Evidence-Based Practices and Multicultural Mental Health

As NAMI advocates are aware, the mental health field is increasingly promoting and requiring evidence-based practices (EBPs) in an effort to boost quality, effectiveness, and accountability in health and mental health care services. Given the importance of EBPs in the current climate of mental healthcare, this resource was created to provide information to NAMI stakeholders—individuals with mental illness, families, providers, and partners—on the literature discussing EBPs, with special consideration of multicultural issues.

Many reports, including the 2001 Surgeon General's report, *Mental Health: Culture, Race and Ethnicity,* identify barriers within ethnic/racial populations to access to quality mental healthcare, promoting a charge to eliminate disparities.

Once barriers to access are overcome, ethnic/racial mental health disparities extend to the quality of care. It is extremely important to break down access barriers and then consider the most effective interventions for diverse communities. While providing EBPs for people of color with mental illness seems to be a logical way to increase the quality of care received by diverse populations and its outcomes, it is not so clear cut (Hogg Foundation for Mental Health, 2006). The following discussion provides information from a wide array of perspectives throughout literature on EBPs and how they relate to improved mental healthcare in diverse populations.

Unfortunately, recent reports have shown that disparities in mental healthcare persist:

- In examination of trends in mental health disparities since the 2001 Surgeon General's supplemental report, Cook, McGuire, and Miranda (2007) found that African Americans and Hispanics continue to receive less mental healthcare compared to their White counterparts.
- The 2007 National Healthcare Disparities report found that, overall, disparities in healthcare have not been decreasing in recent years (based on data from 2000–2005). The report could not make the same conclusion about mental health disparities due to large gaps in available data (as cited by Rivera-Casale, 2008).

EBPs: The Basics

According to the Institute of Medicine 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, an EBP is "the integration of best research evidence with clinical expertise and patient values" (p. 147).

Treatment efficacy is demonstrated through two or more group design studies or a large series of single-case studies conducted by multiple investigators showing significant effectiveness as compared to a control group or placebo (Chambless, 1993). In other words, treatments are considered an EBP once they produce significantly positive outcomes in two or more controlled studies (Gruttadaro, Burns, Duckworth, & Crudo, 2007).

Examples of EBPs include cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT), both well documented and established forms of psychotherapy to address depressive disorders in both children and adults (Miranda et al., 2005).

Resources on implementing EBPs have become widely available, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) Evidence-Based Practice Implementation Resource Kits for the following adult mental health interventions and services:

- Illness Management and Recovery
- Assertive Community Treatment
- Family Psychoeducation
- Supported Employment
- Co-occurring Disorders: Integrated Dual Diagnosis Treatment

History of the EBP Movement

The EBP movement started because of a growing concern that many individuals were receiving ineffective treatments grounded in tradition and, outdated training, and lacking in scientific evidence (Whitely, 2007). A series of landmark reports have led to strong government and research commitment to EBPs:

- In 1995, the American Psychological Association's Division 12 Task Force on Promotion and Dissemination of Psychological Procedures first published a report on empirically validated treatments and established criteria by which to evaluate treatment practices.
- The 1999 *Mental Health: A Report of the Surgeon General* points out a wide range of available mental health treatments with well-documented efficacy (U.S. Department of Health and Human Services, 1999).
- The 2003 President's New Freedom Commission on Mental Health report envisions a transformed mental health system in which there is consistent utilization of up-to-date, evidence-based mental health interventions (U.S. Department of Health and Human Services, 2003).

EBP Challenges

Though a major showing of commitment to promoting and implementing EBPs has emerged in the research community with the support of government agencies, there continues to be concerns related to sufficient capacity to implement and sustain evidence-based programs in many communities.

EBPs are often underutilized even when their benefits are recognized and models are available (Goldman et al., 2001). Major barriers to the implementation of EBPs include inadequacy of supportive funding, training, and policies, and strains on financial appeal—some practices are not reimbursable through Medicaid and other health insurance (Ganju, 2003). Even after implementation and a showing of effectiveness within mental health service systems, many EBPs lack sustainability beyond the period of external funding (Sullivan et al., 2005).

While the 1999 Surgeon General's report boasts a wide evidence base in mental health treatments, the supplemental report examining multicultural issues in mental health notes a lack of ethnic/racial participation in the efficacy studies that determine the evidence for some of these interventions (U.S. Department of Health and Human Services, 2001). Released two years later, the New Freedom Commission report expresses hope that in the future. "Every time any American—whether a child or an adult, a member of a majority or a minority, from an urban or rural area—comes into contact with the mental health system, he or she will receive excellent care that is consistent with our scientific understanding of what works" (p. 12).

EBPs and Multicultural Populations

Cultural competence experts fear that EBPs could worsen existing inequities in mental health care for diverse populations without sufficient attention to cultural competence or existing culturally specific practices (Isaacs et al., 2005). At the same time, researchers such as Vega and Lopez (2001) question the efficacy of existing cultural competence guidelines to reduce mental health disparities when there is a lack of standard operationalization, guidance, resources or support in implementation.

Two major criticisms raised by multicultural mental health advocates are that studies on treatment efficacy have insufficient consideration of cultural and ethnic/ racial factors or fail to include adequate information on ethnic/racial variables within sample populations (Hogg Foundation for Mental Health, 2006). Adequate representation of ethnic/racial populations in data gathered on the effect of a

treatment is a major concern in determining the level of external validity—effective 'real world' application—of clinical efficacy trials.

> **A note on culture in mental health**
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> As many studies and reports have indicated, differences in cultural beliefs and values are important to consider in mental health service delivery, as they affect treatment preferences and outcomes. Furthermore, culture impacts how individuals receiving mental health services
>
> - identify and express or present distress
> - explain the causes of mental illnesses
> - regard mental health providers
> - utilize and respond to treatment
>
> Hogg Foundation for Mental Health (2006)

- The 2001 Surgeon General's report found that between 1986 and 2001, 9,266 participants were included in randomized controlled trials evaluating the efficacy of interventions for bipolar disorder, schizophrenia, depression, and ADHD, and of these participants there were only 561 African Americans (6 percent); 99 Latinos (1 percent); 11 Asian Americans/Pacific Islanders (0.1 percent), and 0 American Indians/ Alaska Natives identified; and not a single study analyzed the efficacy of the treatment by ethnicity.

- In another study, an examination of 379 National Institute of Mental Health-funded clinical trials published between 1995 and 2004 in five major mental health journals found that fewer than half provided complete racial/ethnic information and fewer than half had large enough ethnic/racial representation for subgroup analyses (Mak, Law, Alvidrez, & Peréz-Stable, 2007).

Studies of treatment efficacy that have had significant representation of ethnic/racial population subgroups have provided somewhat promising evidence that EBPs may be successful within diverse populations. In reviewing such studies, Miranda et al. (2005) suggests that evidence-based care may successfully generalize to both African American and Latino populations as effectively as within White American populations. Due to lack of available information on the use of EBPs within Asian American or Native American populations, no conclusive statement could be made on the effect of EBPs in these groups.

- Some of the reviewed studies show that EBPs can be effective in communities of color if delivered as they would be in White majority populations (high levels of fidelity), such as IPT for depression treatment among African American adults.

- Other studies show that EBPs were effective as culturally adapted practices, which are treatments in which the basic therapeutic intervention remained intact but culture-specific issues and concerns were addressed in delivery of the service—such as the Kohn et al. (2002) study of CBT adapted for African American women with depression. Women in this study showed greater decreases in symptoms than women in the same demographic who were treated with unadapted CBT.

Adequate sampling of ethnic/racial populations in efficacy studies seems to be improving. For example, the Child and Adolescent Mental Health Division of the Hawaii Department of Health (2007) compiled information from 26 efficacy trials of CBT deeming this EBP to be a "best support" treatment of anxious or avoidant behavior problems among Asian, Black/African American, Caucasian, Hindu, Hispanic/Latino, Indonesian Dutch, and Multiethnic youth populations.

Though many EBPs note evidence within an ethnic majority population first and then test for generalizability to diverse populations, an evidence base may also be first established within a specific cultural group. Brief Strategic Family Therapy is an effective intervention for adolescent behavior problems and substance abuse for the general population, but initial efficacy studies were done with Hispanic families. It offers a model of EBP development and/or empirical validation within a specific population of interest (Family Therapy Training Institute of Miami, 2004).

Isaacs et al. (2005) suggest two approaches for ensuring culturally competent EBPs for children and families of color:

- Cultural adaptations of existing EBPs
- Utilization of culturally specific interventions: i.e., practice-based evidence models

Cultural Adaptations of EBPs

Cultural adaptations of EBPs are developing as one of the key methodological resources for working with culturally diverse populations in both research and practice settings (Bernal & Jiménez-Chafey). Examples of culturally adapted EBPs include the following:

- The GANA program is a version of Parent Child Interaction Therapy that has been culturally adapted for Mexican American families (as cited by Martinez, 2008).
- The Indian Country Child Trauma Center at the University of Oklahoma Health Sciences Center was created to examine cultural adaptation of EBP trauma-related treatment protocols and service delivery guidelines for tribal communities. To date, the center has created four successful culturally adapted interventions for Native American children and their families including trauma focused CBT and Parent-Child Interaction Therapy.
- With the intent of expanding available culturally adapted EBPs, the Hogg Foundation for Mental Health has established a grant program for them, devoting more than $2.9 million toward five programs for three years.

Practice-Based Evidence

Individuals within the cultural competence movement believe that an over-emphasis on the development and implementation of EBPs decreases attention to cultural variations in service delivery and tends to invalidate and/or exclude culturally specific interventions and traditional healing practices utilized in communities of color (Isaacs et al., 2005).

A concept developed to address this concern is practice-based evidence (PBE). PBE is defined as a set of unique and inherent cultural practices that have non-traditional evidence based upon community consensus (Martinez, 2008). PBE addresses the therapeutic and healing needs of individuals and families within a culturally specific framework.

While PBE practices may not have an empirical evidence base, Martinez (2007) points out that they are valuable for being responsive to and respectful of the community, prioritizing individualized care.

Examples of PBE evaluation and initiatives include the following:

- The Reinvesting in Youth Evaluation Study concluded that while practice-based interventions may be effective within a community, substantial resources are needed to refine these interventions and establish further evidence (Ja, 2008).
- In response to this need, the Community-Defined Evidence Project (CDEP)—a partnership between the National Network to Eliminate Disparities in Behavioral Health (see www.nned.net) and the National Latino Behavioral Health Association, in collaboration with the Department of Child and Family Studies of the Florida Mental Health Institute of University of South Florida—is developing a systematic approach for identifying criteria that constitutes community-defined evidence, a bottom-up approach as an alternative to the traditional top-down academic approach.

The cultural foundation of PBE is a contrast to the scientific basis of EBPs, and, in tandem, the two have the potential to effectively address wellness and recovery in diverse communities. (Isaacs et al., 2005).

Sullivan et al. (2005) playfully demonstrate the difference between the standardization of EBPs and the cultural adaptation of PBE:

> *Consumers who buy their hamburgers at McDonald's can rely on obtaining a standardized product. However, local hamburger stands may produce more tasty hamburgers* (p. 538).

- Sullivan et al. (2005) hypothesize that in utilizing a participatory research (bottom-up) model through collaboration between local providers in the South Central Veterans Healthcare Administration network and researchers, more relevant and sustainable interventions will emerge.
- Whitley (2007) argues that, ideally, EBPs would be tested among diverse populations in their local treatment settings and would be developed in a bottom-up manner in collaboration with cultural groups. Further, such research would infuse cultural competence in EBPs and, at the same time, create a larger evidence base for cultural competency.

Policy Considerations

The following recommendations were developed at a 2005 Consensus Meeting on Evidence-Based Practices for Consumers and Families of Color hosted by the National Alliance of Multi-Ethnic Behavioral Health Associations (as cited by Isaacs et al., 2005):

- **Communities of color must be included in the development of EBPs.** Development and testing of EBPs should be carried out in diverse communities and involve community stakeholders such as consumers and families.
- **Cultural competence must be defined and required for EBPs.** Cultural competence should be incorporated into the development and implementation of EBPs.
- **PBE must be taken into consideration as a critical component of EBPs in communities of color.** Culturally-specific practices and programs are effective but need to be further funded, documented, and tested.
- **The process of developing and credentialing EBPs needs to be modified to be inclusive of communities of color:** Working with communities by way of collaboration with key stakeholders and utilizing approaches such as participatory action research is key.
- **The process of implementing EBPs in communities of color must be supported with resources.** Support includes sustainable resources for systemic change as well as the retention of culturally specific practices and programs existing in a community system of care.

All individuals living with mental illnesses are entitled to effective services and supports that increase resiliency and help them move toward recovery. It is clear that EBPs are not the panacea of effective mental healthcare for all individuals. For mental health care systems to progress in this area, it is important that researchers and providers alike recognize the importance of cultural adaptation and community stakeholder involvement.

Resources

NAMI booklet, *A Family Guide ~ Choosing the Right Treatment: What Families Need to Know About Evidence-Based Practices*, offers valuable information to families about EBPs in children's mental health.

- PDF available to download: http://www.nami.org/Content/ContentGroups/CAAC/ChoosingRightTreatment.pdf
- Spanish-language HTML version: http://www.nami.org/Content/ContentGroups/CAAC/Recursos_en_Español.htm

Hogg Foundation for Mental Health's selected annotated bibliography of resources on cultural competence, EBPs, and cultural adaptation of EBPs: http://www.hogg.utexas.edu/programs_cai_bib.html

SAMHSA Center for Mental Health Services Evidence-Based Practices implementation toolkits, Evidence-Based Practices: Shaping Mental Health Services toward Recovery: http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits

SAMHSA National Registry of Evidence-based Programs and Practices (NREPP): http://www.nrepp.samhsa.gov/index.htm

SAMHSA: A Pocket Guide to Evidence Based Practices on the Web: http://www.samhsa.gov/ebpWebguide/index.asp

NASHMPD Research Institute, Inc. Center for Mental Health Quality & Accountability: http://www.nri-inc.org/projects/CMHQA/

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