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

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Evidence-Based Practice (EBP) is defined as "the integration of best researched evidence and clinical expertise with patient values" (IOM, 2001). EBP is central to the fields of education, child welfare, mental health, criminal justice, medicine, and many other fields of practice and service delivery (NASW, 2010). This paper highlights key points about the evidence-based movement, summarizes the state of evidence-based psychosocial interventions for Hispanics, discusses implications for funding and service delivery, and lists some important recommendations. Our approach included a comprehensive review of the literature on Evidence-Based Psychosocial Interventions for Hispanics, as well as detailed searches in registries of Evidence-Based Interventions maintained by SAMHSA and CDC to examine the number of interventions available for Hispanics and the level of Hispanic representation in the studies that produced evidence for the intervention. This Executive Summary highlights the key points of the paper.

There is an increasing focus on evidence. Increasingly third-party payers are expecting, indeed demanding that Evidence-Based Interventions (EBIs) be selected and implemented as a requirement for payment. Research funding decisions are also increasingly tied to the selection and use of EBIs. Consumers have also embraced the evidence-based movement, and demand from their providers treatments that have evidence of successful outcomes.

Focusing on evidence does not solve all problems. An evidence-based approach to research and service delivery has both strengths (e.g., an emphasis on continuous examination in pursuit of the best outcomes) and limitations (e.g., the challenges associated with moving from pilot to efficacy to effectiveness study, or moving from the laboratory to the community); both strengths and limitations must be considered when allocating funds and other resources.

Evidence must be viewed along a continuum, not just in terms of randomized clinical trials (RCTs). All definitions of EBP and all guidelines for selection of EBIs share in common the emphasis on empirical support, and especially on the highest level of empirical support which is the experiment or randomized clinical trial (RCT). However, evidence must be viewed along a continuum, including evidence from personal experience and word of mouth, community-defined evidence, program evaluation, intervention research studies, expert opinion and narrative reviews, systematic reviews of multiple intervention research studies, and surveillance data. An over-emphasis on a "gold standard" of evidence (RCTs) leads to lost opportunities to gather additional evidence for interventions at various levels of the hierarchy of evidence.

A narrow definition of evidence further disadvantages communities of color, and especially Hispanics. An over-emphasis on RCTs can also further disadvantage communities of color in general, and Hispanics in particular. Cultural appropriateness is recognized as critical in the selection and use of evidence-based interventions, but Hispanics are underrepresented in research studies seeking to establish evidence for interventions, and especially in RCTs. These low levels of participation of Hispanics and other 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. Most evidence-based interventions have been developed and tested largely with and for non-Hispanic White patients; this is especially the case for interventions to treat

mental health and drug abuse problems.

The Perfect Storm. An over-emphasis on focusing only on a gold standard of evidence has broad consequences, among them: (1) Researchers working with the Hispanic community and who are constrained to select EBIs have limited options; (2) Clinicians seeking to "scale up" interventions with high public health significance within Hispanic communities have limited options; and (3) 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. We 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 interventions with the highest levels of evidence.

Given this state of affairs, our recommendations include:

Expanding the definition of evidence and making funding available to interventions along a continuum of evidence. Considering the full continuum or hierarchy of evidence rather than a more narrow definition of evidence (i.e., RCTs) is critical. Furthermore, there must be expanding funding opportunities for interventions with emerging evidence, including community-defined evidence. Making discretionary funds available to researchers working on community-based interventions targeting Hispanic subpopulations is also imperative, as well as encouraging collaborations between researchers and service providers in Hispanic communities to speed up development.

Enhancing our knowledge of culture and context and increasing Hispanic representation in the evidence-gathering process. Increasing Hispanic participation at all levels of the hierarchy of evidence is a must. This will add to the ecological validity of EBIs and broaden our understanding of the community context of Hispanics, resulting in service delivery models that are tailored to Hispanics' circumstances and special needs. We must also encourage the adaptation and cultural modification of those interventions that do not have promising effect sizes with Hispanic samples. Finally, we must attend to the diversity in the Hispanic population by re-examining data from 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.

In summary, a focus on evidence in the selection and implementation of psychosocial interventions for Hispanics is important and should continue. Given that Hispanics are grossly under-represented in randomized clinical trials, however, 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.