EVIDENCE-BASED PRACTICE IN MENTAL HEALTH CARE TO ETHNIC MINORITY COMMUNITIES: HAS ITS PRACTICE FALLEN SHORT OF ITS EVIDENCE?

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Abstract: Evidence-based practice (EBP) has contributed substantially to the advancement of knowledge in the treatment and prevention of adult mental health disorders. A fundamental assumption, based on documented evidence of effectiveness with certain populations, is that EBP is equally effective and applicable to all populations. However, small sample sizes of ethnic minority populations in randomized clinical trials prevent strong and clear conclusions about the effectiveness and generalizability of EBP with regard to people of color. In addition, the appropriateness of EBPs to ethnic minority communities has rarely been investigated. This article critically examines the applicability and dissemination of adult mental health EBP to diverse ethnic minority populations. It highlights limitations of EBP rooted in its epistemological narrowness, exclusion of communities of color, and lack of cultural competence and examines whether the practice of EBP has overstepped its evidence. This article presents a framework characterized by pathways of epistemological partnership and substantive inclusion of racial and ethnic minority groups to facilitate the promotion of culturally responsive EBPs and to inform mental health practice and policy implementation.

Key words: cultural competence; evidence-based practice; mental health disorders; Mental health policy; racial and ethnic minority groups

Evidence-based practice (EBP) in the provision of mental health care for adults is a powerful mandate in the United States, where it has dramatically influenced and transformed mental health services in many communities and contributed significantly to the advancement of knowledge in the treatment and prevention of mental health disorders. A major impetus for EBP is the need to increase the effectiveness of mental health practices with clients through the use of standardized interventions based on rigorous scientific research (Drake et al., 2001). As primary agents in the delivery of mental health services to historically underserved and marginalized ethnic communities, social workers are committed to the provision and use of treatments and services known to promote the health and well-being of

diverse populations of clients. This commitment impels social workers to examine and potentially expand current ideas of what constitutes evidence rather than to assume that scientific knowledge is superior to other sources of evidence, including cultural ways of knowing (Whitbeck, 2006).

In the field of medicine, Sackett, Richardson, Rosenberg, and Haynes (1997) originally conceptualized EBP as being informed by the following types and sources of evidence: the current best evidence in making decisions about the care of the individual, clinical expertise, and the client's experiences and preferences. All three types of evidence were crucial and conjointly respected. Gambrill (2006) likewise noted that important sources of knowledge and evidence include clinicians' knowledge and experience of particular contexts and specific clients as well as qualitative findings on the beliefs, preferences, and practices concerning mental health care within diverse cultural communities. These perspectives support more inclusive approaches to EBP in the provision of mental health care. However, in practice they have been overshadowed by much narrower understandings of EBP that are based on a biomedical research model that sets a priority for evidence derived from well-designed and carefully implemented randomized controlled trials (RCTs) (Egger, Smith, & O'Rourke, 2001). In addition, meta-analyses of RCTs also contribute to the documentation and understanding of the accumulated evidence.

This narrow understanding of EBP, which is promulgated by many researchers, practitioners, state divisions of mental health, funding sources, and legislative bodies as the exemplary paradigm or gold standard for mental health practice, markedly influences the priorities of funding sources, state policies, curriculums in schools of social work and psychology, and editorial policies of scholarly journals (Tanenbaum, 2005). Despite its valuable emphasis on rigor and demonstrated outcome effectiveness, EBP falls short in several key domains, especially with regard to the inclusion of the varying perspectives and stakeholders within communities of color and the generalizability of results to diverse racial and ethnic populations. Thus, a major question persists: Has EBP, despite its prominence in mental health program planning, fallen short of its evidence with ethnic populations?

EVIDENCE-BASED PRACTICE: AN OVERVIEW

The promotion and dissemination of EBP as the standard in mental health care appears very reasonable. EBP has contributed substantially to the advancement of knowledge in the treatment and prevention of mental health disorders to certain populations. Policymakers, funding sources, and service agencies are operating in a milieu of limited resources and increasing cutbacks and demands. In this context, and often beholden to federal funding, states and mental health providers are strongly motivated to use programs and interventions that have demonstrated effectiveness. In addition, political pressures are at times exerted by the federal government or courts on states to implement mental health programs that have been shown to work in cost-effective ways.

Key Assumptions

Three key assumptions undergird the promotion of EBP. First, scientific research is seen to profoundly improve the effectiveness of care. Second, EBPs warrant funding on the basis of their demonstrated successful implementation and effective outcomes. Because they use scientific rigor to document improved outcomes, EBPs have a competitive advantage in securing funding over other interventions that lack such clear evidence of effectiveness. Third, EBP, because it is based on documented evidence of effectiveness with certain populations, is equally effective and applicable across ethnic populations. This assumption of universal applicability directs the dissemination of EBPs.

Substantial research supports the first two assumptions. This body of evidence documents the efficacy of EBP in the treatment of many people with mental health disorders (Miranda et al., 2005; Torrey et al., 2001). In turn, many EBPs are sanctioned and advanced by representative bodies such as the National Institute of Mental Health (NIMH) and the Substance Abuse and Mental Health Services Administration (SAMHSA). However, there is little documented evidence that systematically demonstrates the validity of the third assumption—the generalizability of EBP across ethnic populations. The knowledge base of the efficacy of EBP with regard to communities of color is particularly meager (Schraufnagel, Wagner, Miranda, & Roy-Byrne, 2006). In fact, the appropriateness and applicability of EBPs to ethnic communities have rarely been critically investigated. As Takeuchi and colleagues (1999) noted, "[c]ultural factors are critical to understand access to mental health services, the proper screening and diagnoses that lead to treatment, and the actual effectiveness of treatment" (p. 565). However, the cultural experiences and context of ethnic communities rarely inform the development and implementation of EBPs.

The growing caution about the indiscriminate use of EBP as the gold standard in mental health program planning may signal that EBP has overstepped its evidence and science concerning ethnic populations (Bernal & Scharron-Del-Rio, 2001; Lau, 2006). The caution also compels us to carefully examine the limitations of EBP.

Key Limitations

The promotion of EBP over the years has revealed a number of limitations, ranging from an unclear definition and the exclusion of ethnic minority populations in research to serious epistemological differences and shortfalls in cultural responsiveness in interventions.

Definitional ambiguity. What is EBP? No consensus currently exists on how to define it (Hoagwood & Johnson, 2003; Reid & Colvin, 2005). Drake and colleagues (2001) defined EBP as any practice that has been established as effective through scientific research according to a clear set of explicit criteria. Research has identified the following salient features: designs must be conceptually sound and internally consistent, the intervention must demonstrate superiority to another therapy and

must include a strong evaluation component to measure outcomes, effects must be replicated by at least two additional investigators, treatment manuals must be used, therapist training and adherence must be standardized, and sustained long-term outcomes must be demonstrated (Lonigan, Elbert, & Johnson, 1998; U.S. Department of Health and Human services [HHS], 1999). Focusing exclusively on scientific evidence, this predominant approach contrasts with the broader definition of EBP espoused by Sackett and colleagues (1997): "Evidence-based practice is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual [clients]" (p. 2). This evidence is informed by the conjoint consideration of clinical expertise and the client's experiences and preferences.

The lack of a uniform definition is further blurred when the term "evidence-based practice" is used interchangeably with the terms "best practice" and "promising practice." The indiscriminate use of these terms conveys equivalency in meaning, but different criteria are applied in the literature, across practice settings, and by funding agents to define these practices. At the same time, some agencies make clear distinctions among these terms. For example, the Washington Institute for Mental Illness Research and Training (2003) in adapting definitions from the western regional Center for the Application of Prevention Technologies (1999) distinguished among the terms as follows:

> Best Practices are strategies and programs that are deemed research-based by scientists and researchers through a number of organizations, including … the National Institute of Mental Health (NIMH), National Institute for Drug Abuse (NIDA), American Psychological Association, National Association of Social Workers, National Center for Substance Abuse Prevention (CSAP), National Center for the Advancement of Prevention (NCAP), National Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the National Department of Education (DOE).
>
> Promising Practices are programs that seem effective, but do not have enough outcome data or have not been sufficiently evaluated to be deemed a best practice (p. 3).

Ideally, these programs or strategies have some quantitative data showing positive outcomes over a period, but they lack enough research or replication to support generalized outcomes. Clearly, the use of different definitions and processes to identify EBPs hinders discourse and the advancement of knowledge and contributes to differential expectations in mental health care.

Exclusion and homogenization of racial and ethnic minority populations. Miranda and colleagues (2005) conducted a recent comprehensive review of evidence-based mental health practices for ethnic populations. Their review provides a leading per-

spective on EBP and its applicability to diverse populations of color. They concluded that

> the impact of evidence-based mental health care on ethnic minorities found a growing literature that supports the effectiveness of this care for ethnic minorities. The largest and most rigorous literature available clearly demonstrates that evidence-based care for depression improves outcomes for African Americans and Latinos, and that results are equal to or greater than for white Americans. Much fewer data are available for Asian populations, but the literature that is available suggests that established psychosocial care may well be effective for this population (p. 133).

This optimistic stance reflects much of the current thinking concerning EBP; that is, it can be universally applied to heterogeneous ethnic minority populations with effectiveness similar to that found with white, non-Latino populations. Recent literature supports the effectiveness of evidence-based mental health care for African Americans and some Latino populations in the area of depression and anxiety (Miranda et al., 2005; Schraufnagel et al., 2006). However, this growing literature consists of very few studies, only several of which focus on American Indian/Alaska Native populations. In addition, the body of empirical evidence regarding outcomes in other areas of mental health care for ethnic minority populations is scant compared with evidence of effectiveness for white populations. A closer look at the actual research studies is warranted and reveals a different picture.

The HHS (2001) report, *Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General* provides clear evidence of the historical lack of inclusion of ethnic minority populations in mental health research. The supplement examined controlled clinical trials used by professional associations and government agencies to establish treatment guidelines for four major mental health conditions: bipolar disorder, schizophrenia, depression, and attention-deficit/hyperactivity disorder. From 1986 to 1994, nearly 10, 000 people participated in RCTs to evaluate the efficacy of interventions for the aforementioned disorders. These studies formed the science base upon which EBPs were identified and legitimized. Noteworthy is the fact that studies failed to report information on the race or ethnicity of nearly half of the participants. For an additional 7 percent of participants, studies reported the designation "nonwhite" without specifying the ethnic group. In total, only 561 African Americans, 99 Latinos, 11 Asian Americans/ Pacific Islanders, and 0 American Indians/Alaska Natives were available for analysis (Aisenberg & Robinson, 2004; Miranda, Lawson, & Escobar, 2002). This lack of inclusion and the failure to consider the racial and ethnic identities of adult ethnic minority populations is similarly found among 27 studies from 1986 to 1997, which formed the evidence base for the American Psychiatric Association guidelines for

depression care. Among the nearly 4,000 participants in these studies, there were only 27 African Americans, two Asians, and 241 nonwhite participants (American Psychiatric Association, 2000).

These findings highlight that mental health EBPs have been historically standardized and normed with white non-Latino adult populations. The dearth of people of color represented in RCTs for mental health disorders contributes to the scant published studies that examine the efficacy of specific treatments or service delivery interventions for ethnic minority populations and the lack of well-controlled efficacy studies that examine outcomes of mental health care for people of color (Miranda et al., 2003; Miranda et al., 2005). A review of the literature and a search of the web sites of well-established agencies and associations such as the NIMH, NIDA, and NASW identified only a handful of mental health programs implemented with people of color that meet stringent EBP criteria (Aisenberg & Robinson, 2004).

The unambiguous evidence of exclusion of people of color in RCTs contributes to five major issues. One, it prevents strong and clear conclusions about the efficacy of most mental health EBPs with regard to people of color. Such generalizability has not been substantially demonstrated, especially in terms of their relevance, appropriateness, and applicability to Asian/Pacific Islanders, American Indians, and other ethnic minority populations. Two, it raises serious questions about the legitimacy of disseminating EBPs to ethnic populations, especially because most EBPs have been developed without consideration of the cultural context and identity of communities of color. The universal approach of EBP fails to respect or understand the contextual realities of the histories, languages, values, traditions, and indigenous wisdom of diverse communities of color that affect the use and delivery of mental health services (New Freedom Commission on Mental Health, 2003). Three, it helps promote the use of standardized measures not normed for diverse ethnic groups. Such dependence is problematic because many standardized measures are not culturally appropriate or informed about idioms of distress specific to particular cultures (Stamm & Friedman, 2000). Some behavioral health and mental health terminology common in practice in western countries does not exist in some cultural groups. For example, some Asian cultures lack a word for "depression." Four, scant research examines the heterogeneity within ethnic groups, including ethnic differences in patterns of mental disorders and treatment outcomes. Researchers and practitioners often address the mental health needs and concerns of Chinese, Japanese, Vietnamese, Korean, Cambodian, and Samoan communities as if they are all alike because they are Asian/Pacific Islanders. In doing so, they underestimate the differences in the range of national backgrounds, social classes, legal statuses, levels of acculturation, migration histories, literacies in English, and sense of stigma, among other distinctions that exist across these populations (Alegría et al., 2004). Similarly, although most Latinos share the common language of Spanish, substantial differences exist, for example, between Mexicans, Cubans, Puerto Ricans, and Salvadorans in terms of their per-

ceptions of mental illness, experiences of help-seeking, and preferences for mental health treatment. This heterogeneity within racial and ethnic group classifications is rarely taken into account in the development and dissemination of EBP. Five, the lack of representative numbers of ethnic minority populations in RCTs thwarts the attainment of a primary objective of EBP, namely, the distribution of treatment to address disparities (New Freedom Commission on Mental Health, 2003). Scant data exist on the effectiveness of EBPs, reducing the disproportionality of access and use of mental health services by people of color. However, research consistently highlights that disparities in mental health care to ethnic populations persist (Chow, Jaffee, & Snowden, 2003; Lagomasino et al., 2005).

Epistemological narrowness. A serious limitation stems from the fact that EBP privileges scientific knowledge over other epistemologies. For many ethnic minority communities, wisdom has been passed on through oral tradition. This wisdom has served ethnic minority communities for generations and has been a resource and protective factor in promoting resilience and well-being. However, this wisdom is often met with skepticism from empiricists who are unfamiliar with this form of knowing. An oft-made assumption is that scientific knowledge is superior to cultural ways of knowing (Whitbeck, 2006). Consequently, adhering to EBP without also incorporating indigenous ways of knowing may delegitimize treatments known to be effective in ethnic minority communities (Tannenbaum, 2005).

EBP also reflects and perpetuates the dominant culture's preeminent influence in establishing the norms in defining what is EBP, in determining what constitutes valid problems or needs, and which of those merit intervention. In doing so, EBP adheres to and promotes the western medical model of practice. This model is individualistic and dualistic in nature, accenting the separation of body and mind and spirit. As a result, it is not congruent with many of the values and norms of ethnic minority communities that are allocentric and collectivist in nature (Aisenberg & Robinson, 2004). Adherence to the western model often serves as a powerful barrier to the legitimization of practices engaged within ethnic minority communities that are known to be effective by their members. Adoption of EBPs by American Indian communities, for example, usually necessitates the abandonment of traditional holistic approaches, such as the use of sweat lodges, in favor of fragmented, westernized approaches to care (Baines, 2005; Cross, Friesen, & Maher, 2007).

Another facet of the epistemological narrowness of EBP is its linear, top-down process of implementation, with knowledge being generated in academic settings and then transferred to practitioners. Evidence generated in research settings, with highly trained specialist providers and homogeneous subject samples, may have limited application to community practice settings with diverse patient populations, who frequently have comorbid conditions and often face multiple stressors on a repetitive basis (Miranda et al., 2005; Nock, Goldman, Wang, & Albano, 2004).

This hierarchical, top-down approach in the development and dissemination of EBPs clearly reveals the lack of ties between research and communities of color as

well as between research and service providers. These gaps hinder engagement in authentic partnership that is mutually beneficial and that promotes meaningful and sustainable change in the community and in systems of care. Ethnic populations continue to experience being an afterthought. Such an approach in the dissemination of EBPs perpetuates mistrust within ethnic communities that is rooted in historical experiences of marginalization and oppression by the dominant culture. Also, this mistrust is based on communities' experiences of researchers conducting research without much respect or regard for the community or without helping to promote meaningful change through their scientific endeavors. Consequently, communities of color often experience the dissemination of EBP as something that is being imposed on them, perpetuating a legacy of oppression by the dominant culture or government entity.

Shortfalls in cultural competence and cultural "adaptations." As previously noted, the development and dissemination of EBPs are rooted in a homogenized approach in which the cultural values, norms, and histories of ethnic minority populations are rarely taken into account. Such an approach thwarts the capability of EBPs to be culturally competent. Cross, Bazron, Dennis, and Isaacs (1989) defined cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (p. 13). Cultural competence implies having the capacity to function effectively as an individual and as an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (Cross et al., 1989). On the basis of EBPs' disregard of cultural factors, it is not surprising that ethnic communities recognize the lack of goodness of fit of many EBPs with the indigenous practices already being effectively implemented by culturally competent service providers.

Among the several studies of the efficacy of EBPs for diverse ethnic groups, researchers typically seek to make cultural "adaptations" to their standardized treatment models for purposes of diffusion (Aisenberg & Robinson, 2004). This practice is insufficient for the provision of effective and efficacious treatment. Efforts to "adapt" EBPs to diverse ethnic minority groups without attending to cultural context and indigenous practices are unlikely to lead to effective treatment (Koss-Chioino & Vargas, 1999). Also, the process by which "adaptations" are made lacks scientific rigor. Whereas EBPs provide detailed, manualized descriptions of their treatment with rigid adherence to specific algorithms, in most cases EBPs provide little description on how they ensure fidelity to their treatment model when making adaptations in engaging communities of color and in different contexts. Also, scant research exists regarding adaptations made by EBPs to practice-related exigencies as well as accommodations of practice settings to EBPs (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). Consequently, the following critical questions remain unanswered: How do practitioners and researchers make appropriate cultural adaptations of EBP? To what extent do evidence-based mental health interventions

need to be culturally adapted to be effective for diverse ethnic populations and for diverse contexts (for example, urban or rural)? What characteristics of EBP, the client, or both determine who will respond to treatment? Why have EBPs failed to reduce disparities in the access and use of mental health services across many racial and ethnic minority groups (Miranda et al., 2005; Mullen & Streiner, 2004)?

It is imperative that policymakers, mental health practitioners, and service researchers heed the compelling and unequivocal body of evidence regarding EBP. Few mental health EBPs have been developed with people of color in mind. Most EBPs lack sufficient evidence of their applicability and effectiveness in communities of color. It is unreasonable to expect that evidence-based mental health programs can be uniformly applied to diverse communities and to presume a good fit or the same results when many such programs fail to take culture into account. It is unjust to mandate the provision of EBP to communities of color without including in the processes of defining, implementing, and evaluating EBP members of these diverse communities and representatives of service agencies responsible for providing mental health care within these communities. EBP promotes social inequality because communities of color and their voices are largely excluded from these crucial decision-making processes.

Furthermore, it is misleading and erroneous to assert the superiority and applicability of EBPs for communities of color over existing practices in communities of color. In general, EBPs are no more standardized for application in communities of color than are practices that are currently being implemented by ethnic community-based agencies. These agencies often have evidence of a program's effectiveness but lack the infrastructure or evaluative rigor to promote and legitimize their innovative program or intervention as an EBP. To continue to uphold EBP as the gold standard in mental health care while minimizing or ignoring the multiple deficits in the development, implementation, and dissemination of EBPs to ethnic minority groups promotes injustice. Rather than merely affirming the strengths of EBP, glossing over its limitations, and being uncritical in our acceptance and promotion of EBP, we must acknowledge the prominent weaknesses of EBP and address them in comprehensive ways.

PATHWAYS TO INCLUSION AND INTEGRATION

In working toward the goal of making the practice and application of EBP more just, it is imperative that we retreat from the historically privileged foundation that has informed its development, implementation, and evaluation of EBP and traverse a new pathway of inclusion and integration. Rather than trying to adapt or "fit" people of color into conceptualizations and models of practice derived from a white Eurocentric culture, a paradigm shift is required.

Toward this goal, I make the following recommendations to serve as a framework to begin to address the insufficiently culturally competent implementation of EBPs within communities of color and to promote the acceptance and competent use of EBPs within diverse ethnic minority communities. These recommendations require

substantial engagement with and investment in ethnic minority communities to address persistent disparities in mental health care, promote culturally competent and effective practice, and engage in authentic partnership and meaningful transformation. The following major pathways address the limitations identified earlier:

- from epistemological narrowness to epistemological partnership

- from exclusion and homogenization to substantive inclusion of racial and ethnic minority groups

- from shortfalls in cultural competence and cultural adaptations to cultural responsiveness.

Epistemological Partnership

A shift from a "research into practice" model to a "research in practice" model is needed. In the latter, practitioners and clients partner with researchers in the generation of knowledge and strategies for implementing treatment on the basis of that knowledge. This paradigm shift requires that the history, experiences, and wisdom of people of color along with the expertise of practitioners be valued in much the same way as is the science of efficacy (Tinsely-Jones, 2001).

Another crucial step involves increasing the number of ethnic minority researchers. The persistent lack of ethnic minority investigators leading mental health research studies limits the opportunity to answer research questions that an insider who well understands the culture and nuances of a community might investigate to advance the knowledge base and promote meaningful change in the lives of the residents of the community (Aisenberg & Robinson, 2004).

Research must engage communities of color as legitimate partners in the pursuit of advancing knowledge and transforming the provision of mental health systems of care and services. A recent report by NIMH (2006), "The Road Ahead", calls for such collaborative and sustainable partnerships among diverse stakeholders. Such partnerships ensure community participation and cultural tailoring for successful intervention development and improvement of care. Research of the effectiveness of such partnerships is warranted.

Members of communities of color are weary and leery of researchers with traditional agendas that leave their communities bereft of meaningful change. A crucial step involves the effective recruitment and respectful engagement with diverse ethnic minority populations in scientific endeavors, including RCTs. To engage communities of color and to enhance the provision of culturally competent mental health services, policymakers and practitioners must listen to and learn from these communities and their contextual realities. The voices of ethnic minority communities must be included in the planning stages of EBP rather than seeking them out after the fact to merely rubber stamp policymakers' decisions. Meaningful and authentic participation must be a central aim. As Woody and colleagues (2003) noted, "[b]

ecause only a portion of clients resemble participants in clinical trials, a fully relevant model of EBP must use evidence obtained locally from each client" (p. viii). Important characteristics of successful partnerships involving community-based agencies and academic institutions include shared decision making, equitable sharing of resources and power, and mutually beneficial goals and reciprocity (Holland, Gelmon, Green, Greene-Moton, & Stanton, 2003). Only with such inclusion is it possible for researchers and providers to more fully understand and appreciate current beliefs and past experiences of people of color, and how these have shaped their prevailing attitudes and preferences of the acceptability of treatment, to facilitate the provision of effective care (Schraufnagel et al., 2006).

The inclusion and use of knowledge from multiple sources—science, clinician, and patient—should be equally valued. The original perspective of evidence-based medicine (EBM) provides important leadership toward a new pathway of integration and can serve as a crucial example for social work. Rather than advocating rigid adherence to a manualized program void of cultural context, EBM respects the context of service delivery, the environment of the client, and the client's experiences and preferences. As noted by Sackett and colleagues (2000), EBM esteems the evidence science posits from systematic research in making decisions about the care of individual patients. However, EBM allows for an expanded definition of evidence and integrates the contribution of multiple sources of evidence in the processes of diagnosis and treatment, including clinical expertise and consumers' cultural experiences and wisdom.

This original vision and philosophy of EBM, if fully heeded, would address a major flaw of many EBPs that results from their reliance on scientific empiricism and evidence from clinical, randomized trials. The prescriptiveness of an EBP should not take precedence over or undermine clients' cultural values and community decision making. Adopting an inclusive approach would allow agencies and providers to integrate the best science available with clinical expertise and the client's culture, values, and preferences for the client's well-being. Integrating these sources of evidence and key stakeholders' knowledge and understanding of the sociocultural contexts of these communities is crucial for the acceptance, effectiveness, and sustainability of EBPs.

Substantive Inclusion of Racial and Ethnic Minority Groups

A sharing of power and resources to address disparities in the access and use of mental health and other services is warranted. A culturally sensitive approach toward the use of EBP requires a shared vision and commitment of all stakeholders, both urban and rural. Inclusion at decision-making tables with regard to the definition, development, dissemination, and evaluation of EBPs that is competent with regard to cultural, linguistic, familial, and unique mental health service needs of diverse ethnic minority populations must become standard practice. Outcomes that are valued by consumers and families should influence the EBPs that are developed and studied (Drake et al., 2001).

Substantial long-term funding must be provided to identify existing effec-

tive practices with communities of color and to promote their legitimatization as promising practices and EBPs. Also, funding support is warranted to test current models with diverse populations so as to guide and inform adaptation efforts (Lau, 2006). Such sustained investment is critical to improving trust with ethnic minority communities and promoting culturally competent interventions. The lack of funding to identify and evaluate existing practices that are promising and that support development of known effective practices within communities of color has been a significant barrier to the development of EBPs that are responsive to the real-world context of communities of color.

Representatives of heterogeneous ethnic community-based agencies and ethnic minority researchers must be included in decision-making bodies and processes at local, state, and federal levels to inform the cultural adaptations of EBPs. Also, such representatives must be active participants and leaders in the planning, development, and implementation of the evaluation of EBPs. This representation is warranted to address the intersecting challenges of EBP programs in implementing "high-fidelity replications" while ethnic minority communities are both seeking solutions uniquely suited to their circumstances and wanting to "own" these programs. Also, this inclusion and partnership is essential to ensure relevance, accountability, and credibility.

Cultural Responsiveness

Assessment, treatment, and service delivery models should be informed by the wisdom and experiences of communities of color and should be responsive to the expectations and behavioral preferences of these communities (Marin, 1990; Tinsely-Jones, 2001). Drawing from Bernal and colleagues' (1995) work on key features of culturally valid interventions for Latinos, I posit that it is not sufficient to merely provide a literal translation of a manualized protocol in the appropriate language in the adaptation of EBPs. From a practice perspective, cultural adaptation of EBPs must be more comprehensive and must address both language and context. Metaphors—culturally appropriate idioms, symbols, and nonstigmatizing language—can be included in the process and content of the intervention. The adaptations must incorporate cultural values, customs, and traditions into the content of the intervention. Cultural similarities and differences between clientele and providers, what Bernal et al. called the *persons realm*, should be addressed in a direct but nonthreatening manner. From a research and theoretical perspective, the goals of the EBP should be framed within the values and traditions of the client's culture. The conceptualization of the problem and treatment should be consonant with cultural values. The methods or procedures for achieving treatment goals should also be informed by the client's preference (for example, psychotherapy or medications) and be compatible with the cultural values of the group or groups of interest. It is important that the EBP take into account and be responsive to the historical, economic, acculturative, and social context of the clients. In addition, new assessment

instruments must be developed with the input of underrepresented racial and ethnic populations and age groups to ensure that protocols are culturally relevant, effective, and replicable across multiple settings (National Implementation Research Network [NIRN], 2003).

Data-based outcomes assessment of the cultural competence of EBP programs must be integral to the development and dissemination of EBP (NIRN, 2003). To transform the mental health field and improve the quality and effectiveness of mental health services to ethnic populations such assessment is fundamental.

CONCLUSION

These recommendations represent a critical shift away from a monocultural, Eurocentric framework and from a narrow, positivist perspective on knowledge gathering and dissemination. As mental health practitioners, administrator of behavioral health and community-based agencies, skilled policy advocates, and scholars committed to intervention research to promote meaningful individual and social well-being, social workers should provide dynamic leadership in the development and implementation of EBP and service delivery models that are responsive to diverse ethnic populations. Our engagement with diverse communities and our recognition of the importance of the culture, context, and environment of our clients strongly position us to make a substantial contribution to the planning, development, and implementation of EBP in ways that are responsive to the needs of diverse ethnic minority populations and inclusive of the history, traditions, experiences, culture, and practical wisdom within these communities.

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