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Denise L. Villegas
What Is The Efficacy of
Evidence-Based Practice in
Mental Health Treatment of
Diverse Ethnic Minorities?

ABSTRACT

This mixed-method exploratory study attempted to examine the efficacy of evidence-based practice (EBP) in mental health treatment of diverse ethnic minorities. The study utilized an online survey consisting of demographic, multiple-choice and narrative questions. Twenty-one clinicians who utilized EBP interventions in their clinical practice completed this survey. The current EBP research lacks equal representation of ethnic minorities in the study populations. EBPs are increasingly mandated through agency policy and legislation (Carter, 2008). While broad claims are sometimes made that such interventions will “work” for everyone, it is noteworthy that diverse ethnic minorities are often not included in much of the EBP research. In addition, little has been done to remedy this disparity. The major findings were that many clinicians felt that the success of EBPs in mental health treatment of ethnic minorities to be only effective “sometimes.” Participants noted that cultural modifications played a crucial role on the efficacy of EBP interventions. Future research designed to examine the role of how culture impacts efficacy and ways to account for cultural difference could add to our knowledge base.

WHAT IS THE EFFICACY OF EVIDENCE-BASED PRACTICE IN MENTAL
HEALTH TREATMENT OF DIVERSE ETHNIC MINORITIES?

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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Summer, 2009

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CHAPTER I

INTRODUCTION

An area of research in need of attention is the effectiveness of evidence-based practices (EBP) with diverse ethnic minorities who are receiving mental health treatment. EBP is a widely used term and the definition being used for the purposes of this study includes, “any practice that has been established as effective through scientific research according to a clear set of explicit criteria. . . Such 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 standardized, and sustained long-term outcomes must be demonstrated” (Aisenberg, 2008, p. 299). Most EBP interventions are empirically supported treatment approaches that are validated by random clinical trials. Currently there is limited information on the utility of EBP with varied ethnic groups. The few studies that have been conducted indicate positive trends. This research paper explores to what extent EBP interventions might be beneficial to ethnic minorities.

Research done by Whaley & Davis (2008) notes that there have been “ethnic/racial disparities in the utilization of mental health services,” (p. 565). This may correlate to the inadequate amount of culturally inclusive treatment methodologies for ethnic minority clients. Many past studies show that EBP techniques have been effective among white European Americans (Horrell, 2008). This research project examined the

effectiveness of EBP techniques with diverse populations through the clinicians' perspective. There is a limited amount of research about clinicians' perspectives and this study was aimed at beginning to address some of these research gaps.

A mixed-method design was used to gather exploratory data in order to collect information about the current state of efficacy with underrepresented populations. A questionnaire was distributed through e-mail and the resulting 21 clinician-respondents were used to better understand their clinical perspectives related to the use of EBP in their mental health treatment of ethnic minority clients. The goal of the study was to identify clinicians' perspectives about the efficacy of specific EBP interventions and their impact on overall clinical practice. Open-ended questions were included in the questionnaire to allow for further communication with clinicians. Evaluating the usefulness of these interventions with diverse ethnic populations that are otherwise overlooked and underrepresented in the current EBP research is a step towards addressing the disparity in the research literature.

CHAPTER II

LITERATURE REVIEW

Evidence based-practice continues to be a growing trend in both the medical and mental health field. The concept of being able to “prove” that treatment interventions actually “work” sometimes gives a false sense that certain treatment approaches are “guaranteed” to be effective. Unfortunately, such claims sometimes include the use of evidence-based practice (EBP) interventions that incorrectly suggest that their use to be universally effective (Huey & Polo, 2008). There is a dearth of research related to EBP with diverse populations. The following literature review examines the current data on the effectiveness of EBP in mental health treatment with diverse ethnic minorities.

This researcher first examined the validity and reliability of current EBP research with majority populations and ethnic minorities. Next, this writer scrutinized the problems within those studies related to culture and ethnicity in order to gain a better understanding of issues affecting research. What follows is an examination of factors to consider when undertaking research with diverse populations and the important role of culture. There will also be a review of alternate methods of research that may be helpful and possibly equally effective in relation to work with ethnic minorities. A review of studies that included clinicians’ and clients’ perspective will be taken into consideration in relation to the efficacy of EBP.

Current EBP Research With Majority Populations

In 2006 the Substance Abuse and Mental Health Services Administration (SAMHSA) launched The National-Registry of Evidence-Based Programs and Practices (NREPP) website (Hennessy, Finkbiner & Hill, 2006). The website was aimed “to provide the most transparent and accurate information to the public” (p.22). When “mental health treatment” is selected, 31 interventions are listed (National-Registry of Evidence-Based Programs and Practices, 2007). From the 31 interventions, 21 EBP interventions included a study population comprised of a majority of participants identified as white. Based on the data from NREPP (2007), it appears that a majority of the studies conducted were effective with white participants. The following studies showed efficacy and includes the specific ethnic breakdown shown in the table below (NREPP, 2007).

| EBP Mental Health Intervention | Study Population |
|---|--|
| The Adolescent Coping With Depression (CWD-A) | Study 3: 80.6% White, 19.4% Race/ethnicity unspecified |
| Chestnut Health Systems - Bloomington Adolescent Outpatient (OP) and Intensive Outpatient (IOP) Treatment Model | Study 1: 81% White 12% Black or African American 7% Race/ethnicity unspecified |
| Children's Summer Treatment Program (STP) | Study 1: 95% White, 5% Unspecified, Study 2: 92.6% White, 3.7% American Indian or Alaska Native, 3.7% Race/ethnicity unspecified, Study 3: 79% White, 21% Race/ethnicity unspecified |
| Cognitive Behavioral Social Skills Training (CBSST) | Study 1: 80% White, 20% Race/ethnicity unspecified |
| Cognitive Behavioral Therapy (CBT) for Adolescent Depression | Study 1: 83.2% White, 16.8% Race/ethnicity unspecified, Study 2: |

| | |
|---|---|
| | 82.1% White, 17.9% Race/ethnicity unspecified |
| Cognitive Behavioral Therapy (CBT) for Late-Life Depression | Study 1: 93.3% White, 3.3% Black or African American, 3.3% Hispanic or Latino |
| Coping Cat | Study 1: 78% White, 22% Black or African American, Study 2: 85% White, 5% Black or African American, 5% Race/ethnicity unspecified, 3% Asian, 2% Hispanic or Latino |
| Dialectical Behavior Therapy (DBT) | Study 8: 87.1% White, 12.9% Race/ethnicity unspecified, Study 9: 94% White, 6% Race/ethnicity unspecified |
| Family Behavior Therapy (FBT) | Study 1: 91% White, 9% Race/ethnicity unspecified, Study 2: 87.8% White, 12.2% Race/ethnicity unspecified |
| OQ-Analyst (OQ-A) | Study 1: 94.5% White, 1.5% Black or African American, 1.5% Hispanic or Latino, 1.5% Native Hawaiian or other Pacific Islander, 1% Asian |
| Psychoeducational Multifamily Groups (PMFG) | Study 4: 87% White, 10% Race/ethnicity unspecified, 3% Black or African American, Study 5: 95% White, 5% Race/ethnicity unspecified |
| Seeking Safety | Study 5: 100% White, Study 6: 88.2% White, 11.8% Black or African American |

A majority of the studies have focused primarily on white participants rather than non-minority ethnic groups (Aisenberg, 2008) as well as in research about evidence-based treatments for suicidal adolescents (Muehlenkamp, Ertelt & Azure, 2008). The researchers note the lack of diversity in the research, noting that there are “...no known diversity guidelines for working with suicidal adolescents from varied cultural groups” (Muehlenkamp et al. 2008, p.116). A review of evidence-based psychosocial treatments

for eating problems and eating disorders reflects the same concern, with white participants making up 60% or more of the studies' samples. Again, the research shows EBP in mental health treatment appears to be effective for persons from the dominant group but fails to address the needs of ethnic minorities.

Current EBP Research With Ethnic Minorities

There have been a small number of studies that examined the effectiveness of EBP mental health treatment with ethnic minority populations. Horrell (2008) examined recent cognitive behavioral therapy (CBT) studies in her literature review. There appeared to be some promising findings with a small sample of ethnic minority communities that were targeted in her examination of 12 studies with participant numbers ranging from 5 to 267. The participants were African American, Asian American and Latino. When cultural modifications were made, such as translating the CBT interventions to the client's native language or changing some of the language in the intervention to accommodate the patients' education level, the effectiveness of the treatment appeared to increase. For example, symptoms such as anxiety and depression were reduced. Mental health issues that were treated, in relation to the studies that Horrell (2008) examined, with CBT included Depression, PTSD, Panic Disorder with Agoraphobia, and Substance Abuse. There were some possible confounding variables that may have impacted the "effectiveness" of CBT in the treatment of PTSD. One variable discussed was the use of psychotropic medications congruent with CBT treatment. It was difficult to draw a conclusion that CBT alone was the main factor in the

patients' improvement since many of the participants were also taking medications.

Another possible confounding variable included cultural modifications such as translating CBT into the native language of the participant or ethnic matching of patient and therapist, which may have explained the findings rather than the CBT itself. This type of early research may be helpful when examining the validity of specific EBP treatments with varying ethnicities.

A comprehensive study was done by Huey and Polo (2008) that looked at a variety of evidence-based interventions specifically focusing on ethnic minority youth that included a brief meta-analysis of overall treatment effects. Seven problem areas were identified: anxiety-related problems, depression, conduct problems, substance abuse problems, trauma-related problems, mixed behavioral and emotional problems, other psychosocial problems, and seventeen EBP mental health interventions (Huey & Polo, 2008). A majority of the EBP treatment was focused on African American and Latino youth. The results suggest that the youth seemed to benefit from different treatment modalities such as cognitive behavioral therapy (CBT), interpersonal psychotherapy, behavioral/skills training, and peer modeling interventions. In addition it was noted that certain interventions appeared to be particularly successful with specific ethnic populations. These interventions included Brief Strategic Family Therapy for Latino youth with conduct problems and Multisystemic Therapy for African American youth with delinquency issues. These findings may provide some basis for future

research regarding the effectiveness of EBP mental health interventions with diverse ethnic populations.

Although there are few studies about the use of EBP mental health interventions with American Indian and Alaskan Native communities, Gone & Alcantara, (2007) completed a literature review of treatment outcome studies about mental health interventions that included these populations. A skills training course called Coping with Depression was created for older American Indians at risk for depression with declining health. Another intervention included a Zuni Life Skills Development curriculum that was aimed at high school youth at risk for suicide. The interventions were modified to incorporate aspects of the participants' culture by consulting the tribal community to help ensure cultural relevance (Gone & Alcantara, 2007). Community members were also involved in the development of, or as instructors of, the curriculum. Participants of both studies benefited from the interventions in that their symptoms decreased in severity. The participants were given a self-report survey before and after treatment. They reported being "less suicidal, less hopeless and more skillful at suicide intervention and problem solving" (Gone & Alcantara, 2007, p. 359). More research is needed to address the needs of these communities and increase the access to EBP interventions.

An emerging trend in some of the EBP mental health literature is the role of cultural content in relation to delivery of the intervention. An example of this is Multidimensional Family Therapy (MDFT), which appears to be an effective intervention for African American adolescent males with substance abuse problems (Liddle, Jackson-

Gilfort, & Marvel, 2006). The emphasis on incorporating the culture of the youth's world (i.e. street, family, school) seems to be an integral aspect of the treatment's success. According to Liddle et al. (2006), MDFT research that targeted ethnic minority communities in their controlled trials found that "95% of clients in intensive outpatient MDFT stayed in treatment for 90 days, compared with 59% in residential"(Liddle et al. 2006, p. 222). This study is a critical example about the benefits of using EBP mental health interventions that acknowledge the unique characteristics of different ethnic groups.

Problems With Current EBP Research

Although some research studies suggest that EBP may be beneficial in treatment within diverse ethnic groups, the reliability of some of those results is questionable. There are also a number of evidence based-studies that do not include minority populations, while other studies have very few people of color included in the study sample (Whaley & Davis, 2008). This appears to be a recurrent issue in much of the research on EBP mental health interventions. Some of the figures from Huey and Polo's meta-analysis (2008) illustrate this point in the following two excerpts:

Although the sample size was small ($n=12$), Ginsburg and Drake found that adapted GCBT (group cognitive behavioral therapy) benefited anxious African American adolescents and that adapted GCBT was superior to an attention control placebo (p.279).

Incidentally, Mufson and colleagues found IPT (interpersonal psychotherapy) superior to placebo control and treatment-as-usual in two randomized trials with predominantly Latino youth. However, Latinos comprised less than 75% of each sample, and thus neither met inclusion criteria for this review (p.279).

There appears to be a clear need for more adequate studies that include a statistically representative sample of varying ethnic groups. An important characteristic of sound research is to utilize a sample size that can be better generalized to the population. In this regard, much of the EBP intervention research continues to be lacking. Huey and Polo (2008) note in their meta-analysis that “the literature is characterized by unrepresentative samples, Eurocentric outcome measures, inadequate sample sizes, and few direct tests of key theoretical assumptions (p. 296). Another concern with current research is that at times it can appear exclusionary because factors associated with race and ethnicity are not taken into consideration and analyzed (Whaley & Davis, 2008). This may be attributed to an inadequacy of a particular ethnic group under study, which is needed in order to be considered statistically significant (Chambless & Hollon, 1998). The inadequacy of racial diversity continues to be a critical research problem and needs greater attention. There is a need for more comprehensive recruitment of diverse ethnic populations in research.

Other problematic issues with recent studies have been that randomized clinical trials (RCT) are not necessarily the best way to test for efficacy within diverse communities (Horrell, 2008). The way the research is conducted and measured may only support one ethnocentric perspective, leaving more questions than answers about the true efficacy of EBP in mental health related to issues of diversity. Drop out rates of ethnic minorities in research have been noted to be significantly higher than those of white research participants (Horrell, 2008). There is no mention about what causes higher drop

out among ethnic minorities, and due to the current problems with EBP research this is an issue that needs further examination. Higher drop out rates with ethnic minorities highlights the limitations of the sampling when there is considerably less ethnic diversity represented in a study. An example of this was found in the study by Munoz & Mendelson (2005) who noted a higher drop-out rate in Latino patients who were younger in outpatient treatment at the SFGH Depression Clinic. In research by Evans, Connell, Barkham, Marshall and Mellor-Clark (2003) they described how “ethnic minority clients in the service were more likely to have an unplanned ending than ‘White/European clients’” (p.385). Horrell (2008) also highlighted a similar occurrence in her review of CBT studies that “ethnic minorities are more likely than Whites to drop out of studies” (p. 164). This was illustrated in one CBT study where only 74 of 175 patients completed the study (Horrell, 2008). According to Wong, Kim, Zane and Huang (2003) Asian Americans have a pattern of premature termination in mental health treatment. More research must be done to reduce attrition rates with diverse ethnic groups in order to have an appropriate sample from which to draw generalizable conclusions.

When ethnic minorities have been included in EBP research, there is a disproportionate amount of such research focusing primarily on African Americans and Latino Americans. Drawing attention to this problem in combination with the fact that many of the studies have small sample sizes, we must be aware that flawed research could lead to stereotyping of certain ethnic groups. Huey & Polo (2008) expressed their concern of this issue in the following excerpt: “Given the socially constructed nature of

ethnic categories, and potential risks for stereotyping, caution should be exercised when making claims about the efficacy of treatment for any particular ethnic group” (p. 296). In addition Asians, Asian Americans, Pacific Islanders, Arab Americans and Indian Americans have not been adequately represented in EBP studies (Huey & Polo, 2008). Furthermore, the tools to measure “efficacy,” were created for white European Americans and are not accurate tools to measure effectiveness with those who are considered “ethnic minorities” (Huey & Polo, 2008).

Another area of concern in EBP mental health research is the lack of wait-list groups within some of the studies that are inclusive of ethnic minorities (Horrell, 2008). A waitlist group is usually a comparison group of participants that does not receive the treatment intervention (Chambless & Hollon, 1998). When there is no wait-list group in the study then it may not be considered as efficacious because all participants received the same treatment. Again, although there may be an appearance or claims of positive results because a study has been done with a minority group, the validity of the study may be questionable. Some researchers have noted that there is an unrepresentative sample of diverse ethnic populations in the majority of the EBP research. Aisenberg (2008) highlighted this point in the following excerpt:

“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,” (p.298).

Due to the lack of cultural and ethnic diversity in much of the EBP literature, clinicians are left with very limited treatment options with clinically sound empirical evidence.

There are a very limited number of EBP interventions that have been identified to be effectively used among Alaskan Natives and American Indians. In an examination of prior research by Gone and Alcantara (2007), only 2 studies were identified to include “controlled outcome studies with adequate sample sizes and interpretable results” specific to Alaskan Natives and American Indians (p. 359). Although there is a growing number of EBPs being developed for mental health treatment there is also a growing disparity in EBP treatments specific to Alaskan Native and American Indians. In a study by Dixon et al. (2007) they discovered that *Keepin’ it R.E.A.L.*, a prevention intervention program developed for Latino, African American and European American youth was not appropriate for American Indian youth and may have increased the problem behavior. The researchers note that this may have been due to the fact that “Native specific-theory indicates that adverse health outcomes, such as drug use, may be related to current and past trauma of Indigenous peoples such as colonization, traumatic life events, and discrimination” (Dixon et al. 2007, p. 563). The aforementioned social stressors may not have been able to be addressed by the *Keepin’ it R.E.A.L. program*. This type of outcome raises concerns about generalizing treatment interventions developed for certain ethnic populations. Although an intervention may be deemed successful with a particular minority group, there must be recognition of the diversity among different ethnic communities and that a treatment that works with one population may not be appropriate

for all ethnic minorities. Researchers must confront this issue of acknowledging diversity within ethnic populations and develop methods that could be more inclusive of the layers of diversity among ethnic minorities.

Research With Diverse Populations

One way of identifying differences among varying ethnic groups is to assess cultural processes. This involves a comprehensive look at acculturation, ethnic identity or enculturation and ethnic minority socialization (Cauce, 2002). Cauce (2002) noted that, “Mexican Americans born in the U.S. evidence nearly twice the rate of mental health problems than first generation immigrants,” (p. 295). This is an important point because it notes the vulnerability experienced by Mexican American populations in regards to mental illness. Awareness of these factors may not be as salient when studying white participants, but appears crucial when working with this ethnic group. It is a vital first step to recognize how differences among ethnicities must be considered in relation to efficacy studies of EBP. It is imperative that the research on EBP mental health takes into account the diversity of experiences within the populations being served and how it impacts mental health treatment.

In a study conducted by Wong et al. (2003) the researchers assessed cultural variables and treatment credibility perceptions in relation to treatment effectiveness, “whether a client believes that the therapy will be effective in solving his or her problems” (p.89). The study points to how culture plays an important role in regards to receiving mental help and the effectiveness of mental health treatment. In order to

strengthen the empirically supported evidence of EBP, researchers must acknowledge and consider the role of culture as it relates to ethnic diversity. An important finding from the study is the need to differentiate between ethnic differences versus psychological variations due to ethnic diversity, as is captured in the following quote by Wong et al. (2003): “Findings highlight the complexity and importance of examining specific psychological processes associated with ethnicity rather than focusing on gross ethnic group variations” (p. 94). There is much diversity among different ethnic groups and different cultures. Hall (2001) acknowledges this point in his research and notes, “immigration history and recentness of immigration, language skills, perceived minority status, experiences with discrimination, and socioeconomic status,” are unique experiences among diverse ethnic communities (p. 504). The data that can be gathered by noting these experiences can help inform what cultural variables influence psychological practices. This type of information is needed, not only in identifying effective EBP mental health interventions but also in development of EBP treatments. The findings from this study may also help to explain some of the factors that contribute to ethnic minorities having a higher dropout rate in mental health treatment.

There are many points to consider when undertaking research with ethnic minorities. Interdependence, spirituality, and discrimination were significant constructs that Hall (2001) identified which “differentiate ethnic minority from majority persons in the U.S.” (p.506). This list of constructs helps researchers begin to examine concrete variables related to the individual experiences of persons from different ethnicities and

cultures. Hall (2001) also notes that the increasing research currently being undertaken is focused on ethnic minorities in culturally sensitive therapies (CST). Collaboration between EBP mental health researchers and CST researchers may help both parties in marrying the need for evidence-based practices with culturally sensitive treatment approaches. This is necessary to begin to close the gap with underrepresented ethnic populations in the growing EBP research.

Another crucial component in conducting EBP mental health studies is acknowledging how researchers are perceived by the ethnic community they are studying and how to appropriately engage them in the research. Gone & Alcantara (2007) documented this within the Alaskan Native and American Indian communities. There is a considerable amount of suspicion from the tribal people because of the historical context of their interactions with European Americans. “More specifically, the culture of the mental health clinic is not the culture of the reservation community,” (Gone & Alcantara, 2007, p. 361). There is a belief within these populations that they will be “brainwashed” to be like “Whitemen.” Such mistrust is not unwarranted and is indicative of what must be addressed before beginning any type of research among tribal communities.

One approach to take with the aforementioned consideration is to work with diverse ethnic populations using a collaborative stance rather than a “colonizing perspective,” (Domenech-Rodriguez & Wieling, 2005). There is a degree of sensitivity needed from social scientists in order to engage the underserved minority ethnic groups

in relation to EBP studies focusing on mental health. A shift in the perception of the researcher, among community members, as being invested in the welfare of the community being studied rather than being perceived as just using the community to get information is what Domenech-Rodriguez and Wieling (2005) explained as being a key feature in being able to work more effectively with ethnic minorities. Concrete suggestions such as these appear culturally relevant to the populations being studied and suggest the need for replicated studies within specific ethnic groups or across varying ethnic communities. Being able to foster trust and understanding between the researcher and the persons being studied must be part of the protocol related to such research.

Certain logistical issues must also be taken into account. Horrell (2008) suggested, “providing services such as daycare, transportation to and from the research site, and monetary reimbursement,” as ways to encourage research participation in underserved ethnic communities. Additional recommendations include developing culturally sensitive measures that are not predominantly Eurocentric and emphasizing the need for training researchers to be culturally competent (Horrell, 2008). The process involved in mental health treatment of individuals appears to be the same type of process needed for research. In other words, researchers must be sensitive to the diversity among participants and limit the tendency to be exclusive by being flexible and meeting the needs of the participants. There are a number of considerations that have been proposed to direct future research in a culturally and ethnically inclusive manner.

Incorporating Diversity Into EBP Research and Treatment

There have been a few studies that examined the role of culture and ethnicity with evidence-based practice in mind. Researchers from the United Kingdom have proposed Practice-Based Evidence (PBE) to help complement EBP and incorporate client ethnicity, something EBP research has not been able to do (Evans, Connell, Barkham, Marshall, & Mellor-Clark, 2003). The researchers collected PBE data through a national database, where clinicians and clients would be asked to participate through self-report measures and evaluation forms about mental health treatment. It appears to be a promising endeavor to begin to address the limitations of EBP research in relation to capturing treatment responses of ethnic minority patients. Clearly, cultural modifications of the questionnaires should be made to be inclusive of diverse ethnic communities. Evaluation of how the database addresses issues of diversity needs to be done before adding it as a complement to EBP research.

Another related study by Munoz and Mendelson, (2005) may have potential for effectively developing culturally appropriate EBP interventions based on work with diverse ethnic populations. The researchers used the following concepts when developing changes to treatment approaches. These included the, “selection of therapeutic principles and techniques with (potentially) universal relevance, identification of culturally appropriate intervention approaches, and empirical research evaluation of intervention outcomes” (p. 791). Munoz and Mendelson, (2005) were focused on altering the interventions to be culturally sensitive. One factor that appeared to contribute to the

success of the treatment approaches was the fact that the researchers included members from ethnic minorities and allowed them to help create culturally relevant interventions themselves. It is unclear how or to what extent the researchers incorporated clients' suggested interventions and how much influence the researchers had on the clients' themselves. The use of the approaches needs to be replicated and more studies conducted in order to demonstrate reliability and validity. What the researchers achieved in this particular study is of value in that it addressed the question of efficacy with diverse populations and showed evidence that EBP may be effective with the inclusion of the following key elements: cultural values, religion and spirituality, acculturation, and experiences of racism. In addition, prejudice and discrimination, were also important considerations when making cultural modifications.

A third study (Bernal & Scharron-Del-Rio, 2001) examined methodological approaches in research of diverse client populations. Bernal and Scharron-Del-Rio, (2001) recommended utilizing an ethnographic approach in multicultural contexts because it allowed for "a more comprehensive understanding of cultural knowledge" (p. 336). A criticism of this type of approach is that the information acquired cannot be generalized to the rest of the population. Another suggestion that appears more plausible and scientifically oriented is "methodological pluralism," which the authors have explained, incorporates research that is "both oriented toward hypothesis testing and discovery" in ethnic minority research (Bernal & Scharron-Del-Rio, 2001, p. 336). Ethnography focuses on studying people in their natural setting and how they develop

their world-view (Alexander, 2006). Methodological pluralism incorporates different ways to conduct research and different philosophies that drive the research, which allow for different methods to obtain information (Slife & Grant, 1999). Integrating these two types of research methods has yet to be tested, so there is no conclusive evidence that shows this research design would be effective with diverse populations. The research approaches suggested may begin to address the issue of diversity that is needed in EBP studies.

Another type of research, somewhat similar to PBE is “patient-focused research.” Saggese (2005) defined this paradigm as “concerned with monitoring an individual client’s progress over the course of treatment and feeding back data on their progress or lack of progress to the clinician, supervisor, or case manager. Patient-focused research attempts to answer the question, “Is this treatment working with this patient, at this time, with this therapist?” (p. 562). This appears to be a more direct route in measuring treatment efficacy and is supported by research conducted by Lambert, Whipple, Hawkins, Vermeersch, Nielsen & Smart (2003) who suggested “that formally monitoring patient progress has a significant impact on clients who show poor response to treatment, implementation of this feedback system reduced deterioration by 4% to 8% and increased positive outcomes” (Saggese, 2005, p. 562). Although this may not have the scientific reliability, validity, or generalizability of RCTs, it has the potential to provide valuable information directly from the clients being served. This can be critical in discovering the missing information from current EBP research by conducting this type of study with

ethnic minorities. Saggese (2005) identified two resources, *Assessing Outcome in Clinical Practice* by Ogles, Lambert, and Master (1996) and *Measures for Clinical Practice* by Fischer and Cocoran (1994) as useful tools for clinicians. One possible advantage of utilizing this type of research is the immediacy of results. In an era where managed care settings are beginning to mandate the use of EBP interventions in mental health treatment (Saggese, 2005) patient-focused research may be a promising tool, in showing what is “effective” in a real-world rather than a research setting.

Domench-Rodriguez and Wieling (2005) have identified two investigative approaches that focus on diverse ethnic and cultural groups. The models were created to test the effectiveness and efficacy of both mental health and social interventions. One approach is called *Cultural Equivalence Mode* that, “assumes mostly similarities across groups except for differences due to life circumstances” and the *Cultural Variance Model*, “presupposes that the unique struggles of various ethnic and cultural groups lead to variations in the culture specific values, beliefs, histories, and life experiences” (p. 319). The development of such promising measures that emphasize multicultural responsiveness can help encourage social scientists to seek a diverse sample of participants. These tools can help account for a person’s culture when studying ethnic minorities from various cultural groups.

According to Whaley and Davis (2007), “studying successful clinicians in the field, yields information about treatment efficacy” (p. 568). Again since it is known that diversity is lacking in the research, information can be collected from clinicians using this

type of intervention with diverse ethnic populations. Clinicians can provide a wealth of information about the utility of different EBP interventions and what issues arise that could potentially impact effectiveness. There have been previous criticisms made about EBP research not being conducted in real-world settings. By involving clinicians trained to use EBP mental health interventions we can begin to narrow the gap between research and reality. Whaley & Davis, (2007) note, “What they proposed is research that is based on deductive reasoning, in contrast to the principles of inductive reasoning underlying RCT methodology, to establish treatment efficacy” (p. 568). This is an example of another way of collecting data that is inclusive of ethnic minorities. A closer look at clinicians’ and clients’ perspectives about EBP mental health interventions will likely help shed some light about their impact.

Clinician and Client Perspectives on EBP Interventions

There are limited studies about actual clients’ perspectives on EBPs in mental health. One such study conducted by Scheyett, McCarthy & Rausch (2006) used a focus group consisting of clients and their families. Three significant points that the focus groups highlighted were concerns about clients having less say about the specifics of their services because an EBP was being used, the lack of clients’ voices in the development and implementation of EBPs and that “EBPs were not recovery-focused, but rather illness focused,” (Scheyett, et al. 2006, p. 248). There are only a handful of studies cited in this literature review that address these issues. Although the study sample may not be generalized to the general population, important considerations must be made that

incorporates the perspectives of those receiving the treatment. The researchers noted, “Interestingly . . . potential tension between the EBP principle of providing only those services known to work, and the recovery principle of consumer autonomy and choice in services” (Scheyett, et al. 2006, p. 253). In order to make an informed choice about treatment that has “evidence” to support its effectiveness, there must be research that is reflective of the entire population and is inclusive of diversity. This is one way of easing the “tension” and allowing clients to have control over which treatment they feel would be appropriate for their individual needs. Another significant statement that the researchers make is illustrated in the following: “Rather than only researching and implementing EBPs, we suggest that equal consideration must be given to evidence-based processes—the processes by which services are provided which result in recovery outcomes,” (Scheyett, et al. 2006, p. 253). This argument has not been adequately discussed in EBP research literature and may be a useful in order to find methods to strengthen EBPs’ efficacy.

There are challenges that clinicians face when using EBPs in mental health treatment. Nelson, Steele & Mize (2006) conducted a focus group of clinicians and identified issues that arise when implementing EBPs. Clinicians reported the following problems: EBP interventions take a lot of time to apply in a community setting, learning how to use EBPs takes a significant amount of training, and the belief among some clinicians that the research about EBP interventions cannot be directly applied to their community setting (Nelson et al. 2006). The last point may speak to the issue of ethnic

diversity. Many community settings serve diverse ethnic populations. If there is not adequate research about a particular EBP intervention with a specific ethnic group then the argument being made by clinicians may garner greater credibility.

A similar concern was noted in a study conducted on trauma professionals' attitudes toward EBPs. The researchers found that 36.4% of mental health professionals identified, "lack of generalizability of the literature to my client population" and 29.3% reported an "inability to apply research findings to patients with unique characteristics" as barriers to EBP (Gray, Elhai & Schmidt, 2007, p. 743). Clinicians are acknowledging some of the difficulties they face when using EBPs in relation to the wide diversity of their clients. A survey of childrens' mental health service providers examined the use, training and implementation of EBPs. The researchers noted that many practitioners felt that such practices "limited creativity in practice" and "were not as responsive to individual client differences" (Sheehan, Walrath & Holden, 2006, p. 170). Utilizing clinician and client feedback can significantly improve the treatment research and efficacy of EBPs among ethnic minorities.

Summary

This literature review highlights the limitations of research regarding the efficacy of EBPs in mental health treatment of diverse ethnic communities. An examination of the current research and problems within some of these studies may provide clues toward formulating a better understanding of possible reasons for the limited information on EBP in relation to the treatment of ethnic minorities. Although there have been EBP

interventions identified to have utility with certain ethnic minority groups, the data is far more limited compared to the research available for non-ethnic minorities. It is important to make careful deliberations about issues of difference related to ethnicity that may impact effective treatment. Examining the efficacy of EBPs with ethnic minorities by conducting a survey of clinicians using EBP mental health interventions is one way of discovering clinicians' perspectives on efficacy. It is for this reason that this researcher chose to formulate such an exploratory study. Collecting information from different sources, and not primarily relying on random clinical trials may help us answer the proposed question of the efficacy of EBPs in mental health treatment of diverse ethnic minorities. It appears that EBPs are effective with a large segment of the population from the dominant group. Although there is growing research about the efficacy of EBPs with minority groups, the gap between the two continues to be considerable.

CHAPTER III

METHODOLOGY

The question asked in this thesis was as follows: What is the efficacy of EBPs in the mental health treatment of diverse ethnic minorities? The purpose of this mixed-method, exploratory study was to identify clinicians' perspectives about the efficacy of EBP in mental health treatment of ethnic minorities. Evidence-based practice is a growing trend in mental health. While there are a number of studies specific to Caucasian populations, similar research is far more limited with non-Caucasian groups.

A snowball sample was used to recruit participants. Colleagues, faculty, classmates and friends were contacted to help distribute the questionnaire to clinical professionals who are required or voluntarily use EBP in their clinical practice. Researcher clinicians with published articles about the use of EBP with ethnic minorities were also contacted through e-mail about participating in the study and asked to pass along the information about the online questionnaire to colleagues.

An online survey through SurveyMonkey was distributed among 66 clinicians and 39 were returned. Among the surveys, 21 were utilized in this study. Clinicians were first asked to answer two screening questions to help determine their eligibility for the study. Then participants were asked to answer demographic questions related to their practice as well as demographic information about their client population. The survey consisted of 17 narrative and 11 varying multiple-choice questions. Overall trends were

coded and identified by this researcher and a statistical analyst assisted in the analysis of the quantitative data.

Participants were required to be licensed psychologists, social workers or marriage and family therapists who had been licensed for at least one year and who were using an evidence-based practice in their mental health treatment of ethnic minorities. Participants also needed to be able to read and write in English.

Participants utilizing SurveyMonkey were asked to read the informed consent online before participating in the survey. However, after participants submitted the survey, it was not possible for the information to be removed, because their identity was deleted by the SurveyMonkey service. This was explained in the informed consent. Researcher contact information was also included to allow participants to communicate any questions or concerns they had about the study.

Participants were asked to complete an online survey through SurveyMonkey and at the beginning, were required to answer screening questions that determined eligibility for the study. The 28-item survey via “SurveyMonkey,” consisted of narrative questions, multiple-choice questions along with statements that were rated on a Likert scale, from a scale of 1 “Always” to 5 “Rarely,” and some demographic inquiries. Participants were provided with 17 narrative questions to allow clinicians to elaborate on specific questions or topics.

The potential risks for participating in the study were minimal. Participation in the study was voluntary and respondents were allowed to withdraw from the study without penalty. Participants were allowed to skip questions to which they did not want to respond.

CHAPTER IV

FINDINGS

This study posed the following research question: What is the efficacy of evidence-based practices in the mental health treatment of diverse ethnic minorities? Twenty-one licensed clinicians completed an online survey related to the efficacy of EBP treatments. Some clinicians appeared to be in agreement that some EBP interventions are useful with ethnic minorities while also acknowledging concerns about the lack of research on ethnic minorities in much of the EBP studies. The results from this study were both quantitative and qualitative. The 17 narrative questions from the survey were coded for common themes and composed much of the qualitative data while the eleven remaining were demographic-questions, Likert-rating scale questions and multiple choice questions represented the quantitative data. The quantitative data analysis used were the Oneway ANOVA(F-Ratio), Cronbach's Alpha and T-test.

Descriptive Findings

- A total of 21 out of 66 (31.8%) clinicians completed the survey.
- The clinicians identified the following ethnic minorities they worked with: African American, Asian American, Middle Eastern, Latino, Pacific Islander, Ukrainian, Black, Native American, Afro-Caribbean, Hispanic, Chinese, Korean, Filipino, Vietnamese, Guatemalan, Mexican, Mexican-American, Dominican Republican, El Salvadorian and Cambodian.

The following tables illustrate the demographic information of the clinicians and their clinical population. Table 1 illustrates the gender of the clinicians with a majority being female. Table 2 shows the varying ethnicities and races that the clinicians self-identified. Table 3 illustrates the different professional titles that clinicians held. A majority of the study population were licensed clinical social workers. Table 4 shows the different clinical populations that the clinicians worked with. Many of the clinicians worked with adults. Table 5 shows the percentage range of ethnic minorities that clinicians worked with. A majority of clinicians in the study, 19.7% worked with 60-90% of ethnic minority clients. The set of tables 6-10 illustrate the different percentages of ethnic minorities from varying socioeconomic backgrounds, the percentage of clinicians working with each demographic and self-identified EBPs used by clinicians. Table 6 shows that 18.2% of the clinicians worked with minority clients who were upper class. Table 7 illustrates that an equal percentage of clinicians worked with clients who were middle class. A small percentage of clinicians worked with clients who were low-income in Table 8. Most of the clinicians in this study worked with ethnic minority clients who lived in poverty as shown in Table 9. Table 10 shows the EBPs used by participating clinicians.

Table 1: Clinician's Gender

| Percent | Gender |
|---------|--------|
| 19.7 | Female |
| 12.1 | Male |

Table 2: Ethnicities and races self-identified by participating clinicians

| Quantity | Ethnicity/Race |
|----------|------------------------|
| 8 | White/Caucasian |
| 2 | Black/African American |
| 5 | Asian |
| 3 | Latino |
| 1 | Indian American |
| 1 | Bi-racial |
| 1 | Undisclosed |

Table 3: Clinicians' professional licensure and/or titles

| Quantity | Professional Title |
|----------|--|
| 10 | LCSW |
| 3 | Psychologist |
| 1 | LMFT |
| 1 | Senior Planner and Analyst |
| 3 | MD |
| 1 | Clinical Director |
| 1 | Psychologist-Social Worker-Consultant Trainer |
| 1 | Psychotherapist |

Table 4: Populations served by participating clinicians

| Percentage of Clinicians | Clinical Population |
|--------------------------|----------------------------|
| 7.6% | Older Adults (60 and over) |
| 19.7% | Adults |
| 13.6% | Teenagers (13-17) |
| 10.6% | Children (4-12) |
| 3% | Toddlers (0-3) |

Table 5: Percentage range of ethnic minorities served by participating clinicians

| Percentage of Clinicians | Percentage Range of Ethnic Minorities |
|--------------------------|---------------------------------------|
| 3 | 11-29 |
| 6.1 | 30-59 |
| 19.7 | 60-90 |
| | |

Table 6: Percentage of clinicians serving upper class communities

| | |
|--------------------------|--|
| Percentage of Clinicians | Percentage Range of Upper Class (household income of \$100,000) |
| 18.2 | 1-10 |

Table 7: Percentage of clinicians serving middle class communities

| | |
|--------------------------|---|
| Percentage of Clinicians | Percentage Range of Middle Class (household income of \$45,000-under \$100,000) |
| 10.6 | 1-10 |
| 10.6 | 11-29 |

Table 8: Percentage of clinicians serving low-income communities

| | |
|--------------------------|--|
| Percentage of Clinicians | Percentage Range of Low Income (household income of \$25,000-under \$45,000) |
| 15.2 | 30-59 |

Table 9: Percentage of clinicians serving communities in poverty

| | |
|-------------------------|---|
| Percentage of Clinician | Percentage Range of Poverty Income (household income under \$25,000) |
| 9.1 | 30-59 |
| 10.6 | 60-90 |

Table 10: Self-identified EBPs used by participating clinicians

| |
|--|
| <p style="text-align: center;">EVIDENCE-BASED PRACTICE</p> <p style="text-align: center;">Eye Movement Desensitization Reprocessing (EMDR)</p> <p style="text-align: center;">Cognitive Behavioral Therapy (CBT)</p> <p style="text-align: center;">Child and Adolescent Needs and Strengths Assessment (CANS)</p> <p style="text-align: center;">Prolonged Exposure Therapy</p> <p style="text-align: center;">Cognitive Processing Therapy</p> <p style="text-align: center;">Evidence-based psychopharmacology</p> <p style="text-align: center;">Evidence-based Psychotherapy</p> <p style="text-align: center;">Incredible Years (parent education program)</p> <p style="text-align: center;">Dialectical Behavioral Therapy (DBT)</p> <p style="text-align: center;">Second Step</p> <p style="text-align: center;">Skillstreaming</p> <p style="text-align: center;">Motivational Interviewing</p> <p style="text-align: center;">Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)</p> <p style="text-align: center;">Functional Family Therapy</p> <p style="text-align: center;">Brief Strategic Family Therapy</p> <p style="text-align: center;">Multi-dimensional Family Therapy</p> <p style="text-align: center;">Multi-Systemic Therapy</p> <p style="text-align: center;">Parent-Child Interactive Therapy</p> <p style="text-align: center;">Trauma-Focused CBT</p> <p style="text-align: center;">Multi-Systemic Family Therapy</p> <p style="text-align: center;">Trauma-Focused Therapy</p> <p style="text-align: center;">Family Therapy</p> |
|--|

Quantitative Data

The study sample is limited due to its small sample size. Parametric tests were run to assess group differences (Postal, 2008). The tests used were t-tests, Cronbach's Alpha and a one-way Anova. Cronbach's Alpha was used to determine how well the five Likert (EBPHELP, EBPSSENS, EBPALLI, EBPADAP, and EBPSUCC) questions fit together. They had an internal reliability above the acceptable cutoff ($\alpha=.768$, $n=15$, n of items=5).

A t-test was conducted to determine if there was a difference in self- ratings of EBPs being more helpful with ethnic minority clients between clinicians who work with adults versus teens. There was a significant difference in the mean response to EBP

interventions. It was found that the interventions were more helpful when working with ethnic minority clients by whether clinicians worked with teens or adults ($t(10)=3.099$, $p=.011$, two-tailed). Those who worked with teens had a lower mean ($m=2.60$) than those who worked with adults ($m=4.29$). A lower response to that question indicates more agreement.

To determine if there was a difference in self-ratings of success between mandated and non-mandated clinicians a t-test was run. No significant difference was found. To determine if there was a gender difference in self-ratings of success among clinicians a t-test was run. No significant difference was found. To determine if there was a difference in the mean self-ratings of ethnic sensitivity among clinicians working with adults versus clinicians working with teens a t-test was used. A significant difference was found ($t(10)=2.40$, $p=.037$, two-tailed) but sample size is a concern. Those who worked with teens had a lower mean ($m=3.50$) than those who worked with adults ($m=4.57$). A lower response indicates more agreement. It should be noted that the sample sizes of the two groups were small, with only five clinicians working with teens and seven working with adults. To determine if there was a gender difference in the self-ratings of the therapeutic alliance among clinicians another t-test was conducted. No significant difference was found. To determine if there was a difference in the self-rating of adaptability by socioeconomic status of clients from low-income households a one-way Anova was run. No significant difference was found. To determine if there was a

difference in the self-rating of success with clients who are less educated another t-test was run. No significant difference was found.

No cause and effect conclusions can be made based on the quantitative data from this study. Due to the small sample size the research question cannot be answered by the statistical analysis alone. Examination of the narrative answers that provided the bulk of qualitative information provided rich data about clinicians' perspectives.

Qualitative Data

Narrative questions allowed clinicians to elaborate on their responses to the survey questions. This provided this study with more information about clinicians' varying perceptions and experiences with EBP in mental health treatment. Some respondents brought up important considerations about EBP interventions while others felt strongly about maintaining the fidelity of how EBP is administered. There were some trends identified in relation to the clinicians' responses and their differing points of view about the benefits and challenges of using EBP interventions with ethnic minority clients.

The Use of Evidence-Based Practice:

Question #12: If you are or are not (please indicate) mandated to use EBP interventions at all times how do you feel about this?

When clinicians were asked to rate the helpfulness of EBP interventions in relation to ethnic minority clients, 46.7% marked "sometimes." Several clinicians expressed concern about EBPs being mandated and acknowledged the limits of EBP

interventions, especially when having a mandate. Some of the respondents noted that the EBP interventions have not been studied with the population they serve. The following responses illustrate this particular theme:

“I do not like it when our department makes using EBPs a part of our “performance objective.” EBPs are not well-researched on the population I serve.”

“I am not mandated to use EBP interventions. However, I feel it is necessary to develop the EBP modality that has been successfully applied to ethnically diverse populations. There are definitely cultural factors that make more complicated and challenging in its application.”

“It is important to have some leeway as EBPs are not always normed with minority groups and it is necessary at times to “think outside the box.”

“Right now it is good not to be mandated to use EBP at all times because they are not affordable or not available for all populations—our agency infrastructures do not yet support our effective utilization of them.”

Addressing Ethnicity in EBP:

Question #13: Do you address a client’s ethnic background in EBP treatment versus non-EBP treatment in a different manner and if so, how?

Clinicians rated how ethnically sensitive they thought EBP interventions were as normally utilized. Forty-percent reported, “sometimes” while another 40% reported “rarely.” The narrative response raised a question about any difference in the way clinicians address a client’s ethnic background using EBPs versus non-EBPs. All

respondents replied, “no” and had a variety of explanations. The following statements from the clinicians illustrate the importance of acknowledging ethnicity:

“It is always important to address one’s ethnicity no matter what mode of treatment you are using.”

“When our clinicians use EBPs, we always have to modify the approach to fit the needs of the population we are serving. Otherwise, the EBP is of no use.”

“My addressing of ethnicity is similar in both EBP and non-EBP practice; that is, I always ask clients to tell me about their comforts/discomforts with me or the methods used.”

“I do note the client’s ethnic background in a different manner. The exception is if their ethnic background is relevant to the problem at hand, e.g. “I was assaulted because I was black.”

Therapeutic Alliance With EBP:

Question #14: What factors, if any, contribute to a stronger and/or weaker therapeutic alliance using an EBP intervention in relation to a non-EBP intervention?

When asked about the effect of EBP on the therapeutic alliance and whether clinicians felt that EBP impacted the strength of the alliance, 53% of them answered, “sometimes.” Some clinicians felt that the EBP intervention had a limiting affect on the therapeutic alliance while others felt that the clinical skills, not the EBP impacted the strength of the therapeutic alliance. There were different themes in the clinicians’

responses. The following two responses illustrate the theme that the therapeutic alliance is strengthened by the effectiveness of the EBP:

“Many EBP interventions that I use are CBT and a bit more directive, which can decrease the therapeutic alliance. On the other hand, when an EBP is used, patients have more confidence in the approach and that improves the alliance.”

“Evidence-based components that I utilize better facilitate this alliance because they focus on strengths and on the client taking the lead in treatment process. The client is seen as the expert in many ways and this respectful approach facilitates the therapeutic alliance, VERY well.”

The three following clinicians highlighted the negative impact of EBPs on the therapeutic alliance:

“EBPs are manualized and are not flexible enough to establish a therapeutic alliance.”

“If I adhere too strictly to the EBP manual regardless of client’s cultural background, it would impact on weakening the therapeutic alliance.”

“It may be weaker if the EBP is not working for a particular client and the clinician is too rigid to provide other interventions, thus the alliance is negatively affected (client doesn’t trust clinician).”

Adaptability of EBP Interventions:

Question #15: If you do so, when, why and how do you make such adaptations? If not, why not?

Clinicians were questioned about the adaptability of EBP interventions to meet the needs of ethnic minority clients compared to non-EBP interventions. In 33.3% of the responses, the answer was “usually.” The narrative question asked clinicians to expand on when and how they make such adaptations. The responses were mixed. Some clinicians felt that the interventions were easy to adapt and others reported that such adaptations were needed based on the client’s culture. The following two clinicians’ statements focused on the theme of EBP interventions adaptability:

“The family-focused EBP interventions are built around the kind of flexibility needed to fit a variety of diverse families. Therefore, these models need little adaptation because this flexibility is already a part of these models.”

“Sometimes I use visual or other aids instead of verbal or written materials to help those who are less easily able to read Spanish or English.”

Some of the clinicians felt that EBPs were not adaptable, as expressed in the following responses:

“I do not adapt EBPs in ways that have not been empirically validated, as it might change the effectiveness.”

“Some EBPs you cannot change too much or it takes away the validity.”

“I do not understand the EBP intervention enough to alter it without concern of undermining its effectiveness. The EBP training I have received strives to be racially and ethnically neutral.”

Other clinicians felt that EBP interventions needed to be adapted to incorporate culture as communicated by the following statements:

“It takes a lot of work to adapt the interventions. First of all, we have to translate the materials into the language of our clients if they are not English speaking. Secondly, we might have to change the way some of the content is presented to make it more culturally relevant. Our clinicians spend quite a bit of time to do this. It is fortunate that we have seasoned clinicians who have the ability to make the appropriate adaptations.”

“As a bilingual therapist, I pay attention to the proximity between the spoken words and affective experiences of the speaker (client). It seems to me it is so critical to articulate the client’s subjective experience in a way that makes sense to them. So I feel the EBP approach should be applied in a culture specific way. In other words, there’s a need for cultural adaptability.”

Success of EBPs:

Question #16: Why or why not?

Respondents were asked to rate the level of success of EBPs with ethnic minorities. Many clinicians appeared to be in the middle with 10.6% reporting “sometimes.” Only 3% of participants reported that EBPs are “often” successful with ethnic minority clients. Based on the clinician responses there may be some EBP interventions that benefit diverse ethnic communities.

The following statements made by participants note some success with EBPs but also acknowledge its limitations:

“I am apt to use what works for the client. EBP interventions are good in that the research indicates they have been successful but this may not work with every client.”

“The EBP that we have been using at our clinic has yielded good outcomes. However, the only reason that has occurred is because our clinicians have adapted the interventions so they are in the language of our clients and are also more culturally relevant. We would not be able to use EBPs without adaptations or modifications. However, the developers of such EBPs are always concerned about “fidelity” and do not show much concern about whether the EBP is suitable for everyone. Remember, when you look at research, the individuals that participated in the research usually do not reflect the ethnic minority groups.”

Three clinicians highlight successes of EBPs in the following statements:

“EBPs are usually more effective for all populations, including ethnic minorities.”

“For clients who are having emotional dysregulation issues, application of DBT (dialectical behavior therapy) has been successful for some of my African American, Chinese as well as, European American clients.”

“The models that I utilize have been researched with a variety of ethnicities and have been found to be effective and sustainable versus lack of research showing effectiveness with our more traditional ways of working. Thus, we have higher rates of success when using tested models.”

Educational Level's Relationship to the use of EBPs:

Question #19: Do you think that ethnic minority clients who are less educated respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients?

A question was raised about whether clients who were “less educated” responded to EBP interventions differently. Although 69.2% respondents reported, “no,” there were interesting explanations from clinicians that responded “yes.” The following statements illustrate some clinicians’ belief that EBP interventions are not affected by an ethnic minority client’s education level:

“If you are a skilled clinician, you can be successful with clients that are not educated. These interventions are behavioral in nature. . .not like in psychoanalysis which tends to involve more critical thinking in treatment.”

“Education has nothing to do with wanting better family relationships or knowing what you want for your family and yourself. These family-focused models do not require participants to have a certain level of education to understand the treatment.”

A few clinicians disagreed and felt that EBP interventions were impacted by a client’s education level as expressed in the following:

“Incredible Years (an EBP intervention) requires a certain reading level in order to benefit from the handouts, homework assignments, etc. Therefore, a parent with less education, especially those who are illiterate need a different format in order to benefit. Adaptations to the EBP must be made to adjust for the lower education level.”

“Clients who have limited education are more likely to “go with the flow,” not verbalize concerns, not report what is or is not working, and not want to “challenge” the clinician.”

Impact of Poverty on EBPs:

Question #20: Do you think that ethnic minority clients who are in or near the poverty line respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients?

Again, although a majority of clinicians, 61.5% marked “no,” when asked about the impact of poverty on EBP interventions, the participants who marked “yes,” were able to offer a descriptive explanation in relation to their responses. The sample size of respondents was small with a total of 13 clinicians who answered this question. The following clinician responses reflect the perspective that EBP interventions are impacted by poverty:

“When the client’s basic needs are not being met, it is difficult to get them to engage in the therapy process. The basic needs must be addressed first and then the mental health functioning of the person.”

“Parents who are in or near the poverty line are in need of much more support. They may not have the time to participate in EBPs because they have to work long hours to make ends meet. They usually have other priorities than to participate in an EBP. They may not be as focused because they have other worries. However, ethnic minority clients who do not speak English will have more barriers.”

Impact of Use of EBPs in relation to Psychotic Disorders:

Question #21: Do you think that ethnic minority clients with Schizophrenia and other psychotic disorders respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients?

There appeared to be a mixed set of responses when clinicians were asked about how EBP use works with a psychotic diagnosis. A majority of the respondents, 61.5% marked “not applicable to my practice” while 15.4% reported “yes” and 23.1% marked “no.”

The role of culture, ethnicity and their impact on EBPs in relation to the diagnosis of psychosis seemed to be on the minds of some of the clinicians in the following:

“There needs to be cultural understanding regardless of their diagnosis in general. For a psychotic patient, it is also important to pay attention to how much of their psychotic symptoms are related to culture specific behaviors. With a more accurate assessment, it would make sense to apply EBP accordingly.”

“The flawed assumption of EBP is that certain ethnic traits are interpreted as diagnosable clinical symptoms.”

EBPs and Depression:

Question #22: Do you think that ethnic minority clients with depression respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients?

The responses were limited in regards to clinicians' views about difference between ethnic minorities and non-ethnic minorities response to EBP interventions for depression. Most of the respondents, 61.5% reported, "no," while 30.8% reported, "yes." Only a small number of clinicians elaborated on the reason for their answers. One clinician felt that there was no relationship between the EBP interventions and the diagnosis of depression in the following quote:

"Individual difference makes a greater difference than ethnic ones."

Another clinician felt that EBP interventions are impacted by the diagnosis of depression of ethnic minority clients and reported the following:

"In my experience, different cultures have different ways to conceptualize depression and ways to cope with depression."

Non-Psychotic Bipolar Disorder and EBPs:

Question #23: Do you think that ethnic minority clients with non-psychotic Bipolar disorder respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients?

The responses from clinicians were minimal when asked about non-psychotic Bipolar Disorder. Most of the participants marked, "not applicable to my practice," at a response rate of 50%. Two clinicians reported "yes" and four clinicians reported, "no," without much explanation.

Personality Disorder and EBPs:

Question #24: Do you think that ethnic minority clients with personality disorders respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients?

When asked about differences in responsiveness to EBP with clients with a personality disorder 38.5% marked “no” to the question and 38.5% marked “not applicable to my practice.” Only 23.1% of clinicians marked “yes.”

Anxiety Disorder and EBPs:

Question #25: Do you think that ethnic minority clients with Anxiety Disorders respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients?

A majority of respondents seemed to agree that there was no difference found when treating anxiety disorders with EBP among non-minority and minority clients with 69.2% reporting “no.” A small number of clinicians (15.4%) reported “yes” and another 15.4% reported it to be “not applicable to my practice.” Few clinicians elaborated on their answer. Two clinicians expressed their belief that ethnic minorities diagnosed with an anxiety disorder seemed to respond well to EBPs, as noted in the following statements:

“A CBT application has been helpful for my Korean clients who are suffering from anxiety attacks.”

“If the intervention is effective, the ethnicity of the client does not appear to impact the response. I have noticed that ethnic minority clients at times receive criticism for following the recommendations of white clinicians or providers.”

Attention-Deficit and Disruptive Behavior Disorders and EBPs:

Question #26: Do you think that ethnic minority clients with Attention-Deficit and Disruptive Behavior Disorders respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients?

Many of the respondents (46.2%) marked “no” and again felt that there was no difference in clients’ responsiveness to EBPs whether they were ethnic minorities or not. Fifteen-point-four percent of the respondents stated “yes” and 38.5% “not applicable to my practice,” in relation to this question.

Impact of Gender on EBPs:

Question #27: Do you think that there are gender differences between male and female ethnic minority clients in their response to the EBP practice(s) that you use?

A large majority of clinicians (76.9%) answered “no” in relation to gender differences with ethnic minority clients. The remaining responses (15.4%) stated that there was a difference in responses between genders and 7.7% indicated “not applicable to my practice.”

Study Feedback

Ten clinicians provided feedback or had a question about the study. Some of the critical feedback was about the style of the survey while other clinicians expressed their

belief that culture is an important issue to consider in relation to the use of EBPs. A majority of the participants had no response to the last question that invited clinicians to offer feedback or ask questions. Two clinicians commented on the importance of culture in relation to EBPs, as noted in the following feedback:

“I think your issue is a very important one. Administrators who push EBPs must take into consideration the efficacy of a particular practice for a particular population. You cannot just assume that an EBP is effective just because it has been researched.”

“The role that culture plays on one’s mental health overall needs to be studied more rigorously.”

“I believe that in general the approach and the therapist’s ability to establish trust and rapport are what makes a difference in the effectiveness of the intervention, regardless of whether or not the intervention is an EBP. Being sensitive to cultural differences is what makes any method effective regardless of ethnicity, diagnosis or socioeconomic background.”

One clinician commented on an observation about issues of trust with ethnic minorities, in the following:

“I work closely with psychiatrists. I have noticed that ethnic minorities may be less willing to trust medication recommendations and be more suspicious of being “experimented upon” than white clients being treated in a (largely) white institution. Sometimes the most effective intervention I make is to encourage the clients to keep

working with the psychiatrist until a medication regime effective for symptom relief is found.”

A common trend found in several of the clinicians’ narrative responses was how the role of culture impacted the utility of EBP interventions. More than one clinician noted the importance of being culturally sensitive and making the intervention used culturally relevant. Although these findings cannot be generalized the data collected does offer some information about clinical issues that arise from using EBP in mental health treatment of ethnic minorities. A small number of clinicians communicated their awareness of the lack of research on ethnic minorities in development of EBP interventions. This knowledge appeared to strengthen some skepticism about the effectiveness of EBPs with clients they are serving, who are not part of the study populations in EBP research. Despite this fact, clinicians appeared to be on middle ground in regards to the success of EBPs with diverse ethnic minorities. Participants were able to identify that some EBP interventions seemed to be effective with their ethnic minority clients while also acknowledging that adaptations were necessary to help increase the success of the EBP intervention in treatment. Overall, the study revealed factors that appear to affect the efficacy of EBP interventions but not necessarily measure the efficacy of EBPs as a tool in mental health treatment. There were many limitations within the study that will be discussed further in the next section.

CHAPTER V

DISCUSSION

The purpose of this research study was to examine clinicians' perspectives on the efficacy of evidence-based practices in mental health treatment of diverse ethnic minorities. There were various responses among participants. Overall, clinicians noted that there were some EBP interventions, like CBT (Cognitive Behavioral Therapy) and DBT (Dialectical Behavioral Therapy) that were identified to be effective with ethnic minorities. Family-focused evidence-based therapies were also named by one clinician who used Brief Strategic Family Therapy and Multi-systemic Family Therapy, which have supporting research with diverse ethnic communities. The literature about CBT with ethnic minorities is consistent with the clinicians' responses, especially when CBT was culturally modified and translated. There was not as an expansive set of studies that highlighted DBT's effectiveness with diverse ethnic communities but the study populations from DBT research do reflect some racial diversity in some of their research studies, which helps link the effectiveness of DBT with ethnic minorities.

The role of culture appeared to be a significant theme in the clinicians' narrative responses. One caveat that some of the clinicians commented on was that only after certain adaptations were made to fit the clients' needs, was the EBP deemed helpful for clients. Some bilingual clinicians reported that the EBPs needed to be translated into concepts relevant to the client's culture to be judged as "effective." Clinicians felt the influence of culture was lacking in EBP development and research. One clinician

commented that EBPs should have “cultural adaptability.” This belief is supported by the literature about increased effectiveness of treatment when such cultural modifications have been made (Horrell, 2008). The issue of cultural relevance was a point made by one of the participants that is also noted in EBP literature with work done by Gone and Alcantara (2007) with American Indian and Alaskan Natives. The researchers adapted a curriculum intended for these populations and recruited people from those communities to ensure that the material presented was culturally relevant. Not only must the clinician make literal translations of the EBP interventions, but must also translate them so that the concepts relate to the client’s culture in order to enhance its effectiveness.

In general clinicians seemed to feel that EBP mental health interventions were successful with ethnic minorities only “sometimes.” Clinicians were split in their responses about whether EBPs were deemed ethnically sensitive or adaptable to their ethnic minority client populations. Three clinicians noted that EBPs have not been studied on the treatment populations that they serve. This feedback is congruent with current literature that questions the utility of EBP effectiveness in relation to work with diverse ethnic minorities. Three clinicians commented that EBPs are not easily adaptable in relation to meeting the needs of the ethnic minority clients they are working with. Similar to research studies, four clinicians felt that at times, evidence-based practices do not allow for flexibility in relation to the therapeutic alliance, which is similar feedback from some of the participants in this study.

The study also uncovered differences among clinicians' perceived ability to accommodate the needs of ethnic minorities in relation to the use of EBP treatment. Some clinicians felt that it was necessary to adapt EBPs in order to address the client's problems. Three clinicians focused on maintaining the validity of the EBP and not changing any of its parameters. It appeared that those clinicians were very concerned about maintaining the "fidelity" of the model.

Narrative questions allowed clinicians the opportunity to expand on their answers and provided the bulk of information for the study. The rating scale questions were useful capturing clinician perceptions of helpfulness, ethnic-sensitivity, therapeutic alliance, adaptability and the utility of EBPs.

Limitations

There were a significant number of problems with the survey. For example, there were more positive identifiers and only one negative identifier, which may have skewed the scale. There were 28 items on the survey, which made it a lengthy task to complete if clinicians answered all the questions and reflected on each narrative part. This may have been a hindrance to clinicians choosing not to participate in the survey because of time constraints. Many clinicians did not include narrative responses. Although there were mandatory screening questions at the beginning of the survey, one participant did not actually meet full criteria but took the survey anyway. Wording of some of the questions was unclear to some clinicians, including the last eight questions of the survey which some felt did not accurately capture the clinical encounters they had with clients. There

were many flaws in the content of the survey, which highlight its limited reliability and validity as a tool to measure efficacy. Clinicians who were mandated to use EBPs in mental health treatment may not have felt comfortable to freely express their opinions which may have contributed to the lack of greater participation in the survey. A factor that may have contributed to the weakness of the study was researcher bias in the construction of the survey. This investigator identifies as an ethnic minority and does not accept the claim among current EBP research that EBP interventions were created for diverse ethnic populations. Value judgments by the researcher may have negatively influenced what questions were posed and how results were interpreted.

A cause and effect relationship cannot be made from the data collected from this study. The number of participants was too small to have any conclusive results. There were flaws in the composition of the survey that impacted clinicians' responsiveness to certain questions that resulted in missing data because many participants did not answer some of the questions. The research questions that asked clinicians to self-rate using a Likert scale was flawed. The scale was skewed and did not accurately measure clinicians' perceptions of efficacy. The use of an online survey in contrast to in-person interviews may have limited clinicians' ability to expand on their answers despite the narrative questions included in the survey. Interviews allow for more free-flowing spontaneous responses with appropriate follow-up questions. Another limitation is the possibility that clinicians utilizing EBP interventions may be "overloaded" due to the involved nature of EBPs themselves. Having to complete a survey about the efficacy of

EBPs may have felt redundant for clinicians who may be required to complete outcome studies for their own clients in treatment using an EBP. Due to the many flaws and limitations within the study, the reliability and validity of the survey as a viable tool to measure efficacy of EBPs remains questionable.

Implications For Future Study

An interesting observation that was not part of the study was some differences in responses for white clinicians versus non-white clinicians. The study examined differences in responses between ethnic minorities and non-ethnic minorities to EBP interventions based on education, socioeconomic status and diagnosis. A majority of self-identified White/Caucasian clinicians responded “no” to almost all questions related to awareness of the differences in responses between ethnic minorities and non-ethnic minorities. In contrast, five out of thirteen of the self-identified non-white/Caucasian clinicians answered “yes.” For example, question 19 asked, “Do you think that ethnic minority clients who are less educated respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients.” In addition, a related question arose about what clinicians noticed and failed to notice in relation to their ethnic minority clients. It appeared that non-white clinicians were more sensitive to variability in expression of symptoms for different diagnoses and differing environmental circumstances of ethnic minority clients in relation to white clinicians. Additional research about how a clinician’s ethnicity and cultural background impacts the

effectiveness of how EBPs are implemented could provide vital information about factors that enhance or detract from the usefulness of the interventions.

The lack of diversity in a majority of the EBP research continues to be another area that needs further exploration. Although one cannot generalize the data from this research project, the need to incorporate the role of culture when implementing interventions with diverse ethnic minorities is a relevant concern. Attention to culture in clinical transactions in relation to the literature on EBP research appears to be lacking and clearly understudied. It appears that there are benefits for both clinicians and clients receiving mental health treatment when certain cultural modifications are made. While the focus of the study was on ethnic minorities, the information provided from participants highlights the need not only to acknowledge the ethnicity of the client but also the culture they identify with.

Clinicians must be fully supported in training and supervision in administering EBP interventions in mental health treatment. This is likely to enhance efficacy and help clients to flourish and benefit from the treatment. This point has been noted in studies done by Nelson et al. (2006) and Gioia (2007). There are very few studies on clinicians or clients within the paradigm of evidence-based practice in mental health treatment. As pointed out by Gioia (2007), “In mental health practice, there is a strong focus and concern about client outcomes whether EBPs are used or not. Rarely, though, do members of a treatment team get asked for feedback on their use and delivery of any of their mental health practices” (p.3). Since there continues to be under-representation of

diverse ethnic minorities in the majority of EBP research, ways of addressing this problem must be on the agenda of future researchers. Diverse ethnic communities continue to be in a vulnerable position because some EBP interventions may not have flexibility in the way they are implemented. The concern is that the EBP may not allow for cultural considerations because of strict adherence of maintaining empirical procedures. Future research may be helpful to identify barriers in recruitment and retention of the much-needed participants that reflect ethnic diversity is essential to EBP studies. More diversity within EBP mental health research should be designed to translate into an increase in available treatment modalities that are inclusive of ethnic minorities. In addition, collaboration between developers of culturally sensitive therapies (CSTs) and EBPs could potentially begin to decrease the gap in relation to issues of diversity within EBP research (Wong, Beutler & Zane, 2007). A recommendation by Alvidrez, Azocar and Miranda (1996) note that the use of simple questions measuring how participants self-identify in order to help investigators provide a better description of the study sample could help describe ethnic diversity in sampling. Conducting more extensive research on the significance of culture and its impact on implementation of EBP interventions is an area of study that needs more attention with various ethnic and cultural groups.

Summary

This study was designed to garner rich information about the experiences and concerns of clinicians at the frontlines of mental health treatment. Ultimately the aim of the study was to emphasize the importance of ethnic minority representation in EBP

research by exploring if these empirically supported practices were effective in treating diverse ethnic communities. The study was unable to conclusively measure the efficacy of EBPs in mental health treatment of diverse ethnic minorities. However, other pertinent information, such as the importance of cultural adaptability of EBPs was uncovered in the process.

It is the ethical duty of those in the mental health field to provide the best possible treatment options for the clients we serve. In an era where the promotion and development of evidence-based practices is on the rise, the same amount of attention must be used to include ethnic minority populations that are left out of the majority of EBP studies. Until ethnic minorities are fully included in the research, it is not possible to assume that “evidence-based” interventions are necessarily suitable for all communities.

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APPENDIX A

Human Subjects Review Approval Letter

March 6, 2009

Claire Denise Villegas

Dear Denise,

Your second set of revisions has been reviewed and all is fine. Your screening page looks great and you explained it very well in both documents. We are glad to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your interesting project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Alan Schroffel, Research Advisor

APPENDIX B

Informed Consent

Dear Valued Clinician,

My name is Denise L. Villegas and I am an MSW candidate from Smith College School for Social Work. I am inviting you to participate in research about the efficacy of evidence-based practices (EBP's) in the mental health treatment of ethnic minorities. I hope to learn from your experience as a clinician using an EBP as a mental health intervention with ethnic minorities. There is very little research about clinicians' perspectives in regards to this particular topic and your knowledge would be very helpful. The information that you are providing will be used in my thesis, school publication and the results will be disseminated to the those interested in these findings.

You are eligible to enter this study in that you have met the criteria to participate, based on your answers to the screening questions at the beginning of this survey. The online survey should take approximately 15 minutes to complete. Please click on "next" at the end of this page to confirm that you have agreed to become a contributing member of this study.

There is minimal potential risk for participating in the study. Your responses to the survey will be used in the dissemination of the research results and will not be kept completely confidential since the data will be utilized for presentation purposes.

There are no direct monetary benefits from participating in this project. This research is designed to yield knowledge about your impression of the effectiveness of EBP's with diverse ethnic populations. This may result in enriching the information base in the mental health field.

The responses that you provide will be disguised and presented as part of a whole data set. All the results gathered from the study will be viewed by my thesis advisor, myself, and the statistical analyst. Your information will be completely anonymous, as SurveyMonkey deletes all identifying information before sending me the survey results. In my thesis and in any publications or presentations thereafter, the information will be presented as brief illustrative quotes or vignettes. All data will be kept in a secure locked location for a period of three years as required by Federal guidelines and any data stored electronically will be protected as well. If I should need the materials beyond the three year period, they will continue to be kept in a secure location and will be destroyed when no longer needed.

Your participation is voluntary and you are allowed to withdraw from the study at any time without penalty. However, after you submit the survey, it will no longer be possible for the information to be removed, in that your identity will have been deleted by the SurveyMonkey service. You are allowed to skip questions if you do not want to respond. You can contact me through e-mail at cvillega@smith.edu if you have additional questions. If you have any concerns about your rights or about any aspect of the study, please call the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

CLICKING ON THE BUTTON “NEXT” INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Please keep a copy of this form for your records and feel free to e-mail me at cvillega@smith.edu if you have any concerns or questions.

Thank you very much for participating. The information you provide is valuable to my thesis. I appreciate your time and effort in volunteering for this survey.

APPENDIX C

Recruitment Letter

March 4, 2009

Dear (blank);

My name is Denise L. Villegas and I am an MSW candidate from Smith College School for Social Work. I am inviting you to participate in research about the efficacy of evidence-based practices (EBP's) in the mental health treatment of ethnic minorities. I hope to learn from your experience as a clinician using an EBP as a mental health intervention with ethnic minorities.

There is very little research about clinicians' perspectives in regards to this particular topic and your knowledge would be very helpful. The information that you are providing will be used in my thesis, school publication and the results will be disseminated to the those interested in these findings.

If you are interested in this study, go to SurveyMonkey at the following link:
http://www.surveymonkey.com/s.aspx?sm=KT28BwNSH5llSew29ZUNxw_3d_3d

If you have any questions or concerns you can e-mail me at cvillega@smith.edu.

Thank you very much for your time and consideration.

Sincerely,

Denise L. Villegas,
MSW Candidate, August 14, 2009
Smith College School for Social Work
www.smith.edu/ssw

APPENDIX D
Survey Questions

Screening Questions

1) Are you a clinician who has worked at least one year, as a licensed practitioner with ethnic minority clients?

Yes

No

2) Have you been trained to use a manualized EBP mental health intervention in your clinical work?

Yes

No

Demographic Questions

1) Are you mandated to use an EBP intervention?

Yes

No

2) What is your professional title? (Please indicate in the space below.)

3) What is your gender?

Female

Male

4) What is your ethnicity? (Please indicate in the space below.)

Client Population

1) What clinical population do you primarily work with? (Please check all that apply.)

Older adults (60 and over)

Adults

Teenagers (13-17)

Kids (4-12)

Toddlers (0-3)

2) Please identify the ethnic minorities you have worked with in the space provided.

(Ethnic minority refers to individuals who are not European American, generally persons that are non-white.)

3) Over the past year, approximately what percentage of your clients were ethnic minorities?

1%--10%

11%--29%

30%--59%

60%--90%

4) Please indicate percentage of ethnic minorities clients you have worked with in the past year under the following categories:

Female

1%--10%

11%--29%

30%--59%

60%--90%

Male

1%--10% 11%--29% 30%--59% 60%--90%

Transgender

1%--10% 11%--29% 30%--59% 60%--90%

5) Please indicate the percentage of ethnic minorities clients you have worked with in the past year under the following categories:

Upper class (household income of \$100,000 +)

1%--10% 11%--29% 30%--59% 60%--90%

Middle class (household income of \$45,000-under \$100,000)

1%--10% 11%--29% 30%--59% 60%--90%

Low income (household income of \$25,000-under \$45,000)

1%--10% 11%--29% 30%--59% 60%--90%

Poverty income (household income under \$25,000)

1%--10% 11%--29% 30%--59% 60%--90%

17 Item Survey

Please rate your responses from a scale of 1 “Always” to 5 “Rarely,” with the following statements and please respond to the narrative questions.

1) As a clinician I find the use of EBP interventions more helpful when working with ethnic minority clients.

| | | | | |
|--------|-------|---------|-----------|--------|
| Always | Often | Usually | Sometimes | Rarely |
| 1 | 2 | 3 | 4 | 5 |

Narrative box: If you are or are not (please indicate) mandated to use EBP interventions at all times how do you feel about this? (Please write a 2-3 sentence response in the space provided.)

2) EBP mental health interventions are ethnically more sensitive than non-EBP interventions.

| | | | | |
|--------|-------|---------|-----------|--------|
| Always | Often | Usually | Sometimes | Rarely |
| 1 | 2 | 3 | 4 | 5 |

Narrative box: Do you address a client’s ethnic background in EBP treatment versus non-EBP treatment in a different manner and if so, how? (Please write a 2-3 sentence response in the space provided.)

3) The therapeutic alliance with my clients is stronger when I use EBP interventions compared to non-EBP interventions.

| | | | | |
|--------|-------|---------|-----------|--------|
| Always | Often | Usually | Sometimes | Rarely |
| 1 | 2 | 3 | 4 | 5 |

Narrative box: What factors, if any, contribute to a stronger and/or weaker therapeutic alliance using an EBP intervention in relation to a non-EBP intervention? (Please write a 2-3 sentence response in the space provided.)

4) Do you feel able to readily adapt the EBP intervention(s) you are using to better meet your ethnic minority client's needs in relation to a non-EBP intervention(s)?

| | | | | |
|--------|-------|---------|-----------|--------|
| Always | Often | Usually | Sometimes | Rarely |
| 1 | 2 | 3 | 4 | 5 |

Narrative box: If you do so, when, why and how do you make such adaptations? If not, why not? (Please write a 2-3 sentence response in the space provided.)

5) Based on my experience, the use of EBP in mental health treatment has a higher success rate than non-EBP interventions working with ethnic minority populations.

| | | | | |
|--------|-------|---------|-----------|--------|
| Always | Often | Usually | Sometimes | Rarely |
| 1 | 2 | 3 | 4 | 5 |

Narrative box: Why or why not? (Please write a 2-3 sentence response in the space provided.)

PLEASE RESPOND TO THE FOLLOWING QUESTIONS. IF THE QUESTION DOES NOT APPLY TO YOUR PRACTICE, PLEASE CHECK THE APPROPRIATE BOX.

1) What is/are the EBP practice(s) that you currently use with clients?
(Please write a 2-3 sentence response in the space provided.)

2) What are the most frequent or most common diagnoses that you treat with the EBP(s) that you are using? (Please write a 2-3 sentence response in the space provided.)

3) Do you think that ethnic minority clients who are less educated respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients?
 Yes No

(Please elaborate in 2-3 sentences in space provided)

4) Do you think that ethnic minority clients who are in or near the poverty line respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients? Yes No

(Please elaborate in 2-3 sentences in space provided)

5) Do you think that ethnic minority clients with Schizophrenia and other Psychotic Disorders respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients?
 Yes No Not applicable to my practice

(Please elaborate in 2-3 sentences in space provided)

6) Do you think that ethnic minority clients with Depression respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients?
 Yes No Not applicable to my practice

(Please elaborate in 2-3 sentences in space provided)

7) Do you think that ethnic minority clients with Non-Psychotic Bipolar Disorder respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients?
 Yes No Not applicable to my practice

(Please elaborate in 2-3 sentences in space provided)

8) Do you think that ethnic minority clients with Personality Disorders respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients?

Yes No Not applicable to my practice

(Please elaborate in 2-3 sentences in space provided)

9) Do you think that ethnic minority clients with Anxiety Disorders respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients?

Yes No Not applicable to my practice

(Please elaborate in 2-3 sentences in space provided)

10) Do you think that ethnic minority clients with Attention-Deficit and Disruptive Behavior Disorders respond differently to the EBP practice(s) that you use in comparison to non-ethnic minority clients?

Yes No Not applicable to my practice

(Please elaborate in 2-3 sentences in space provided)

11) Do you think that there are gender differences between male and female ethnic minority clients in their response to the EBP practice(s) that you use?

Yes No Not applicable to my practice

(Please elaborate in 2-3 sentences in space provided)

12) Do you have any additional questions or comments that might be helpful in relation to the question of the use of EBP methods with minority clients?

(narrative response required)