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Citation Details

Briggs, H. B. (2010). Infusing Culture into Practice: Developing and Implementing Evidence-Based Mental Health Services for African American Foster Youth. Child Welfare, 89(1), 31-60.

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Infusing Culture into Practice: Developing and Implementing Evidence-Based Mental Health Services for African American Foster Youth

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The lack of culturally appropriate health and mental health care has contributed to the large number of African American youth and families involved in the child welfare system. This article reviews the consequences of the insufficient access to culturally sensitive, evidence-supported interventions for African American foster youth. The authors describe a framework for the development of culturally appropriate mental health interventions responsive to the needs of African Americans.

If child welfare service providers are committed to ensuring access for African American foster youth to culturally appropriate and evidence-based mental health services, then they will need to address the institutionalized inequalities in social service systems that hinder efforts to provide appropriate services to African Americans (Miller, Gil-Kashiwabara, Briggs, & Smith-Hatcher, 2009). African American youth and their families face multiple, interrelated health challenges (Smedley, Stith, & Nelson, 2003): they have the highest death rate relative to all other racial and ethnic groups; they disproportionately experience major illnesses such as heart disease, cancer, diabetes, and HIV/AIDS; and they are as likely, if not more likely, than other racial or ethnic groups to live in neighborhoods with high levels of community violence and insufficient access to public health services (Hare, 2008; Jenkins, 2009).

Partly due to these biological and environmental stressors, the need for effective, culturally competent, and evidence-based mental health services is growing among the population of African American youth in foster care (Braithwaite & Xanthos, 2009; Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Joe, Baser, Neighbors, Caldwell, & Jackson, 2009; Timmer, Urquiza, Herschell, McGrath, Zebell, Porter, & Vargas, 2006). Mental health service needs, which have been identified to be greater for African Americans than other racial or ethnic groups (Baker, Kurland, Curtis, Alexander, & Papa-Lentini, 2007), are often unaddressed by service providers while youth are in foster care (Risley-Curtiss, Combs-Orme, Chernoff, & Heisler, 1996). While a primary pathway for African American youth to receive mental health services is through juvenile justice system involvement (Rawal, Romansky, Jenuwine, & Lyons, 2004; Yeh, McCabe, Hurlburt, Hough, Hazen, Culver, Garland, & Landsverk, 2002), the supply of mental health services through the juvenile corrections system is often less than what is needed for African American foster youth.

Any systematic effort aimed at resolving the mental health crisis for African American foster youth will need to include attention to cultural knowledge, to client perspectives, and to using evidence-based practice (EBP) and empirically supported interventions (ESIs)

in culturally appropriate child welfare and mental health service systems (Briggs, 1994, 1996, 2009a; Briggs, Briggs, Miller, McBeath, & Paulson, 2009). Using cultural knowledge and client perspectives along with scientific knowledge is consistent with the National Association of Social Workers Code of Ethics. Unfortunately, African American–specific practice guidelines and lessons learned from the use of EBP and ESIs with nonmajority populations are rare. Few studies identify culturally competent interventions (i.e., interventions that are reflective of cultural values, customs, and perspectives on healing and wellness), practice strategies that are universally appropriate for the general population, or specific evidence-based mental health services for African American youth (for exceptions, see Bell, 2006; Huey & Polo, in press; Jackson, 2009; Miranda, Bernal, Lau, Kohn, Hwang, & Lafrombose, 2005). Moreover, few such interventions are commonly used by child welfare agencies (Chaffin & Friedrich, 2004).

In this article, the authors refer to two evidence-informed approaches to the provision of mental health services to African American foster youth. ESIs are single intervention methods with the strongest empirical support, often derived from laboratory or community-based conditions through the use of randomized controlled trials. In contrast, EBP is a sequential, client-centered process initiated by developing and securing answers to a client-oriented practical evidence search (COPES) question. The EBP process is designed to promote transparency, client participation, research utilization, information literacy, and shared decisionmaking in direct practice. As pertaining to the mental health needs of foster youth, this process uses client, professional, scientific, cultural, and implementation knowledge bases to aid in identifying services to address specific problem areas.

While ESIs and EBP may be used to respond to the mental health needs of African American foster youth, it is questionable whether each may be used in agencies serving minority populations. It has been suggested that child welfare client populations may not have access to ESIs and EBP partly because of providers' lack of awareness of these approaches and due to insufficient resources to

implement ESIs and engage in the EBP process (Gambrill, 2007; Gold, Glynn, & Mueser, 2006). Other reasons for the limited availability of ESIs and EBP among the African American foster care population are tied to professional, interprofessional, service provider, client, and political considerations that are explicated further herein (Briggs & McBeath, 2009; Rzepnicki & Briggs, 2004).

This article first reviews literature concerning why African American foster youth have disproportionately high mental health service needs. The second section highlights the role of culture in the design and delivery of mental health services as well as the implications of nonculturally sensitive mental health service provision for foster youth and their families. The third section presents a framework for the development of culturally appropriate mental health programming. The fourth section integrates this framework within an evidence-based context. Throughout, attention is paid to the experiences of African American foster youth.

Cumulative Stressors Impacting African American Youth and Families

African American youth are disproportionately involved in the foster care system (Derezotes, Testa, & Poertner, 2004; Hill, 2007; Needell, Brookhart, & Lee, 2003; Wulczyn & Lery, 2007). This race-based disproportionality in child welfare has been attributed to many factors, including poverty rates and other neighborhood characteristics, race-based differences in child protective services (CPS) involvement, the dearth of culturally appropriate family preservation and universal prevention programs, and institutional racism (Miller & Gaston, 2003; Roberts, 2002; Wells, Merritt, & Briggs, 2009). The disproportionate child welfare system involvement of minority populations, and African American youth in particular, mirrors the race-based trends in other human service systems such as juvenile justice (Iguchi, Bell, Ramchand, & Fain, 2005). From a cumulative risk perspective, these factors may be interrelated and may contribute to the significant need for mental health services experienced by African American foster youth (Briggs & Paulson, 1996; Williams & Collins,

2001). McCrae and Barth (2008) document how cumulative risk exposure is tied to poor mental health functioning. Theoretically, a cumulative risk perspective allows for attention to the effects of multiple stressors rather than the impact of a single condition, such as poverty, and provides a greater ability to attend to the systemic influences of race-based policies and practices on the mental health needs of African Americans. In contrast, individually focused explanations may overshadow the structural foundations of racism and its historic link to the disproportionately high rates of foster care involvement and mental health service needs among African Americans.

Using a cumulative risk lens, the significant mental health needs of African American foster youth may be tied to the effects of racial residential segregation and socioeconomic inequalities that are themselves rooted in social policies that disproportionately affect African Americans (Kunitz & Pesis-Katz, 2005), particularly those pertaining to criminal justice. Roughly one in three African American males experiences state or federal incarceration in his lifetime (Bonczar, 2003), with racial profiling tied to the increase in the different rates of incarceration of African Americans compared to Caucasian and Hispanic juveniles and adults (Iguchi et al., 2005). Briggs and Paulson (1996) find that criminal justice system involvement disqualifies individuals from securing future benefits in prevention- and intervention-focused systems that restore or preserve health and mental health; on release, convicted individuals face restrictive covenants of social policies that limit eligibility to financial benefits, enrollment in higher education, access to housing, employment, health care insurance, food stamps, and emergency health care. Within a household environment, the presence of men with criminal justice involvement is associated with depressed household income, unstable living arrangements, and domestic violence, all of which are associated with child welfare system involvement and mental health service needs (Howell, Kelly, Palmer, & Mangum, 2004; Jonson-Reid, 2004).

Community-based factors may also contribute to the cumulative health- and mental health-related stress experienced by African American families. The link between neighborhood poverty and CPS and foster care involvement is well-established (Coulton, Crampton,

Irwin, Spilsbury, & Korbin, 2007), with studies suggesting that neighborhood poverty may act as a proxy for community violence (Aisenberg, Garcia, Ayón, Trickett, & Mennen, 2008) as well as the dearth of public access to formal and informal social institutions that might provide opportunities for pro-social interaction and healthy development (Freisthler, Gruenewald, Remer, Lery, & Needell, 2007; Talvi, 2002). An additional factor that contributes to the continuing policies and practices that negatively impact African Americans in child welfare, health and behavioral health, and public welfare systems is the lack of enforcement of regulations and protections against racial discrimination that reinforces the persistence of incentives for majority cultures and inequalities, penalties, and barriers for communities of color (Freeman & Payne, 2000; Randall, 2002; Themba-Nixon, 2001). Billingsley and Giovanni (1972), Hill (2004), and Stehno (1982) provide evidence of historical and contemporary policies and practices in child welfare that have resulted in the mistreatment of African American youth, families, and communities. This lack of remediation of historical injustices may also contribute to the mental health needs of African American families involved in the child welfare system (Leary, 2005).

The Role of Culture and its Use in Mental Health Services

Beginning with McGoldrick, Pearce, and Giordano (1982), culture and ethnicity have been considered essential components of appropriate mental health care. While using culture as a practice framework has been supported on ethical grounds, there has been comparatively little empirical exploration of the influence of cultural factors on the use and effectiveness of mental health care. In describing the state of research on culturally centered interventions, Bernal (2006) notes, "Too few studies have incorporated culture and ethnicity as part of the intervention or even tested the effectiveness of these interventions" (p. 144).

Under the principle of *parens patriae,* child welfare systems are obliged to provide basic services to suit the biopsychosocial needs of

all foster youth. Unfortunately, African American populations have experienced differential treatment by child welfare service providers dating back to the origins of the formal child welfare system at the end of the 19th Century (Hill, 2004). Developed to serve exclusively Caucasian families, the child welfare system initially excluded African American children and women from services. In the service provider vacuum that resulted from segregationist policies and practices following slavery, black churches provided medical, housing, economic, social, political, and spiritual resources (Lincoln & Mayima, 1990). This use of informal mental health supports has been altered by the influx of African American youth and families into foster care largely because of integrationist efforts in the child welfare sector in response to state-initiated efforts as well as class action lawsuits focused on the unequal treatment experienced by African American youth in foster care.

The movement toward evidence-based practice has also influenced the development and provision of mental health services to foster youth and their families. Child welfare agencies are increasingly experimenting with ESIs to respond to common, often intractable client needs and problems, particularly in the mental health and substance abuse service areas (Chaffin & Friedrich, 2004; Usher & Wildfire, 2003). To be considered an ESI, a specific therapeutic practice with proven fidelity measures must be subjected to evaluation under randomized clinical trial conditions by at least two independent investigators (Walker, Briggs, Koroloff, & Friesen, 2007). Using ESIs has increased in the past decade in reaction to the adoption and diffusion of innovative developments in social, health, and medical care (Eddy, 2005) and the subsequent sponsorship of the National Institutes of Health, private accrediting bodies including the Joint Commission and the Council on Accreditation, and professional membership organizations such as the National Association of Public Child Welfare Administrators (Zlotnick, 2007). Resultantly, child welfare agencies are increasingly being encouraged to apply ESIs with their foster care populations.

Implications of Culturally Insensitive Mental Health Programming

Because few ESIs have been developed specifically for use with African American populations (Breland-Noble, Bell, & Nicolas, 2006), African American foster youth may be affected by the nonculturally competent services available in the field. The lack of culturally appropriate health and mental health services may therefore contribute to the disproportionately large numbers of African American youth who enter and remain in foster care.

Although mental health services may be provided in formal child welfare settings, they may not be provided in a culturally appropriate manner or adapted to the unique needs of diverse families. Researchers have suggested that the development of nonculturally appropriate services may lead to African American youth underutilizing mental health care (Miller & Gaston, 2003; Queener & Martin, 2001; Yeh et al., 2002). The lack of culturally appropriate mental health service provisions may compound the sense of marginalization and shame experienced by African American families involved in the foster care system (Prelow & Weaver, 2006; Pumariega, Rogers, & Rothe, 2005). Furthermore, under the rigid permanency timelines required by the Adoption and Safe Families Act of 1997, African American families may be placed in a double-jeopardy situation: mental health needs may have contributed to the formal allegation of child maltreatment leading to foster care involvement, and unaddressed mental health needs (among either the biological parents or the foster youth) may prevent the initiation and sustainment of parent-child visitation efforts, thus reducing the odds of reunification.

Foster youth whose mental health needs remain unaddressed while in care may experience worse biopsychosocial outcomes as their initial conditions become more severe. Curtis, Dale, and Kendall (1999) describe the poor adjustment, need for subsequent psychiatric care, and worsened mental health outcomes that result from foster youth receiving insufficient appropriate psychological resources and social support. Foster care permanency outcomes may also be impacted if

mental health services are not provided in a culturally appropriate manner. A body of research suggests that common approaches to mental health diagnostic assessment, treatment, and evaluation in mental health and primary health care systems may not be based on Afrocentric values and customs, and thus may not be appropriate for use with African American clinical populations (Briggs, Briggs, Miller, McBeath, & Paulson, 2009; Corneille, Ashcraft, & Belgrave, 2005; Kruzich, Friesen, Williams-Murphy, & Longley, 2002). These studies imply that racial and cultural differences in clients' expectations and needs concerning mental health treatment may impact their treatment experiences and outcomes. Another potential effect of using nonculturally competent mental health interventions with African American foster youth is the possibility of contributing to race-based stereotyping and "othering." Snowden (2003) argues that therapist distance, misinterpretation, disbelief, and labeling interfere with ethnically diverse people benefiting from mental health services. The traditional effort to preserve professional practitioner-client boundaries and the limited exposure to diverse life experiences may create a divide between the racially diverse client and Caucasian therapist. Miller and Gaston (2003) argue that child welfare service providers may fail to recognize the spiritual and relationally oriented qualities of African American youth and families as well as the culturally bounded protective factors that can be used in developing sound programs and services for use with this population and may instead label African Americans as "deviant and deficient" (p. 238). The issue of respect is another factor that is often mentioned by African American youth as being essential to the development of pro-social therapeutic relationships (Leary, Brennan, & Briggs, 2005). Within the context of mental health assessments, this "othering" may lead to the inaccurate representation of African American family and youth conditions and needs, and may therefore contribute to inappropriate mental health diagnoses and service planning.

Interventions that do not respond directly to experiences of race-based discrimination may have less relevance for African American foster youth. Bernal and Saez-Santiago (2006) argue that prior experiences of discrimination may moderate the efficacy of psychological

interventions with ethnically diverse clients. This hypothesis has received some empirical support. Caughy, O'Campo, and Muntaner (2004) found that African American parents who directly confronted their past experiences of discrimination were more likely to have children with positive behavior than parents who ignored or denied having been affected by past discrimination.

Similarly, mental health interventions that do not consider African Americans' levels of community engagement, or that do not specifically incorporate community-centered social support activities, may be perceived as alienating, thereby limiting the development of therapeutic alliances. Palmer (2001) notes that African Americans with clinical depression should be assessed to determine their perceived levels of social support, and finds that the lack of social support is a stable predictor of suicide risk among African Americans. Moreover, the role of spirituality—in particular, the connection between African American families and local religious institutions—has been considered an important protective factor for African American youth since Chestang (l972) and remains an essential factor to consider in mental health care with African American individuals and families.

Other potential consequences of using nonculturally appropriate interventions with African American youth exist. The influences of poverty and adaptation to economic deprivation are often difficult to include in foster care and mental health assessments, despite their contribution to youth developmental trajectories (Wight, Botticello, & Aneshensel, 2006). When practitioners ignore the role of poverty and lack of access to socioeconomic opportunities experienced by foster youth prior to entering care, they may be inconsiderate of youth's cultural experiences or the coping strategies they have drawn on to deal with deprivation (Bernal & Saez-Santiago, 2006). These omissions may contribute to practitioners ignoring clients' perceived strengths and may therefore reinforce a deficit-based model of intervention and self-identity.

Developing Culturally Competent Mental Health Services for Foster Youth

Scholars have supported specific strategies to promote frontline caseworkers' culture-specific knowledge as a foundation for working with African Americans and other ethnically diverse populations. Table 1 summarizes this literature via a question-based format to aid practitioners in assessing the cultural appropriateness of their interventions with African American youth and families. Miller and Gaston (2003) propose that child welfare staff develop an understanding of the cultural and community mechanisms that African Americans and other ethnically diverse youth and families draw on for support. Similarly, Woodroffe and Spencer (2003) believe that any serious effort at developing a culturally competent child welfare system should begin by working together with culturally and ethnically diverse youth and families. The authors argue that providing a forum for discussing and debunking race-based stereotypes and forming alliances with diverse community stakeholders is necessary to retool the child welfare system. Cohen (2003) argues that frontline structured decision-making processes should be informed by an understanding of clients' cultural, social, political, and economic backgrounds.

Infusing a cultural focus (cultural beliefs, customs, and strengths as units of attention) throughout the knowledge-into-action relationship is necessary for culturally competent child welfare practice. That is, in addition to retaining culturally specific knowledge, child welfare staff must engage in culturally sensitive interactions (interactions that incorporate cultural values and customs) with nonmajority youth and families. Bernal and Saez-Santiago (2006) argue that child welfare caseworkers should be able to recognize, articulate, and verify the role of various ethnic and cultural themes, language, expressions, and behaviors in the therapeutic process. Also, practitioners should be sensitive to whether and how the therapeutic process requires modification in response to individual, familial, and cultural customs (Bernal, 2006).

For example, in their model for developing culturally centered interventions, Bernal and Saez-Santiago (2006) describe the eight

Table 1
Organizational Experience with Cultural Difference as Context for Intervention Selection

What Have We Learned from Our Clients About Serving African American Children and Families in a Culturally Appropriate Manner?	What Have We Learned from Others About Serving African American Children and Families in a Culturally Appropriate Manner?
• Why do we believe that our existing staff have the ability and desire to work with our clients? • What evidence do we have to justify the belief that our program innovations are appropriate for our clients? How strong is this evidence? • Are our service approaches congruent with the cultural values of our clients? To what extent are these models compatible with their language, norms, beliefs, and values? • To what extent are these program models responsive to our knowledge concerning our clients' disability status, sexual orientation, gender, age, literacy, income, and within-group diversity? • Do our clients do appreciably better when served by our programs? Why or why not? • What needs to be added or removed from these program models to ensure that they are culturally appropriate for our clients?	• What information exists to identify the staff characteristics necessary to work with African American children and families? • What evidence exists to suggest that our program models are appropriate for African American children and families? How strong is this evidence? • Are these program models congruent with the cultural values of African American children and families? To what extent are these models compatible with their language, norms, beliefs, and values? • To what extent are these program models responsive to population factors such as disability, sexual orientation, gender, age, literacy, income, and within-group diversity? • Is there evidence to suggest that African American children and families do appreciably better when served by these program models than when served in other ways? • What needs to be added or removed from these program models to ensure that they are culturally appropriate for African American children and families?

processes that should be considered by practitioners providing mental health care to ethnically diverse people:

(1) Because language is a central mechanism through which cultural and emotional experiences are conveyed, practitioners need to familiarize themselves with the way ethnically diverse people convey values and norms through language. Misunderstanding idiomatic messages may negatively impact the treatment process and treatment efficacy.
(2) Practitioners must be able to elicit client expectations, acknowledge cultural differences and similarities in the therapeutic relationship, and develop appropriate and culturally sensitive therapeutic relationships (relationships between the therapist and client that incorporate cultural values, beliefs, and customs in the change process).
(3) Using culturally informed metaphors allows the practitioner to draw on important images and materials that reflect cultural symmetry and that have cultural meaning.
(4) Practitioners should have content knowledge concerning important standards, belief systems, and practices that are common to individuals of a particular cultural group. This information is essential for normalization, grounding the treatment experience within a familiar context for the client, and thereby avoiding client alienation. (A practice resource is "The Provider's Guide to Quality and Culture" [Management Sciences for Health, 2009].)
(5) Attention to cultural concepts allows practitioners to gauge the degree to which their communication is compatible with the client's cultural context.
(6) The creation of therapeutic goals and objectives should reflect cultural expectations and positive cultural norms to reinforce the client's indigenous and evolving cultural interests, resources, and frames of reference.
(7) Practitioners should be trained in and use culturally sensitive processes that recognize, honor, and incorporate cultural customs as well as engage in activities that aid the

therapeutic approach and draw on cultural customs of health and healing.

(8) Practitioners should consider the "social, economic, and political contexts" (Bernal & Saez-Santiago, 2006, p. 128) in which culturally diverse youth and families exist.

These contextual considerations are important to avoid treating African Americans or other minority youth and adults with therapeutic approaches that are incompatible with their ethnic socialization, enculturation, or acculturation experiences (Cauce, 2002).

In summary, culturally sensitive mental health interventions for use with African American youth and families should share some common attributes. They should incorporate client preferences and cultural knowledge; ensure that their major concepts, philosophies, and treatment paradigms are consistent with participants' worldview; remove barriers in language and use symmetrical cultural and treatment concepts; include culturally based supports in program delivery that may involve indigenous family resources or include functions that can be done by community residents of like minds and perspectives; and elicit participants' input into the treatment planning and delivery process.

Creating an Organizational Environment Supporting Culturally Appropriate Practice

How caseworkers take culture into consideration is an issue of organizational adaptation; one particular aspect of this issue is how and by who services and programs are designed and implemented. McPhatter and Ganaway (2003) suggest that culturally effective practice requires the elimination of organizational, interprofessional, and individual barriers to professional development rooted in dominant Caucasian values and customs. Ongoing organizational assessment and sustained management-led change processes are essential to move practitioners toward cultural competence. Mederos and Woldeguiorguis (2003) identify three nested models that facilitate culturally appropriate frontline service provision. The first model, cultural sensitivity, encompasses using relevant cultural knowledge as a basis for using empowerment practices; hiring staff who reflect the

target population; developing culturally bounded community partnerships and frontline staff training, system redesign, and service modification; and using performance measurement to track the delivery of culturally sensitive child welfare programming. The second model, self-reflective cultural sensitivity, builds on the first by sponsoring the use of management and staff self-inventories. Such efforts engage staff and management in ongoing critical inquiry by calling into question the organizational and cultural values shaping frontline service practices as well as the objectives and overall goals of major child welfare programs. The third model, cultural solidarity, allows management to assess the potentially oppressive nature of existing agency and programmatic policies, practices, and community partnerships that may lead to or ameliorate negative outcomes for racial or ethnic minority client groups. This three-stage embedded perspective locates client empowerment centrally in the process of improving service systems, and validates clients as legitimate resources and essential cultural allies. These models represent increasingly engaged levels of culturally competent service provision and thus give service providers a graduated set of principles for infusing cultural considerations into the service efforts of child welfare staff and their managers. These models also reflect the relational processes and managerial and staff behaviors of an inner-city child welfare and mental health agency in which one of the authors used EBP to improve the cultural appropriateness of service provision to and clinical outcomes for African American foster youth and their families (Briggs, 1994, 1996).

Developing and Implementing Evidence-Based Mental Health Services for African American Foster Youth

Given the attention to evidence-based practice by policymakers and child welfare systems, building cultural considerations into mental health services for foster youth will necessarily involve integrating culture into ESIs. Because few mental health ESIs have been adapted for use with nonmajority cultures (Aisenberg, 2008), it is unclear whether available mental health ESIs serving African American

foster youth can respond to the culturally specific considerations described in the preceding section. Greater efforts should therefore be made to develop ESIs suitable for use with diverse child welfare client populations and in different community contexts (Wells, Merritt, & Briggs, 2009). Studies in EBP (Briggs & Rzepnicki, 2004; Wells & Briggs, 2009), behavioral social work (Pinkston, Levitt, Green, Linsk, & Rzepnicki, 1982), and knowledge of Afrocentric values and culturally competent practice (Briggs, 2009a; Gambrill, 1997; Tolson, Reid, & Garvin, 2003; Leary, Brennan, & Briggs, 2005) comprise the knowledge and database supports for the delivery of evidence-based mental health services in child welfare settings.

Designing and implementing ESIs for racially diverse child welfare populations may be facilitated by a collaborative planning approach that allows clients to engage as partners in the process of identifying client and community strengths and needs, problem definition, and intervention development (Briggs, 1994; Gambrill, 2004; Shlonsky & Stern, 2007). Attending to client perspectives may improve the cultural compatibility between program goals and client expectations (Briggs, 2001, Briggs, 2009a). The task-centered practice model, an ESI that incorporates all aspects of EBP, provides a culturally sensitive approach for planning ESI selection and EBP use with African Americans (Briggs, 2009b; Briggs, McBeath, & McCracken, 2009). Participants in this process should be sensitive to differences within as well as across ethnic groups or other demographic characteristics. Finally, administrators of child welfare service systems should examine what additional training and resources service providers will need to adequately implement different ESIs (McCracken & Corrigan, 2004). Briggs (2009a) has developed culturally sensitive roles for social workers providing training and technical assistance to African American foster parents using EBP to select and apply culturally sensitive or ESI methods to improve service effectiveness for African American foster youth with serious emotional disorders.

At a community level, the development of culturally sensitive ESIs should be carried out in collaboration with community partners. Client self-determination and allowing clients to select between different treatment options should be included as specific components

of the intervention, which should be piloted and evaluated systematically prior to being disseminated community-wide. Process evaluations should be used to identify which aspects of the intervention were perceived by participants as being the least/most useful and culturally sensitive, and outcomes studies should be conducted only after community partners are comfortable with the pilot intervention.

Attending to Culture in Other Evidence-Based Models

EBP, practice-based evidence (PBE; Briggs, 2009b), and evidence-based management (EBM; Briggs & McBeath, 2009; Kovner & Rundall, 2006) models specifically incorporate client perspectives into the search for and implementation of best practices and allow for service tailoring in response to service provider and client strengths. The EBP and PBE models allow providers to develop therapeutic alliances with youth and families along the lines of Bernal and Saez-Santiago (2006). Originating in medicine and social work in the 1960s, EBP requires that practitioners infuse client preferences into the treatment decision-making process. PBE approaches implemented through partnerships with diverse cultural groups are indigenous practices endorsed by the community. These practices are developed and used by indigenous groups and their efficacy has not yet been evaluated through randomized controlled trials. The service engagement model developed by Briggs (2009b) and African American community leaders in Portland, Oregon resulted in the increased use of mental health services by adult African Americans. An example of a culturally appropriate ESI is the task-centered practice model (Briggs, McBeath, & McCracken, 2009). Briggs (1994, 1996, 2001) notes that this model was used successfully to improve foster care permanency outcomes and mental health outcomes in an inner-city child welfare agency. Finally, EBM provides a quality assurance method for managers to elicit client and staff perspectives in addressing agency-based and management-related dilemmas (Briggs & McBeath, 2009).

The basic aims and advantages of the aforementioned evidence-based approaches are summarized in Table 2. The EBP, PBE, and EBM models specifically allow frontline service providers to link

Table 2

Aims and Benefits of Different Evidence-Based Approaches

Evidence-Based Practice (EBP)

- Practitioners are asked to integrate the best available evidence, client values and preferences, available resources, and their clinical expertise in making practice decisions.
- EBP is a problem-solving process in which the practitioner seeks to individualize care to the specific needs of the client as well as the agency context.
- Practitioners use skepticism, critical questioning, and evidence-informed inquiry.
- This perspective is compatible with culturally sensitive service provision, in that it includes a focus on the client culture and values, allows for client participation in decision-making and practice, and uses many types of evidence.

Practice-Based Evidence (PBE)

- PBEs are historically developed community-based practices shown to be effective via nonexperimental research methods.
- PBEs are often evaluated using participatory action research methods to identify their effectiveness.
- PBE is compatible with cultural competent practice, in that indigenous practices offer a blend of strengths-based, culturally informed care and treatment-based services.
- PBE promotes transparency, creativity, and local community innovation.
- Community input is vital to address how adaptation should occur and whether indicators and measures are culturally appropriate.
- Effective cultural adaptation requires strategies to implement the principles of the model program in accordance with the values of the target community.

Culturally Adapted Evidence-Supported Interventions (CAESIs)

- CAESIs are culturally equivalent adaptations of a model program. The process of cultural adaptation of an existing CAESI requires scientific justification.
- Research and community assessments are used to identify which aspects of the CAESI must be adapted to suit a particular racial/ethnic group.

Evidence-Based Management (EBM)

- EBM is the conscientious, explicit and judicious use of current best reasoning and experience in making managerial decisions.
- EBM, which was developed using an EBP platform, is also compatible with culturally competent practice.
- EBM promotes transparency, creativity, and experimentation.

client cultural knowledge and scientific evidence to facilitate client empowerment. These approaches are sensible alternatives for practitioners when culturally sensitive ESIs are unavailable for African American youth and families requesting mental health services.

These models use different evidentiary standards than the ESI model, in that "evidence" is understood to include quasi-experimental designs, single-case studies, qualitative approaches, and information drawn from clinicians' professional and personal history. These models may therefore be suitable for non-Western epistemological approaches, and thus potentially more compatible with culturally competent service models than the ESI approach. Allowing child welfare systems to engage in EBP, PBE, and EBM may enhance service providers' ability to respond to the mental health needs of youth and families from majority and culturally diverse backgrounds.

Benefits and Challenges Associated with the Use of Different Evidence-Based Approaches

Benefits may accrue to child welfare agencies that are able to use different evidence-based approaches as opposed to an ESI–focused or a non-evidence-based approach to mental health service provision. The EBP, PBE, and EBM models allow providers to draw from clients' cultural knowledge as well as to engage in COPES–driven searches for evidence-based treatments, and thus directly impact agencies' ability to deliver services in a culturally competent manner. Additionally, each approach emphasizes the importance of transparency and shared decisionmaking: while possibly ancillary to treatment objectives, the focus on continuous client monitoring and the calibration of mental health treatments in response to client preferences may serve to strengthen client engagement (Kruzich et al., 2002). Exploratory studies suggest that agencies using an array of evidence-based approaches to deliver mental health services to racially diverse foster youth and their families may experience improvements in service quality, client satisfaction, and staff perceptions of organizational climate (Briggs, 1996, 2001).

Challenges to the use of these different evidence-based approaches include the difficulty of engaging involuntary clients in the process of

assessment and service decisionmaking. Despite their focus on client empowerment, none of these models includes specific provisions for client engagement, even though it can be extremely difficult to engage foster youth and their biological families in child welfare services (Kemp, Marcenko, Hoagwood, & Vesneski, 2009). Another challenge involves the research-based resources required to implement different evidence-based approaches. Few child welfare agencies have sufficient research and development capacity to identify culturally appropriate ESIs or to train staff in the EBP, PBE, or EBM approaches (McBeath, Briggs, & Aisenberg, 2009). Similarly, few agencies are able to develop managerial and information technology-based methods to track client progress over time and correlate such changes with staff efforts. A final challenge to child welfare agencies seeking to use these evidence-based approaches concerns the non-evidence-based nature of many child welfare service interactions. Mental health services to foster youth may be provided in response to the requests of court officials or due to their availability in the agency or community, with the choice of the type, modularity, and intensity of service often dependent on service availability. In contrast, these evidence-based models depend on child welfare agency staff exhibiting leadership in developing service plans in collaboration with clients, engaging in literature searches for new practice innovations, and advocating for culturally informed service programming with agency supervisors and administrators. Such frontline leadership may be compromised by the presence of significant frontline caseloads and documentation requirements and may be unwelcomed by agency managers, despite the potential benefits to clients from the provision of culturally competent, evidence-based mental health services.

Conclusion

The development of culturally sensitive care for African Americans and efficacious mental health services for youth have traditionally been independent of one another. The historic exclusion of different cultural groups from the program development and research process has limited the applicability of ESIs with individuals from culturally diverse

backgrounds. The effectiveness of common mental health interventions for African American foster youth and families is therefore unclear.

Despite the organizational, practitioner, and historical factors preventing the creation and implementation of culturally conscious and efficacious mental health service systems, these processes are not mutually exclusive. This article introduces a framework for the development of these services for culturally diverse youth and families. The considerable mental health needs of foster youth, and the overrepresentation of African American youth in the foster care system, strongly obliges child welfare systems and foster care programs to invest in culturally appropriate mental health services. Given the dearth of studies examining the effectiveness of ESIs within different cultural and community-based contexts, policymakers should not apply ESIs indiscriminately across different racial and ethnic groups. Because clients may differ within and across diverse contexts, local service providers should be given the flexibility to tailor their child welfare programming to the specific needs of different client populations.

Research on the efficacy of specific child welfare services remains limited (Thomlinson, 2005). While it is plausible to hypothesize that some existing ESIs may be adapted for use with culturally diverse populations, the common characteristics of efficacious mental health programming for African American client populations have not yet been denoted. Nonculturally adapted programs should not be applied to culturally diverse populations until research has determined that these programs are appropriate for use.

Research must therefore be conducted to develop culturally competent mental health services for foster youth and families. Process and outcome evaluations should be developed and conducted, and their results used to inform the cycle of program planning, implementation, refinement, and dissemination. In the child welfare sector, process evaluations are often used to identify how services are delivered to individuals and barriers that have been encountered and adaptations that have been made by service providers. Outcome evaluations pertain to the biopsychosocial and system-related experiences of individual program participants. More sophisticated evaluation designs seek to merge what is learned from process evaluations with

information gained via outcome evaluations. These evaluations (using qualitative as well as quantitative data) should be used to identify promising, evidence-based approaches and to determine which pilot programs can be best translated across different client populations.

Finally, attention should be paid to sustaining culturally appropriate, evidence-based service delivery initiatives. Growing a system-wide commitment to culturally sensitive child welfare programming requires providing staff supports and additional organizational resources. Staff supports should include the addition of staff positions focusing specifically on training and implementation of different evidence-based approaches, providing and regularly updating culturally specific trainings and workshops, and the provision of flexible funding for service providers to collaborate with community groups to develop new evidence-based initiatives. Local managers should also be provided with resources to regularly assess the availability of high-demand mental health services. If ESIs are unavailable, inappropriate, or impossible to implement, then agencies need to clearly document these service gaps and advocate for their removal. In this manner, evidence-based programs that respect the cultural values and preferences of diverse populations may be nurtured.

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