leaders; and
- The respect that staff gives to the culture of families who enter their doors.

Knowing how culture influences so many aspects of mental health care underscores the importance of adapting agency practices to respond to and respect the diversity of the surrounding community.

## The need for cultural competence

For decades, many mental health agencies neglected to recognize the growing diversity around them. Often, people from nonmajority cultures found programs off-putting and hard to access. They avoided seeking care, stopped looking for care, or—if they managed to find care—dropped out.

Troubling disparities resulted. Many minority groups faced lower access to care, lower use of care, and poorer quality of care. Disparities are most apparent for racial and ethnic minority groups, such as:

- African Americans;
- American Indians and Alaska Natives;
- Asian Americans;
- Hispanic Americans; and
- Native Hawaiians and other Pacific Islanders.

However, disparities also affect many other groups, such as:

- Women and men;
- Children and older adults;
- People from rural and frontier areas;
- People with different sexual orientations; and
- People with physical or developmental disabilities.

Altogether, those disparities meant that millions of people suffered needless disability from mental illness.

Starting in the late 1980s, the mental health profession responded to the issue of disparity with a new approach to care called *cultural competence*. Originally defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and that enables that system, agency, or those professionals to work effectively in cross-cultural situations, cultural competence was intended to do the following:

- Improve access to care;
- Build trust; and
- Promote engagement and retention in care.

## How cultural competence relates to EBPs

According to the Surgeon General, evidence-based practices are intended for every individual who enters care, regardless of his or her culture. But many providers ask, "How can we know if EBPs apply to a particular ethnic, racial, or cultural group if the research supporting those practices was done on a very different population?"

The answer is that we do not yet know how these EBPs may apply to various cultural groups. However, the research base on adapting EBPs across multicultural groups is beginning to accumulate. In *Evidence-Based and Promising Practices* in this KIT, which describes the EBPs in greater detail, formal adaptations of EBPs that are being tested for particular ethnic and racial groups are described. (See *Parent Child Interaction Therapy and Parent Management Training-Oregon* in that booklet.)

While more research is being conducted, programs may try to adjust EBPs to make them accessible and effective for cultural groups that differ in language or behavior from the original study populations used to develop the EBP.

It is important to be aware, however, that any adjustments made to the original EBP model that was found to be effective could affect the fidelity and outcomes of the EBP. Therefore, it is very important to carefully document adjustments and to monitor the outcomes that result from these adjustments.

## How to put cultural competence into practice

Since the goal is for all programs is to be more culturally competent, we offer a variety of straightforward steps to help agency administrators respond more effectively to the people it serves. These steps apply to all facets of a program; they are not restricted to the EBP program. Please note that these steps are meant to be illustrative, not prescriptive.

- Understand the racial, ethnic, and cultural demographics of the population served.
- Become most familiar with one or two of the groups you most commonly encounter.
- Create a cultural competence advisory committee consisting of youth, family, and community organizations.
- Translate your forms and brochures.
- Offer to match a consumer with a practitioner who has a similar background.
- Have ready access to trained mental health interpreters.
- Ask youth and families about their cultural backgrounds and identities.
- Incorporate cultural awareness into assessment and treatment.
- Tap into natural networks of support, such as the extended family and community groups that represent the culture of the youth and family.
- Reach out to religious, faith and spiritual organizations to encourage referrals or as another network of support.
- Offer training to staff in culturally responsive communication or interviewing skills.
- Understand that some behaviors that one culture may consider to be signs of psychopathology may be acceptable in a different culture.
- Be aware that people from other cultures may hold different beliefs about causes and treatments of illness.
- Collect and analyze data to examine disparities in services.
- Designate specific resources for cultural competence training.
- Include cultural competence in quality-assurance and quality-improvement activities.
- Compare outcome data for different cultural groups that are receiving EBPs.
- Collect and analyze fidelity and outcome data for any adjustments made to specific components of EBPs to make them more sensitive to different cultural groups.

# Implementation Considerations

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