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Guest Editorial

Culturally Competent Outcome Evaluation in Systems of Care for Children's Mental Health

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The need for outcome evaluation is becoming more evident as we progress in the development of systems of care for children's mental health, which involve the coordination of different services and service delivery systems in the provision of individualized care for children with serious emotional disturbance in their communities. As we face increasing challenge to funding for such public services, we need evaluation paradigms which can test their overall effectiveness, which services or interventions work for which children and families, and identify essential components of model programs for replication. As managed care approaches are applied to these systems, such evaluation is even more crucial, because such evaluation can serve to test the effectiveness of their resource utilization and assist in managing such resources.

The philosophy of community-based systems of care lends itself to effective outcome evaluation. Community-based systems of care are customer-oriented and emphasize consumer satisfaction, which is a significant rationale and component of such evaluation. The orientation of community-based systems of care, as with outcome evaluation, is focused on functional improvement rather than exclusively on the evaluation of symptoms and diagnosis. Since such systems are based on coordination amongst agencies and the community at-large, evaluation of systems functioning becomes an important component of outcome evaluation.

At the same time, these systems serve an increasing proportion of clients from underserved minority populations. This is due to the increasing minority population in the U.S., particularly amongst children and adolescents where

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minorities are often the majority, as well as the significant proportion of this population receive public mental health and substance abuse services. If such systems are to effectively serve a major and increasing proportion of their clients, they must examine the impact of culture and cultural difference on their clients.

Culture clearly governs normal and dysfunctional behavior and disturbance, including the definition of symptom threshold (how much is too much, and what is a pathological level), the threshold for distress and seeking services, the understanding and attribution for disturbances of behavior and emotions (religious, supernatural, spiritual, interpersonal, physical/biological), coping strategies and help-seeking behaviors, attitudes about illness and receiving services (including stigma and attitudinal barriers to accessing services), and culturally prescribed services (ceremonies, rituals, intervention approaches). Culture also defines functional capacity, the roles which individuals serves daily, and the behaviors which are considered adaptive for different roles.

The concept of culturally competent systems of care for children with serious emotional disturbances was developed by Cross, Bazron, Dennis, and Isaacs (1988). They defined cultural competence as the ability to serve individuals of diverse cultural backgrounds. This implies valuing cultural diversity, understanding how it impacts on normal functioning and problems during disease/disorder, and the changes that are needed in service delivery to meet the needs of culturally diverse children and their families. This requires practitioners and the system of care as a whole to develop skills, knowledge base, attitudes, policies, and procedures which enable them to effectively serve people from the diverse cultural backgrounds in their region/ catchment area. They pointed out that the cultural blindness approach which American society has so frequently used keeps us from finding out important differences in needs and orientation to service utilization across ethnic groups. Identifying and addressing such cultural differences and how to address them makes programs more clinically and cost-effective. This becomes the overarching goal of culturally competent outcome evaluation. However, for such outcome evaluation to be effective and non-injurious to the populations being served, cultural competence principles must be applied in its implementation.

DEFINING PROGRAM CHARACTERISTICS, PHILOSOPHY, AND INDICATORS

As part of designing an outcome evaluation study for either a program or a system of care, population/client, process, and outcome indicators or

variables must be defined. This allows the evaluation to answer the key questions of which interventions work, for whom, and how. Population/client indicators include information about the race and ethnicity of the population as well as other key demographic characteristics which often interact with culture, such as gender, age,socioeconomic status, and urbanicity. Such data might be available from agency databases which can be inter-linked for more effective identification. Methodology to relate such characteristics to the region being served such as geocoding (mapping such characteristics out by towns or neighborhoods) will shed further light on factors which will influence service delivery, such the proximity of the population to natural stressors and physical access to services. Information defining the types of clinical conditions which clients usually present can be obtained either from agency databases or even from epidemiological studies. If there are significant culturally diverse populations, one should determine how the target populations are similar or different than the prevailing community population.

Program characteristics are also key in developing an evaluation design. The philosophy of the program or system determines the service model/modalities delivered (how it expects to facilitate change) and the associated process (performance) variables or indicators to be examined. Process indicators can include type and frequency of interventions, length of stay, meeting individual treatment goals on care plans, staff involved in interventions, and the demonstration of precursor changes or behaviors as a result of applying interventions. Culturally relevant process questions include: (a) How program philosophy directs staffing composition, including the distribution of professional disciplines and their ethnic composition, (e.g., should clients be matched with staff for their ethnicity?); (b) The availability and effectiveness of cultural competence training for staff and how it impacts on program philosophy; (c) How program philosophy compares and interacts with the cultural values of the target population (e.g., emphasis on spirituality; individual vs. group support vs. family orientation) and how clients are assigned to different therapeutic modalities (particularly any cultural rationales). This includes the utilization of traditional healing approaches (religious ceremonies, rituals, specific cultural interventions such as sweat lodges or community intervention), and which clients benefit from such interventions as opposed to Western approaches; and (d) Portals of referral/entry into the program, barriers to access to care, and how those relate to the clients' cultural and socioeconomic needs.

Outcome indicators in evaluation usually involve domains of symptom change, functional change, safety, cost, community tenure and level of restrictiveness, and consumer/family burden and satisfaction. Possible culturally related outcome questions include: (a) Differential outcomes

across different cultural, racial, or ethnic groups; (b) Expected outcomes from the program and how those outcomes compare to the functional expectations of individuals of the cultures/ethnicities/socioeconomic status being served. For example, if emotional separation and autonomy is viewed as an important outcome from the program, is this appropriate for a cultural group for which multigenerational closeness and communal dwelling are the norm? If gainful employment is viewed as a parent outcome, is this valid in an impoverished region?; and (c) Relations/liaison with the community organizations/leadership which represent minority groups served, which can be an important systems outcome.

PARTICIPATION BY THE COMMUNITY, PROVIDERS AND AGENCIES

In order to begin implementing the evaluation of a program or system of care, client and staff cooperation and participation must be obtained and nurtured. Attitudes about evaluation and research in minority communities are often quite negative due to their prior negative experiences. They have often been exposed to much research without pay-off. There is also mistrust about whether evaluation can be used as a tool of government agencies, immigration, social services/child welfare agencies for custody termination or termination of benefits. Evaluation methodology often conflicts with cultural values, tradition, and accepted means of communication of sensitive information. Attitudes about cross-cultural research and issues in agencies can also serve as barriers to addressing these issues in evaluations. Pre-competence attitudes persist ("all people are the same") in agencies, with agency staff wanting to be perceived as "politically correct" and not being open about attitudes, biases, and lack of skills. There is also the fear that evaluation/research might frighten clients away from services.

A number of approaches can be used to gain access to and the cooperation of minority clients and program staff. Actively seeking out advise, input, and endorsement from the minority community is quite effective, particularly from leaders and elders. This not only builds bridges of trust, but can also serve to inform the selection of instruments, methods, and procedures which are more acceptable and more effective. Recruiting research/evaluation assistants from the community can also build in such community input and expertise. Cultural competence introduction and training for staff as outcome evaluation is introduced can heighten awareness for the need to examine issues relating to cultural diversity and reduce defensiveness. Integration of evaluation tools and indicators into clinical care helps to minimize staff and client time and burden. Informed consent

procedures must also be easily understood and should involve appropriate family members when culturally indicated (Windle, Jacobs, & Sherman, 1986).

EVALUATION DESIGN AND SAMPLING

The nature of the actual design chosen can be a significant issue for cultural diverse groups. Pre-post or multiple baseline designs are often more acceptable. However, culturally diverse populations served frequently change over time for other reasons than interventions provided, such as due to exposure to mainstream culture, generational change, and signal events in the life of the community (Szapocznik, Scopetta, & King, 1978). It is important to keep track of such intervening changes in these designs. Single case methodology, which is increasingly used in behavioral studies, is useful in evaluations involving small numbers. These serially follow rating of certain target behaviors pre- and post-intervention to determine effect. Experimental designs (random assignment to different interventions) are often considered the "gold standard" scientifically. However, these are hard to achieve in the reality of service provision. It also leads to ethical problems when any group is not receiving a worthwhile intervention, and this reinforces suspicions in ethnic minority clients. Longitudinal designs following a cohort of clients over time to measure outcome can be useful. Their drawback is that some behavioral changes may be specific to certain "cohort" groups if they share many life experiences in common, and may be hard to generalize to other groups.

Sampling of culturally diverse groups must assure that the racial/ethnic, socioeconomic, age, gender composition of any sample reflects the service population. However, sampling within a given region or cultural group/subgroup leads to limited applicability of the results to that group. Sampling across different regions or sub-groups often require a much larger sample. Oversampling or "stratification" of samples may be necessary if the samples of culturally diverse individuals are too few in number to be representative.

MEASUREMENT STRATEGIES

Instrumentation and measurement strategies require many cultural considerations. Very few instruments are appropriate for use across different cultural groups, and some have subtle but distinct cross-cultural biases (Pumariega, Holzer, & Swanson, 1991). Instruments should have some of these characteristics if being used or compared across cultural groups:

(1) *Conceptual Equivalence.* The same theoretical construct is being measured across different cultures (e.g., parental role function defined differently in different cultures).

(2) *Semantic Equivalence.* Not only translation across language, but also idioms and expressions of the groups being studied are accounted for (e.g., the term feeling "blue" for low mood used by Anglos is non-sensical for Hispanics, and has a historical context for African-Americans). Bilingual versions for people in cultural transition are often necessary.

(3) *Content Equivalence.* The content of each item in the instrument is relevant to the phenomenon being studied in that culture (e.g., the concept of being "put-upon" may not be comparable in another culture). Lack of familiarity with clinical jargon and different attribution/understanding of symptoms or illnesses and culturally-bound presentations/syndromes (e.g. schizophrenia vs "being possessed") must be taken into account. It may be necessary to include descriptors of illness or behaviors in questions.

(4) *Criterion Equivalence.* Interpretation of the variable measured is in reference to the norms for that culture (e.g., the level of depression and cut-off for significant depression is based on the normative response for that culture). Measures of symptoms or behaviors need to account for culturally determined thresholds of dysfunction within the community. It may be necessary to develop different cut-off scores for different ethnic groups using culturally-specific normative samples.

(5) *Methodological Equivalence.* Different methods of assessment may not yield comparable responses across cultures. (e.g., some groups are more open in self-administered questionnaires, while others more when they interact with an interviewer, the cultural acceptability of answering on the extremes of a Likert-type question may differ across groups). The setting in which the collection of data takes place can also influence results. A neutral site may be most desirable so as to preserve confidentiality and reduce stigma. (Guillermin, Bombardier, & Beaton, 1993).

A common issue which arises is that of using monocultural instruments versus cross-cultural instruments. Monocultural instruments may be necessary when specific aspects of a culture are being evaluated as a variable in the impact of a program, such as ethnic pride/ethnic identification in a particular culture or particular cultural beliefs/practices. Such instruments should be normed for the particular group or sub-group studied. Cross-cultural instruments, or instruments which theoretically can measure constructs cross-culturally, are necessary when making comparisons across cultural-ethnic groups. It may be necessary to develop parallel versions of instruments which are specific for different groups, or even to pilot-test instruments with community populations to obtain normative data and to

identify problems in acceptability and response (Pumariega, Holliday, & Holzer, 1995).

Qualitative/ethnographic approaches may also be useful in obtaining information about culturally related variables, eliciting important perceptions or attitudes without the stringent categorical limits of rating instruments. These approaches are often consonant with cultural values and means of transmission of information in many communities, which include differences in traditions of oral vs. written language and what types of information are to be shared with whom and when. Such methods include open-ended questions, questionnaires, interviews, or observational data. Focus groups of community members or leaders can discuss certain problems to be addressed by intervention and develop associated themes. These can be compared to similar groups post-intervention. Ethnographic measures can be used in combination with standardized instruments or used to develop culturally sensitive standardized measures.

There are special issues to be considered around the measurement of specific culturally related variables. The measurement of cultural identification and cultural value orientation present particular challenges. The construct which is most commonly endorsed in the cross-cultural mental health field is that of biculturality or multiculturality (i.e., that culturally diverse individuals by necessity are bicultural or multicultural in order to adapt successfully). The domain of cultural-ethnic identification must allow for this construct, and must take into account a number of domains, such as self-identification, relational patterns, culturally related traditions and preferences (clothing, foods, traditions, language, media), and cultural value orientation. In order to measure the latter, one must decide on a model for value orientation and on which dimensions to measure (e.g., attitudes vs. behaviors). For children and for many families, the measure of concrete behaviors or activity orientations (culturally related activities of daily living) are a valuable means of assessing cultural identification. These include simple activities such as the amount of time spent with family, religious activity, and time spent exposed to the media. (Pumariega, Swanson, Holzer, Linskey, & Quintero, 1992). As mentioned previously, the measure of functional status needs to differ ecologically according to cultural expectations for role functioning. Measures of socioeconomic status need to be non-intrusive so as to assure cooperation and valid responses. The implementation of traditional cultural healing methods require special measures and methods for certification of the appropriate application of the intervention by a healer/practitioner as well as for the expected behavioral or attitudinal responses. The collaboration of spiritual healers in developing such measures may be crucial so that they are relevant as well as acceptable (Robbing, 1994).

USE OF DATABASES AND CLINICAL RECORDS

Information from clinical or agency databases may be important sources for outcome evaluation. However, there are common problems with the rating of ethnic/racial identification in databases. Often clinicians do not ask race/ethnicity directly, but infer it from appearance or surnames! There are also problems with the coding categories used for cultural and ethnic groups, with insufficient or unclear categories (e.g. a single Hispanic category or Asian/Pacific Islander combined). There are also problems with the coding of much culturally related information in databases, such as socioeconomic status, diagnosis, and service utilization information. It may be important to develop rational coding categories for clinical database information, with instruction for clinical staff or other staff entering information. Racial/ethnic bias in clinical diagnosis is well documented, especially by clinicians not familiar with the culture (Kilgus, Pumariega, & Cuffe, 1995), and their data may have limited utility. It may be more valuable to have clinicians rating the presence of symptoms reported by the client or family, which offer a better base of objectivity and is not contaminated by the biases of classification systems.

CONCLUSIONS

The area of culturally competent outcome evaluation and cross-cultural mental health research in general needs to be greatly developed given the culturally diverse nation we live in and the different needs of culturally diverse children and their families. Such evaluation is crucial in supporting the need for and effectiveness of culturally competent programs and special programs with a focus on particular cultural populations. The imperatives for cost effectiveness and clinical effectiveness which have been promoted by the transition to managed systems of care may actually promote the development of higher levels of cultural competence in community-based systems of care. Culturally competent care may well be the most cost-effective and clinically effective care.

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