Evidence-Based Programs
and Cultural Competence

Karen A. Blase, Ph.D., and Dean L. Fixsen, Ph.D., Co-Directors
National Implementation Research Network

July, 2003

Evidence-Based Programs and Cultural Competence

Funded by the Annie E. Casey Foundation and the
Louis de la Parte Florida Mental Health Institute

Participants

Wanda Acevedo (Hillsborough Federation of Families for Children's Mental Health)

Jim Alexander (Functional Family Therapy: family-based treatment for delinquent youth delivered in the clinic or at home)

Melanie Barwick (Hospital for Sick Children: Implementing standardized outcome assessments in mental health organizations)

Carl Bell (Chicago Community Mental Health Council; implementation of evidence-based programs within a system of care)

Karen Blase, Facilitator, National Implementation Research Network (the Louis de la Parte Florida Mental Health Institute)

Charlotte Booth & Shelley Leavitt (Homebuilders Program: intensive, in-home crisis intervention, counseling, and life-skills education for families to avert placement)

Eric Bruns (Wraparound Approach: highly individualized and strengths-based treatment planning and implementation involving organized and flexible use of resources)

Patti Chamberlain (Multidimensional Treatment Foster Care: treatments include individual and family therapy, skill training, and academic support in a foster care context)

Dean Fixsen (Teaching-Family Model: an integrated, skill building approach to community-based treatment in group homes, foster care, intensive in-home interventions, and school classrooms)

Robert Friedman & Mario Hernandez (Systems of Care: developing and evaluating organized and coordinated networks of necessary mental health services)

Vijay Ganju (National Association of State Mental Health Program Directors Research Institute)

Regenia Hicks (American Institutes for Research)

D. J. Ida (National Association for the Mental Health of Asian American and Pacific Islanders)

Ethleen Iron Cloud-Two Dogs (National Indian Child Welfare Association and Nagi Kicopi (Calling the Spirit Back) Project, Children's Mental Health Services, Oglala Lakota Nation)

Mareasa Isaacs, Patrick McCarthy, & Marta Pernas (Annie E. Casey Foundation)

Toni Johnson (National Leadership Council on African American Behavioral Health)

Patrick Kanary (Center for Innovative Practices)

Ruth O'Brien (Nurse-Family Partnership Program [formerly the Nurse Visitation Program]: specially trained nurses visit first-time mothers to improve pregnancy outcomes, promote child development, and impact parental life-course development)

Josie Romero (National Latino Behavioral Health Association)

Rebecca Rooney (Hillsborough Federation of Families for Children's Mental Health)

Rolando Santiago (Substance Abuse and Mental Health Services Administration)

Sonja Schoenwald (Multi-Systemic Therapy: intensive family- and community-based treatment encompassing individual, family, and extrafamilial factors for delinquents)

Evidence-based Programs and Cultural Competence
March 5 - 6, 2003

Introduction

In many ways, this was an historic meeting among developers of evidence-based programs, leaders of various cultural, racial, and ethnic professional associations, and representatives of family associations. Evidence-based program implementation and cultural competence in human services have had parallel paths with limited intersection and dialogue. This meeting provided an opportunity for mutual understanding and mutual gain as well as an opportunity to integrate those paths so that:

- Evidence-based program developers can benefit from the expertise, experience and perspectives offered by professionals from diverse communities.
- Professionals from diverse communities (and all participants) can benefit from the decades of history, successes, and challenges faced by evidence-based program developers as they have developed, replicated, and implemented their programs and practices.

Hopefully the longer term results will be increasingly accessible, effective, and culturally competent programs.

Each person was invited because of his or her experience and expertise (note that representatives from the nationally implemented Positive Behavior Supports Program, Program for Assertive Community Treatment, and Portage Program were invited but could not attend). We purposefully selected individuals for their differing perspectives and experiences to increase the diversity of wisdom to be shared and provide greater opportunities to learn from one another. The overall goal for the meeting was to develop a network so that participants could become resources and partners for one another in moving forward with a variety of agendas including:

_____
Acknowledgements

- Creating strategies for ensuring that cultural competence is embedded in development and research activities related to the evolution of evidence-based programs and practices.
- Ensuring that evidence-based programs and practices provided by and for diverse racial, ethnic, and cultural groups become an important part of the landscape with respect to behavioral health services.
- Promoting a broader and more conceptual understanding of the issues involved in replicating and implementing evidence-based practices as well as developing a functional framework that can be referenced, researched, utilized and revised over time.

The overall meeting process was structured to systematically solicit information by using a modified Nominal Group Technique (Delbecq, Van de Ven, & Gustafson, 1975; Van de Ven & Delbecq, 1971). The Nominal Group Technique is a well-researched process for structuring group interactions. The processes involved facilitate and help ensure that there are equal opportunities for participation and equal opportunities to listen. The process assures that all voices can be heard, that there is respect for diverse views (coupled with a willingness to be curious), and that listening is as important as speaking. In addition to this facilitated large group work, there was small group work with report outs and a "Wondering Wall" to post comments, questions, and issues to be addressed at this meeting or in future meetings.

Review of Implementation Efforts

In preparation for this meeting, Blase and Fixsen reviewed a number of current and past large-scale efforts to replicate and implement evidence-based programs. In that review, two things became clear. First, the processes of developing procedures for prototype programs and conducting research on a treatment model are complex but do rely upon fairly well known and time-tested procedures and paths including:
- Defining treatment settings (family-style group homes, foster homes, family homes),
- Selecting and implementing treatment interventions (therapeutic alliance, skill teaching methods, systems for motivation, problem solving, advocacy),
- Selecting relevant outcomes and research measures (direct observation of behavior, record reviews, questionnaires, psychological tests).
- Utilizing research designs to test efficacy and/or effectiveness (within-subject time-series designs, randomized clinical trials, quasi-experimental designs), and
- Utilizing research results to further refine the practice or program.

The second observation is that the replication and implementation process is very complex and there are no well-known methods or research-based approaches upon which one can rely. That is, there is no science of program replication and implementation at this point. However, six common stages

related to broad-scale replication and implementation efforts were identifiable across a variety of evidence-based programs:

1. *Exploration Stage:* A variety of circumstances and setting events lead the evidence-based program developers and the leaders in a community to make contact with one another and begin exploring the possibility of replicating the evidence-based program in the community. Individuals get to know one another, information is exchanged and assessed, and the working relationship proceeds to the next stage (or not).

2. *Selection Process:* A mutual decision is made to proceed with implementation of an evidence-based program in a given community, province, or state based on formal and informal criteria developed by the community and by the evidence-based program. While each has its own independently derived criteria, the community and evidence-based program developers often create a common set of criteria related to the potential implementation of the evidence-based program in that specific community.

3. *Installation Stage:* Once the decision is made, structural supports necessary to initiate the program are put in place. These include identifying and ensuring the availability of funding streams, human resource strategies, and policy development as well as creating referral mechanisms, reporting frameworks, and outcome expectations. These activities are the necessary first steps to begin any new human service endeavor, including the replication of an evidence-based program in a new community setting. Broad-based community education and ownership that cuts across service sectors often can be important to installing an evidence-based program with its unique characteristics, requirements and benefits.

4. *Initial Implementation Stage:* In this stage the new program begins to provide services to clients. Practitioners must be selected, trained, and supervised in the uses of the evidence-based program to benefit clients and consumers. Similarly, supervisors/coaches need to be selected, trained, and supervised to support the clinical skill and professional development of the practitioners. Fidelity evaluators and program evaluators need to be selected, trained, and supervised to carry out regular evaluations of the implementation of the evidence-based program and its effectiveness in the new community setting. Program managers need to be selected, trained, and supervised to provide facilitative administrative supports to practitioners, trainers, supervisors, and evaluators and work to keep the entire process integrated and focused on achieving client outcomes. Promises and agreements made by others outside the organization need to be honored and sometimes renegotiated. The implementation stage is the time when people, procedures and processes begin to work together, if only in a halting fashion, on the way toward becoming an integrated, smooth functioning program benefiting from continued experience and feedback.

5. *Advanced Implementation* Stage: As the new evidence-based program staff become skillful and the procedures and processes become routinized, the replication program becomes fully operational with full staffing complements, full client loads, and all of the realities of "doing business" impinging on the newly implemented evidence-based program replication. At this point, fidelity measures are above criterion levels most of the time and the effectiveness of the evidence-based program replication should approximate the effectiveness of the prototype evidence-based program.

6. *Sustainability Stage:* After the intensity of establishing an evidence-based program replication in a new community (often requiring 2 to 4 years), the replication program needs to be sustained in subsequent years. Practitioners and other well-trained staff leave and must be replaced, trained, supervised, etc. Leadership, funding streams, and program requirements change. New social problems arise; partners come and go. External systems change with some frequency, political alliances are only temporary, and champions move on to other causes. Through it all the replication program leaders and staff, together with the community, must be aware and adjust without losing the functional components of the evidence-based program or dying due to a lack of continuing financial and political support. The goal during this stage is the long-term survival and continued effectiveness of the replication program in the context of a changing world.

With these ideas in mind, questions were posed to highlight the intersection of these program development stages with issues of cultural competence. The questions were designed to assist participants in exploring evidence-based program development and replication efforts from diverse perspectives as program developers engaged in replication efforts, experts in cultural competence and the provision of service to diverse communities, and as family members who request, receive and evaluate services. Participants reflected on issues relevant to the exploration, selection and implementation of evidence-based programs. In addition, the group decided to explore some related areas in greater depth through small group work. Thus, the following results of the evidence-based program and cultural competence meeting reflect both the planned and the spontaneous agendas.

NOTE: The following are summaries of the two days of discussion. Unless otherwise noted, the summaries provided here do NOT represent unanimous agreement among the participants. For this document, an attempt has been made to fairly represent the various opinions that were expressed without any attempt to point out or reconcile differences. It should be noted, however, that there was considerable agreement among the participants on the major topics and the extent of that agreement is reflected in the following summaries.

4

Replication, Implementation, and Cultural Competence

EXPLORATION PHASE

Exploration Phase Questions
- What about your program (an evidence-based program) attracts the attention of potential implementation sites?
- What would attract the participation of implementation sites in culturally diverse communities or communities serving diverse racial or ethnic groups?

Evidence-based programs are implemented in the context of community and come to the attention of diverse communities because such programs are viewed as having the potential to solve problems important in that community. Developing a working relationship with the community requires evidence-based programs to approach all communities with honesty, full disclosure, and ethical marketing strategies. The more that evidence-based programs value the community, respect its diversity, and carefully listen to what the community has to say about its needs, strengths, hopes, and desires the more likely it is that the community will choose to pursue adopting such programs. In short, evidence-based programs should state their case, state their weaknesses, avoid over-promising, and invite community partnerships.

A significant challenge for evidence-based programs involves determining how best to "fit" their program to the unique characteristics of a community. The group acknowledged the intersecting challenges of evidence-based programs trying to implement a "high fidelity replication" while communities are trying to find solutions uniquely suited to their individual circumstances and want to "own" the program. Thus, creating a fit between the evidence-based program and the community is a priority during the exploration stage. The "prescriptiveness" of an evidence-based program should not and need not undermine community decision-making.

Participants offered the following perspectives and advice for communities and program developers during the exploration phase. Face-to-face contact was seen as essential to a respectful and functional exploration stage with its processes of give and take, functional compromise, and trust building. In addition, evidence-based program representatives need to very skilled in initiating and creating respectful partnerships. This skill set includes excellent engagement skills, the ability to facilitate meetings, excellent negotiation and consensus building skills, a demonstrated ability to be attentive listeners, and a superb knowledge of the evidence-based program so they know what aspects of the program can and cannot be modified to "fit" a community and why changes can or cannot be made.

Cultural competence during the exploration stage can take many forms. Non-majority children currently are over-represented in more restrictive and coercive

service settings. Families in diverse communities want their children back and they want the advantages that evidence-based programs have to offer. However, most evidence bases for programs currently do not include data specific to various cultural, racial, or ethnic groups so it is difficult to tell if evidence-based programs will be effective. The advice to evidence-based program developers was to pay close attention to factors related to diversity, listen closely when the community speaks, and acknowledge up front issues of racism, power, culture, and ethnicity. Actions congruent with attending to cultural issues include providing added value to the community with respect to jobs, fostering opportunities to exercise leadership, along with realizing benefits to children and families. While there is no one, clear path to cultural competency, flexibility, honesty and respect will move the agenda forward.

The group also discussed access issues. Currently, evidence-based program replications are implemented where they are most welcome, not necessarily where they are most needed. High-needs communities may lack many of the preconditions necessary for successful replication of evidence-based programs. In those cases, a longer-term community development approach may need to be taken to help the community organize, define strengths and needs, develop its theory of change, identify potentially useful evidence-based programs, and prepare to access one or more evidence-based programs. Even without specific data on the impacts of evidence-based programs in high needs communities, system-level efforts need to work toward more closely matching resources and needs. Systems issues often present barriers to community development in high-needs neighborhoods and communities (fostering dependence and reliance on outside experts rather than strengthening the social fabric and self-reliance).

SELECTION PHASE

Selection Process Questions
- What are the top four factors/local variables that are critical for you to assess at a new implementation site?
- In what ways do you consider culture, race and ethnicity when assessing the fit between an evidence-based program and a potential implementation site?
- What do you do to create a better fit between a potential implementation site and your/a program to improve the chances of success?

The most prominent factors regarding selection included fit, leadership, buy-in, readiness, and agreement on goals, costs, and outcomes.

The "fit" between the evidence-based program and the needs and goals of the community must be examined along a number of dimensions including:
- The congruence between the needs identified by the community and the population for which the evidence-based program has demonstrated effectiveness.
- The congruence between the philosophy and values expressed and enacted by the evidence-based program and those of the community.

- The compatibility of the evidence-based program with the current array of services in the local System of Care.
- The congruence between the necessary conditions for the replication of an evidence-based program and the abilities of a host service organization to meet those conditions.
- The philosophical congruence between the culture of science and the community cultures that may have a very different view of and experience with "evidence."

Advice for evidence-based program developers was to have a thorough knowledge of the community. Further advice was not to view selection as "either-or" but more as a process that includes dialogue, identification of barriers, efforts to remove or work around those barriers, and *creating* a good fit over time.

Effective, determined leadership also was seen as key during the selection stage. Champions of change, champions of particular evidence-based programs, and champions of community outcomes were mentioned as important to the selection process. Leadership was seen as especially important to galvanize local collaboration and coordination efforts to bring in an evidence-based program, and to bring about any changes in policy, funding, or other systems level variables to accommodate an evidence-based program.

"Buy-in" was another concept delineated by the group as important during the selection stage. Community leaders, funders, service system directors, referral agents, and other key players need to be provided with accurate information so they can understand the program, understand the implementation process, and understand their role in making the evidence-based program a success in their community. They need to be motivated and willing to facilitate the process of implementation with their support and influence.

Readiness was seen as important to selection in several ways. Systems and organizational mandates must be in place to support the evidence-based program and collectively there must be an overall capacity to "pull it off." Practitioners, supervisors, and middle level managers need to be strong and willing participants in the replication effort. All of the other local stakeholders need to be well informed and agree to do their part to support implementation of the evidence-based program. Critical barriers must be identified during the selection stage and dealt with or a plan must be in place to deal with them in the future. During the selection stage the host organization has demonstrated the ability to make changes and the leadership of the host organization understands what changes they will have to make to accommodate the evidence-based program in the next few years.

Agreement on goals, costs, and outcomes means clearly specifying the agreed-upon community and evidence-based program goals for implementing the program, specifying the costs and sources of funding, specifying the intended outcomes and time frames, and agreeing to the methods and measures related to those outcomes. This is likely a natural extension of the discussion that has occurred during the Exploration Stage.

Cultural competence during the selection phase probably relies on these same concepts but looking at the content and issues through different cultural lenses, languages, and experiences with the majority culture (see the Implementation section for more details).

Another theme that emerged during the discussion of the selection phase was the lack of evidence regarding selection factors. Currently, there are no evidence-based selection procedures or factors identified that are known to reliably predict later success or failure of attempted replications. Thus, communities should review the past ability of an evidence-based program to produce successful replications. And, evidence-based programs should carefully look at failures to replicate to learn as much as they can about assessment and selection of replication sites.

IMPLEMENTATION PHASE

Implementation
- What do you do to create, support and sustain behavior change of the practitioners?
- How do you actively create change at the management and administrative levels at implementation sites?
- (In your program) What role (does) should race, ethnicity and culture have in selecting and training practitioners, supervisors, evaluators, and managers? ….in constructing training agendas and methods?

Initiating an evidence-based program is a complex process involving staff preparation, assessing and developing organizational structures and climate, and creating evaluation and feedback systems. It often takes two to four years to fully develop a replication site.

Staff preparation consists of selection, preservice training, continuous coaching and consultation, inservice training, and performance and fidelity evaluations done in a supportive administrative environment. Equally essential are processes for training and coaching the trainers, training and coaching the consultants, training and coaching the evaluators, and training and coaching the managers so that the replication organization can develop its own staff. Not all evidence-based programs do all the training described here. And there is considerable variability regarding the degree to which the evidence-based program trains others for key sustainability roles (e.g., training and evaluation of trainers, supervisors, evaluators) and the degree to which they retain responsibility for these services through contracts with the community or host organization. Most evidence-based programs do have a "community of practice" that facilitates ongoing learning by staff members and stakeholders as well as the discussion of common issues, research and evaluation agendas and next steps.

Organizational structures need to be created and integrated to reinforce the processes surrounding the delivery of an evidence-based program. This includes creating a learning community with a culture that reinforces continuous

skill development and aligning and integrating infrastructure components (contracts, finances, personnel, management) so they are efficient and supportive of the evidence-based program.

Evaluation feedback systems are another key element in the implementation of evidence-based programs in new organizations. This involves the systematic collection of data on program operations and outcomes with feedback loops to provide timely access to data for decision-making by practitioners, supervisors, managers, and directors. Fidelity evaluations are a part of the overall evaluation plan with assessments of adherence to philosophy, values, processes, and procedures essential to the effectiveness of the evidence-based program. Data reporting sessions and de-briefing sessions help create a culture that is outcome –oriented and process sensitive. Promoting this outcome orientation and focusing on continuous quality improvement are keys to successful implementation.

Cultural competence with respect to evidence-based program implementation needs to be attended to at each step. Staff members who are selected for positions need to reflect the racial, ethnic, and cultural demographics of the people to be served in the community. However, given the diversity found within diverse communities (language, culture, class), this is only a start. Each organizational staff person needs to be involved in a continuous developmental process of becoming more knowledgeable about the diverse groups that exist within the community. Discussions of cultural dilemmas, crossing cultural boundaries, accommodating different languages, recognizing generational and class differences, and so on need to be built into training, supervision, and management structures and data feedback systems. A recommended book for better understanding the cultural dilemmas and challenges is The Spirit Catches You and You Fall Down (Fadiman, 1998).

Evaluation measures need to be discussed with members of diverse communities. Many standardized measures are not culturally appropriate and some behavioral health concepts do not exist in some cultural groups. In addition, the experience of diverse cultural groups with research and evaluation efforts has not always been positive or respectful. In that same vein, recovery or other "consumer defined" goals often are not reflected in current measurement systems. Research and evaluation are often justifiably viewed with suspicion so care must be taken to involve the community fully in the design and implementation of any evaluation strategies and measures.

"Fitting the community" is an ongoing process. Many people are suspicious of scientific approaches and motives, including the idea of evidence-based programs, because of past abuses and institutional racism. Program developers need to simultaneously recognize this as "healthy paranoia" and help people understand and appreciate the value that an outcome-oriented program can bring to the community, families, and children. Successful implementation of evidence-based programs is more likely when the process of implementation also helps communities achieve universal goals of being bonded and connected, develop new skills and use existing skills to improve the social fabric, form "adult

9

protective shields" around their children, and have access to good health care and effective services. The evidence-based program can be a way for communities and the program developers to work toward these universal goals.

In many respects, the ability to respectfully and effectively approach diverse cultural groups is the same way to respectfully and effectively approach anyone. It involves asking for information, listening before doing, developing relationships, asking permission, helping solve problems as defined by the person or community, knowing and communicating your own strengths and limitations, asking for and accepting feedback, and recognizing that you are a part of the relationship.

Implementation of evidence-based programs in diverse communities will need to include service delivery strategies that take into account the languages spoken in the community. Recruiting staff fluent in one of the languages spoken in the community can greatly improve access and use of the evidence-based program. It also may be necessary to contract with or hire interpreters. However, interpreters are more than translators. They need to be trained in the evidence-based program like any other staff person so they know how to convey the nuances and meanings associated with the service delivery system. They can help consumers who are engaged with the evidence-based program to achieve their goals and help staff understand the consumers' perspectives, concerns and hopes. It is also important to understand that knowing the language does not make one an expert on that culture. Interpreters, like all staff who are developing their cultural competence, need to be aware of their own cultural biases and beliefs and continue to increase their cultural competence. In addition, one should not assume that any individual interpreter can speak or would presume to speak for an entire culture. While implementation efforts will be challenged by language diversity, it is important that programs develop these staff competencies and program capacities in order to improve access.

WHAT DOES "EVIDENCE BASED" MEAN?

The discussion of "evidence-based programs" naturally led to a discussion of the nature and uses of "evidence." What is evidence-based? What is research based? What do we mean by "the best evidence available?" What are the dangers/advantages of focusing so much on outcomes? Is there a difference between an "evidence-based program" and a "research-based program?" And how does the debate and dialogue about "evidence" interact with issues of culture, race, and ethnicity?

Clearly, there are differences in ways of knowing among cultures. What counts as "evidence" is defined differently from group to group. We need to keep in mind that there is a cultural gap between a "scientific way of knowing" and clinicians' professional ways of knowing, and an even wider gap between those ways of knowing and community group and specific cultural ways of knowing. The scientific way can be seen as discounting what people believe based on other ways of knowing. And cultural ways of knowing may create challenges related to understanding science-based approaches. These diverse world views

need to be communicated, respected and reconciled through respectful communication and functional comprise.

We also need to keep in mind that evidence-based programs are not the only effective programs. The development of what is now called evidence-based programs depends upon access and close collaboration with researchers who are committed to program development and who know how to write grants and how to conduct the research to establish the research base for a program. The program itself may or may not be any better than other options that are available but not thoroughly researched.

It also is important to recognize that a program may have developed its evidence base through a program of research focused on that particular intervention. However, programs also can make use of elements that are based on evidence already available in the literature. Thus, it is important to have a plan to access and assess the range of evidence that is available. Perhaps there are clusters of core skills useful in several contexts (evidence-based program or otherwise), key elements of interventions that cluster together to produce good effects across several treatment settings.

For example, a group of stakeholders in the state of Hawaii developed a theory of change about how to work together to develop social policy and intervention strategies. The state convened a group of scientists, consumers, family members, community members, and relevant stakeholders to assess the available evidence based on science, culture, and need. This diverse group then decided as a "community" what strategies and programs to implement to meet the specific needs in their state. Planning, funding, training, supervision, etc. were then specifically directed to implementing the desired programs and MIS systems were put in place to measure desired outcomes. As a "community" they then review the evidence of effectiveness in Hawaii, identify strengths and issues of concern, and help solve any problems. While there is not yet scientific evidence that the Hawaii process is efficacious, the process (involving inclusive decision making structures and group buy-in) may help other communities as they devise strategies and determine what will work for them.

Choosing a particular evidence-based intervention may mean choosing "effectiveness" as defined by the range of research conducted around that particular program. Most evidence-based programs have demonstrated their effectiveness with particular populations of children, families, or adults who have particular kinds of problems. As communities assess evidence-based programs they need to assess the needs of children and families in their communities and the degree to which the population of concern has been positively impacted to date by the evidence-based program under consideration.

Evidence-based programs focus their evaluation and research agendas at the individual and family level. System-level interventions (Systems of Care) are intended to produce outcomes at the system and service delivery level (e.g. collaboration, coordination, pooled resources) and bring values and principles into the delivery arena (e.g. family-centered, individualized, culturally competent).

We need to develop theories of change that try to incorporate both levels of change, determine effective strategies at both levels, and have MIS evaluations at each level (Bernfeld, et al., 1990; Rosenblatt & Woodbridge, 2003). For example, strategies and methods are needed to achieve system-level outcomes that encourage the use of evidence-based programs and support those programs after they are implemented.

As we discuss the nature of evidence and evidence-based programs, we should remember that there is evidence concerning two additional categories of programs: good evidence showed some programs are harmful and good evidence showed some programs are ineffective. In spite of this evidence, public funding is available for these programs year after year. Thus, the public funding and policy debates should not be about the relative merits of more or less evidence or about the type of evidence that should define an evidence-based program. Rather, the debate should be about why public funds are being used to support demonstrated ineffective or harmful programs instead of programs that have at least some evidence to support their effectiveness. We need to educate legislators, legislative staffs, and the public about the evidence available to support better policy and funding decisions.

WORK GROUP RESULTS

As the group of participants got to know one another and appreciate their common ground and diverse interests, additional agendas emerged and were pursued through three work groups. These work groups explored the following themes:
- What would a public health approach to mental health look like and how could that include use of evidence-based programs?
- If there were no barriers, how might evidence-based programs be utilized to benefit communities?
- There is much we know and much we do not know. Can we develop a consensus statement on cultural competence and evidence-based program development and utilization?

The results from the three work groups are presented below.

A PUBLIC HEALTH APPROACH TO
STATEWIDE USES OF EVIDENCE-BASED PROGRAMS

One work group of participants outlined a "public health" approach to adopting evidence-based programs as ways of solving social problems statewide (and nationally). Currently, evidence-based programs go where they are most welcome, not necessarily where they are most needed. From a public health perspective, a more deliberate and advantageous use of evidence-based programs is needed to more closely align resources (especially scarce resources such as evidence-based programs) with needs. The group did not focus squarely on prevention/early intervention (a hallmark of public health) but did

take a more "population-based" approach as opposed to a "client-based" approach to planning.

The group developed a general framework to characterize a public health approach to the use of evidence-based programs. The elements of the framework include:

1) Social, political, economic context
Governance, financing, definitions of need, provision of services, etc. all operate in a political and socioeconomic context that influences the overall perspectives and the possibilities for the development and delivery of human services.

2) Values and principles
At each level of functioning, individuals, programs, and organizations have values, philosophies, and principles that influence the perspectives and possibilities for human services.

3) Governance structures
Federal, state, county, and city governments have departments that oversee education, juvenile justice, health, mental health, child welfare, and other human services. The mandates, boundaries, policies and procedures at each level influence and interact with service delivery.

4) Financing mechanisms
Federal, state, and local governments have established mechanisms to finance human services. These financing mechanisms and pathways are not the same as governance structures. For example, Medicaid financing structures fund a wide variety of services across a number of different governance structures.

5) Public and non-profit providers
People (practitioners, supervisors, managers) provide the support and treatment needed by others. Those people operate within programs that define the services offered. Those programs operate within organizations that define and support programs. Leadership, training, coaching, administrative support, organizational culture and climate, etc. are important aspects of organizations.

6) Population
The demographics and the whole range of diversity within the population: young and old, rich and poor, various cultures, races, and ethnicities all impact service definition, development and delivery.

With these elements in mind, a public health approach must be based firmly on a definition of the demographics, risk factors, protective factors, and problems within the population. Neighborhoods, families, children, and adults do not have just one problem. Often, they are coping with many issues in their lives (housing,

employment, child care, education, etc) as well as the "identified problem." It is important to get a picture of the whole person/family and their fit within the ecology of the community. Neighborhoods, families, children, and adults are seen as having strengths as well as needs and these strengths must be identified as well.

Based on these strengths and needs, governance structures, financing mechanisms, and providers need to align their activities and resources to assure:

- availability of services to meet the need
- access to effective services for high-needs areas or groups
- services are effective and appropriate to the need
- services and organizations are accountable
- supportive administrative and management of services
- services and organizational structures are cost effective

Evidence-based programs can be used within this public health context. At the outset, it must be recognized that evidence-based programs have been developed for and tested with specific populations and specific problems. Thus, selection of an evidence-based program must match the defined needs within the population. Second, it must be recognized that evidence-based programs intersect with all levels defined above (socio-political, values, governance, financing, providers). Indeed, the key to the success of implementation is the ability of an evidence-based program to link with, adapt to, and influence the policies and practices at each level.

With respect to taking a public health approach, the group discussed an "experimenting societies" strategy (Campbell, 1969) where states could try a public health approach and evaluate the extent to which the social problems are affected. With experience and sensitive evaluation feedback, public health programs for human service problems could improve within a state and effective approaches could be shared across states. The planning and program development efforts currently underway in Hawaii and Ohio and the statewide evaluation system in Michigan provide a basis for moving forward with this agenda.

The group identified key issues inherent in any organized approach to solving problems within larger systems. These issues include the costs of providing effective services, lack of definition of problems and who (exactly) might have those problems in the population, the degrees of comfort with unfamiliar culture/race/language, the difficulties inherent in individualizing services, and the way competence in one part of a system threatens other parts of systems. Jurisdictional issues include lack of trust within and between organizations, lack of pooled resources to align resources with needs, focus on process instead of outcome, lack of uses of data for decision-making, and lack of support for training, consulting, fidelity and performance evaluations, and supportive administration (the factors that drive implementation of evidence-based programs).

In summary, a public health approach would be a needs-driven system with methods in place to sensitively measure processes and outcomes so that, as particular strategies are tried out, the results of those attempts can be fed back to decision-makers so problems can be solved.

A CONCRETE EXAMPLE FOR A COMMUNITY

A second work group of participants created a specific example of how evidence-based programs could be used to solve problems within an overall system of care. The example is based on Carl Bell's knowledge of Chicago and his work with the Chicago Community Mental Health Council. The group worked on how to make use of evidence-based programs to reduce social and individual problems, align various federal/state/city/local interests, align funding streams to support more effective programs than ineffective or harmful programs, and create a context to support evidence-based program implementation.

The group felt it was important to start by creating a leadership roundtable made up of the people who can make decisions and put money on the table. The roundtable can be made up of department and program executives and community leaders who are well connected to governance structures, funding streams, and community operations. The leadership roundtable needs to get a lot of input from the community to create a vision of what might be. Case studies concerning current operations can be presented to highlight needed changes in current system functioning and ways to integrate system operations. Common information systems can be connected with systems analyses (strengths, barriers) to provide reliable and consistent information. Such information can form the basis for decision making at the leadership roundtable. Building these roles and functions into an overall leadership roundtable may help inoculate the system of care from leadership changes in any given system.

This information gathering-feedback-decision making cycle can help the leadership roundtable group "connect the dots" to solve problems, strengthen the social fabric, and create a work culture with incentives tied to outcomes. The aim is to create partnerships to strengthen the social fabric, improve access via single points of entry and assessment, and create pools of flexible funding. Evidence-based programs can be introduced into this decision-making system as a way to improve outcomes for those most in need. Providers, system managers, and evidence-based program developers can be connected to infuse practices where they are most needed geographically and support them once they are operational.

A large mental health system of care such as this can find common pathways to meet the needs of a diverse population and geography. A mission-driven, outcome-oriented system of care can create a synergy that produces better systems, better outcomes, sustainable leadership and more jobs and economic benefits where it counts.

WHAT WE KNOW AND DON'T KNOW ABOUT EVIDENCE-BASED PROGRAMS AND CULTURAL COMPETENCE

A third subgroup worked on summarizing what we know and what we don't know about evidence-based programs and cultural competence. The concepts developed by this subgroup were explored during the meeting and a draft document later was circulated to all the participants inviting their comments and corrections (thanks to Vijay Ganju (National Association of State Mental Health Program Directors Research Institute) for preparing the original drafts of this document). This process resulted in the following statement that represents a consensus of the participants in the meeting.

CONSENSUS STATEMENT ON EVIDENCE-BASED PROGRAMS AND CULTURAL COMPETENCE

Introduction

In March, 2003, the National Implementation Research Network of the Louis de la Parte Florida Mental Health Institute convened a meeting of experts in the area of children's mental health and cultural competence. These included the developers of evidence-based programs for children; individuals with expertise on African American, Asian American Pacific Islander, Latino, and Native American issues; as well as researchers, family members, and stakeholders. The goals of the meeting were twofold. The first was to address the applicability and appropriateness of evidence-based programs for children and adolescents of different cultures and, second, to increase the capacity of systems to develop and implement culturally relevant approaches.

At the meeting, participants developed a consensus statement of what we know and what we do not know about the relationship between evidence-based programs and cultural competence. The objective of this consensus statement is to provide both a platform and a guide for discussions and decisions related to the cultural relevance of evidence-based programs for children and adolescents. Participants also developed recommendations for future action. Both are presented in the following sections of this document.

It is important to note that the information in this document is based on the knowledge and experience of the participants at the meeting and is not based on a systematic review of the literature.

EVIDENCE-BASED PROGRAMS AND CULTURAL COMPETENCE: WHAT WE KNOW AND DO NOT KNOW

- We know more about effective practices and programs than what is reflected through research done using randomized control trials. There are practices and interventions that consumers and practitioners have found to be helpful in addressing their problems and achieving their goals but for which the evidence base has not been fully established. Therefore, assertions about the effectiveness of these programs are premature.

- There is evidence to show that there are programs that are effective with a high degree of certainty based on randomized control studies or carefully controlled single-case studies conducted by multiple investigators in multiple sites for specific problems for specific populations in specific settings.

- Little research related to evidence-based programs has been conducted with diverse populations making it difficult to ascertain whether currently identified evidence-based programs are in fact best practices models for specific racial, ethnic, and cultural communities. Assessing differences in outcomes for persons of different racial and ethnic origins or for persons of different cultures has not been a focus of such research.

- Where studies have been done that include different racial, ethnic, or cultural groups, small sample sizes have prevented any conclusions regarding the effectiveness of evidence-based programs for these populations. Within this important limitation, existing data suggest that there are no significant differences in outcomes across different racial, ethnic, or cultural groups. There are, however, tantalizing data that suggest some evidence-based programs may actually result in better outcomes for some racial, ethnic, or cultural groups.

- In communities where evidence-based programs have been implemented, there is no discernible pattern of success or failure for those that have higher disenfranchisement or poverty levels when compared to other communities that have lower levels.

- Implementation of evidence-based programs depends on the availability of an adequate infrastructure (e.g., financial and human resources, strategies to promote community organization and readiness, implementation and knowledge transfer strategies, fidelity measurement procedures, support from stakeholders). We are just beginning to learn about the infrastructure needs associated with the implementation of evidence-based programs. We do not yet know whether and how the infrastructures needed to support evidence-based programs will differ from those that support current services. To the extent that infrastructure inadequacies and system failures disproportionately affect people who are poor and who are not white, strategies are needed to address such deficiencies.

- Implementation of evidence-based programs is likely to be facilitated by incorporating systems accountability, quality improvement, and knowledge transfer frameworks. A data-based outcomes orientation is a critical component of these frameworks.

- Currently we do not know whether and what types of adaptations and modifications of an evidence-based program are needed to ensure that its implementation does not create or exacerbate disparities across cultural groups. However, there is a body of emerging research and knowledge that suggests that appropriate adjustments can be made for specific cultural groups and partnerships with representatives of cultural communities can result in more successful implementation. Further research is required to understand what adaptations and modifications need to occur to improve the implementation of best practices models in diverse communities. At the same time, support for exploring the development of evidence-based programs targeted to specific cultural communities is needed. Only in this manner can the field begin to address the disparities in service delivery to at-risk populations.

- While it is important to conduct research involving specific racial, ethnic, and cultural communities, their role should not be limited to just being subjects of research. It is imperative for partnerships to be developed with specific racial, ethnic, and cultural communities so they can participate fully in the design, implementation, and evaluation of promising and best practices models. Moreover, such partnerships should design evaluations of practice-based interventions in order to demonstrate their effectiveness and potential for replication in other communities.

- There is evidence that there are current services and programs that are ineffective for the problems they are intended to address and, under certain circumstances, may actually be harmful. These harmful effects have a high probability of having disproportionately greater impact on persons belonging to specific racial, ethnic, and cultural groups. Mechanisms for shifting funds from these ineffective and harmful practices to evidence-based and best practice models should be developed and implemented.

RECOMMENDATIONS FOR ACTION

Federal agencies and entities funding mental health research should place a high priority on research related to the effectiveness of evidence-based programs for persons belonging to diverse groups. More specifically, they should fund research to:

1. Investigate differences in outcomes, if any, for persons belonging to different racial, ethnic, and cultural groups as well as any modifications or adaptations that may be needed to enhance the effectiveness of specific evidence-based programs within these groups.

2. Investigate factors that contribute to consumer and practitioner access to evidence-based programs and the extent to which these factors differ across racial, ethnic, and cultural groups and design strategies to increase access accordingly.

3. Investigate the critical system, infrastructure, and knowledge transfer components related to the successful, sustained implementation of evidence-based programs and any adjustments or variations needed to address the needs of different cultural groups.

4. Explore the extent to which positive outcomes for children and their families who are receiving evidence-based programs are related to the inclusion of common programmatic elements such as being individually-oriented, home-based and family-focused, and placing a strong emphasis on supports for practitioners.

5. Develop new models of research that incorporate differences in language, race, ethnicity, and culture in their design, methodology, and analyses.

6. Seek to understand the relationship of racial, cultural, and community infrastructure and "protective" factors that reduce risk and increase resilience of specific groups with respect to mental health, and incorporate knowledge about such protective factors into the development and testing of mental health treatments and services.

7. Develop curricula of training and professional programs that explicitly cover evidence-based programs and best practice models and racial and cultural aspects and differences which may affect access to, and effectiveness of, such programs; and conduct research to examine whether such training and professional programs are effective. These curricula should be flexible and updated regularly so that they can be inclusive of the expanding knowledge base.

8. Provide resources to develop and increase the workforce capacity to effectively implement racially and culturally appropriate intervention strategies.

References

Bernfeld, G. A., Blase, K. B., & Fixsen, D. L. (1990). Towards a unified perspective on human service delivery systems: Application of the Teaching-Family Model. In R. J. McMahon and R. D. V. Peters (Eds.), <u>Behavior Disorders of Adolescents: Research, Intervention and Policy in Clinical and School Settings.</u> New York, Plenum, 191-205.

Campbell, D. T. (1969). Reforms as experiments. <u>American Psychologist, 24</u>, 409-429.

Delbecq, A., Van de Ven, A.H., & Gustafson, D.H. (1975). <u>Group techniques for program planning: A guide to nominal group and Delphi processes.</u> Glenview, Ill.: Scott, Foresman.

Fadiman, A. (1998). <u>The Spirit Catches You and You Fall Down</u>. New York: Farrar, Straus, & Giroux.

Rosenblatt, A., & Woodbridge, M. W. (2003). Deconstructing research on systems of care for youth with emotional and behavioral disorders: Frameworks for policy research. <u>Journal of Emotional and Behavioral Disorders</u>, <u>11</u>, 27-37.

Van de Ven, A. & Delbecq, A. (1971). <u>Guidelines for leaders in conducting nominal group meetings</u>. Madison, WE: Center for the Study of Program Administration.