Evidence-based psychosocial treatments for ethnic minority youth
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CRD summary
This review evaluated the effectiveness of psychosocial interventions for ethnic minority youth. The authors concluded that there was moderate evidence to support a range of interventions to treat various problems in this population. There were methodological weaknesses in the review process, and those potentially connected with synthesising variable studies, that made the reliability of the authors' conclusion unclear.

Authors' objectives
To evaluate the effectiveness of psychosocial interventions for ethnic minority youth.

Searching
PsycINFO was searched from 1960 to 2006 to identify relevant studies for inclusion in the review. Search terms were reported. Additional articles were sought from a manual review of relevant meta-analyses and reference lists, and through consultation with field experts.

Study selection
Studies of psychosocial treatment interventions directed at participants 18 years or younger (maximum mean age 18 years) with behavioural or emotional problems were eligible for inclusion in the review. Included studies needed either 75 per cent of the sample to be ethnic minority or have separate analyses with ethnicity that showed superiority over a control/comparison, or analysis that indicated ethnicity was not a key moderator of outcomes or that treatment was effective in this sub-group despite moderator effects.

Included were African Americans, Latinos and mixed or other ethnic minorities with a range of problems (including anxiety, depression, aggression and delinquency). Treatment was defined as any intervention to alleviate psychological distress, reduce maladaptive behaviour or enhance adaptive behaviour through counselling, structured or unstructured interaction, a training programme or a predetermined treatment plan. Interventions focusing only on medication, teaching, reading, knowledge, relocation or primary prevention and those primarily focusing on any other predisposition than behavioural or emotional difficulties were excluded.

All included studies assigned participants randomly to an active treatment or a different comparative active treatment, no treatment, placebo or treatment-as-usual. A wide range of different active treatments (reported in the paper) were included. A range of outcome measures were included and these were summarised in terms of positive or negative effects of the intervention.

The authors stated neither how the papers were selected for the review nor how many reviewers performed the selection.

Assessment of study quality
The authors included studies only if they met criteria specified by Nathan and Gorman (2002) as Type 1 or Type 2 studies. Type 1 studies included randomisation, clear inclusion and exclusion criteria, blinding, use of valid and/or reliable outcome measures, adequate sample size and clearly described statistical methods. Type 2 studies were clinical trials that had one or more of these components missing. The authors did not state how the validity assessment was performed, but a subset of studies was independently coded by two reviewers to assess inter-rater reliability.

Data extraction
Where available, means and standard deviations were extracted in order to calculate the effect size – standardised mean difference (SMD) and standard error (SE) – between comparisons at post-treatment or follow up. If possible where these data were unavailable, the effect size was estimated from other statistics. The authors stated neither how the data were extracted for the review nor how many reviewers performed the data extraction.
Methods of synthesis
Studies were combined in a narrative synthesis. Effect sizes for studies comparing an active treatment with a no treatment, placebo or treatment-as-usual control group were pooled in a meta-analysis (the method was not reported) and weighted by the inverse sampling error variance. The Q statistic was used to explore heterogeneity. Sensitivity analysis was carried out to explore the exclusion of the treatment-as-usual control group.

Results of the review
Twenty-five studies were included in the meta analysis (n>2,028). Sample sizes ranged from 12 to 213.

Pooled results showed an overall low to medium post-treatment mean effect size of 0.44 (SE 0.06; 95% CI: 0.32, 0.56, p=0.001). Medium effect sizes were reported when treatments were compared to no treatment, 0.58 (SE 0.14; 95% CI: 0.30, 0.86, p=0.001) or psychological placebos, 0.51 (SE 0.09; 95% CI: 0.33, 0.69, p=0.001). In an analysis that excluded the treatment-as-usual control group, the effect size was again raised to a medium level at 0.57 (SE 0.08; 95% CI: 0.42, 0.72). There was statistically significant heterogeneity (p<0.001).

Limited follow-up data from studies largely of youth with conduct problems undergoing multisystemic therapy suggested that treatment effects for ethnic minorities were maintained up to a period of 13.7 years (range four months to 13.7 years). The authors reported that youth ethnicity (African American, Latino and mixed or other minority), problem type, clinical severity, diagnostic status and culture-responsive treatment status were not moderators of treatment outcome (results were presented in the paper).

Authors' conclusions
The authors' conclusion appeared to be that there was moderate evidence to support the effectiveness of interventions to treat various psychosocial problems in ethnic minority youth.

CRD commentary
This review addressed a broad question. It was supported by well-defined inclusion criteria for participants, intervention and some aspects of study design defined in the process of validity assessment. There were no inclusion criteria for outcomes, and this resulted in a plethora of measures to be included in the analysis. The search strategy was limited. No apparent attempts were made to identify unpublished studies. So, relevant studies may have been missed and publication bias could not be ruled out. There was largely no detail on how the review process was carried out, meaning that the potential for reviewer error and bias represented a substantial threat to the reliability of the findings. Details of the included studies were extensive, where reported. However, not all those included in the meta-analysis were available. Given the heterogeneity uncovered and the absence of reporting on the chosen method, it was not clear to what extent a meta-analysis of included studies was appropriate. The reliability of the authors' conclusion was not clear, given the various methodological limitations; there was some acknowledgement of this in the authors' cautious interpretation provided.

Implications of the review for practice and research
Practice: The authors indicated that interventions based on cognitive behavioural therapy and tailored to suit cultural needs were of potential practical interest.

Research: The authors stated that future research should include larger studies of a wider range of minority groups, including further evaluation of moderating effects on treatment, isolating and reporting on the effectiveness of culture-responsive strategies, and assessing culturally appropriate outcomes.

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