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Through the Lens of Multiculturalism

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FEATURE

Evidence-Based Practice in Psychology: Challenges for Effectively Serving Ethnic Minority Populations

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In its most recent national convention, the American Psychological Association adopted a policy that (a) defined evidence-based practice in psychology (EBPP), (b) affirmed the importance and utility of using EBPs to enhance health, and (c) delineated the various principles that guide EBPP. The new APA policy defines EBPP as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences." Essentially, effective psychological treatment involves three essential processes: (a) applying the best available research evidence in the selection and application of treatments, (b) using clinical expertise that encompasses a number of competencies that have been found to promote positive therapeutic outcomes, and (c) being responsive to the patient's characteristics, culture, and personal preferences.

From a multicultural perspective, clearly psychological services are most effective when responsive to the patient's specific problems, strengths, personality, sociocultural context, and preferences. Thus, attending to sociocultural aspects of the patient is a critical and essential component of EBPP. However, since 1978, various presidential commissions have documented ethnic disparities in mental health in terms of the unmet mental health needs of members of ethnic minority groups such as African Americans, American Indians, Asian Americans, and Latino/as (Commission on Mental Health to the Surgeon General, 1978; President's New Freedom Commission, 2003). These commissions concluded that the disparities were not so much due to racial and ethnic differences in rates of psychopathology but were due to inaccessible and ineffective treatment. Ethnic minority clients often saw therapists or were administered treatments that did *not* provide consideration of the clients' lifestyles, cultural and linguistic backgrounds, and life circumstances. In view of the policy adopted by APA on EBPP, those very considerations involving the patient's culture and race are essential to effective psychological practice. Clearly, this is a major priority for EBPP and our profession.

The evidence-based practice movement appears to provide some impetus to reduce ethnic and racial disparities in mental health. After all, EBPP involves using those treatments that are effective according to controlled research studies in which the issue of generalizability must be considered. Likewise, a major competency associated with clinical expertise involves cultural competence, namely, the ability of the clinician to work with a client and provide treatment in a manner that is culturally meaningful and ecologically valid. Cultural competency can be defined as having the cultural knowledge and/or skills to deliver effective interventions to members of a particular culture. Finally, EBPP uses the best available evidence on patient characteristics, culture, and personal preferences to adapt the treatment to best serve a particular client. Nevertheless, the substantial promise of EBPP for addressing cultural diversity issues should be tempered by the fact that little of this "best available evidence" exists with respect to ethnic minority populations.

If we just consider the most researched aspect of the three essential components of EBPP, evidence-based treatments, the challenge to psychology for culturally competent EBPP becomes clear. The major problem in trying to use the EBP model to guide treatment interventions with ethnic minority clients is that relatively little research has been conducted on these clients, especially research that satisfies rigorous research criteria such as those involved in randomized clinical trials (RCTs) or empirically supported treatments (ESTs). In the case of ESTs (formerly named as EVTs or empirically validated treatments), Chambless and associates (1996) could not find a single rigorous study that examined the efficacy of treatment for any ethnic minority population. The U.S. Surgeon General (2001) reported that the gap between research and practice is particularly acute for racial and ethnic minorities. Research involving controlled clinical trials used to generate professional treatment guidelines did not conduct specific analyses for any minority group. Since 1986, about 10,000 participants have been included in randomized clinical trials evaluating the efficacy of treatments for certain disorders. For nearly half of these participants (N = 4,991), no information on race or ethnicity was given. For another 7 % of participants (N = 656), studies only reported the general designation "non-white." For the remaining 47 % of participants (N = 4,335), very few minorities were included; not a single study analyzed the efficacy of the treatment by ethnicity or race.

These earlier reviews did not include outcome studies conducted since the National Institute of Health mandated that grant applicants include adequate samples of minority, women, and children or explain why such samples could not be obtained. Some believe this mandate may have significantly increased treatment research on underserved populations, especially ethnic minorities. Findings from a recent study seem to indicate that even the most current treatment research programs are not producing "best available evidence" on minority populations or issues. The study involved a review of 379 NIMH-funded clinical trials published between 1995 and 2004 in the five leading mental health journals (Mak, Law, Alvidrez, & Perez-Stable, 2005). The investigators found that less than half of the studies provided information on the specific ethnic composition of their samples. Among those that specified their ethnic composition, most ethnic minority groups were underrepresented, notably Asian Americans, Hispanics, and Native Americans. White Americans continued to dominate as participants in clinical

trials (61% in studies that provided specific ethnic information). Moreover, few studies analyzed for ethnic or cultural effects.

Cultural competence is an important and necessary condition of evidence-based practice in psychology, and, as such, EBPP can be a great catalyst for reducing ethnic and racial disparities in mental health treatment and services. However, researchers and funding agencies have not paid much attention to addressing ethnic and cultural research that determines if these treatments are effective, in other words, culturally and ecologically valid. The conclusions reached by the President's Commission on Mental in the late 1970s are echoed today, some 35 years later, in the U.S. Surgeon General's Supplement (2001) and the President's New Freedom Commission (2003). Research is needed that is inclusive of ethnic minority populations but also explanatory in nature about the effects of cultural variables. Hopefully, the optimism and enthusiasm (as well as the controversy) generated by the EBP movement can energize the field to meet this critical challenge.

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CPA VICTORIOUS

In Retaining Independent Board of Psychology

In mid-September CPA, the legislative leadership, and the Governor's Administration worked out a compromise to extend the independent Board until 2008. SB 229 (Figueroa), the bill which will extend the Board of Psychology, was amended to reflect the compromise position. The bill passed with wide majorities in the Senate and Assembly and the Governor is expected to sign the bill. Our thanks go to all of you who helped us with this fight! We have laid the groundwork for what we know will be an ongoing battle to retain the Board of Psychology and the independence of psychology in California. We will continue to keep you informed.