Evidence-Based Psychosocial Interventions for Hispanics: Research and Policy Implications

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Evidence-Based Practice: Definitions and an Example

What is Evidence-Based Practice?

Initially a term used primarily in medicine, "evidence-based practice" (EBP) is now central to the fields of education, child welfare, mental health, criminal justice, and many other fields of practice and service delivery.[1] There are several definitions of Evidence-Based Practice emerging from these various fields, and all are variations of each other. Three key definitions are those put forth by the Institute of Medicine (IOM), the American Psychological Association (APA), and the National Association of Social Workers (NASW).

The IOM defines evidence-based medicine as the "integration of best researched evidence and clinical expertise with patient values," [2] while the APA defines evidence-based practice in psychology as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences." [3] Meanwhile, the NASW defines evidence-based social work practice as "a process involving creating an answerable question based on a client or organizational need, locating the best available evidence to answer the question, evaluating the quality of the evidence as well as its applicability, applying the evidence, and evaluating the effectiveness and efficiency of the solution." [1] These definitions all emphasize three important components that we will discuss in short order: the central role of empirical support or research, evidence-based practice as a process in addition to a finished product, and the importance of attending to patient characteristics including culture and context.

From Evidence-Based Practice to Evidence-Based Interventions

Evidence-based practice is not new: practitioners have long used current scientific knowledge to support their assessment and intervention choices.[4] What has changed, however, is that third-party payers, as well as policy and funding entities, are now increasingly expecting, and in some cases demanding, that evidence-based interventions be used as a requirement for payment or funding.[5] Providers in medicine, human services, and social services are under increasing pressure to select treatment interventions with empirical support for positive outcomes. Whether it be for cancer or depression treatment, enhancing parenting or relationship functioning, preventing drug use, unplanned pregnancies, or HIV transmission, or increasing self-esteem or high school completion rates, service providers are under increasing pressure to select interventions that work (i.e., to select and implement evidence-based interventions). Researchers are also under increasing scrutiny to include evidence-based interventions in their grant applications, and funding decisions are increasingly being tied to the selection and use of evidence-based interventions.

Consumers of services have also embraced the evidence-based movement and expect the best treatment evidence can provide. The Internet has made accessing information as easy as opening up a browser and entering a search term in a search engine. Even the most sophisticated information, previously available only to providers, is now available to consumers with the click of a mouse. When a client goes to see a provider for the first time, chances are that the client has "done her homework" and has already researched her symptoms and has specific questions to ask the provider.

It is not uncommon these days for a client to tell the provider "this is the treatment I want because I read online that it's the best treatment for my symptoms."

These are important developments to be sure. An emphasis on continuously questioning and searching for new and better evidence, and a move toward using interventions with evidence of success, can only make our services better. However, a blind embracing of the evidence-based movement is not without risk, and we will discuss some of these risks shortly.

An Example of the Evidence-Based Movement: SAMHSA's Strategic Prevention Framework

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework (SPF) is a five-step planning process that guides the work of states and communities in their substance abuse prevention activities. The third and fourth step in the process calls for developing a comprehensive strategic plan that *outlines evidence-based programs, practices, and policies* to address the needs of the target community, and to *implement the outlined evidence-based programs, practices, and policies.*[6] Since funding priority is given to programs that select evidence-based interventions, SAMHSA also provides guidelines for the selection of evidence-based interventions (see Table 1 below).

Table 1. Summary of Evidence-Based Guidelines used by SAMHSA and APA

SAMHSA's Strategic Prevention Framework
1. Inclusion in Federal registries of evidence-based interventions.
2. Reported in peer-reviewed journals, with positive effects on the primary targeted outcome.

3. Documented effectiveness of the intervention, supported by other sources of information and the consensus judgment of informed experts, as described in four guidelines, all of which must be met.
  a. Based on a theory of change that is documented in a clear logic or conceptual model.
  b. Similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature.
  c. Supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects.
  d. Reviewed and deemed appropriate by a panel of informed prevention experts that includes well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate (e.g., officials from law enforcement and education sectors or elders within indigenous cultures).

American Psychological Association Task Force Criteria for Evidence-Based Treatments
Well-Established Treatments 1. At least two good group-design experiments, conducted in at least two independent research settings and by independent investigatory teams, demonstrating efficacy by showing the treatment to be superior to pill or psychological placebo or to another treatment, OR equivalent to (or not significantly different from) an already established treatment in experiments with statistical power being sufficient to detect moderate differences. 2. Use of treatment manuals or logical equivalent in the treatment. 3. The treatment was conducted with a population, treated for specified problems, for whom inclusion criteria have been delineated in a reliable, valid manner.

4.	Use of reliable and valid outcome assessment measures, at minimum measuring the problems targeted for change.
5.	Use of appropriate data analyses.

Probably Efficacious Treatments
1. At least two experiments showing the treatment is statistically significantly superior to a wait-list or no treatment control group, OR one or more experiments meeting the Well-Established Treatment Criteria (they do not need to have been conducted in at least two independent research settings and by independent investigatory teams).

Possibly Efficacious Treatments
1. There must be at least one study showing the treatment to be efficacious and no evidence to the contrary.

Source: SAMHSA/CSAP, 2009 and APA, 2002.

The definitions of evidence-based practice put forth by IOM, APA, and NASW and presented earlier in this paper, and the guidelines for selection of evidence-based interventions given by SAMHSA and APA and summarized in Table 1, have a common thread: the emphasis on empirical support. This typically limits the definition of evidence to the gold standard of empirical evidence: tightly controlled research studies known as experiments or randomized clinical trials.[5] Lost in this over-emphasis on evidence from experimental research designs is the fact that there is no single litmus test of evidence. Instead, evidence must be viewed along a continuum or hierarchy of evidence.[1, 5]

A Continuum of Evidence
There is no consistent agreement on what a hierarchy of best available evidence looks like.[1] At one end of this continuum, however, we must consider evidence from sources such as personal experience, word of mouth, and community-defined evidence. An individual might be helped by an intervention that lacks a large basis of empirical support, and that individual will most certainly tell others about it. In communities of color, where word of mouth referrals are critical,[7] this creates a demand for the intervention, as well as the opportunity to test the intervention more systematically. That opportunity could be lost due to the emphasis on funding interventions that already have a higher form of evidence. The successful, cumulative experience of this one individual and others like him/her forms the basis of community-defined evidence (CDE). Martinez and colleagues describe CDE as "the knowledge accumulated through the ongoing successful implementation and/or evaluation of practices developed locally with significant community input." [5] More specifically, CDE is defined as "a set of practices that communities have used and determined to yield positive results as determined by community consensus over time, and which may or may not have been measured empirically but have reached a level of acceptance by the community." [8] Interventions with CDE might be more likely to succeed in scaling-up efforts because they have originated in the community first rather than in the laboratory. The resulting increase in ecological validity can be an important asset in the translation from efficacy studies (i.e., does it work in the laboratory or a randomized clinical trial?) to effectiveness studies (i.e., does it work in the real world?), which is where many evidence-based interventions flounder. The National Association of Social Workers considers both consumers and professionals important stakeholders in helping research move from effectiveness and efficacy to intervention research, and emphasizes taking into account real-world issues of resources, access, consumer and organizational culture, and organizational climate.[1] However, the opportunity to expand the base of evidence by examining community-defined evidence would once again be lost if the focus is just on the gold standard of randomized clinical trials implemented by researchers with the most access to resources and expertise.

As we move along this continuum of evidence, we can then begin to consider evidence that stems from more traditional empirical venues, like program evaluation, intervention research studies, expert opinion and narrative reviews, systematic reviews of multiple intervention research studies, and surveillance data.[1] These are important sources of evidence and should continue to be emphasized, but not at the expense of other forms of evidence on the hierarchy. An evidence-based approach to research and service delivery has both strengths and limitations, and both should be considered when allocating funds and other resources. The major strength of an evidence-based approach is the emphasis on continuous examination in pursuit of interventions that produce the best treatment outcomes. A major weakness involves the pitfalls associated with moving from pilot to efficacy to effectiveness study, or moving from the laboratory to the community. This is especially true with regard to communities of color, given their limited representation at the upper levels of the evidence-gathering continuum.[5, 9]

Evidence-Based Interventions and Communities of Color

Another critical consideration when examining the question of evidence relates to the use of evidence-based interventions with diverse populations. All three definitions of evidence-based practices discussed earlier—by the Institute of Medicine, the American Psychological Association, and National Association of Social Workers—emphasize the practical fit with the community's needs and resources, and the appropriateness of the intervention to the community's population, cultural context, and local circumstances.[1-3, 6] SAMHSA's guidelines also highlight the importance of cultural competency in eliminating disparities in services and programs offered to people of diverse racial, ethnic, and linguistic backgrounds, gender and sexual orientations, and those with disabilities.[6] Cultural competence, SAMHSA states, "will improve the effectiveness of programs, policies, and practices selected for targeted populations." [6] NASW posits that evidence-based treatments must be adapted and personalized for individuals based on their culture, interests, and circumstances. Evidence-based social work practice is seen as a process in which the practitioner "combines well-researched interventions with clinical experience, ethics, client preferences, and culture to guide and inform the delivery of treatments and services." [1] Thus, cultural appropriateness is recognized as critical in the selection and use of evidence-based interventions.[10]

A major challenge exists, however, when we examine the state of evidence-based practices designed or adapted for minorities. Researchers attempting to meet the needs of clients in a variety of fields must ensure that effective interventions are applicable across cultural groups.[11] It is widely recognized, however, that members of vulnerable groups, especially from communities of color, are underrepresented in research studies.[9, 7, 12, 13, 14] A historical legacy of mistreatment by researchers has led to a healthy reticence on the part of minorities to participate in research investigations.[7] For instance, an analysis conducted for the Surgeon General's report *Mental Health: Culture, Race and Ethnicity*[15] found that of 9,266 participants involved in the efficacy studies (RCTs) that shaped the major evidence-based treatment guidelines for bipolar disorder, schizophrenia, depression, and attention deficit/hyperactivity disorder (ADHD), only 561 (6%) were Black, 99 (1%) were Hispanic, 11 (0.1%) were Asian American/Pacific Islanders, and none (0%) were American Indians/Alaskan Natives.[9] This under-representation of minorities in RCTs continues, despite a mandate by the National Institutes of Health to include and increase the representation of women and minorities in clinical trials.[16]

These unacceptably low levels of participation of racial/ethnic minority populations in health-related

research severely limits our ability to achieve and measure progress in addressing racial/ethnic disparities in health status and health care.[14] Limiting funding decisions to a gold standard definition of evidence, or making funding decisions in a manner that does not allow interventions with lesser evidence to be further examined, will gravely compound this situation. Vast resources are being devoted to the goal of eliminating health disparities, and a narrow definition of evidence and evidence-based interventions would work against this goal.

Evidence-Based Interventions for Hispanics

Like at the birth of our nation, we are once again largely a nation of immigrants and minorities, fueled primarily by U.S. births to immigrant families and secondarily by immigration,[17] and Hispanics are at the forefront of this immense growth. Currently, Hispanics are the largest and fastest growing minority group in the country, and projected to be a quarter to a third of the U.S. population in the next three to four decades.[18] One in five children in U.S. Public Schools is already Hispanic.[19] Latino children and families also represent the fastest growing group in the child welfare system.[20] Many Hispanic families face multiple stressors associated with adjusting to U.S. mainstream culture. These stressors, in addition to living in poverty and residing in inner-city communities, may further predispose Hispanic families and their children to risks for negative outcomes.[21]

Hispanics are impacted by multiple health disparities

Despite the growing demographic importance of Hispanics, their health, mental health, and psychosocial problems continue to be under-studied and under-treated. Hispanics bear a disproportionate burden of disease, injury, death, and disability due to many health conditions. Hispanic health disparities include stroke, chronic liver disease and cirrhosis, cancers of the cervix and stomach, obesity, diabetes, human immunodeficiency virus (HIV) disease, and homicide.[22] Other high-prevalence Hispanic health issues include mental health problems, suicide, and teenage pregnancies.[22] Many Hispanic families are also impacted by domestic violence, alcohol, tobacco, and drug use.[22]

Most interventions are not developed with or for Hispanics

Despite the high prevalence of health, mental health, and psychosocial problems among Hispanics, interventions to prevent and treat these conditions, and especially those interventions designated as evidence-based, have been developed and tested largely with and for non-Hispanic White patients.[5,9] These interventions also tend to overlook the role of cultural values, beliefs, and practices or to account for cultural differences, and as a result they often fall short of expectations or fail altogether when they move from efficacy trials to effectiveness trials.[11, 23] The resulting cultural mismatch between evidence-based interventions and the needs of Hispanic communities also contributes to the well-documented gross under-utilization of services by Hispanics; premature termination of services when Hispanics do access services; and sub-optimal outcomes for Hispanics who remain in treatment for the duration of services.[24, 25, 26] This situation does little to address and eliminate health disparities, a goal toward which our country is devoting billions of dollars. The need to identify and improve access to evidence-based treatments for health and mental health problems is a public health priority, particularly in relation to racial/ethnic minorities and other underserved group.[27]

Unfortunately, serious problems remain in the generation of evidence-based interventions for Hispanics, in the dissemination of those evidence-based interventions that do exist, and in the attitudes of many intervention developers and funding decision-makers about whether tailoring interventions to specific ethnic or cultural groups is even necessary.[23, 25] Many researchers and

funding decision-makers hold the belief that an intervention that was not developed for or with a particular demographic group needs to fail before we can say that an alternative intervention is needed. This attitude runs counter to that in pharmacology and biological psychiatry, where thinking about and pursuing pharmacological agents that are very specifically tailored is increasingly the norm. For example, pharmacological treatments have gone from "shot-gun" medications that worked all over the brain, to *Selective-Serotonin Reuptake Inhibitors* (SSRIs) that target just one neurotransmitter, and we are now pursuing agents that target specific receptor sites under specific situations. In other words, we are looking for an antidepressant that will act on a precise neural pathway to alleviate a particular type of depression in a distinct type of individual under very narrow circumstances. This type of specificity may not be possible in the realm of psychosocial interventions, but the opposite, "one-size-fits-all" approach should not be the default either. To do so will mean that large segments of our population will continue to be under-served and under-treated. The pharmacological industry may be much closer to answering the question posited four decades ago by Paul: "what treatment, by whom, is most effective for this individual, with that specific problem, and under which set of circumstances"[28] than we will ever be with psychosocial interventions. Our guiding question with regard to psychosocial interventions should be somewhere between this level of specificity and a shotgun approach: personalizing treatment to the needs and situation of the individual.[11]

An example: Hispanics and mental health

Hispanics have greater difficulty than most groups in accessing and remaining in psychiatric treatments, including psychotherapy, their stated preference. The literature on cultural competence in treating Hispanic patients provides few details of psychotherapeutic adaptations.[26] Latinos are only half as likely as non-Hispanic whites to utilize mental health services, and when they do, they tend to drop out of treatment more quickly. In contrast, Latinos are overrepresented in psychiatric hospitals, and they are twice as likely as non-Hispanic whites to be hospitalized in a restrictive psychiatric facility. These alarming patterns of mental health service utilization suggest an urgent need to develop psychotherapeutic models responsive to Latinos' cultural characteristics.[24] But Hispanics are especially under-represented in research protocols aimed at generating evidence for mental health interventions, and this under-representation increases as we move up the hierarchy of evidence: the higher in the evidence-generation chain we go, the less likely it is that we will find significant numbers of Hispanics in the study samples, if at all.[9]

We know that translation from research to practice is fraught with numerous problems, among them replicating effectiveness, fidelity to the protocol and processes, and adaptations to different types of target populations.[29] Inherent in implementing an evidence-based practice model is the challenge of maintaining the integrity of the model while ensuring cultural responsiveness.[10] Evidence-based mental health treatments may require culturally informed modifications to best address the unique needs of the Hispanic population, but few existing empirical studies have assessed these cultural elements.[21] As a result, there is a stark contrast between the frequent calls for research and practice that are applicable across a broad spectrum of cultural and ethnically diverse groups, and the dearth of empirical knowledge about Hispanics and Hispanic families.[11] This lack of knowledge makes for limited efforts at cultural responsiveness.

To be sure, there has recently been increased attention given to understanding how cultural variables may have an impact on the efficacy of treatments with Hispanic families seeking psychological services.[30] However, these efforts are lagging far behind the tremendous growth of Hispanic

communities. Unable to wait for the research to catch up to the population, many researchers and agencies are implementing evidence-based practices without careful consideration of cultural and community nuances. Using an intervention with Hispanics when Hispanics were under-represented or un-represented in the studies that found support for that intervention is fraught with pitfalls that can adversely impact treatment outcomes. Limiting funding to those interventions that already possess a high level of evidence will only make this situation worse.

A second example: Hispanics and substance abuse

Another prime example of the few evidence-based interventions that are available for Hispanics is the seen in the case of substance abuse interventions. The National Institutes of Health's Strategic Plan committed to strengthening and expanding research on diseases that disproportionately affect minority populations in the U.S., with a special focus on (1) drug use, abuse, and addiction; (2) on their interrelationship with the health of minority communities; and (3) on treatment and prevention of these problems.[31] However, delivery of services to Hispanic drug users remains a tremendous challenge, illustrated by low service access and retention rates, and disproportionate negative consequences of drug abuse in the Hispanic population.[32]

Furthermore, when considering the evidence for empirically supported substance abuse treatments for Hispanics, there is great concern about the shortage of treatments that have been adequately tested with Hispanics.[33] For example, only one treatment approach, Brief Strategic Family Therapy, has been empirically shown to be efficacious in treating Hispanic adolescent drug abusers.[34] With regard to substance abuse prevention, the situation is somewhat improved, albeit far from adequate. SAMHSA's National Registry of Evidence-Based Programs and Interventions lists 164 total interventions. Searching the registry with the parameters "experimental" (i.e., RCTs), "Hispanic/Latino," and "at least 25% representation" in the studies yielded 34 interventions (20%).[35] Clearly, more empirical research is needed to determine which treatments are efficacious with Hispanic populations.[36]

Implications for the Health of Hispanic Communities

We thus have brewing before us a perfect storm: a large and growing Hispanic population characterized by remarkable diversity, a limited pool of evidence-based interventions that adequately consider culture and context and that were developed with or for Hispanic communities, and an over-emphasis by policy makers and funding sources on selecting for funding only proposals for research and demonstration projects that include interventions with the highest levels of evidence. This perfect storm threatens to impede progress in eliminating health disparities for an important, highly productive segment of the U.S. population.

This over-emphasis on the gold standard of evidence has broad consequences. Researchers whose work is with the Hispanic community and who are constrained to select evidence-based proposals for their grant proposals have limited options from which to choose. Clinicians seeking to "scale up" interventions with high public health significance and who want to target Hispanic communities have limited options. And community-based organizations and researchers who already have limited resources to obtain the necessary evidence to compete for additional federal funding will be at a disadvantage. Everybody loses.

Recommendations

To address this situation, we put forth a series of recommendations supported by scholars in the field of Hispanic health and mental health. These include:

1. Expanding funding for interventions that have emerging evidence, including community-defined evidence, rather than limiting funding only to those with clinical trials evidence. An emphasis on evidence is important and should continue, but we should look at evidence along a continuum.

2. Designating funds for researchers working on community-based interventions targeting Hispanic subpopulations. This also involves the federal government making funds available directly to community-based researchers via discretionary funds rather than only through block grants to the States.

3. Encouraging collaborations between researchers and service providers through funding mechanisms that require those collaborations. This can speed up the time for development and can ease the implementation of empirical randomized trials.[29]

4. Broadening our understanding of the circumstances of Hispanics in their own communities (i.e., community context) toward developing and testing service delivery models that are tailored to Hispanics' circumstances and special needs.[32]

5. Encouraging the adaptation and cultural modification of those interventions that do not have promising effect sizes with Hispanic samples, as well as follow-up analyses and/or studies for interventions that do have promising effect sizes with Hispanic populations, to examine whether the treatment is differentially efficacious with various Hispanic subgroups, with Hispanics at different levels of acculturation, and with Hispanics from various socioeconomic backgrounds.[36]

In conclusion, a focus on evidence in the selection and implementation of evidence-based psychosocial interventions for Hispanics is important and should continue. However, given the gross under-representation of Hispanics at the higher levels of the evidence-gathering process, and especially with regard to the gold standard of randomized clinical trials, a broader definition of evidence must be adopted. Evidence must be seen along a continuum that includes community-defined evidence, and funding opportunities need to be made available to interventions at every level of the evidence-based hierarchy. Only then will we begin to move closer to the goal of eliminating minority and Hispanic health disparities.

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