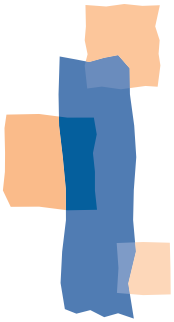

EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Getting Started with Evidence-Based Practices

Consumer-Operated Services

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
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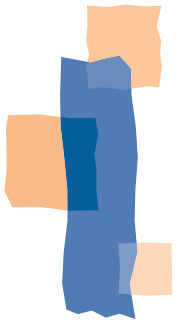

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U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

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Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
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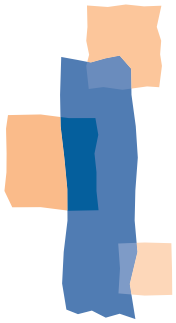


EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Getting Started with Evidence-Based Practices

Getting Started with Evidence-Based Practices gives you an overview of the activities that are generally involved in implementing evidence-based practices (EBPs) and tells you how to make EBPs culturally competent. This booklet is particularly relevant to mental health authorities and agency staff who develop and manage EBP programs.

Consumer-Operated Services

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 Consumer-Operated Services KIT, which includes seven booklets:

How to Use the Evidence-Based Practices KITs

Getting Started with Evidence-Based Practices

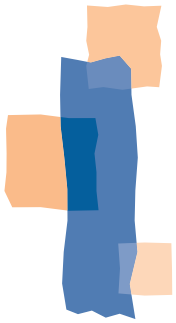
Building Your Program

Training Frontline Staff

Evaluating Your Program

The Evidence

Using Multimedia to Introduce Consumer-Operated Services



EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

What's in *Getting Started with Evidence-Based Practices*

Consumer-Operated Services

EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Getting Started with Evidence-Based Practices

Practitioner training alone is not effective. The experience of mental health authorities and agencies that have successfully implemented evidence-based practices (EBPs) reinforces this fact. Rather, practitioner training must be complemented by a broad range of implementation activities, including the following:

- Building support for the EBP;
- Integrating the EBP into agency policies and procedures;
- Training staff agency-wide on basic EBP principles; and
- Facilitating ongoing monitoring and evaluation of the program.

This overview introduces the general range of activities involved in successfully implementing EBPs.

For guidelines and suggestions for EBP-specific activities, see the remaining booklets in this KIT.

Consensus Building: Build Support for Change

Within a system, change affects various stakeholders differently. Consequently, when making changes in the mental health system, mental health agencies should expect varied reactions from staff, community members, consumers, and families. Since misunderstandings can stymie your efforts to implement EBPs, it is important to build consensus to implement EBPs in the community.

How to build support for your EBP

Consensus-building activities are designed to build support for implementing EBPs. Here are some ways to accomplish this:

Step 1 **Identify key stakeholders or people who will be affected by the EBP.** Stakeholders may include agency personnel at all levels, mental health authority staff, and consumer and family representatives. Depending on the EBP, you may also wish to build relationships with other community organizations, such as the Department of Vocational Rehabilitation, homeless shelters, domestic violence programs, criminal justice programs, food banks, police, hospitals, peer-support services, and consumer and family groups.

Step 2 **Invite a potential EBP champion 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. While at first you may feel that creating an advisory committee slows the process, any amount of time used to build stakeholder support is worth the effort.

EBPs have little hope for success if communities don't see them as 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 stakeholder groups, you will be able to broadly disseminate information in the community.

After training committee members in the basic principles of the EBP, ask them to hold informational meetings or to regularly disseminate information to their stakeholder groups.

Step 3 **Ask for advice.** Developing the advisory committee and educating its members in the EBP early in the planning process will allow you to ask committee members for their advice during all phases of implementation. Community members may help assess community and agency readiness 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 EBP services.

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

Step 4 **Build an action plan.** Once key stakeholders basically understand the EBP, the advisory committee should 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; and
- Designing procedures to regularly monitor and evaluate the EBP.

Base the activities in your action plan on the needs of the population you serve, your community, and your organization.

Step 5 **Involve the advisory committee in an ongoing evaluation of the EBP.** Committee members can help you decide which outcomes you should target. They can help you integrate continuous quality improvements. In addition to advising on the implementation process, committee members can assume additional responsibilities such as participating in training, promoting the EBP, and participating in evaluation.

To start implementing your EBP

- Pinpoint key stakeholder groups that will be affected by implementing the EBP.
- Identify potential champions from each group and invite them to participate in an EBP advisory committee.
- Ask the committee to advise you during the process.
- Build an action plan.
- Outline responsibilities for committee members, such 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.

Integrate the EBP into Policies and Procedures

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. 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. EBP-specific suggestions in *Building Your Program* in this KIT will help mental health authorities and agency staff determine the appropriate mix and number of staff, define staff roles, and develop a supervision structure.

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 membership rights and responsibilities, staff competencies, or program activities.

Integrating EBP principles into policies and procedures will build the foundation of the EBP program and help ensure program sustainability. Examine policies and procedures early in the process. While most changes will occur in the planning stages, regular monitoring and program evaluation (see discussion below) will allow you to periodically assess the need for further changes.

Identify funding issues

Identifying and addressing financial barriers is critical, since 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, local government, and private foundation funds. You can work with your EBP advisory committee to project startup costs by identifying the following:

- Time and costs for meeting with stakeholders;
- Time and costs for staff training;
- Staff and member time for strategic planning;
- Costs related to finding and maintaining facilities where consumer-operated services are offered;
- 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 to support continuous quality improvement efforts, such as 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 on the federal, state, and local levels.

Get these valuable resources to help implement your EBPs

Numerous materials are available through the U.S. Department of Health and Human Services (**http: www.hhs.gov**) about using Medicaid and Medicare to fund necessary services. If you are implementing EBPs, one useful resource is *Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook*, published by the Assistant Secretary of Planning and Evaluation, January 2005.

http://aspe.hhs.gov/daltcp/reports/handbook.pdf

This handbook gives you an excellent introduction to the Medicaid program, including essential features, eligibility, and coverage of mental health services, community services, and waivers. It also provides helpful information for states seeking Medicaid funding to implement the following EBPs:

- Family Psychoeducation;
- Assertive Community Treatment;
- Illness Management and Recovery;
- Integrated Treatment for Co-Occurring Disorders;
- Medication Management;
- Supported Employment;
- Permanent Supportive Housing; and
- Consumer-Operated Services.

Assess Training Needs

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 doesn't know about the EBP practice and doesn't recognize 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.

In addition to assessing training needs in the community, agency administrators should gauge how well staff across their own agencies understand the EBP. Agency administrators who have successfully implemented EBPs highlight the importance of providing basic training on the EBP to all staff throughout the agency. Educating and engaging staff will ensure support for the EBP in the long run. EBP programs will have an easier time obtaining referrals, collaborating with other service programs, and facilitating a continuum of care and support.

Ongoing in-service training is an efficient way to provide background information in a comfortable environment, including the philosophy and values underlying the EBP and the basic rationale for EBP service components. 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 people throughout the agency should receive basic EBP training, the EBP program leader and staff will require more intensive training. To help people integrate EBP principles into their daily practice, offer comprehensive skills training to those who provide EBP services. Each EBP KIT contains a variety of EBP-specific training tools to help you provide both basic and intensive training.

Although most skills that people need may be introduced through these training tools, research and experience show that the most effective way to teach EBP skills is through on-the-job consultation. Consultants may provide comprehensive training and case consultation to EBP practitioners.

Consultants may also help mental health authorities and agency administrators in these following activities:

- Providing basic information to key stakeholders;
- Assessing the community's readiness for change;
- Integrating EBP principles into policies and procedures; and
- Designing ongoing training plans.

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.

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

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; and
- Determine whether EBP staff may visit a model EBP program.

EBP-specific suggestions in *Building Your Program* in this KIT will help mental health authorities and agency staff members develop an EBP training plan.

Monitor and Evaluate Regularly

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

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

Asking these two questions and using the answers to improve your EBP program is a critical component for ensuring your program's success.

- To answer the first question, **collect process measures** (using the EBP Fidelity Scale and General Organizational Index) that 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, we strongly recommend 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. *Evaluating Your Program* in this KIT contains an EBP-specific Fidelity Scale, the General Organizational Index, and sample outcome measures.

Why you should collect process measures

Process measures, such as the EBP Fidelity and General Organizational Index Scales, help you assess whether the core elements of the EBP are in place in your agency. The items in these scales are associated with a number of positive outcomes (See *Evaluating Your Program* in this KIT). For this reason, it is important to score well on these scales and achieve high fidelity.

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, while helping to clarify strengths. Feedback should be provided regularly to guide program improvements over time.

Process measures also give mental health authorities a comparative framework by which to evaluate statewide implementation of an EBP. They allow mental health authorities to identify statewide trends and outliers.

Developing a Quality Assurance system will help you

- Diagnose your program's strengths and weaknesses;
- Formulate action plans to improve the program;
- Help consumers achieve their goals for recovery; and
- Deliver mental health services both efficiently and effectively.

Why you should collect outcome measures

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

Some outcomes directly result from an intervention, such as getting a job by participating in a Supported Employment program. Others are indirect, such as improving consumers' quality of life as a result of peer support. Some outcomes are concrete and observable, such as the number of days worked in a month. Others are subjective and private, such as being satisfied with EBP services.

Therefore, you should collect outcome measures, such as well-being, crisis prevention, and recovery that show the effect that services have had on consumers, in addition to the EBP fidelity measures. Once your EBP program shows high fidelity, ongoing process and outcomes monitoring allows you to test local innovations while ensuring that the EBP does not drift from its core elements. Using process evaluations with outcomes monitoring will allow you to understand whether your changes positively affect consumers.

How process and outcome data improve EBPs

Collecting and using process and outcome data can improve consumer participation and staff performance. Consider the following story:

> Participants in a vocational support group sponsored by a Consumer-Operated Service consistently showed very little vocational interest or activity. Program staff began gathering data monthly about consumers' vocational status and reporting the data to their program consultant. Every 3 months, the consultant returned the data to them using a simple bar graph. Program changes were made based on the bar graph that resulted in increased interest in vocational activities.
>
> The positive result of gathering and using information about consumers' vocational activity was evident almost immediately. Three months after starting this monitoring system, the percentage of the program's consumers who showed an interest or activity in vocational areas increased from 36 percent to 66 percent. Three months later, 72 percent of program participants were now involved in some form of vocational activity.

This example shows that sharing process and outcome data with consumers can stimulate participation in EBP programs. Similarly, disseminating evaluation information can enhance the performance of the EBP and increase motivation, learning, and a sense of accomplishment. In their study of successful companies, Peters and Waterman (1982) observed:

> We are struck by the importance of available information as the basis for peer comparison. Surprisingly, this is the basic control mechanism in the excellent companies. It is not the military model at all. It is not a chain of command wherein nothing happens until the boss tells somebody to do something. General objectives and values are set forward and information is shared so widely that people know quickly whether or not the job is getting done—and who's doing it well or poorly (p. 266).

Information in *Evaluating Your Program* in this KIT will teach quality assurance team members how to collect, analyze, and use process and outcome data to improve their EBP program.

Maximize Effectiveness by Making Services Culturally Competent

Cultural competence is the principle that asserts 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.

You can improve the quality of your EBP program by ensuring that it is culturally competent—that it adapts to meet the needs of consumers from diverse cultures. First, it's important to understand what culture and cultural competence are and how they affect care.

What culture is and how it affects care

Broadly defined, *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, not all members who are grouped together will share the same culture or identify with all others in the group.

Of course, each broad category is itself quite diverse. Individuals may identify with a given racial or ethnic culture to varying degrees, while others may identify with multiple cultures, including those associated with their religion, profession, sexual orientation, region, or disability status.

Culture is dynamic. It changes over time and is influenced both by people's beliefs and the demands of their environments. Immigrants from different parts of the world arrive in the United States with their own culture 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 U.S. 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 and support, starting with how they define these terms and the extent to which they think either is even needed. Culture influences the concerns that people bring to any setting, the language they use to express those concerns, and their coping styles.

Culture affects family structure, living arrangements, and the degree of support that people receive during difficult times. Culture also influences patterns of help-seeking, such as whether people start with a support group; their primary care doctor; a mental health program; or a minister, spiritual advisor, or community elder. Finally, culture affects how much stigma people attach to mental health problems and how much trust they will place in the hands of others.

Culture isn't just a consumer issue

It's easy to think that culture only comes into play regarding the people a program serves without realizing how it also applies to staff and administrators. Professional culture influences how they organize and deliver their care. Some cultural influences are more obvious than others—like the manner in which people ask questions or how they interact with others. Less obvious but equally important are issues like these:

- Agency operating hours;
- The importance given to reaching out to family members and community leaders; and
- The respect that staff gives to those of differing cultures and backgrounds who enter their doors,

Knowing how culture influences so many aspects of mental health care helps us to appreciate the importance of adapting agency practices to respond to, and be respectful of, 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 getting 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 the following:

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

But disparities also affect many other groups, such as the following:

- Women;
- Children and older adults;
- People from rural areas;
- People of different religions;
- People who are poor;
- People with different sexual orientations; and
- People with physical or developmental disabilities.

Altogether, those disparities meant that millions of people suffered needlessly. Starting in the late 1980s, the mental health profession began recognizing the importance of responding to the issue of disparity by attending to cultural competence.

What is cultural competence?

The Surgeon General 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.

Originally cultural competence was defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals to enable people to work effectively in cross-cultural situations. Cultural competence is intended to improve access, build trust, and promote recovery. 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 consumers, families, providers, policymakers, and administrators have long acknowledged the intrinsic value of cultural competence, insufficient research has been dedicated to identifying its key ingredients. Therefore, the field still struggles to define cultural competence, put it into operation, and measure it.

The word *competence* is somewhat misleading. It usually implies a set of criteria on which to evaluate a program. But this is not yet true; cultural competence is still underresearched. In this context, competence means that the responsibility to tailor care or support to different cultural groups belongs to the system, not to a few designated individuals. Every provider or administrator who is involved in delivering care—from mental health authorities to supervisors and practitioners—bears responsibility for trying to make their programs accessible, appropriate, appealing, and effective for the diverse communities that they serve. Many do it naturally.

How cultural competence relates to EBPs

Evidence-based practices are intended for every consumer who can benefit from them, regardless of their culture. But programs often need to adjust EBPs to make them accessible and effective for cultural groups that differ from the original study populations. The adjustments should help, rather than interfere with, a program's ability to implement EBPs using the KITs.

In a nutshell, to deliver culturally competent EBPs, you must tailor either the practice itself or the context in which the practice is delivered to the unique communities you serve, for instance, by translating the informational brochures into the languages often used in their communities. For more suggestions, *see How to put cultural competence into practice*, on the next page.

In time, specific fidelity measures will be available to assess a program's cultural competence. Many providers ask this question:

> 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 will not know for sure until we try; but the limited research that does exist suggests that EBPs, perhaps with minor modifications, work well across cultures.

Furthermore, because EBPs represent the highest quality of care currently available, it is a matter of fairness and prudence to provide them to all people who may need them. Yet the question remains, how can we do this effectively?

How to put cultural competence into practice

Since the goal is for all programs to be culturally competent, we offer a variety of straightforward steps to help agency administrators respond more effectively to the people they serve. These steps apply to all facets of a program; they are not restricted to the EBP program alone. Please note that the following guidelines 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 consumers, family, and community organizations.
- Translate your forms and brochures.
- Offer to match people who have similar backgrounds.
- Use bilingual staff, including those trained in American Sign Language, when needed. If this is not possible, then have ready access to qualified interpreters.
- Ask consumers about their cultural backgrounds and identities.
- Incorporate cultural awareness into consumers' needs.
- Tap into natural networks of support, such as the extended family and community groups that represent the consumer's culture.
- Reach out to religious 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 consumers from other cultures may hold different beliefs about causes and treatment of illness.

How mental health authorities can help

We offer you a few examples of how public mental health authorities can help develop a more culturally competent mental health system:

- Designate someone with part-time or full-time responsibility for improving and monitoring cultural competence.
- Create a strategic plan to incorporate cultural competence into the mental health system.
- Establish an advisory committee that includes representatives from all the major racial, ethnic, and cultural groups you serve.
- Address barriers to care (including cultural, linguistic, geographic, or economic barriers).
- Promote staffing that reflects the composition of the community you serve.
- Promote regular organizational self-assessments of cultural competence.
- 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.

For more suggestions about adapting EBPs to diverse groups, see the remaining booklets in the KIT series.

A look at cultural competence through a vignette

Maria, a 30-year-old Puerto Rican woman, has been talking to her family about going back to work. Lately, however, she's been feeling more than a little overwhelmed and fears that her family will think she's loca (crazy). She would like to talk about it with someone, but the motto in her family is, "Whatever happens in the house or is said in the house, stays in the house."

Maria hears about a peer support group and decides to try it out anyway. When it's her turn, she talks about herself and her family as one person. Someone replies, "Try to keep it about yourself and what you think." She says her family always gives their opinion whether she likes it or not.

She decides not to come back, but doesn't tell the group why. A month goes by and she wonders if she's been fair. When the group asks her why she didn't come back, she replies, "I don't know if this group's for me, or if I'm not right for this group." The other group members are confused and ask why. She explains a bit about the central role that family plays in her culture.

One group member, Elaine, says that she knows very little about how other cultures do things, and thinks that the group would benefit by learning more.

The group decides to explore different cultural perspectives about family, work, mental health, and other topics. The members feel that these discussions can help them incorporate their growing knowledge about the beliefs and practices of different cultures into the work of the peer center.

Selected resources on cultural competence

The following resources are for consumers and families, mental health authorities, administrators, program leaders, and practitioners:

National resources for consumers and families

Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
SAMHSA's Health Information Network
Rockville, MD 20857
Phone: 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).
http://www.samhsa.gov/shin

Depression and Bipolar Support Alliance (DBSA)
730 N. Franklin Street, Suite 501
Chicago, Illinois 60654-7225
Phone: (800) 826-3632
Fax: (312) 642-7243
http://www.dbsalliance.org

First Nations Behavioral Health Association
P.O. Box 55127
Portland, Oregon 97238
Phone: (503) 953-0237
Fax: (503) 954-1741
http://www.fnbha.org

National Alliance on Mental Illness (NAMI)
3803 N. Fairfax Drive, Suite 100
Arlington, Virginia 22203
Phone: (800) 950-NAMI (6264)
Fax: (703) 524-9094
TTY: (703) 516-7227
http:/www.nami.org

National Asian American Pacific Islander Mental Health Association
1215 19th Street, Suite A
Denver, Colorado 80202
Phone: (303) 298-7910
Fax: (303) 298-8081
http://www.naapimha.org

National Institute of Mental Health (NIMH)
Office of Communications
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, Maryland 20892-9663
Phone: (866) 615-NIMH (6464)
Fax: (301) 443-4279
TTY: (301) 443-8431
http://www.nimh.nih.gov

National Latino Behavioral Health Association
P.O. Box 387
506 Welch, Unit B
Berthoud, Colorado 80513
Phone: (970) 532-7210
Fax: (970) 532-7209
http://www.nlbha.org

National Leadership Council on African American Behavioral Health
615 Wellington Way
Jonesboro, Georgia 30238
Phone: (770) 472-7814
http://www.nlcouncil.com/board.html
wilmatownsend@bellsouth.net

Mental Health America
2000 North Beauregard Street, 6th Floor
Alexandria, Virginia 22311
Phone: (800) 969-6642
Phone: (703) 684-7722
Fax: (703) 684-5968
TDD: (800) 433-5959
http://www.nmha.org

Resources for mental health authorities

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Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
SAMHSA's Health Information Network
Rockville, MD 20857
Phone: 1-877-SAMHSA-7 (1-877-726-4727)
(English and Español).
http://www.samhsa.gov/shin

Hogg Foundation for Mental Health
The University of Texas at Austin
P.O. Box 7998
Austin, Texas 78713-7998
Phone: (800) 404-4336
Fax: (512) 471-5041
http://www.hogg.utexas.edu

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Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
SAMHSA's Health Information Network
Rockville, MD 20857
Phone:1-877-SAMHSA-7 (1-877-726-4727) (English and Español).
http://www.samhsa.gov/shin

National Alliance of Multi-Ethnic Behavioral Health Associations
3 Bethesda Metro Center
Bethesda, MD 20814
Phone: (301) 941-1834
Fax: (301) 657-9776
http://www.nambha.org

National Center for Cultural Competence
Georgetown University Center for Child and Human Development
P.O. Box 571485
Washington, D.C. 20007-1485
Phone: (202) 687.5387
TTY: (202) 687-5503
http://gucchd.georgetown.edu/nccc

The Evaluation Center@HSRI
2336 Massachusetts Avenue
Cambridge, Massachusets 02140
Phone: (617) 876-0426
http://tecathsri.org/

Western Interstate Commission for Higher Education (WICHE)
Mental Health Program
P.O. Box 9752
Boulder, CO 80301-9752
http://www.wiche.edu/staff/unit/mh

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National Institute of Mental Health (NIMH)
Office of Communications
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, Maryland 20892-9663
Phone: (866) 615-NIMH (6464)
Fax: (301) 443-4279
TTY: (301) 443-8431
http://www.nimh.nih.gov

Instruments to assess cultural competence

Consolidated Culturalogical Assessment Toolkit (C-CAT). Ohio Department of Mental Health, 2003.

- Measures cultural competence in mental health systems and organizations
- Includes comprehensive training and promotional materials

For more information, contact:

Multiethnic Advocates for Cultural Competence
1335 Dublin Road, Suite 105C
Columbus, Ohio 43215
Phone: (614) 221-7841
Fax: (614) 487-9320
http://www.maccinc.org

Cross-Cultural Counseling Inventory (CCCI). 1991.

- Measures knowledge, attitude and beliefs about cultural diversity
- Measures cross-cultural counseling skills

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- Measures the cultural competency of services
- Measures organizational accommodations and practices
- Consumer preferences and satisfaction

For more information, contact:

Human Services Research Institute
2336 Massachusetts Avenue
Cambridge, Massachusetts 02140
Phone: (617) 876-0426
Fax: (617) 492-7401
http://www.hsri.org

Cultural Competency Assessment Scale (CCAS). Nathan S. Kline Institute for Psychiatric Research, 2000.

- Assesses organization's level of cultural competence
- Consistent with EBP fidelity instruments

For more information contact:

Nathan S. Kline Institute for Psychiatric Research
140 Old Orangeburg Road
Orangeburg, New York 10962
Phone: (845) 398-5500
Fax: (845) 398-5510
http://www.rfmh.org/nki

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- Assesses cultural awareness, knowledge, and skills

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Scales for practitioners to recognize cultural identity

Acculturation Rating Scale for Mexican-Americans (ARSMA)

Cuellar, I., Harris, C., & Jasso, R. (1980). An acculturation scale for Mexican-American normal and clinical populations. *Hispanic Journal of Behavioral Sciences, 2,* 199–217.

African Self-Consciousness Scale

Baldwin, J. A., & Bell, Y. (1985). The African Self-Consciousness Scale: An Afrocentric Personality Questionnaire. *The Western Journal of Black Studies, 9,* 61–68.

Black Racial Identity Attitude Scale-Form B (BRIAS-Form B)

Helms, J. E. (Ed.). (1990). *Black and White racial identity: Theory, research, and practice.* New York, NY: Greenwood Press.

Chinese Values Survey

The Chinese Culture Connection. (1987). Chinese values and the search for culture-free dimensions of culture. *Journal of Cross-Cultural Psychology, 18,* 143–164.

Cultural Adaptation Pain Scale (CAPS)

Sandhu, D. S., Portes, P. R., & McPhee, S. A. (1996). Assessing cultural adaptation: Psychometric properties of the Cultural Adaptation Pain Scale. *Journal of Multicultural Counseling and Development, 24,* 15–25.

Cultural Information Scale (CIS)

Saldana, D. H. (1994). Acculturative stress: Minority status and distress. *Hispanic Journal of Behavioral Sciences, 16,* 116–128.

Multidimensional Measure of Cultural Identity for Latino and Latina Adolescents

Feliz-Ortiz, M., Newcomb, M. D., & Meyers, H. (1994). A multidimensional measure of cultural identity for Latino and Latina adolescents. *Hispanic Journal of Behavioral Sciences, 16,* 99–115.

Multidimensional Racial Identity Scale (MRIS)-Revised

Thompson, V. L. S. (1995). The multidimensional structure of racial identification. *Journal of Research in Personality, 29,* 208–222. *doi:10.1006/jrpe.1995.1012*

Multigroup Ethnic Identity Measure (MEIM)

Phinney, J. (1992). The Multigroup Ethnic Identity Measure: A new scale for use with adolescents and young adults from diverse groups. *Journal of Adolescent Research, 7,* 156–176.

Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA)

Suinn, R. M., Richard-Figueroa, K., Lew, S., & Vigil, P. (1987). The Suinn-Lew Asian Self-Identity Acculturation Scale: An initial report. *Educational and Psychological Assessment, 47,* 401–407.

Short Acculturation Scale for Hispanics (SASH)

Marin, G., Sabogal, F., Marin, B. V., Otero-Sabogal, R., & Perez-Stable, E. J. (1987). Development of a short acculturation scale for Hispanics. *Hispanic Journal of Behavioral Sciences, 9,* 183–205.

White Racial Identity Attitude Scale (WRIAS)

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