

The Road to Evidence: The Intersection of Evidence-Based Practices and Cultural Competence in Children's Mental Health

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December 2005



“Today we are making
history, and assuring the
future”



“Hoy estamos haciendo
historia, y asegurando
nuestro futuro”

Acknowledgements

This paper was developed with support from the Annie E. Casey Foundation and a contract with DB Consulting Group (Contract #280-02-0101), a logistics contractor for the Child, Adolescent and Family Branch (CAFB), Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA). However, the views expressed in this paper are those of the authors only and do not represent the views of either the Annie E. Casey Foundation, DB Consulting Group, or the federal government.

The authors would also like to thank all the participants who attended the National Alliance of Multi-ethnic Behavioral Health Associations (NAMBHA) Consensus Meeting on Evidence-Based Practices and Communities of Color. The meeting was held in Chicago, Illinois in September, 2005 and was composed of consumers, family members, and community providers from the National Latino Behavioral Health Association (NLBHA), the National Leadership Council for African American Behavioral Health (NLC), the First Nations Behavioral Health Association (FNBHA) and the National Asian American/Pacific Islander Mental Health Association (NAAPIMHA). In addition, representatives from various divisions within the Center for Mental Health Services and the Center for Substance Abuse Treatment also attended and participated in the meeting. Consensus statements developed at this meeting are highlighted in the Policy Implications and Recommendations section of this document. We would like to acknowledge the importance of the rich exchange of knowledge at this meeting as a major influence on the final version of this policy paper.

The authors would like to thank the team at the Florida Mental Health Institute, University of South Florida, Tampa, for their major contributions to the production of this paper. We would like to thank Teresa Nesman, Laurel Friedman, and Debra Mowery for their contributions to the literature review, content, and editing of the paper. Special thanks also go to Linda Callejas and Maya Harper for their final reading and editing of the paper. Finally, sincere thanks to Victor Trinidad for his excellent format design and lay-out of the paper for publication.

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Overview

This policy paper on the intersection of evidence-based practices (EBPs) and cultural competence grows out of recent research findings and policy trends that encourage greater use of EBPs in clinical programs with children, adolescents, and their families to improve the quality of care and outcomes of mental health interventions. In fact, the use and expansion of EBPs in mental health care are considered a major component in the transformation of the mental health system as envisioned by the President's New Freedom Commission (2003). The report notes that "in a transformed mental health system, consistent use of evidence-based, state-of-the-art medications and psychotherapies will be standard practice..." (p. 12). At the same time, the Commission report highlights the importance of eliminating disparities in mental health care for culturally diverse populations and rural and geographically remote areas (Goal 3). The Commission report states that the way to do this is to recognize cultural competence as an essential element in improving services and systems and in reducing current gaps and disparities. They also recommend greater efforts to diversify the mental health workforce.

Many consider greater access to appropriate services and a more culturally competent workforce to also be critical to the successful transformation of the mental health system.

Yet, discussions of EBPs and cultural competence commonly take place at separate tables and with two distinct sets of stakeholders (Hall, 2001). There have been few attempts to integrate or coordinate these two important components of mental health transformation. This policy paper seeks to explore the reasons for the lack of intersections between two simultaneous movements within the mental health field and to determine whether the well-being and mental health of the increasingly diverse populations in the United States can be achieved through these separate and unequal silos. This paper will explore the reasons for the lack of interaction between these two major trends and suggest approaches that better blend EBPs and cultural competence so that the probability of improvements in access, quality and outcomes in mental health services for

diverse populations can be achieved.

A substantial body of research suggests that disparities in mental health care for diverse populations are widening, especially as it relates to access, availability, quality, and outcomes of care. These continuing and persistent disparities are troubling, given that racial and ethnic groups are the most rapidly growing segments of the U.S. population and currently are either underserved and/or inappropriately served in the mental health system (President's New Freedom Commission on Mental Health, 2003). Collectively, ethnically/racially diverse populations experience a greater disability burden from emotional and behavioral disorders than do white populations (Huang, 2002; USDHHS, 2001a). This higher disability burden is partially attributed to receiving less care (Bui & Takeuchi, 1992; Chabra et al, 1999; Costello, Farmer & Angold, 1997; Cunningham & Freiman, 1996; Juszczak, Melinkovich, & Kaplan, 2003; Novins, Beals, Sack, & Manson, 2000; Novins et al, 1999; Pumariega, Glover, Holzer, & Nguyen, 1998) and poorer quality of care (Walkup, McAlpine, & Olfson, 2000; Wang, West, & Tanielian, 2000; Young, Klap, & Sherbourne, 2001), rather than from mental disorders being inherently more severe or prevalent in racially/ethnically diverse populations (U.S. Department of Health and Human Services [USDHHS], 2001a). In general, these disparities have been attributed to an inadequate ability of publicly-funded mental health systems to understand and value the need to adapt service delivery processes to the histories, traditions, beliefs, languages and values of diverse groups. This inability results in misdiagnoses (Fabrega, Ulrich, & Mezzich, 1993; Kilgus, Pumariega, & Cuffe, 1995; Malgady & Constantino, 1998; U. S. Department of Health and Human Services [USDHHS], 2001a; Yeh et al, 2002), mistrust, and poor utilization of services by ethnically/racially diverse populations (Snowden, 1998; Takeuchi, Sue, & Yeh, 1995; Theriot, Segal, & Cowsert, 2003; USDHHS, 2001a).

The introduction of evidence-based practices (EBPs) would appear to be a solution to the misdiagnoses and poor outcomes that so many in diverse populations have encountered in the mental health system. However, it is equally as likely that EBPs could exacerbate and deepen existing inequities if they are implemented

without sufficient attention to cultural competence and/or if policymakers fail to take into account the many practices within diverse communities that are respected and highly valued by these groups. Such practices may not be considered “evidence-based” as they often lack access to research and evaluation funds that are critical for studying the efficacy and effectiveness of mental health interventions. Therefore, in order to ensure that these disparities do not widen further or that children and families of color are not further burdened with less than state-of-the-art care, this paper explores what it means to focus a culturally competent lens on EBPs. The implications of this lens for both governmental policy and research strategies are also examined.

In summary, this policy paper will address the following:

- The current knowledge base related to cultural competence. i.e. definitions, population parameters, and major characteristics/components of cultural competence, as well as the major shortcomings of this approach from the perspective of greater inclusion in EBP development;
- The current knowledge base related to EBPs – what they are, criteria used for identification, and core characteristics of currently recognized EBPs, as well as the concerns about their use and applicability for diverse populations;
- The need for policy and research that requires building cultural competence into EBPs and the critical inclusion of field-based models (i.e. practice-based evidence (PBE) models) in mental health service delivery structures; and,
- Recommendations from the field for better integration of EBPs, PBE models, and cultural competence.

Cultural Competence: Origins, Definitions, and Characteristics

The cultural competence movement crystallized in the late 1980’s under the leadership of ethnic minority mental health practitioners, administrators, policy makers,

families, consumers, and community leaders. These leaders in the public sector drew attention to the disparities in access to quality services; the frustrations of communities of color in securing needed treatment for their children, adults, and families; and the structural racism and discrimination in the mental health care system (Cross, Bazron, Dennis, & Isaacs, 1989).

In many ways, those who initially conceptualized “cultural competence” viewed it as a strategy for addressing the inherent racial/ethnic disparities that prevailed in mental health systems for children and families at that time. Cross et al. (1989) aptly noted that children of color lacked access to mental health services and often found themselves in more punitive settings, such as juvenile justice and child welfare, rather than receiving therapeutic interventions in the mental health system. When these children did become involved in mental health systems, they were more likely to be placed in restrictive settings, such as residential and other out-of-home/out-of-community placements. Cross et al. (1989) noted that even when children of color received mental health services they did not receive the same quality of care as their white counterparts.

In response to these and other disparities, Cross et al. (1989) strongly recommended that mental health and other child-focused systems serving children with emotional disturbances, become more culturally competent. Cultural competence was introduced as a process for addressing disparities, based on race, ethnicity, and culture, within mental health care for children and their families. Cultural competence was defined as:

a set of behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables them to work effectively in cross-cultural situations. . . . Cultural competence is the acceptance and attention to the dynamics of difference, the ongoing development of cultural knowledge, and the resources and flexibility within service models to meet the needs of minority populations (Cross et al., 1989, p.1).

Cultural competence was also viewed as a “developmental process” – one in which both individuals and organizations could be engaged. The core elements of cultural competence

– valuing diversity; cultural self-assessment; understanding cross-cultural differences; institutionalization of cultural knowledge; and adaptation of policies, services, and structures based on diversity – implied the types of strategies that might be utilized to implement cultural competence. Finally, Cross et al. (1989) suggested that cultural competence should be viewed as a continuum, ranging from cultural destructiveness to cultural proficiency, thus enabling an individual or an organization to establish a baseline and measure progress.

The importance of culture as a factor in all aspects of behavioral health care was reinforced and elevated with the publication of the Surgeon General's Supplemental Report, *Mental Health: Culture, Race and Ethnicity* (USDHHS, 2001a). This report noted that one of the fundamental weaknesses of behavioral health services and research has been the failure to recognize the importance of culture in the epidemiology, conceptualization, treatment, recovery, and prevention of behavioral health disorders. The report highlights the pivotal role culture should play in designing and implementing behavioral health services for communities of color. Simply stated, the report identified culture as a factor that influences what people bring into the mental health service setting. This includes: how communities define wellness and mental illness; how consumers and their families communicate about and express their symptoms; how and from whom help is sought; the types of coping styles and social supports that are utilized; and, the level of stigma attached to mental illness.

Given the significance of culture, strategies have been suggested for improving access and quality of care for diverse populations, including addressing key organizational factors such as fragmentation, availability and cost of services, stigma about mental illness, mistrust and fear of treatment, different help-seeking styles, different conceptualizations of illness, racism/discrimination, and language and communication patterns (Huang, 2002). Strategies have also been suggested for increasing cultural competence in larger systems and at the service level. (Smedley, Stith, & Nelson, 2003), such as resource allocation and financial incentives for treatment of racial/ethnic minorities, interpretation services, communication and trust-building between

providers and clients, appropriate screening, preventive and evidence-based care adapted to specific populations, and payment systems that ensure equitable care (Smedley, et al., 2003). Kouyoumdjian, Zamboanga, & Hansen (2003) also made recommendations for (a) increasing the dissemination of information about services, addressing challenges associated with time, costs, and location of services; and (b) continuous efforts to better educate mental health practitioners, physicians and clergy about culturally sensitive approaches. Service-level recommendations included increasing proportions of underrepresented minorities in health professions, providing culturally appropriate patient education and cross-cultural training for staff, use of community health workers and multidisciplinary teams, and collecting, reporting and monitoring patient access and utilization by race, ethnicity, socio-economic status (SES) and primary language (Smedley, et al., 2003).

Culture also influences the professionals and agencies treating children and families. Behavioral health professionals in the United States are trained in practices rooted in Western medicine. An example of this training issue comes from the American Psychiatric Association (APA), as reported in the Surgeon General's Report (1999). The APA identified that diagnostic assessments based on the widely used DSM-IV classification system used to train mental health professionals can be problematic when clinicians apply the DSM-IV categories to the evaluation and eventual diagnosis of an individual from a non-western ethnic or cultural group. Further, the APA expressed concerns that a clinician not familiar with an individual client's cultural frame of reference could incorrectly judge normal culturally bound variations in behavior, beliefs, or experience as psychopathological.

EBPs: Current Definitions and Characteristics

Promoting and requiring the use of EBPs is a current nationwide trend to build quality and accountability in health and behavioral health care service delivery (Drake, Goldman, Leff, Lehman, Dixon, Mueser, & Torrey, 2001; Kiesler, 2000; Victora, Habicht, & Bryce, 2004).

Underlying this concept are: (1) the belief that individuals with mental health disorders should receive care that meets their needs and is based on the best scientific knowledge available; and (2) the fundamental concern that, for many of these individuals, the care that is delivered is not effective care. This movement to evidence-based practice is described as the “new revolution” in health care that focuses on assessment and accountability (Kiesler, 2000). Although there are many questions about the definition of “evidence-based” practices and what constitutes the “evidence” that supports their use (Chambless & Hollon, 1998; Chambless & Ollendick, 2001; Jensen et. al, 2005; Messer, 2004; O’Donohue, Buchanan & Fisher, 2000; Sackett, et. al, 1996; Tanenbaum, 2005), it is clear that policy trends are toward greater adoption and promulgation of EBPs (Carpinello, et. al, 2002; Chorpita, 2003; Goldman et.al, 2001; Hawaii Department of Health [HDH], 2004; Virginia Commission on Youth [VCY], 2003).

There is consensus in the field that the most widely held doctrine in the working definition of evidence favors results produced from randomized clinical trials (RCTs) or single case studies conducted by multiple investigators in multiple sites for specific problems, populations, and settings (Consensus Statement on Evidence-Based Programs and Cultural Competence, 2003). Although some researchers and policymakers recognize other research practices as effective (Victoria, et al., 2004), without clear scientific evidence produced through an RCT, many mental health practices are classified as only ‘promising’ rather than ‘evidence-based’. However, the Institute of Medicine (IOM, 2000) offers a more expansive and comprehensive definition of evidence-based practice. The IOM (2000) defines EBPs as “...the integration of the best research evidence with clinical expertise and patient values” (p. 147). A similar definition, approved by the American Psychological Association (2005), mirrors the IOM definition and states that evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. These definitions make it clear that EBPs involve the incorporation of research, but not in lieu of clinical expertise and consumer values/choices.

Despite this broader conceptualization of EBPs, prevailing thought and implementation in the field still seem to emphasize only the “scientific” underpinnings of interventions. For example, the National Registry of Evidence-based Programs and Practices (NREPP) guidelines were recently published in the Federal Register (2005) for comment and review as part of a federal effort to expand and refine NREPP’s ability to better serve as a leading national resource on the scientific base and efficacy of mental health and substance abuse prevention and treatment interventions. The NREPP Request for Comments process was also, in part, seeking policy guidance on how best to use NREPP to appropriately select and promulgate specific interventions that, in addition to other factors, included contextual information such as level of clinical expertise needed and consumer/family values. However, following a two year series of scientific/stakeholder panels, it is proposed that all practices and programs be categorized using a four-level scale that ranges from “strong evidence with replication” to “emerging evidence without replication”. Although such a continuum would seem to eliminate the issues related to definition and provide a strategy to accommodate programs at various stages of development, it also reinforces the notion that some programs are supported by stronger evidence than others, with an emphasis on internal validity at the expense of external validity (Rogler, 1999; Sue, 1999). As policymakers, insurers, funders, and others seek cost-effective approaches to providing mental health care, there is a fear that the proposed NNREP program schemata will lead to greater restrictions on the types of interventions that can be offered and reimbursed.

Unlike cultural competence, which is essentially a field-based movement, the EBP movement has been promoted by researchers primarily in academic settings typically working with non-diverse populations (Sue, 1998). With the results of landmark studies in the 1990s, such as the Schizophrenia Patient Outcome Research Team study (Lehman & Steinwachs, 1998) and the Multimodal Treatment Study of ADHD (MTA Cooperative Group, 1999; Richters, Arnold, Jensen, Abikoff, Conners, Greenhill, Hechtman, Hinshaw, Pelham, & Swanson, 1995), federal funding expanded research focused

on identifying effective interventions for individuals with various mental health disorders. At the same time, mental health services research and evaluation also expanded. In its early stages, the EBP movement rarely involved consumers or family members nor did it explicitly embrace principles of cultural competence. Its primary focus was to build empirical support for interventions tested in controlled environments, which were often divorced from the every day realities of individuals with complex mental health disorders. For example, EBPs are usually associated with specific isolated conditions (e.g., cognitive behavioral therapy for depression; psychosocial interventions and medications for ADHD) rather than the types of multiple and co-morbid conditions that children and their families from diverse populations frequently experience (Miranda et.al, 2005).

When Worlds Collide: EBPs and Cultural Competence*

There is general agreement among all mental health professionals and researchers that there is a need to produce better outcomes for those receiving mental health care. Many of those involved in the development of EBPs believe that this is best achieved through the application of scientific methodologies and that “science” trumps culture. Those who are proponents of cultural competence believe that science is important, but that culture and other social factors, such as class, race, gender, and place, cannot be ignored. In terms of ability to produce better outcomes for ethnic minority consumers and families, “culture” may, in fact, trump science. Also known, but seldom discussed, is that the two movements operate from two different perspectives and with two different worldviews (Nagayama Hall, 2001; United Advocates for Children of California [UACC], 2005). Given the current status of integration between these two worldviews, it is safe to say that there is a real possibility that these “worlds will collide” rather than successfully collaborate.

In a series of articles that appeared in the Washington Post, June 26-28, 2005 entitled

Culture and Mind: Psychiatry’s Missing Diagnosis, Post reporter Shankar Vedantam succinctly captured the different perspectives currently dominating the growing debate in the mental health field at this time: the medical model, best exemplified by the emphasis on brain research and evidence-based practices; and the cultural perspective, best exemplified by those who call for greater attention to culture, race, ethnicity, class, and gender in the application of mental health diagnoses and treatment. Vedantam stated this polarity as follows:

Scientists have broadly played down the role of cultural factors in the diagnosis, treatment, and outcome of mental disorders. In part, this is because modern psychiatry is based on the idea that mental illnesses are primarily organic disorders of the brain. This medicalized approach suggests that the symptoms, course, and treatment of disorders ought to be the same whether patients are from the Caribbean, Canada, or Cambodia. This model has produced striking successes. Neuroscientists have uncovered key details about how the brain functions and malfunctions, and drug companies have found many effective medications. More patients than ever before have received treatments that have been proven to work... Advocates for cultural competence counter that no matter how much science learns about the brain, culture and the environment will continue to play a huge role in why people develop emotional problems, what treatments they respond to, and whether they recover. Doctors, they say, cannot afford to ignore the numerous effects of culture on diagnosis and treatment that have been documented through various streams of evidence and multiple studies in peer-reviewed publications (Vedantam, 2005, p. A01).

Vedantam’s piece essentially captured the polemics that currently guide the stances of those stakeholders associated with science and those associated with culture. They are seemingly opposites rather than complementary in their work. The arguments for or against EBPs and for or against cultural competence are complicated by

*This is a phrase coined by Karen Blasé, Ph.D., National Implementation Research Network, Florida Mental Health Institute, University of South Florida, Tampa.

the fact that within each of these efforts there are challenges that could best be resolved by working in tandem.

Challenges Confronting Cultural Competence

While the concept of cultural competence (Cross et al., 1989) has gained widespread recognition and provoked changes in thinking about serving diverse communities in the past 30 years (Hernandez & Isaacs, 1998; Huang, 2002), much work remains before the concept can be effectively implemented for purposes of reducing mental health disparities (Vega & Lopez, 2001). One explanation for this is that cultural competence, as developed by the early authors, has remained largely an ideological framework with a set of guiding principles. The lack of operationalization (Vega & Lopez, 2001) of the framework has largely been due to implementation being left to the provider field without adequate guidance, resources or support. Greater understanding is needed about how and what organizational and interorganizational practices reduce barriers to care (Snowden, 1998; USDHHS, 2001b). Sue (2003) suggests that operationalization is an important step toward being able to test the effectiveness of cultural competence in improving mental health service delivery.

Some attempts have been made to operationalize characteristics of exemplary culturally competent mental health programs and to survey states in order to measure the degree of implementation of policies and practices that utilize culturally-competent principles (Isaacs & Benjamin, 1991; Isaacs, 1998). However, research on how effectively culturally competent organizations/systems improve access, utilization, and quality of care, is limited (President's New Freedom Commission on Mental Health, 2003; Takeuchi, et al., 1995). Research that focuses on systematic application and measurement of operationalized indicators of cultural competence is needed in order to improve access to services and reduce mental health disparities for diverse children and their families served by local systems of care and state child mental health programs.

Given the paucity of research efforts devoted to exploration of cultural competency, those who

are EBP researchers and proponents often believe that the concept of cultural competence lacks scientific rigor and documentation. Many of the challenges affiliated with implementing cultural competence have been summarized by Isaacs (2005). These include:

- Lack of definitional clarity and an operational framework and strategy
- Lack of synergy and sustained attention
- Lack of uniformity across human service sectors and professional disciplines in mental health
- Over-reliance on non-validated self-assessment protocols
- Lack of evaluation and empirical research

Lack of definitional clarity and an operational framework and strategy. There are many definitions of cultural competence (Betancourt, Green, & Carrillo, 2002; Betancourt, Green, Carrillo, & Park, 2005; Cross et al., 1989; Roberts et.al, 1990; Siegel, Haugland, & Chambers, 2004; USDHHS, 2001b). The field has spent an inordinate amount of time defining and re-defining the concept, as there has been resistance to the notion of “competence” as well as confusion with other concepts such as cultural diversity, cultural awareness, cultural sensitivity, and multiculturalism. The “noise” related to the definition has served to arrest the development of cultural competence at a conceptual level and made it more difficult to move towards operationalization (Geron, 2002). Without consensus on the major components that make up cultural competence, it is difficult to create a set of measurable outcomes for research and evaluation purposes, or to provide clear guideposts for systems change and transformation. In their review of the health literature, Brach & Fraser (2000) found that every organization and author they reviewed defined cultural competence differently. However, they noted that most are variants of the Cross et al. (1989) definition.

To validate the lack of definitional clarity of cultural competence, Cunningham, Foster, and Henggeler (2002) found that experts disagree about the specific characteristics that comprise the cultural competence construct. The lack of consensus about a definition and

the core elements and characteristics of cultural competence is a significant stumbling block to its implementation. According to Huang, Isaacs, & Ida (2004) variations in both definitions and differential understandings of cultural competence are disturbing because they make it more difficult to measure and describe the impact of culturally competent practices on mental health and related service systems.

More recently, federal agencies and other organizations have modified the term to “cultural and linguistic competency”, a redundancy in the sense that use of language and communication processes are essential characteristics of culture and are culture-bound. In other words, one necessary aspect of cultural competence is linguistic competence and language access (National Association of State Mental Health Program Directors [NASMHPD], 2003). This new phrase has tended to place greater emphasis simply on language access at the neglect of many other critical cultural factors. Although linguistic competence is extremely important in implementing cultural competence, especially when there are significant populations that do not speak English, it is important that the implementation of cultural competence not be consigned simply to translation of materials and interpreters. Sometimes, by emphasizing this one dimension of cultural competence, organizations have neglected other iterations of culture that are also crucial.

Lack of synergy and sustained attention.

Given the lack of clarity in definition, it should not be surprising that cultural competence efforts have been somewhat scattershot and limited by meager budgets, limited human resources, and superficial starts with wavering political will (Huang & Isaacs, 2004). Federal, state and local efforts have lacked the necessary commitment and sustained energy that would create the level of synergy needed for system change and transformation. This is not to imply that states and local systems of care have not undertaken many activities related to cultural competence. However, with few exceptions, those activities targeted to produce as cultural competence, such as training, have not been sustained nor have they been sufficiently integrated into organizational structures and functions to demonstrate their long term impacts. Many of these cultural competence activities have been undertaken

in response to federal mandates and funding expectations rather than as a result of local and state analyses and planning outcomes (Isaacs, 1998). Like all real transformation efforts, cultural competence requires time and high levels of commitment in order to trigger sustainable change within a service system or program.

Lack of uniformity and cross-fertilization.

Closely related to the inability to create the necessary synergy for change is the lack of uniformity across human service sectors and professional disciplines. For the most part, physical health, mental health, substance abuse, child welfare, and academia all have separate initiatives related to cultural competence, with different budgets, trainers, participants, curricula, and requirements. Thus, there is no consistency or uniformity of effort to support a core set of knowledge and skills regarding cultural competence across disciplines or systems. This lack of uniformity creates great variability in the quality of training and in the associated knowledge and skills acquired (Betancourt et al., 2005). Most cultural competence training has focused on the philosophical framework of cultural competence and the related individual and organizational change process, with some discussion of organizational assessment resources. Fewer training opportunities are offered that specifically focus on improving cultural competence at the clinical practice levels and implementing an organization-wide process and approach. This lack of uniformity, and sometimes competing frameworks, also fragment effective research and demonstration efforts as there is no agreement on methods, approaches, or underlying assumptions and goals. For example, is the goal of cultural competence efforts improved access and quality of care, or reduction of disparities and equity? Are these the same or different goals?

Over-reliance on non-validated self-assessment protocols.

There have been attempts to measure culturally competent practices and to evaluate their implementation in organizations and their associated practice settings. Many self-assessment instruments have been developed to measure both individual and organizational cultural competence (see Amherst H. Wilder [AHM], 2002; Andrusis, Delbanco, Avakian, & Shaw-Taylor, 2004; Campinha-Bacote, 2002; Child Welfare League of America [CWLA],

2002; The Lewin Group, 2002; Siegel, Haugland, & Chambers, 2002; Siegel et al., 2004). The National Cultural Competence Center (NCCC) at Georgetown University collects and provides samples of self-assessment tools on their website (www.nccc.georgetown.edu). For example, an organizational self-assessment protocol developed by the Lewin Group (2002) for health related organizations identified domains and focus areas as well as indicators for measurement of cultural competence. However, the developers and users of this protocol have suggested the need for further refinement of performance domains and indicators, definitions and validation of performance measures, identification or development of data collection instruments and data sources, and additional field-testing in order to apply the self-assessment protocol across a variety of settings. Critiques of cultural competence self-assessment tools suggest that most lack scientific reliability and validity (Geron, 2002; Harper et al, 2006; Sue, 2003).

Further development of assessment instruments specific to children's mental health services would contribute new knowledge that can assist in reaching the Surgeon General's goal of being responsive to the cultural concerns of racial/ethnic minority groups, including their languages, histories, traditions, beliefs and values (USDHHS, 2001a). For example, identification and description of key organizational practices related to improved access and utilization could be essential for the creation of measures to monitor effectiveness and promote quality improvement (Takeuchi, et al., 1995). Furthermore, the operationalization of cultural competence could contribute to its recognition as an important aspect of organizational behavior and its incorporation into the regular functions of management (The Lewin Group, 2002). Recent developments in cultural competence assessment protocols are encouraging because there is a growing possibility that there are common domains of cultural competence that can be subjected to more rigorous analyses (Center for Mental Health Services [CMHS], 1997; Harper et al, 2006; The Lewin Group, 2001; The Lewin Group, 2002; The Ohio Department of Mental Health and The Outcomes Management Group, Ltd., 2002; Siegel et al., 2000; Siegel et al., 2002).

Lack of evaluation and research. There have been few empirical studies of cultural

competence. Those that have been undertaken to determine the impact of cultural competence on practice and client outcomes have been mixed and inconclusive (Campbell & Alexander, 2002; Ridley, Baker, & Hill, 2001). The supplement to the Surgeon General's report (USDHHS, 2001a) noted that "no empirical data are yet available as to what the key ingredients of cultural competence are and what influences, if any, they have on clinical outcomes for racial and ethnic minorities" (p. 36).

Although research on cultural competence is vitally necessary, it has not been a priority for mental health research institutions. Further development of cultural competence cannot be sustained without ongoing feedback from evaluation and discovery from research. As reported in the American College for Mental Health Administration's (ACHMA) Summit on Reducing Disparities in Behavioral Health, Davis (2003) concluded that:

...the level of scientific knowledge, as shown in high quality epidemiological studies of people of color and behavioral disorders, is minimal... These populations are often left out of samples or the analysis of the data does not focus on differences by culture or ethnicity (p.4).

The background paper for the President's New Freedom Commission, developed by the Subcommittee on Cultural Competence (Huang, Isaacs, & Ida, 2004), also suggests that basic research is needed to determine the effectiveness of cultural competency measures on reducing disparities. Research that clearly delineates the measurable and implementable components of effective cultural competence is needed.

A substantive literature review of cultural competence in health-related disparity issues also reached the same conclusion. Brach and Fraser (2000) stated that:

Unfortunately, at this point there is little by way of rigorous research evaluating the impact of particular cultural competency techniques on any outcomes, including the reduction of racial and ethnic disparities... Most linkages among cultural competency techniques, the processes of health care service delivery, and patient outcomes have yet to be empirically tested... Amassing this evidence is an essential step if

cultural competency is to be widely adapted by health systems...Rigorous research on cultural competency would both enable the testing of cultural competency's theoretical premises and provide health systems with constructive information about which techniques are most successful and under what circumstances (p. 203).

In general it cannot be said that cultural competence in mental health has not been addressed. Rather, there has been sporadic and uneven progress in the field with limited focus on sustained implementation (NASHMPD, 2003). Thus, the challenges discussed have provided ample opportunities for EBP researchers and proponents to ignore and minimize the need to address cultural competency in their development of model interventions and in the efficacy and effectiveness trials of their treatment protocols.

The Challenges Confronting Evidence-Based Practices

Despite the issues related to implementing cultural competency, EBPs face many similar challenges of their own. In a survey of attendees at an annual research conference on children's mental health, Fixsen, Wallace, and Naoom (2005) asked participants to identify the top five reasons not to use evidence-based programs. The surveyors distilled the three most frequently mentioned responses which were: the research base for EBPs is not convincing; evidence-based programs are incomplete given the problems practitioners face; and, the infrastructure for implementation does not exist or is not supported.

In addition, EBPs, like cultural competency, also lack definitional clarity in the field. There are currently numerous lists of EBPs promulgated by different agencies and organizations. Although there is overlap, the listings of EBPs often contain different program models and services. Family members and consumers also question the efficacy of EBPs, as they typically do not include extensive family or consumer participation in their development and seem to lack the integration of "values and beliefs" that have been found to be important to families in the treatment of their children (California Institute of Mental Health [CIMH], 2004; UACC,

2005). Finally, Jensen et al. (2005) suggested that EBPs may not have as much "evidence" as they claim, since so many factors, such as attention, empathy, belief, expectations, and values are not controlled or ruled out as possible reasons for positive outcomes reported in most studies of EBPs. Jensen et al. (2005) concluded that there is not sufficient evidence and that more vigorous research needs to be conducted on those practices that are currently labeled as EBPs.

In addition to these concerns from the field, cultural competency proponents have identified a number of specific issues and concerns related to EBPs from their perspectives. These include:

- Inadequate inclusion of ethnic and cultural groups in study samples
- Lack of analyses on the impact of ethnic, linguistic, or cultural factors
- Limited resources devoted to research on culturally-specific practices
- Lack of theory development related to the relationships between culture, mental health disorders, and treatment
- Absence of culturally relevant treatment outcomes
- Limited involvement of ethnically and culturally diverse researchers

Inadequate inclusion of ethnic and cultural groups in study samples. Most treatment efficacy and effectiveness research has not included large numbers of ethnic and cultural minorities (Blasé & Fixsen, 2003; Miranda, et al., 2005; Sue, 1998). As a consequence, this research may have limited applicability and acceptability to these groups. In recognition of this concern, the National Institutes of Health (1994) created policy guidelines requiring the inclusion of ethnic minority persons in federally funded research projects. Hernandez and Isaacs (2004) conducted a review of all studies funded by the National Institute of Mental Health (NIMH) since this policy was enacted, through the CRISP database, to determine the number of grants awarded from 1995 through 2003 that included or focused on mental health research with minority child and adolescent populations. Of a total of 3,470 awarded grants, 579 or 16% included or focused on one or more groups of minority children. The percentage of grants focusing on minority youth is only a small fraction of the total grants awarded

by NIMH, and the percentage is far below their representation in the U.S. population. For example, African Americans constitute 13 percent of the national population, yet in the year 2003 grants targeting African American children were only 8.5% of the total NIMH grants awarded. The data were even more striking for Latinos who then made up 13% of the population but were only included in 4.6% of NIMH awarded grants. Native American youth were only included in 2.1% and Asian American/Native Hawaiian and Other Pacific Islander youth in 1.4% of the awarded grants. Since many of the awarded grants did not all focus on treatment effectiveness, the actual percentage of studies targeting mental health practice for these populations is even smaller. The need for increased attention to prevention and treatment effectiveness for ethnic minority youth is even more critical when one examines the continuing disproportionality of these youth in the child welfare, special education, juvenile justice and, later, adult corrections systems (Cross et al, 1989; President's New Freedom Commission, 2003).

Clearly research needs to focus on culturally diverse groups (Miranda et al., 2005; Miranda, Nakamura, & Bernal, 2003; Nagayama Hall, 2001; Sue, 1998). However, there are obvious methodological and practical limitations to this solution. A compromise between reliance on the general applicability of an EBP across diverse ethnic and cultural groups and promotion of culturally-specific practices will need to be reached. Additionally, while it is important to conduct research involving specific cultural communities, their roles should not be limited to being just "subjects" of research. It is imperative that more extensive partnerships be developed with diverse communities so that they can participate fully in the design, implementation, and evaluation of promising and best practice models (Miranda et al., 2003).

Lack of analyses on the impact of ethnic, linguistic, or cultural factors. When diverse groups are included in a study's sample, the numbers are often so small that ethnic and cultural factors cannot be included in the analyses (Miranda et al., 2003). In such cases, the use of randomized controlled trials may not be the most effective or appropriate approach for more fully determining the mental health needs and preferences of populations of color (Miranda

et al, 2003). A greater effort to sample diverse cultural groups and employ qualitative and other research strategies that are appropriate for small sample sizes need to be implemented.

The American Indian Research and Program Evaluation Methodology (AIRPEM) work group addressed these issues and detailed cultural considerations as part of best practices in research and program evaluation. Also reinforced was the need for participatory research approaches and corresponding attention to cultural, socio-economic, ethnic life style, and life span issues (Davis et al, 2002). Clearly, the broader research field needs to consider recommendations from their ethnic minority counterparts and make the cultural analyses and sample size issues a focus of deliberation.

Limited resources devoted to the research of culturally specific practices. Culturally-specific practices often arise from ethnic-specific services and community-based organizations. Many of these organizations lack the capacity and resources to do more than offer services. Mainstream research organizations have not been motivated and often lack the cultural knowledge, skills and incentives to partner with these organizations. Federal and private funding agencies have not viewed research of ethnic and culturally-specific practices as a priority. As a result, the research literature on culturally specific practices remains sparse (Sue, 1999).

In addition to actual direct service practices, organizational factors play a significant role in the ability to test, disseminate, and deploy culturally-specific practices. Systematic research that focuses on organizational factors, and related economic and political factors, that impede or enhance the effective implementation and sustainability of culturally-specific practices is also needed.

Lack of theory development related to the relationships between culture, mental health disorders, and treatment. Given the rapidly growing population of ethnic and cultural groups, and the importance of cultural variables in conceptualizing mental health needs and seeking and participating in treatment, it is critical to increase efforts to develop and test theories about how these variables influence mental health and subsequent responses to treatment (Miranda et al., 2003; Nagayama Hall, 2001; Rogler, 1999). The lack of theory development is directly related to the definitional confusions within both the

EBP and cultural competency movements and the inability to reach consensus on a universal set of broad results and outcomes. Theory development is also stymied by the complexity of the relationships between culture and mental health and the many important related factors that would need to be reviewed, i.e. levels of acculturation, language accessibility, socio-economic status, region of the country, family structure, community efficacy, etc. Further, theory development may need to take into account that some mental health practices will be expected to be effective across all groups while others may need to be culturally-specific/sensitive.

The absence of culturally relevant treatment outcomes. Some mental health stakeholders have argued that the outcomes that are traditionally studied in the EBP literature are less relevant to diverse ethnic or cultural groups (Nagayama Hall, 2001; Rogler, 1999). For example, professionals of color note that “independence” is often a desired outcome for adult and adolescent clients in the mental health system but “interdependence” may be a more culturally appropriate and acceptable outcome of mental health interventions for racial and ethnic group populations. Although an increase in the inclusion of culturally relevant outcomes will strengthen efficacy/effectiveness research, it is reasonable to assume that while many of the traditional goals that have been the focus of efficacy/effectiveness studies have relevance across many ethnic and cultural groups, how they are measured may be different depending upon the group being researched. Examples of such goals are increasing mood and energy amongst individuals experiencing depression, reducing recidivism among individuals at-risk of criminal behavior, and improving parent-child relationships and school performance among children at-risk of conduct disorder and school failure. New ways to identify relevant outcomes need to be developed rather than relying on simple inclusion of ethnic minorities in a study without attention to specific aspects of culture in the selection of measures (Miranda et al., 2003; Sue, 1999).

Limited involvement of ethnically and culturally diverse researchers. Multiple factors contribute to the lack of ethnically and culturally diverse researchers in the field of mental health.

While the stigma associated with mental disorders often prevents culturally diverse consumers and families from seeking help, it also prevents people of color from selecting research as a viable and respected profession and field of study. For those who do enter the field, there is often a lack of mentors and institutional and personal supports to pursue research careers in this field. Increasing the number of mental health researchers of color is critical as these individuals often bring a unique and valuable perspective on ethnic and cultural issues in mental health care. Culturally diverse researchers may be more inclined to study the effectiveness of ethnic-specific interventions and more likely to provide an important cultural perspective on existing studies of treatment appropriateness, acceptability and effectiveness for diverse groups.

Historically, populations of color have had negative experiences with research institutions. They have been the subjects of unethical research practices resulting in physical harm, have had their communities described in “deficit terms”, and, for young minority researchers, recognition of the value of their research and their status as competent researchers in mental health has been missing. Additionally, ethnic minority researchers are challenged by the tendency of mainstream research to treat culture as a nuisance variable, to assume that work is universally applicable in spite of exclusion of heterogeneity in sampling, and to place the burden of proof for differences on researchers concerned with race, ethnicity, and bias (Sue, 1999).

In summary, for communities of color, culturally-specific, community-driven interventions have historically and anecdotally “worked” for these groups. However, these practices lack systematic research and evaluation to support their effectiveness. In March, 2003, the National Implementation Research Network of the Louis de la Parte Florida Mental Health Institute, with support from the Annie E. Casey Foundation, convened experts in the area of mental health and cultural competence to address this issue. The conclusions from this meeting highlighted some of the factors fueling the gap between science and practice for these populations:

- What we know to be effective cannot always be what is reflected through

research conducted using RCTs (Chambless & Ollendick, 2001);

- Existing data are inadequate to generalize the effectiveness of evidence-based programs to communities of color, since they are not typically involved in the test population;
- The infrastructure to support involving diverse populations in designing, implementing, and evaluating EBPs is lacking;
- A body of emerging research and knowledge suggests that appropriate adjustments can be made for specific cultural groups. Further research is required to understand what adaptations and modifications are needed to improve implementation of EBPs in diverse communities. (Consensus Statement on Evidence-based Practice and Cultural Competence, 2003).

Services to Science: The Emergence of Practice-Based Evidence (PBE)

As highlighted in the discussion above, both cultural competence and EBPs are viewed as models for effecting reductions in mental health disparities and in mental health transformation. Each has had difficulty in “real world” implementation. Despite their differences, there needs to be much greater intersection between these two movements if fundamental transformation of the mental health system is to be realized. The most commonly articulated strategy for integration of these two movements in mental health is a focus on adaptation of existing EBPs to accommodate cultural variations. Many in the field believe that it is possible to make cultural adaptations to existing EBPs for ethnic minority populations (Miranda et al., 2003; Nagayama Hall, 2001), thus assuring that cultural competence is taken into account in the implementation and use of these practices. A recent article by Miranda et al. (2005) seems to suggest that this approach will, in fact, work for most groups of color. In a thorough review of efficacious interventions for children and youth, as well as adults, Miranda and her colleagues

summarized published outcomes for use of evidence-based treatments with ethnic minority populations and groups. For children and youth, they identified efficacious interventions for depression, anxiety, ADHD, and disruptive behavioral disorders. They also reviewed similar research for ethnically diverse adults. From this impressive review of the research and treatment literature, they concluded that many of the established EBPs are effective in the care for ethnic minorities, especially for African American and Latino populations. Much less data is available for Asian groups and Native Americans. Miranda et al. (2005) further concluded that:

Our review of the literature has led us to believe that evidence-based care is likely appropriate for most ethnic minority individuals. In the absence of efficacy studies, the combined use of protocols or guidelines that consider culture and context with evidence-based care is likely to facilitate engagement in treatment and probably enhance outcomes. We also believe that two areas of research need immediate attention. First, methodologies for tailoring evidence-based interventions for specific populations would be extremely helpful. Because culture is continually evolving, the ability to identify factors that are amenable to adaptation, while maintaining the critical ingredients of care, would provide a methodology for continually insuring that care is sensitive to the needs and concerns of any client group. Second...we believe that research focusing on methods for actively engaging ethnic minorities in mental health care is extremely important. For example, studies of American Indian youth have included entire classrooms. Could there be appropriate ways for identifying and treating American Indian youth with disorders that would avoid stigmatizing them? Clearly, working with communities to identify ways to bring appropriate care to minority populations is a priority (p. 132-133).

The Indian Country Child Trauma Center, part of the SAMHSA National Child Traumatic Stress Network, was established to explore the cultural adaptation potential of EBP trauma-related treatment protocols and service delivery guidelines for tribal communities. Clinical treatment interventions have been culturally adapted to the traditional world view of

American Indian cultural beliefs and include Native practices related to behavior, health, healing, humor, and children. The treatment interventions that were culturally analyzed and adapted included Parent Child Interaction Therapy, Trauma-focused Cognitive Behavioral Therapy, and Treatment for Children with Sexual Behavior Problems. Careful analysis is conducted to determine the EBP factors that may be amenable to adaptation with additional attention paid to clinical training and local coaching using real-time telemedicine technology.

Although quite promising, many questions remain unanswered about cultural adaptations of existing EBPs. For example, how much adaptation can occur before fidelity to the model is jeopardized? How can the adaptations that are made for cultural groups be captured in a way that will allow for inclusion and consistency in the implementation of the EBPs for a given population? How will EBP developers measure and “norm” cultural adaptations that are made to accommodate the differing values and responses of cultural groups and racial/ethnic minority populations? Finally, how are EBPs applied to children who have multiple problems that sometimes do not fit into single diagnostic categories?

Although cultural adaptations of EBPs not normed on or developed for populations of color seem the appropriate scientific response, many cultural competence experts believe that an over-reliance on EBPs not only decreases attention to cultural variations, but it also tends to invalidate and exclude many culturally-specific interventions and traditional healing practices that are utilized in communities of color (Espiritu, 2003; Huang, Hepburn, & Espiritu, 2003). These culture and value-driven interventions, many of which pre-date modern psychotherapy and other modern clinical interventions, reflect local community beliefs on healing and wellness. Some of the traditional practices reinforce community support for a passage in child or human development while other practices were developed as a way to restore individual and/or community emotional and spiritual balance following a traumatic event. Core to all traditional practices is the use of cultural belief systems and traditions as tools to restore and strengthen the cultural self and

positive place in the collective community (Echo-Hawk et al, 2005). In this paper, such interventions will be referred to as Practice Based Evidence (PBE).

Similar to underlying constructs of EBPs outlined earlier, the concept of PBE is based on the belief that individuals with temporary emotional imbalances should receive care that addresses their cultural selves; that care provided must be based on the best cultural knowledge available and adhere to cultural traditions and belief systems; and, that care reflects high levels of quality and accountability and is provided by community-sanctioned providers. After extensive discussion with peers and review of the literature on PBE, this paper (Echo-Hawk, Isaacs, Huang, & Hernandez, 2005) has adopted the following definition and description of Practice Based Evidence:

The field of Practice Based Evidence (PBE) can be defined as a range of treatment approaches and supports that are derived from, and supportive of, the positive cultural attributes of the local society and traditions. Practice based evidence services are accepted as effective by the local community, through community consensus, and address the therapeutic and healing needs of individuals and families from a culturally-specific framework. Practitioners of practice based evidence models draw upon cultural knowledge and traditions for treatment and are respectfully responsive to the local definitions of wellness and dysfunction. Practitioners of practice based evidence models have field-driven and expert knowledge of the cultural strengths and cultural context of the community and they consistently draw upon this knowledge throughout the full range of service provision: engagement, assessment, diagnosis, intervention, and aftercare. The practice based evidence approach includes a logic-driven selection of appropriate interventions based on a range of factors, including the cultural and historical belief systems of the community related to healing and wellness. Practice based evidence mandates consistent and authentic adherence to family choice.

PBE services can be delivered by paraprofessionals, professionals, or paraprofessional-professional teams whose

knowledge of local cultural beliefs, traditions, and nuances are respected by community consensus and/ the cultural leadership within the community. Inherent to PBE is knowledge of the:

- function of cultural help-seeking patterns;
- cultural context of problem identification;
- culturally-informed process for therapeutic intervention(s);
- provision of therapeutic interventions and supports in a manner that consistently recognizes the values of the cultural self to wellness and recovery; and,
- engagement of local community and/or cultural resources to achieve and sustain the long-term positive effects from intervention(s).

The range of expert knowledge embodied by the PBE practitioner includes awareness of the role of preferred local language(s) and/or key phrases; local communication style(s), including the pace of the conversation; knowledge of culture-based gender and generational roles and corresponding protocols of engagement and communication; awareness of cultural migration factors on the engagement and intervention process (e.g., minority youth hip hop culture, multiple tribes, or ethnicities within the family); awareness of the dynamics of difference resulting from cross-cultural interactions and histories; and, the demonstrated ability to share the role of “expert” with the local community.

The cultural foundation of PBE is in contrast to the scientific underpinnings of EBPs, but they should not be mutually exclusive. For example, EBPs may be “scientific” in nature, but the research studies that resulted in EBPs were not created with diverse populations in mind (Hernandez & Isaacs, 2004). Conversely, the field of PBE may gauge effectiveness primarily by the cultural fit between the intervention and the recipient of the intervention, but may need the tools, assessments, and intervention components from the “evidence” to address the full range of needs which the client might present.

Both PBE and EBPs have the potential to contribute valuable resources and insights to the

complex needs of local communities. In fact, some communities have successfully combined these perspectives as a way to match service delivery to cultural help-seeking patterns, to demonstrate respect for the value of the cultural self as an integral part of wellness, and to model partnership between the medical model world view and the cultural world view (Gregory, 1997).

The Sault Ste. Marie Band of Chippewa Indians, located in the remote upper peninsula of Michigan, offer a unique example of such fusion through a partnership between primary health care and traditional healing practices. Traditional healers partner with the tribal health services and have clinic office space for “intake” and healing services. The traditional healers are viewed as experts in their field, just as the medical doctors are viewed as experts in their field. Each of these healers view each other as colleagues. The practice based practitioners (traditional healers) offer services both in the same health clinic exam room or in off-site locations that can better accommodate traditional practices. The end result is a partnership of services that address the medical, psychological, and traditional healing needs of the tribal consumer -- all through collective attention to the value of cultural touchstones as the integral component of treatment.

While PBE offers powerful lessons on the operationalization of cultural competence, the research base and “evidence” on the effectiveness of these practices needs to be more fully developed and disseminated while maintaining the integrity of its cultural genesis. Conversely, the EBP field can address the voids of cultural insight in scientific research designs and methods through partnership with their PBE colleagues.

Policy Implications and Recommendations

It is clear that EBPs, PBE, and cultural competence have much to offer the field of mental health. They have many common goals that can be better achieved by working together in a complementary fashion. Cultural competence proponents acknowledge that there are advantages to implementing EBPs, such as increased accountability, the potential for

enhanced quality, and having access to concrete tools for implementation, such as manuals and guidelines. EBPs also have the potential to improve outcomes, decrease variability in the quality of services, increase efficiency in resource use, and assure accountability. Whether or not these advantages are realized will depend upon how policy and implementation progress. There are also EBP developers and researchers who have a great interest in ensuring that such practices take into account the cultural variations and diversity that is America. They must be more willing to adapt their models to accommodate cultural differences and to assist in identifying and developing methodologies to further develop promising PBE models with practitioners, researchers, and communities of color.

Recommendations from the field. In order to achieve effective integration of these important transformation efforts, five recommendations are offered that were derived from a Consensus Meeting on Evidence-Based Practices for Consumers and Families of Color (National Alliance of Multi-Ethnic Behavioral Health Associations [NAMBEHA], 2005). NAMBEHA held this Consensus Meeting on September 23-25, 2005 in Chicago, IL. In attendance were representatives from the four affiliated member organizations (The First Nations Behavioral Health Association [FNBHA], The National Asian American Pacific Islander Mental Health Association [NAAPIMHA], The National Latino Behavioral Health Association [NLBHA] and The National Leadership Council on African American Behavioral Health [NLC]) of NAMBEHA, the Federation of Families for Children’s Mental Health, the National Alliance of the Mentally Ill (NAMI), the federal Substance Abuse and Mental Health Services Administration (Center for Mental Health Services and Center for Substance Abuse Treatment), and several research centers and universities.

The overall goal of the meeting was to develop a consensus statement that would describe what the current policy trend toward the adoption of EBPs means for communities of color. A series of facilitated discussion groups were held and the main points identified by each group were recorded. An outline of themes that emerged from discussions within each of the groups was developed and presented to all

meeting participants. During the combined group meeting, changes were made to the outline of themes by consensus. After this was completed, the facilitators analyzed the themes and provided details from the small group discussions that supported or clarified the themes that emerged in the final discussion. Quotes representing the ideas of the participants were also selected during this final analysis and associated with the emergent themes. The recommendations that resulted from these themes are presented in Table 1.

Table 1

RECOMMENDATIONS FROM THE FIELD
<ul style="list-style-type: none"> • Communities of color must be included in the development of EBPs.
<ul style="list-style-type: none"> • Cultural competence must be defined and required for EBPs.
<ul style="list-style-type: none"> • PBE must be taken into consideration as a critical component of EBPs in communities of color.
<ul style="list-style-type: none"> • The process of developing and credentialing EBPs needs to be modified to be inclusive of communities of color.
<ul style="list-style-type: none"> • The process of implementing EBPs in communities of color must be supported with resources.

The first recommendation, that communities of color be included in the development of EBPs was identified as most important. One participant stated that, “We can’t ignore communities, otherwise we will not reap the benefits of EBPs.”

Development of effective practices has to start in partnership with local communities and be part of the community. For example, there needs to be an understanding of differences within groups and adaptation to differences in culture and vocabulary, even within the same or similar language groups. There also needs to be an understanding of economic situations and immigration experiences. This can only be accomplished by entering into dialogues with the community.

We suggest an approach in which development and testing of EBPs is carried out in communities of color, and involves community stakeholders in decisions about what is most appropriate. It should be consumer/

family driven, with participation beginning locally. Researchers and policymakers also have to become more knowledgeable about how to collaborate with communities of color in the process of EBP development.

First, they must learn how to ensure that all stakeholders are at the table and information is explained in non-academic terms so that all are able to participate. Second, researchers and policymakers must pay attention to the evidence that communities of color provide about what works for them. This is an important type of knowledge that should be assimilated into structuring strategies for EBP implementation in communities of color.

The second recommendation is that cultural competence must be defined and required for EBPs. A participant stated that, “[We] need to move cultural competence to the next generation. We know, given our current data, that culture is critical. We see striking disparities for people of color, less access to mental health care, poorer quality. The critical issues for cultural competence are access, quality and disparities in outcomes.”

Cultural competence must be incorporated into the process of EBP development and implementation. Cultural nuances are important and attention needs to be paid to these when developing practices. For example, cultural identity of practitioners and families must be considered for cultural congruency. There is a need for recruitment, training, and retention of bi-cultural/bi-lingual staff. There is also a need for increased understanding of the variation within groups due to country of origin, level of acculturation, age, class, and preferred language.

Recommendation three is that PBE must receive validation and support, and be taken into consideration for setting standards and guidelines for EBPs. Further, there is a need for guidelines about what to include in EBPs in order to make them culturally congruent. EBPs tend to be based on majority population values related to measurement, research, and hypothesis testing – an approach that is cognitive rather than relational or emotional. As a result, curricula and manuals are cognitive in approach so that people often “can’t tell their

stories”. Curricula must be adapted by infusing emotional and relational elements in the form of stories, metaphors, and analogies (see Table 2).

Table 2

POPULATION	ASSOCIATED RECOMMENDATIONS
African American	<ul style="list-style-type: none"> · Role playing · Peer mentoring · Exploring knowledge of one’s self and cultural history · Importance of religion/spirituality
Latino	<ul style="list-style-type: none"> · Importance of family · Reciprocity in relationships · Justice in actions · Establishing credibility and trust
Native American	<ul style="list-style-type: none"> · Communities are human resource-rich and should be used wisely · Respecting the community by inclusion in treatment planning, service delivery and program evaluation · Not taking more than one needs to survive · Tolerance as a strength and door to mutual respect
Asian American	<ul style="list-style-type: none"> · Combining medications with treatments acceptable in homeland · Address employment issues · Using medical rather than mental health providers · Developing peer support

Recommendations derived from the NAMBHA Consensus meeting identifying EBP curricula standards and guidelines.

EBPs must be adapted for communities of color by including different approaches to education, treatment planning, and evidence of effectiveness. Education must be seen as a two way process between therapists/providers and people of color in recovery. It must be acknowledged that “Individuals are and have the evidence in their experiences.” Cultural strengths must also be recognized, such as a strong religious or spiritual orientation, work ethic, kinship orientation, importance of community, value of education, and achievement orientation. Addressing culture and language as resiliency and protective factors is an important part of a strength-based approach.

Culturally specific practices and programs have been used for a long time and are being used effectively in communities of color but need to be funded, documented, and tested

further. Examples include programs based on NTU principles for African Americans, the Primos program for Latinas, programs that use “promotoras de salud” (community health promoters), programs that build on tribal traditional practices such as the American Indian Life Skills program, and programs that bridge physical health and mental health for Asian American populations. PBE models, which are often effective, need to be further developed, disseminated, and incorporated into the process of EBP development. For example, some culturally specific healing practices have received state and federal reimbursement for services in Alaska and Arizona, but other states must be convinced to buy in to this approach.

The fourth recommendation is that the process of developing and credentialing EBPs needs to be modified to be inclusive of communities of color. A participant noted that “In the process of consensus on what is considered an EBP, it is consensus of whom? Experts, guilds, researchers. Who is left out? Consumers and families.”

The process of identifying EBPs involves researchers with certain credentials and methods of research and includes very few researchers of color. The procedure by which EBPs are defined excludes those who are not funded by large federal programs, who are not included in federal lists, and who do not publish their research as “evidence-based”. There is a need to increase the number of researchers of color who can document practices used in communities of color, test them, and publish their results. Support for the development of these researchers is needed from policymakers, the research and academic community, and communities of color. Exploring ways to involve Tribal Colleges, Historically Black Colleges and Universities (HBCUs), Minority Serving Institutions, and racial/ethnic specific research organizations is critical.

An effective means of working with communities is participatory action research (CPAR). This approach partners with the community to be studied to jointly define questions and design methodology. The CPAR approach demonstrates consistent respect for community values and preferences. Researchers who take time and make the effort to develop trust and train community members as researchers have been more effective in gathering

information that is representative of communities of color. One important aspect of entering some communities is seeking the approval of elders for research, which validates the community’s input into the process and understanding of how the study will benefit the local community.

There needs to be enough flexibility in EBPs to allow for adaptation to communities of color. Some EBPs are written in ways that are far too structured or rigid to integrate values and cultural pieces. In addition, “fidelity” to the EBP has the potential to reduce cultural competence because of limitations to adaptations that can be made. If fidelity is a concern, EBPs with adaptations for different communities need to be developed and tested separately from the general version, with each adaptation being given a unique name.

There needs to be research and acknowledgement of what really is effective about an EBP. There is evidence that the actual interventions account for only a fraction of the positive effect they might have on outcomes. There is a need for much greater understanding about what is helpful to people in recovery, building on the work of non-specific factors such as personal interactions, empathy, and compassion. As components that contribute to effectiveness are better understood, requirements for adherence or fidelity to the model can become more flexible. Although EBP language includes adaptability in the concept, there is a need to document how to make acceptable adaptations and a need to understand how they work so that adaptations can stay true to the essence of what works. As one participant stated, “We need to get to the nitty gritty of what is meant and what expectations are for family driven care and cultural competence. Family engagement may play a stronger role than the actual practice...and have a critical impact on whether or not the intervention is successful.”

There is great concern that EBPs will be promoted and supported to the exclusion of other practices, as evidenced by a growing number of federal and state mandates. Procedures and policies need to be developed that would ensure support for PBE models as well. As Native American participants noted, “In order for treatment to be successful, all types of interventions are needed, tribal community practices, Western medicine, and various forms of treatment... It all depends on the individual.

However we don't want to veer away from the traditional practices. We simply want to enhance what we have at this point and to improve them".

The fifth and final recommendation is that the process of implementing EBPs in communities of color must be supported with resources. A participant noted that "This is an opportunity to implement the science to practice idea, accelerating what is good and putting it into application. But it must be funded for implementation."

It is the experience of communities of color that Medicaid does not pay enough to cover EBP costs, and therefore, other resources are needed to implement EBPs. Currently Medicaid covers only certain components of an EBP, thus, many organizations serving communities of color cannot afford to implement EBPs since all components have to be implemented in order to have fidelity. State funding and block grants are possible sources of funding, but these are not available to everyone, and often only fund pilot projects. Full implementation of expensive, manualized EBPs may not be possible for organizations that serve communities of color and may result in greater disparities as the movement progresses. Consideration must be given to how EBPs will be implemented, including the funding and infrastructure that are required. Support for implementation also includes resources for organizational/systemic change, such as efforts to develop an evidence-based culture and linking this to quality improvement strategies. And, accountability is needed at all stages of EBP development and implementation.

Other elements in the community's system of care must not be reduced or eliminated with the implementation of EBPs. Every attempt must be made to ensure real choice in services, practices, providers, and types of outreach and information dissemination. Support for outreach and informal services in communities of color ensures access to populations that would not otherwise participate in treatment. Support is also needed for on-going training of natural helpers and paraprofessionals from the community to partner with formal providers. Practitioners struggle with the issue of "How do you get folks to feel like they need treatment and it's safe to enter the door of treatment?" Existing outreach and informal services have demonstrated that "people respond when you bring information to them" at locations

where they feel comfortable and in a language that they understand.

Final Note

The importance of incorporating cultural competence into behavioral health services has long been an issue and struggle for the field. Over the years, culturally diverse groups have essentially had to adopt programs and practices on their own to fit their cultural realities. These efforts have not been without success but have often failed to find their way into the research literature. Also, it is rare to find developers of mental health interventions who have worked with ethnic and racial groups in order to design or adapt their interventions to fit the worldview and cultural needs of that particular population other than mainstream America. Unfortunately, this trend has been repeated in the current EBP movement with policy makers making the same omission in their rush to adopt and require the use of EBPs.

For most EBPs, even those that have had considerable research histories, the actual active ingredients of their effectiveness are still unknown (Jensen et.al, 2005). There are a number of reasonable alternative hypotheses about the effectiveness of various EBPs, which have little to do with the expressed components of the EBPs themselves. For example, it may be that careful recruitment and selection of staff with high qualifications (and adequate pay), intensive training, coaching, supervision, and ongoing clinical feedback loops are responsible for the effectiveness of the EBP. Or, it may be the intensity of the intervention or its staffing structure, flexibility in treatment response, and rapport, which actually compose the active ingredients. Additionally, many of the EBPs currently available for children with severe emotional disturbances are short term (up to six months). Given that most children with serious mental health challenges have multiple needs crossing several service sectors, including issues of poverty, substance abuse, and co-occurring chronic physical problems, it is naïve to assume that there is a short-term single treatment solution that can remediate such problems.

Currently the child mental health field does not know whether and what types of adaptations and modifications of an EBP are needed in

order to ensure that the EBP's implementation does not further create or exacerbate mental health disparities. Given the assumption that culture is an important variable in determining how people see and interpret the world around them and the basis of how they make decisions in life, then research including stakeholders as well as subjects from diverse populations is of paramount importance to achieving the goal of reducing mental health disparities. Further, culture, and its associated characteristics, must be more purposefully included in the design and implementation of mental health intervention research. If culturally competent research and the implementation of its results continue at its current pace, then the burdens resulting from mental health disparities will continue to be experienced by diverse children and their families. Moreover, this lack of culturally competent research will continue to have negative impacts on our health care systems and on the American society as a whole leading to mostly large ineffective investments in juvenile justice, child welfare, and health care costs. These investments include overuse of emergency medical care, incarceration, and placement of children in out of home placements – all of which have no “evidence” about their ability to produce positive outcomes. In summary, increased effort to operationalize cultural competence and support for the development of PBE approaches to mental health care, coupled with an increased focus on culturally inclusive research, will together support the goal of reducing mental health disparities, improving the implementation of EBPs, and transforming the mental health system as we know it.

References

- American Psychological Association (2005). *The APA policy statement on evidence-based practice*. Retrieved March 30, 2006 from <http://www.apa.org/practice/ebp.html>
- Amherst H. Wilder Foundation (2002). *Cultural competence program self-assessment: Services to children, elderly and families*. Saint Paul: Amherst H. Wilder Foundation.
- Andrulis, D., Delbanco, T., Avakian, L. & Shaw-Taylor, Y. (2004). *Conducting a cultural competence self-assessment*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved March 30, 2006 from <http://erc.msh.org/mainpage.cfm?file=9.1g.htm&language=english&module=provider>
- Betancourt, J., Green, A., & Carrillo, E. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches*. The Commonwealth Fund.
- Betancourt, J.B., Green, A.R., Carrillo, J.E. & Park, E.R. (2005). From the Field: Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs*, 24, 499-505.
- Blasé, K. A., & Fixen, D. L. (2003). *Evidence-based programs and cultural competence*. Retrieved December 6, 2004, from <http://nirn.fmh.usf.edu/resources/index.cfm>
- Brach, C. & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, 57, 181-218.
- Bui, K., & Takeuchi, D.T. (1992). Ethnic minority adolescents and the use of community mental health care services. *American Journal of Community Psychology*, 20, 403-417.
- California Institute of Mental Health (2004). *Towards effective mental health practices: A strategic work plan to develop organizational capacity for incorporating values and science in mental health practices*. Retrieved March 30, 2006 from www.cimh.org/projects/values.cfm.
- Campbell, C. & Alexander, J. (2002). Culturally competent treatment practices and ancillary use in outpatient substance abuse treatment. *Journal of Substance Abuse Treatment*, 22, 109-119.
- Campinha-Bacote, J. (2002). Inventory for assessing the process of cultural competence among healthcare professionals (IAPCC-R). In J. Campinha-Bacote (Ed.), *The process of cultural competence in the delivery of healthcare services*. Cincinnati, OH: Transcultural C.A.R.E. Associates
- Carpinello S.E., Rosenberg L., Stone J., Schwager M., & Felton, C.J. (2002). Best practices: New York state's campaign to implement evidence-based practices for people with serious mental disorders. *Psychiatric Services*, 53, 153-5.
- Center for Mental Health Services. (1997). *Cultural competence standards in managed care mental health services for four underserved/underrepresented racial/ethnic groups (report from working groups on cultural competence in managed mental health care)*. Rockville, MD: Center for Mental Health Services.
- Chabra, A., Chavez, G. F., Harris, E. S., & Shah, R. (1999). Hospitalization for mental illness in adolescents and the use of community mental health care system. *Journal of Adolescent Health*, 24(5), 349-356.
- Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66, 7-18.

- Chambless, D. & Ollendick, T. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology* 52, 685-716.
- Child Welfare League of America (2002). *Cultural competence agency self-assessment instrument*. Washington, D.C.: CWLA Press.
- Chorpita, B. F. (2003). The frontier of evidence-based practice. In A. E. Kazdin & J. R. Weisz (Eds.) *Evidence-based psychotherapies for children and adolescents* (pp. 42-59). New York: Oxford.
- Consensus Statement on Evidence-Based Practice and Cultural Competence. (2003). Conclusions from March 2003 meeting sponsored by the National Implementation Research Network of the Louis de la Parte Florida Mental Health Institute at the University of South Florida and the Annie E Casey Foundation, Tampa, Florida.
- Costello, E. J., Farmer, E. M. Z., & Angold, A. (1997). Psychiatric disorders among American Indian and white youth in Appalachia: The great mountains study. *American Journal of Public Health*, 87(5), 827-832.
- Cross, T., Bazron, B., Dennis, K. & Isaacs, M. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.
- Cunningham, P.B., Foster, S.L., & Henggeler, S.W. (2002). The elusive concept of cultural competence. *Journal of Children's Services: Social Policy, Research, and Practice*, 5, 231-243.
- Cunningham, P. J., & Freiman, M. P. (1996). Determinants of ambulatory mental health service use for school-age children and adolescents. *Mental Health Services Research*, 31, 409-427.
- Davis, K. (2003). The disparity hypothesis: An overview of current research findings on mental health of people of color in the United States. In American College of Mental Health Administrators (Eds). *Reducing disparity: Achieving equity in behavioral health services*. Proceedings of the 2003 Santa Fe Summit. New Mexico: ACMHA.
- Drake, R. E., Goldman, H. H., Leff, H. S., Lehman, A. F., Dixon, L., Mueser, K. T., & Torrey, W.C. (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services*, 52(2), 179-182.
- Echo-Hawk, H., Isaacs, M.R., Huang, L.N. & Hernandez, M. (2005). *Practice-based evidence (PBE): A framework*. Draft paper.
- Echo-Hawk, H., Becker-Green, J., Calvert, Z., Cross, T., Fox, K., & Manness, K. (2005). *The Role of Traditional Practices in American Indian/Alaska Native Systems of Care*. Washington, DC. American Institutes for Research.
- Espiritu, R. (2003). What about promotoras, shamans, and kru khmers? The need to expand the evidence base for diverse communities. *Data Matters*. No.6. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.
- Fabrega, H., Ulrich, R., & Mezzich, J. E. (1993). Do Caucasian and black adolescents differ at psychiatric intake? *Journal of the Academy of Child and Adolescent Psychiatry*, 32, 407-413.
- Federal Register. (August 26, 2005). *Notice: Request for comments; National Registry of Evidence-Based Programs and Practices (NRREP)*. Volume 70, Number 165, 50381-50390.

- Fixsen, D., Wallace, F. & Naoom, S. (2005). Top five reasons NOT to use evidence-based programs – Results from the 17th annual research conference: A system of care for children’s mental health. *A system of care for children’s mental health: Expanding the research base, 17th annual proceedings*. Tampa, FL: The Research and Training Center for Children’s Mental Health, Department of Child and Health Studies, The Louis de la Parte Florida Mental Health Institute, University of South Florida.
- Geron, S. M. (Fall 2002). Cultural competency: How is it measured? Does it make a difference? *Generations*, 26, 39-45.
- Goldman, H.H., Ganju, V., Drake, R.E., Gorman, P., Hogan, M., Hyde, P.S. & Morgan, O. (2001). Policy implications for implementing evidence-based practices, *Psychiatric Services*, 52, 1591-1597.
- Gregory, S. D., & Phillips, F. B. (1997). Of mind, body, and spirit: Therapeutic foster care--an innovative approach to healing from an NTU perspective, *Child Welfare*, 76, 127-142.
- Hawaii Department of Health. (2004). *Summary of effective interventions for youth with behavioral and emotional needs*. Evidence Based Services Committee Biennial Report. Retrieved March 30, 2006 from <http://www.hawaii.gov/health/mentalhealth/camhd/library/pdf/ebs/ebs011.pdf>
- Hernandez, M. & Isaacs, M. (2004). *Promises and challenges of evidence-based practices: A review and analysis of the NIMH CRISP database – 1995 to 2003*. Draft paper prepared for the National Alliance of Multi-ethnic Behavioral Health Associations (NAMBHA), Washington, D.C.
- Hernandez, M., & Isaacs, M. (1998). *Promoting Cultural Competence in Children’s Mental Health Services*. Baltimore, MD: Paul H. Brookes Publishing.
- Huang, L. (2002). Reflecting on cultural competence: A need for renewed urgency. *Focal Point*, 16, 4-7.
- Huang, L.N., Hepburn, K. & Espiritu, R. (2003). To be or not to be evidence based. *Data Matters*. No.6. Washington, DC: National Technical Assistance Center for Children’s Mental Health, Georgetown University Child Development Center.
- Huang, L.N. & Isaacs, M.R. (2004). Cultural competence: Moving to the next generation. Draft article for *Data Matters*. Washington, DC: National Technical Assistance Center for Children’s Mental Health, Georgetown University Child Development Center.
- Huang, L.N., Isaacs, M.R., & Ida, D.J. (2004). *Eliminating disparities for racial and ethnic populations: A renewed urgency for cultural competence in behavioral health care*. Background paper for the Subcommittee on Cultural Competence, President’s New Freedom Commission (draft).
- Institute of Medicine. (2000). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.
- Isaacs, M. (2005). Creating change: Finding the intersect between cultural competence and evidence-based practices. Powerpoint presentation for the Conference on Change Management in Mental Health Systems, Albuquerque, New Mexico, June 22-24, 2005.
- Isaacs, M. (1998). *The state of the states: Responses to cultural competence and diversity in child mental health*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children’s Mental Health.
- Isaacs, M. & Benjamin, M. (1991). *Towards a culturally competent system of care, volume II, programs which utilize culturally competent principles*. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

- Jensen, P., Weersing, R., Hoagwood, K.E., & Goldman, E. (2005). What is the evidence for evidence-based treatments? A hard look at our soft underbelly. *Mental Health Services Research, 7*, 53-75.
- Juszczak, L., Melinkovich, P., & Kaplan, D. (2003). Use of health and mental health services by adolescents across multiple delivery sites. *Journal of Adolescent Health, 32*, 108-118.
- Kiesler, D.J. (2000). *Beyond the disease model of mental disorder*. Westport, CT: Praeger Publishers.
- Kilgus, M. D., Pumariega, A. J., & Cuffe, S. P. (1995). Influence of race on diagnosis in adolescent psychiatric inpatients. *Journal of the American Academy of Child & Adolescent Psychiatry, 34*, 67-72.
- Kouyoumdjian, H., Zamboanga, B. L., & Hansen, D. J. (2003). Barriers to community mental health services for Latinos: Treatment considerations. *Clinical Psychology: Science and Practice, 10*, 394-422.
- Lehman, A.F. & Steinwachs, D.M. (1998). Translating research into practice: The schizophrenia patient outcomes research team (PORT). *Schizophrenia Bulletin, 24*, 1-10.
- The Lewin Group. (2001). *Health resources and services administration study on measuring cultural competence in health care delivery settings. A review of the literature*. Rockville, MD: U.S. Dept. of Health and Human Services, Health Resources and Service Administration.
- The Lewin Group. (2002). *Indicators of cultural competence in health care delivery organizations: An organizational cultural competence assessment profile*. Rockville, MD: The Health Resources and Services Administration.
- Malgady, R. G. & Constantino, G. (1998). Symptom severity in bilingual Hispanics as a function of clinician ethnicity and language of interview. *Psychological Assessment, 10*, 120-127.
- Messer, S. B. (2004). Evidence-based practice: Beyond empirically supported treatments. *Professional Psychology: Research and Practice, 35*, 580-588.
- Miranda, J., Bernal, G., Lau, A., Kohn, L., Hwang, W., & LaFromboise, T. (2005). State of the science on psychosocial interventions for ethnic minorities. *Annual Review of Clinical Psychology, 1*, 113-142.
- Miranda, J., Nakamura, R., & Bernal, G. (2003). Including ethnic minorities in mental health intervention research: A practical approach to a long-standing problem. *Culture, Medicine and Psychiatry, 27*, 463-481.
- MTA Cooperative Group. (1999). A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. *Archives of General Psychiatry, 56*, 1073-1086.
- Nagayama Hall, G.C. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology, 62*, 502-510.
- National Alliance of Multi-ethnic Behavioral Health Associations. (2005). *Draft meeting report*. NAMBHA Consensus Meeting on Evidence-based Practices. Chicago, Illinois. September 23-25, 2005.
- National Association of State Mental Health Program Directors. (2003). *Cultural competency: Measurement as a strategy for moving knowledge into practice in state mental health systems*. Alexandria, VA: National Technical Assistance Center.
- National Institutes of Health. (1994). NIH guidelines on the inclusion of women and minorities as subjects in clinical research. Retrieved March 30, 2006 from <http://grants.nih.gov/grants/policy/emprograms/overview/women-and-mi.html>
- Novins D.K., Beals J., Sack W.H., & Manson S.M. (2000) Unmet needs for substance abuse and mental health services among Northern Plains American Indian adolescents. *Psychiatric Services, 51*, 1045-7.

- Novins, D. K., Duclos, C. W., Martin, C., Jewett, C., & Manson, S. M. (1999). Utilization of alcohol, drug, and mental health treatment services among American Indian adolescent detainees. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*, 1102-1108.
- O'Donohue, W., Buchanan, J. A., & E., F. J. (2000). Characteristics of empirically supported treatments. *Journal of Psychotherapy Practice Research, 9*, 69-74.
- The Ohio Department of Mental Health & The Outcomes Management Group, Ltd. (2002). *The Consolidated Culturalogical Assessment Tools (C-CAT)*. Columbus, OH: The Ohio Department of Mental Health, Office of Consumer Services.
- Ortega, A., Bourne, T., Strand, C., Rojas, S., & Olayinka, S. (2002). Working toward cultural competence through family involvement. *Focal Point, 16*, 18-20.
- President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America, final report* (Pub. No. SMA-03-3832). Rockville, MD: Department of Health and Human Services.
- Pumariega, A. J., Glover, S., Holzer, C. E., & Nguyen, N. (1998). Utilization of mental health services in a tri-ethnic sample of adolescents. *Community Mental Health Journal, 34*, 145-156
- Richters J, Arnold, L.EA, Jensen, P.S., Abikoff, H, Connors, C.K, Greenhill, L., Hechtman, L., Hinshaw, S., Pelham, W., & Swanson, J: (1995). NIMH collaborative multisite, multimodal treatment study of children with ADHD: I. Background and rationale. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*, 987-1000.
- Ridley, C., Baker, D. & Hill, C. (2001). Critical issues concerning cultural competence. *The Counseling Psychologist, 29*, 822-832.
- Roberts, R.N., Barclay-McLaughlin, G., Cleveland, J., Colston, W., Malach, R., Mulvey, L., Rodriguez, G., Thomas, T., & Yonemitsu, D. (1990). Monograph and workbook: *Developing culturally competent programs for families of children with special needs*. Logan, UT: Early Intervention Research Institute, Developmental Center for Handicapped Persons, Utah State University. Prepared by Georgetown University Child Development Center, Washington, DC.
- Rogler, L.H. (1999). Methodological sources of cultural insensitivity in mental health research. *American Psychologist, 54*, 424-433.
- Sackett, D.L., Rosenberg, W.M.C, Gray, J.A.M., Haynes, R.B., & Richardson, W.S. (1996). Evidence-based medicine: What it is and what it isn't. *British Medical Journal, 312*, 71-72.
- Siegel, C., Chambers, E. D., Haugland, G., Bank, R., Aponte, C., & McCombs, H. (2000). Performance measures of cultural competency in mental health organizations. *Administration and Policy in Mental Health, 28*, 91-106.
- Siegel, C., Haugland, G., & Chambers, E. D. (2002). *Cultural competency methodological and data strategies to assess the quality of services in mental health systems of care: A project to select and benchmark performance measures of cultural competency*: New York Office of State Mental Health, Nathan Kline Institute for Psychiatric Research, Center for the Study of Issues in Public Mental Health.
- Siegel, C., Haugland, G., & Chambers, E.D. (2004, June). Cultural competency assessment scale with instructions: outpatient service delivery agency level. Orangeburg, NY: Nathan S. Kline Institute for Psychiatric Research. Unpublished.

- Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: Institute of Medicine of the National Academies, Board on Health Sciences Policy, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care.
- Snowden, L. (1998). Managed care and ethnic minority populations. *Administration and Policy in Mental Health, 25*, 581-592.
- Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist, 53*, 440-448.
- Sue, S. (1999). Science, ethnicity, and bias: Where have we gone wrong? *American Psychologist, 54*, 1070-1077.
- Sue, S. (2003). In defense of cultural competency in psychotherapy and treatment. *American Psychologist, 58*, 964-970.
- Takeuchi, D. T., Sue, S., & Yeh, M. (1995). Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. *American Journal of Public Health, 85*, 638-643.
- Tanenbaum, S. J. (2005). Evidence-based practice as mental health policy: Three controversies and a caveat. *Health Affairs, 24*, 163-173.
- Theriot, M. T., Segal, S. P., & Cowsert, Jr., M. J. (2003). African-Americans and comprehensive service use. *Community Mental Health Journal, 39*, 225-237.
- United Advocates for Children of California. (2005). *The roles of family organizations in the evidence-based practices movement*. Sacramento, CA: Authors.
- U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: DHHS, U.S. Public Health Services, Office of the Surgeon General.
- U.S. Department of Health and Human Services. (2001a). *Mental health: Culture, race and ethnicity. A supplement to mental health: A report of the Surgeon General*. Rockville, MD: DHHS, U.S. Public Health Services, Office of the Surgeon General.
- U.S. Department of Health and Human Services. (2001b). *National standards for culturally and linguistically appropriate services in health care: Final report*. Retrieved March 20, 2006, from <http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf>
- Vedantam, S. (2005). Culture and mind: Psychiatry's missing diagnosis. *Washington Post series, June 26-28*. Washington, DC: The Washington Post.
- Vega, W. A., & Lopez, S. R. (2001). Priority issues in Latino mental health services research. *Mental Health Services Research, Special issue: Barriers to providing effective mental health services to racial and ethnic minorities in the United States, 3*, 189-200.
- Victora, C. G., Habicht, J.P., & Bryce, J. (2004). Evidence-based public health: Moving beyond randomized trials. *American Journal of Public Health, 94*, 400-405.
- Virginia Commission on Youth. (2003). *Collection of evidence-based treatment modalities for children and adolescents with mental health treatment needs. House Document No. 9*. <http://coy.state.va.us/Modalities/refchart.htm>
- Walkup, J. T., McAlpine, D. D., & Olfson, M. (2000). Patients with schizophrenia at risk for excessive antipsychotic dosing. *Journal of Clinical Psychiatry, 61*, 344-348.
- Wang, P. S., West, J. C., & Tanielian, T. (2000). Recent patterns and predictors of antipsychotic medication regimens used to treat schizophrenia and other psychotic disorders. *Schizophrenia Bulletin, 26*, 451-457.

- Yeh, M., McCabe, K., Hurlburt, M., Hough, R., Hazen, A., Culver, S., Garland, A., & Landsverk, J. (2002). Referral sources, diagnoses, and service types of youth in public outpatient mental health care: A focus on ethnic minorities. *Journal of Behavioral Health Services & Research, 29*(1), 45-60.
- Young, A. S., Klap, R., & Sherbourne, C. D. (2001). The quality of care for depressive and anxiety disorders in the United States. *Archives of General Psychiatry, 58*, 55-61.

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