Chapter 10
Empirical Status of Culturally Competent Practices

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Effective prevention and treatment programs are rooted in a deep understanding of the etiology of substance abuse and integrate the strengths inherent in each individual client, their families, and their larger social and cultural networks. Culture of origin can be a source of resiliency, protecting individuals against substance abuse, and at the same time social minority statuses can be a source of stress and risk (Davis & Proctor, 1989; Marsella & Yamada, 2007). Because culture impacts the nature and expression of substance use and misuse, substance abuse treatment and prevention interventions are more effective when they are grounded in the clients' culture (La Roche & Christopher, 2009). Cultural specific interventions tend to be more efficacious in recruiting and retaining participants and in attaining prevention and treatment goals (Coatsworth, Santisteban, McBride, & Szapocznik, 2001; Kandel, 1995).

Although there is a shared awareness of the importance of culture of origin in the prevention and treatment of substance abuse, empirically supported interventions have been traditionally developed and tested with middle class white Americans. White middle class interventions typically are applied to members of diverse ethnic and racial groups under the assumption that evidence of efficacy with one group is transferable to other groups with similar needs (Miller, 2004). More recently, the prevention and treatment fields have recognized that individuals, to varying degrees, retain many aspects of their culture of origin, and that their values, beliefs, and behavior systems influence substance use choices and behaviors (Cheung, 1991; La Roche & Christopher, 2009).

Integrating culture into interventions is not an easy task. As humans we are beautifully complex beings and as such we are the product of intersecting identities (Collins, 1995). NASW defines culture as "the integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values,

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and institutions of a racial, ethnic, religious, or social group" (NASW, 2000, p. 61). This definition includes aspects of deep culture, such as thought patterns and value systems, as well as surface characteristics, such as language and customs (Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999). In addition to ethnicity and race, other key factors to consider when designing culturally competent interventions are socioeconomic status, gender, sexual orientation, and ability status (Abrams & Moi, 2009).

Ecological systems theory helps us understand that individuals are simultaneously influenced by several dimensions of their social system (Bronfenbrenner, 1977). Culture is a key factor affecting individual beliefs and behaviors (micro level), family norms and values (mezzo level), and how the person interacts with larger structures (macro level) such as the school system or local law enforcement (Szapocznik & Coastworth, 1999). Social work approaches culture of origin, cultural identities, and the individual client's social context not as something to be changed or suppressed, but as factors to be recognized and integrated into practice (Marsiglia & Kulis, 2009). This chapter presents specific strategies on how to apply cultural competency principles while identifying and adopting evidence-based culturally competent prevention and treatment interventions. The premise behind the chapter is that communities deserve to have access to the best available science without having to sacrifice cultural competency. Culture of origin is approached here as a source of resiliency and as a possible determinant of health.

Evidence-Based Prevention and Treatment Interventions

The evidence-based practice movement has radically influenced the social work profession, including the drug abuse prevention and treatment specialization (Grinnell & Unrau, 2011). In addition to its strong support for culturally competent practice, social workers advocate for empirically validated or science-based practice (Nathan & Gorman, 2002). There is a growing expectation that drug abuse prevention and treatment interventions be validated through Randomized Control Trials (RCTs) and through other rigorous evaluation methods and designs. Evidence-based interventions also incorporate empirical knowledge about the mechanisms that lead to addiction and other factors that might protect individuals from substance abuse. The design and testing of efficacious prevention and treatment is informed by a deeper understanding of the social and cultural processes that create and maintain certain desired or undesired behaviors.

Although empirically tested treatment and prevention interventions are the gold standard in prevention and treatment, many innovative culturally competent approaches are not rigorously tested because of the lack of research capacity to conduct RCTs. In fact, there is a large gap between science and practice in the substance use prevention and treatment field (Glasner-Edwards & Rawson, 2010; Merrell, 2010). Available interventions often lack empirical evidence of efficacy while treatment and prevention interventions that have been shown to be efficacious are rarely implemented in the field (Sorensen & Midkiff, 2000; Torrey & Gorman, 2005).

In part, researchers' strong reliance on scholarly journals to disseminate their findings about efficacious interventions limits the translation of findings into the field (Sobell, 1996). On the other hand, practitioners feel overwhelmed by the ever-expanding choices of prevention and treatment modalities and have limited time for evaluation and research-related activities (Levinson, Schaefer, Sylvester, Meland, & Haugen, 1982).

The existence of efficacy does not automatically translate into outcomes in the field because evidence-based interventions are often implemented without consideration for fidelity (Backer, 2001; Gottfredson & Gottfredson, 2002). Fidelity is the act of verifying that an intervention is being implemented in a manner consistent with the treatment or prevention model and matches the research that produced the practice. Fidelity is achieved when implementers can demonstrate that there is consistency in the manner in which the treatment is delivered to all participants and that it follows the underlying theory and goals of the research (Dumas, Lynch, Laughlin, Phillips-Smith, & Prinz, 2001). Several reasons have been cited for the lack of fidelity, including poor training and inadequate resource, low morale, and high levels of burn out (Botvin, 2004). Regardless of the intervention or the setting, practitioners naturally make explicit and implicit adaptations (Backer, 2001). In order for treatment or prevention interventions to be implemented with fidelity, the staff implementing the program must be trained to administer the treatment and be aware of what elements of the program are essential for effectiveness and what elements are more flexible (Bridge, Massie, & Mills, 2008).

The divide between research and practice is even more pronounced for culturally specific interventions (Cross et al., 2011). Funding sources are increasingly requiring the implementation of evidence-based practices and expect agencies to only adopt interventions included in approved lists of evidence-based interventions (Gira, Kessler, & Poertner, 2004). In order to oblige, some agencies might rush to select an evidence-based program without considering if it is culturally appropriate (Willis, 2007).

Identifying, Evaluating, and Implementing Culturally/ Empirically Supported Interventions

The process of selecting and implementing evidence-based empirically supported interventions has been summarized by Rycroft-Malone et al. (2004) into an easy to use three step review process:

1. *Evidence*. Does the evidence exist? Has the research been conducted rigorously?
2. *Context*. Is the intervention appropriate for my community or my organization?
3. *Facilitation*. How will it be implemented with fidelity?

In order to insure that this process is culturally competent, it has been suggested that even before a intervention is selected the practitioner should consider: the clients being served, are they culturally homogeneous, what are the key components of

their culture that interacts with their substance use behaviors, and whether or not treatment or prevention programs need to reflect their cultural values, norms and identity to be effective (Bridge et al., 2008).

Once the culture of origin and identities of the clients to be served are identified attention is given the repertoire of available interventions. This process also follows a set of standards to assess empirically supported treatment and prevention interventions (SAMHSA, 2009):

1. Rigor of evaluation design (use of intervention and control or comparison group; appropriateness of assignment to groups; control for other explanatory factors. Did the researchers conduct a RCT?).
2. Rigor and appropriateness of methods used to collect and analyze data (use of measures that match desired outcomes).
3. Magnitude and consistency of effects of the intervention on desired outcomes (it is agreed that evidence becomes stronger when it is replicated).
4. The extent to which the findings can be applied to other populations in other settings.

The most reliable sources of empirically supported treatment and prevention interventions are national registries and peer-reviewed journal articles. Registries often offer a rating system that judges the quality of the evidence offered, but the level of evidence required and the rating system utilized varies by registry. While national registry's of empirically tested substance abuse interventions are helpful, when possible it is important to find the original article and examine the study design, in order to critically evaluate the strength of the findings. Most lists of empirically tested interventions include the citations of the studies, as well as information regarding the availability of program materials and training.

Two examples of national registries that include culturally specific substance abuse prevention and treatment interventions are: (1) SAMHSA Nation Registry of Evidence Based Programs and Practices (NREPP) www.nrepp.samhsa.gov and (2) OJJDP Model Programs Guide www.ojjdp.gov/mpg. Both lists are a very helpful resource for practitioners. Peer-reviewed journals/articles reporting on the results of RCTs are also a reliable source of information about the efficacy of interventions. In order for an intervention to be considered to have strong evidence it should be shown to be efficacious in two or more studies (Roth & Fonagy, 2004). Finding and reviewing evidence for interventions in journals can be very labor intensive and requires a certain level of expertise to discern quality evidence from flawed studies.

This process of discernment can have many different outcomes depending on the characteristics of the targeted population and the availability of efficacious interventions. If concerns persist about the cultural appropriateness of existing evidence-based interventions, certain strategies can be considered:

1. The most basic strategy is providing cultural competency training to the service providers delivering the treatment without changing the intervention.
2. Adapting the evidence-based practice to reflect cultural values and norms, and
3. Creating and testing original cultural-specific interventions (Santisteban, Vega, & Suarez-Morales, 2006).

Each of these strategies promotes cultural competent practice to a varying degree, from surface to deep culture (Castro, Barrera, & Martinez, 2004) and will result in cultural competence training, program adaptation, or the design and evaluation of a new culturally specific intervention.

Cultural Competency Training

Cultural competency training often gives clinicians a general overview of specific cultures and culturally based norms and behaviors that may affect the clients' engagement and treatment process without addressing specific skills or practices (Santisteban et al., 2006). While cultural competency training is helpful and may lead to more culturally sensitive practice, it cannot address the larger structural factors that are impacting substance abuse; in other words it might not go deep enough. It requires an in-depth knowledge of how culture of origin impacts the family process, adolescent development, couple decision-making, and interaction with the community at large, and a variety of other factors (Santisteban, Muir-Malcolm, Mitrani, & Szapocznik, 2002). Cultural competency training has been added to interventions that have been originally shown to be efficacious with majority populations and then have later been applied with ethnic and racial minority clients (Turner, 2000). While culturally competency training is positive and helpful, one cannot presume that training the interventionist alone will make a treatment more effective for minority clients. In the absence of culturally specific interventions, applying an evidence-based practice validated with a different population in a culturally competent way is a move in the right direction but may not adequately address the deeper cultural norms and beliefs that drive substance use behavior or that protect individuals from it.

Cultural Adaptation

Cultural adaptation is an ongoing phenomenon often informally conducted by practitioners or facilitators who identify a mismatch between aspects of the intervention and the population they are serving (Botvin, 2004; Castro et al., 2004). There have been efforts to provide practitioners and/or agencies with the tools necessary to systematically modify interventions for specific groups rather than creating and testing cultural-specific intervention from the ground-up (Kazdin, 1993). If evidence-based interventions lack cultural appropriateness or cultural fit, they will benefit from cultural adaption in order to assure that they are relevant to the population being served (Kumpfer & Kaftarian, 2000). While culturally tailoring interventions to better match the norms and behaviors of a population increases program efficacy (Jackson & Hodge, 2010), if the modifications are not part of a specific

adaptation protocol, they may compromise the integrity of the original intervention and affect the overall efficacy (Bridge et al., 2008; Castro et al., 2004). Two basic steps proposed to conduct such an adaptation and to protect the integrity of the program (La Roche & Christopher, 2009) include: (1) identifying the core ideas and theories of the mechanism for change within the original curriculum and (2) partnering with the cultural group to assure their involvement in making the necessary changes that would make the intervention more relevant to the population (Castro et al., 2004; Castro, Barrera, & Holleran Steiker, 2010).

When adapting an intervention, a deep understanding is needed for both the theoretical underpinnings of the intervention and the cultural norms and values of the culture that it is being adapted for. Frequently adaptations change surface aspects of the intervention like the cultural contexts of stories or the identity of actors in a film. This allows the individual in the treatment or the prevention program to identify themselves in the curriculum but fails to address the larger cultural norms that may be impacting their use or decision-making process. While modifications that change certain surface aspects of an intervention might work, it runs the risk of continuing to communicate dominant cultural values on which the intervention was designed, undermining the cultural groups experience (Frable, 1997). Another challenge that arises with adaptation is the tendency for providers to pick and choose aspects of several programs and combine them into one intervention impacting the integrity of the program and negating the empirical evidence of the original intervention (Kumpfer & Kaftarian, 2000). Programs that are implemented as they were written, with little variation from the original curriculum, are more effective (Elliott & Mihalic, 2004).

Culturally Specific Interventions

Evidence has shown that substance prevention and treatment programs are more successful when they are grounded in the participant's culture (Kandel, 1995; Kulis, Nieri, Yabiku, Stromwall, & Marsiglia, 2007; Shadish et al., 1993). In addition, treatments that are tailored to meet specific cultural needs have been shown to have high program retention rates, which is crucial for success (Santisteban et al., 1996). An intervention is cultural-specific when it begins with the culture and builds the program around that culture's experiences with drug use and related cultural norms, attitudes, and beliefs. Cultural-specific interventions not only incorporate cultural symbols and language but also core values that influence how a person, their support systems, and their community perceive their substance use. A culturally specific approach accounts for deeper aspects of culture such as norms and values by considering the cultural context at every level of program development.

Different providers and agencies may be at different levels of readiness and capacity to implement one or more of these strategies at the same time. The ideal situation would be to identify an existing evidence-based intervention that is also culturally appropriate for the targeted population. There are a growing number

of empirically tested substance abuse prevention and treatment interventions to consider. The following summary of selected interventions specifically designed and tested with adolescents serve as an example of such a review. Although this section focuses on adolescents, the process for selecting and evaluating prevention and treatment intervention is similar for adult programs.

American Indians

Prevention

Bicultural Competence Skills Approach (Schinke, Tepavac, & Cole, 2000) has been identified by the Office of Juvenile Justice and Delinquency as an effective program. This intervention is designed to prevent substance use among American Indian youth by teaching social skills within the context of both the American Indian and mainstream American culture. The intervention is administered by American Indian facilitators and focuses on communication skills and coping skills, in order to enhance a participant's ability to resist substances both in his/her native community and in the dominant culture as well. Every intervention session included native values, legends, and stories. This intervention does not necessarily focus on substance abuse but rather on the more general subject of holistic health. Its Bicultural Competence Skills Approach includes a community component that is unique from other substance abuse prevention with American Indians. This intervention was evaluated in two separate studies using an experimental design. The first study found a statistically significant difference in the reported attitudes and substance use of the youth in the treatment group versus the control condition, and these results remained at the 6-month follow-up (Schinke et al., 1988). In the second RCT, the use of alcohol, tobacco, and marijuana was significantly lower in schools that received the cultural-adapted life skills training rather than the control at the three-year follow-up (Schinke et al., 2000).

Critical assessment of evidence: Strengths of this study include the incorporation of a bicultural approach identified as protective in the literature, large sample size, random assignment of schools to treatment and control groups and study sites ten different reservations in five different states.

Project Venture (Carter, Straits, & Hall, 2007) is an outdoor program for 5–8th grade American Indian youth. Project Ventures seeks to enhance antidrug norms and facilitate personal development through the incorporation of traditional American Indian values. The intervention consists of a minimum of 20 one-hour sessions in the classroom and weekly after school and weekend and summer activities such as hiking and camping trips. Project Venture emphasizes service learning, spiritual awareness, and the importance of family. This intervention was assessed using a quasi-experimental design. When this intervention was tested, rates of drinking increased for both the intervention and control group, but leveled off for the intervention group and continued to rise in the control group at the 6- and 18-month

follow-up. When this study was replicated, rates of drinking for the intervention group remained the same while they continued to increase in the control group. The same pattern was observed for the use of illicit drugs, with the intervention group remaining the same and the control groups use increasing.

Critical assessment of evidence: While the strength of the evidence is supported by multiple studies and longitudinal data (several follow ups over time) because of the use of a quasi-experimental design rather than a randomized control trial, we cannot be sure that the effects observed were due to the intervention and not on baseline differences in the two groups.

Treatment

There is a limited number of culturally specific treatment interventions designed with and for American Indian youth and even less that can be considered evidence-based (Goodkind et al., 2011). Cultural adaptation such as the White Bison, a cultural competent version of the traditional 12 step program, has been designed introducing traditional healing practices, such as sweat lodges, but their efficacy has not been tested (Moore & Coyhis, 2010). While some studies have shown that treatment program incorporating traditional healing improves retention, no studies have been done testing their efficacy in treating substance abuse problems (Fisher, Lankford, & Galea, 1996).

Latinos

Prevention

Families Unidas (Coatsworth, Pantin, & Szapocznik, 2002; Pantin et al., 2003) is a substance use prevention program designed for Latino families with children between the ages of 12–17 and is guided by ecological systems theory. This intervention is administered in 2 h once-a-week groups for 3–5 months. Families Unidas focuses on increasing effective parenting skills though psychosocial education, participatory exercises, and group discussion and is administered in three stages. Facilitators were Spanish speaking, bicultural, and trained to implement the intervention with fidelity. This program was tested using an experimental design, where participants were randomly assigned to Families Unidas or a variety of other interventions (ESOL classes, HeartPower, PATH) and adolescences were surveyed at several time periods after the completion of the intervention. When testing Families Unidas, no difference was found between the intervention and the control group on measures of alcohol use; however significant decreases in cigarette and illicit drug use were shown. Like many other interventions for adolescence, substance use is not the primary target of this intervention, but is included in a bundle of other problem behaviors being targeted.

Critical assessment of evidence: Strengths of this study include a lengthy discussion of theoretical foundation, use of a randomized control trials, and a great deal of attention has been paid to implementing this intervention with fidelity; however, lack of outcomes for alcohol should be considered when selecting this intervention.

Storytelling for Empowerment (Nelson & Arthur, 2003) is a school-based bilingual intervention based on combination of narrative therapy and empowerment theory. It is designed to address substance abuse, HIV and other behaviors of at risk teenagers. Storytelling for Empowerment was created for Latino/Latina youth and is rooted in the development of positive cultural identity and resiliency models of prevention. The intervention guides youth through a Storytelling PowerBook that includes an exploration of physiology, decision making, multicultural stories, identification of historical figures, defining culture, identifying cultural symbols, identifying role models and setting goals. This intervention was tested using a quasi-experimental design with one group participating in the program and the other serving as an assessment only comparison group. When tested this program was shown to significantly decrease alcohol and marijuana use at post test and 1 year follow-up relative to the no treatment control group. The dosage of the treatment seemed to be significant in the outcome with student who received 28 h or more of contact showing significantly greater decreases in substance use outcome than those that experienced less. While there was no significant decrease in marijuana usage, the same interaction with contact hours was observed, with those who received more contact hours reporting significantly less usage than those who had less.

Critical assessment of evidence: While this prevention program is solidly based on theory and showed positive outcomes, the differential effect based on dosage suggest that it may be the amount of time spent with the adolescents rather than the prevention program that is having an effect on the adolescents' outcomes.

Treatment

Brief Strategic Family Therapy (Santisteban et al., 1997, 2003) has been developed to prevent, reduce and treat a wide variety of problem behaviors in adolescents including substance use and has been tested in several quasi-experimental designs with Latino youth and found effective. This intervention was designed to be administered in 12–16 sessions but can take as little as 8 depending on the communication patterns and functioning within the family. These sessions are 1 h, 1 day a week in an office setting. BSFT is grounded in the theory that substance use and misuse in adolescences is rooted in dysfunctional family interactions, alliance and boundaries, and is based on the assumption that if the overall functioning of the family improves then adolescence substance use will be addressed as well (Dishion & Andrews, 1995; Santisteban & Szapocznik, 1994). When conducting Brief Strategic Family Therapy the therapist works to improve functioning by joining the family system, diagnosing repetitive patterns in relationships that reinforce the problem and then

finally restructuring the family system (Santisteban et al., 1997). Brief Strategic Family Therapy has been shown to be more effective than controls (including group, individual and family therapy) at engaging and retaining families in treatment and reducing substance use in adolescences (Santisteban et al., 1997, 2003).

Critical assessment of evidence: Comparison groups were used rather than randomized control groups opening results up to threats to internal validity; however, the researchers in these studies conducted statistical tests on the two groups at pre-test to ensure they were comparable. Brief Strategic Family Therapy has also been adapted and tested with African-American adolescents. It should be noted that substance abuse treatment is not the sole goal of this intervention with conduct disorder, socialized aggression, and over all family functioning as concurrent outcomes.

African Americans

Prevention

Hip-Hop 2 prevent substance abuse and HIV (Turner-Musa, Rhodes, Harper, & Quinton, 2008) is a school-based prevention program designed for African-American youth, 12- to 16-year years of age and incorporates hip-hop culture into prevention messages. This intervention consists of ten sessions in which students developed self-efficacy, clarity of norms and values, and conflict resolution skills. The first four session occur in an after-school program and the remaining 6 are implemented in a 4-day camp. A randomized control trial of this intervention was conducted at the same school for two consecutive years to test the treatment effectiveness of increasing the perceived risk of using drugs and overall disapproval of drug use. In both groups there was a significant increase in the perception of risk associated with using marijuana, but there were no other significant differences between treatment and control group. At post test, a significantly higher percentage of students who participated in H2P reported believing that it is wrong for youth to drink alcohol, smoke cigarettes, or smoke marijuana regularly, but only the negative beliefs about marijuana remained at the 6-month follow-up.

Critical assessment of evidence: While this study used a randomized control trial to test the intervention, the use of only one school, and the study small sample size with 135 students total (68 in the control and 67 in the treatment) with only 68 participants completing the 6-month follow-up, weaken the strength of the evidence.

Treatment

Healer Women Fighting Disease: Integrated Substance Abuse and HIV Program for African American Woman (HWFD) (Nobles, Goddard, & Gilbert, 2009) is in

intervention designed to target both substance abuse and HIV risk in woman age 13–55. The program curriculum is based on the idea that understanding African-American culture is central to behavior and must be incorporated when discussing behavioral change. In HWFD women are presented pro-health values rooted in traditional African culture in the hopes that adapting these attitudes and beliefs will counteract negative main stream messaging that promote unsafe sex and substance abuse in a 16 weekly 2 h sessions. The program is implemented by trained professionals and paraprofessionals in a fixed format that may be modified with input from participants in an urban community setting. To test this intervention effectiveness African-American women were recruited from a community agency and were assigned to two different groups, half participating in HWFD and the other half receiving treatment as usual. Although improvements across all areas were observed in both the treatment and comparison group, HWFD was shown to be more effective than treatment as usual when addressing safer sex attitudes, feeling of self-efficacy, and motivation and depression symptoms, but not in attitudes toward drug use and self-esteem (Nobles et al., 2009).

Critical evaluation: It should be recognized that this study used a comparison group rather than a control group, had high rates of attrition, and while this intervention was shown to be better than treatment as usual in some areas it did not improve outcome in attitudes toward drug use. A strength of this intervention is that it has been outlined in detail in a manual and training for facilitators is available.

Multiethnic Prevention

Keepin' it REAL (Hecht et al., 2003; Marsiglia & Hecht, 2005) is a multicultural substance abuse prevention program designed to be implemented with adolescents. This intervention is presented in 10, 45-min classroom sessions and is administered by teachers who have been trained in the curriculum. Based on communication competency theory and a resilience model, *keepin' it REAL*'s curriculum focuses on helping students assess risk, enhance resistance skills, increase antidrug belief and attitudes and ultimately reduce substance use. *keepin' it REAL*'s is culturally grounded, with culturally specific and multicultural versions available. Using an experimental design, 30-day substance use was measured at 2, 8, and 14 months after the intervention was completed. Adolescents that received the intervention reported significantly lower levels of alcohol, marijuana and tobacco use through the 8-month follow-up. A higher percentage of students in the treatment group reported a reduction or discontinuation of alcohol use from baseline when compared to the control group.

Critical assessment of evidence: Strengths of this study include teacher training and attention to implementation with fidelity, the use of an experimental design, assessment at multiple time points and a large sample size. Weaknesses include differing dosages and use of measure of resistance strategies that had not been assessed from reliability prior to the intervention.

Treatment

Alcohol Treatment Targeting Adolescents in Need (Gil, Wagner, & Tubman, 2004), or ATTAIN, is a randomized controlled trial of a guided self-change treatment that is brief and focuses on skills building and motivation enhancement. The authors argue that guided self-change treatment is appropriate for a cultural diverse population due to the emphasis on individual treatment goal setting based on the clients personal experience, making it more flexible and culturally. Sensitive ATTAIN was implemented in juvenile detention facilities with both Latino and African American offenders. Materials were adapted to be culturally and developmentally appropriate, including material about other problem behaviors that often co-occur with substance use in adolescents and were provided in both English and Spanish. The staff implementing the intervention was both multiethic and multilingual and focus groups were used to address cultural and language preference in the creation of the manual. Study participants were randomly assigned into the individual intervention, family involved format, a condition where they were given their choice between the two formats or a wait list control group. Surveys were completed at baseline and after the intervention (3-, 6-, and 9-month follow-up were done but the results have not been published). A significant decrease in 30-day substance use was observed in all three treatment conditions, with the most dramatic decrease occurring among African-American participants. In addition this study found that participants with more ethnic mistrust benefited less from the treatment and those with higher reported levels of ethnic pride and orientation reported fewer days of alcohol consumption post-treatment when controlling for reported use at baseline. This program has been shown to be efficacious in reducing the number of days participants using in the past 30 days but no analysis was done comparing the treatment group with the control group due to a small sample size.

Critical assessment of evidence: Some of the strengths of this study include the use of a control group, the inclusion of clients in the curriculum development, the use of a manual and the analysis of treatment effects considering different levels of acculturation, mistrust, and ethnic pride. This study is, however, limited due to the absences of analysis comparing the treatment to the control group, the lack of females in the sample and exclusion of the analysis of follow-up data.

Discussion

While it has been widely accepted that services provided by social workers must be culturally competent, researchers designing and testing cultural-specific intervention and practitioners implementing them are challenged and enriched by the complexity of culture, heterogeneity among cultural groups, issues of fidelity and implementation and lack of evidence-based practice specifically designed for some populations. A common misunderstanding in both research and practice is

approaching culture, ethnicity, race, non-western, and minority as interchangeable ideas; when in reality, culture embodies concepts separate from race and some so-called minority groups have cultures deeply rooted in Western civilization (McAdoo, 1997; Phillips, 2007). Even in the presence of a concrete definition of culture, it can be difficult to distinguish the edges and boundaries of culture as they mix together with other cultures; they change over time, and they are affected by individual and generational differences and sociopolitical factors. A culturally competent social worker acknowledges that each individual is unique within his/her cultural group and remembers that individuals identify with their community cultural norms at different degrees (La Roche & Christopher, 2009; McGoldrick, Giordano, & Garcia-Preto, 2005).

There is a paucity of research on culturally specific drug use and abuse prevention and treatment interventions for some groups. For example, it is difficult to locate control randomized trials testing the efficacy of substance abuse treatment-specific to Latinas (Amaro & Cortés, 2003) or American Indian adolescents in general (Goodkind et al., 2011). While some culturally specific research exists about substance abuse within the Asian American communities, no rigorous prevention or treatment programs have been developed to meet this very heterogeneous population needs.

Evaluating Your Culture Specific Intervention, Adding to the Evidence Base

Communities have been addressing the substance abuse needs of their members within their culture for hundreds of years. While these treatments or methods may not have been scientifically tested for efficacy, they have benefited from the wisdom that comes with time. In the same way, social workers that have been working with substance abusing clients for several years may have found techniques and interventions that they believe work, but do not have the evidence to support their claim. Historically, researchers at the university level have been primarily responsible for generating and disseminating empirically supported substance abuse treatment; in many cases without fully incorporating the rich experiences of the community members and community-based treatment professionals' experience. In the absence of empirical support, practitioners may be required to implement treatment and prevention programs that have been found to be efficacious in place of interventions that have been reined over the years. So that this wisdom is not lost, researchers, practitioners, and communities need to begin a conversation about what works within a given culture, so that traditional practices can be scientifically tested for efficacy. In addition to partnering with researchers, an effort can be made to train communities and social workers to rigorously evaluate their practices and disseminate their findings adding to the literature of culturally competent empirically supported substance abuse prevention and treatment.

Practitioners and agencies are increasingly being asked to provide services that are not only culturally relevant but also that have been shown to be efficacious in rigorous studies. Many of the substance abuse treatment and prevention interventions that have been used for years have not yet been tested. They are not necessarily ineffective; we simply do not know. While social workers are briefly taught in both the BSW and MSW programs to evaluate their practice, the practitioner–researcher role often does not emerge due to the large case loads, increases in documentation and reporting, or a lack of confidence in their own research abilities. Single subject research designs have been suggested as a viable technique for evaluating social work practice on a small scale (Thyer, 2004). To execute a single subject research design, the social worker assesses the client at intake and then repeatedly throughout treatment using a valid measure so that any change in the outcome can then be attributed to the treatment. These types of research designs can produce the preliminary findings needed for follow-up adaptation or development studies and randomized control trials. Agencies can also evaluate their practice by administrating valid pre- and post-test measures of efficacy. By partnering with universities and evaluating treatment and prevention outcomes social workers can empirically validate programs, not only insuring the success of their clients but also adding to the existing knowledge about culturally specific evidence-based prevention and treatment interventions.

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