EVIDENCE REPORT

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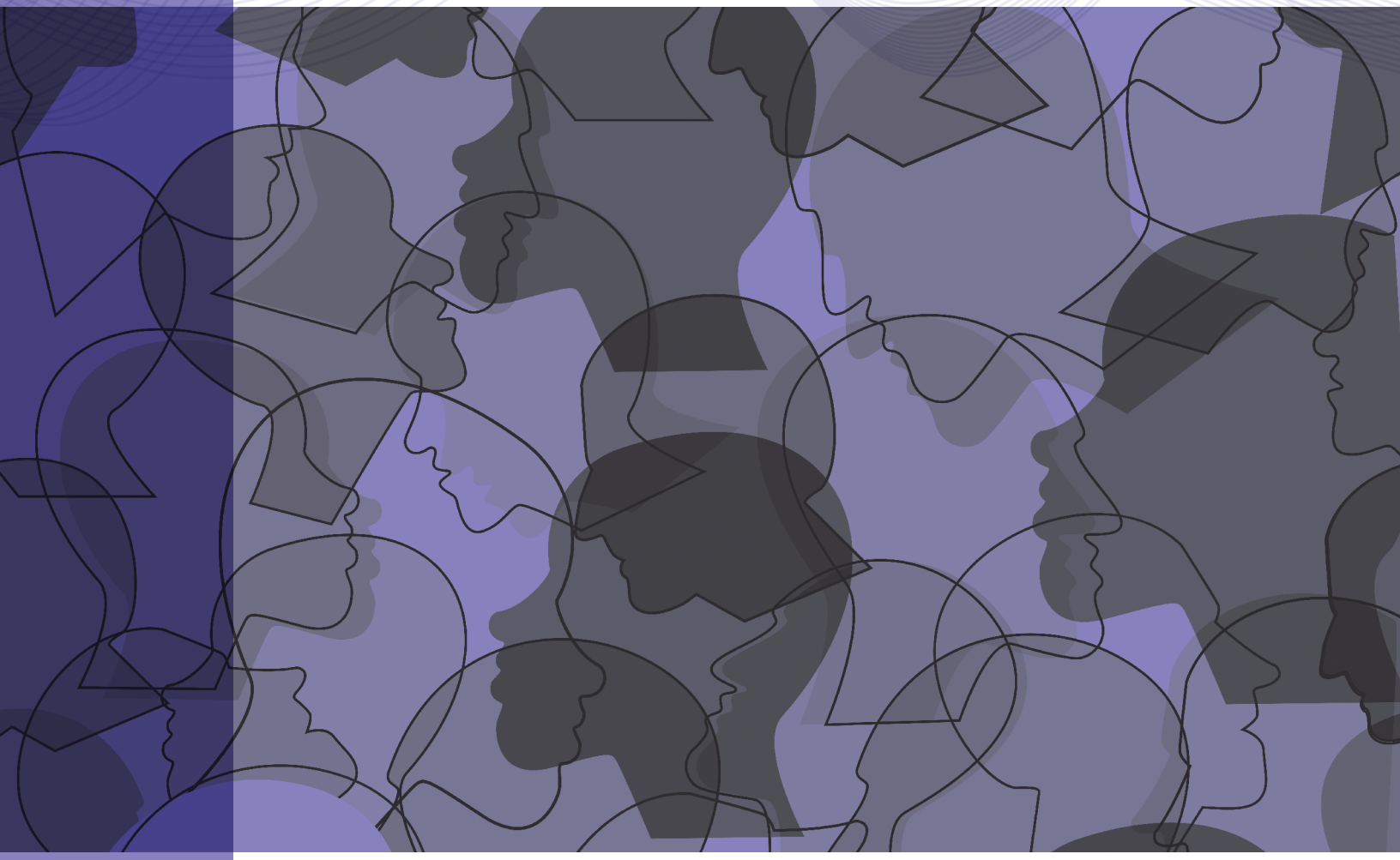
Converge3

Integrating health, economic and equity evidence to inform policy

Mental Health and Addictions Treatment Interventions for Immigrant, Refugee, Ethno-Cultural and Racialized (IRER) Populations in Ontario: Scoping Review

Provincial System Support Program, Centre for Addiction and Mental Health



About this Report

Converge3 commissioned the Centre for Addiction and Mental Health (CAMH) to conduct a review of literature to identify and describe effective models of mental health and addictions programs and services for immigrant, refugee, ethno-cultural and racialized (IRER) populations. In particular, this work focused on two general approaches: culturally appropriate programs and services that have been adapted from existing mainstream programs and services, and newly designed culturally appropriate programs and services. Converge3 receives funding from the Province of Ontario. The views expressed in this report are those of the authors and do not necessarily reflect those of Converge3 or the Province of Ontario.

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About Converge3

Converge3 is a policy research centre based in the Institute of Health Policy, Management and Evaluation at the University of Toronto, that focuses on integrating health, economic and equity evidence to inform policy. The Centre is funded by the Province of Ontario and includes multiple partner organizations, including Li Ka Shing Knowledge Institute at St. Michael's Hospital, McMaster University, Ottawa Hospital Research Institute, ICES, Health Quality Ontario, Public Health Ontario, and the Ministry of Health and Long-Term Care.

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Scoping Review

Mental health and addictions treatment interventions for immigrant, refugee, ethno-cultural and racialized (IRER) populations in Ontario

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Introduction

Converge3, at the Dalla Lana School of Public Health, seeks to understand the optimal mix of effective mental health and addictions treatment interventions for immigrant, refugee, ethno-cultural and racialized (IRER) populations (please see definitions on page 2) in Ontario including mainstream services adapted for specific populations and services designed for specific populations. Converge3 reached out to the Provincial System Support Program (PSSP) at the Centre for Addiction and Mental Health (CAMH) to conduct a scoping review of the literature on culturally appropriate mental health and addictions treatment interventions for IRER populations.

The objective of this scoping review is to examine the literature to identify and describe effective models of mental health and addictions treatment interventions for IRER, in particular, two general approaches: 1) culturally appropriate treatment interventions that have been adapted from existing mainstream treatment interventions; and 2) newly designed culturally appropriate treatment interventions.

Ontario is home to diverse populations with various mental health and addictions needs. Recent data from the 2016 Census of Population Program shows that over 200 ethnic groups are represented in Ontario's population (Statistics Canada, 2016). Moreover, the 2016 Census illustrates that 29.1% of Ontarians identify as foreign-born (immigrant) and 29.3% identify as being a member of a visible minority (Statistics Canada, 2016). Research evidence shows that IRER populations are more exposed to the social determinants that contribute to mental health problems and illnesses. They also tend to access mental health and addiction services less often than the general population, face numerous barriers when accessing services, and often receive poorer quality of care (Mental Health Commission of Canada (MHCC), 2016). One of the most significant barriers is the cultural incompatibility of existing services. Research evidence shows that, in order to reduce inequities in access and outcomes, mental health and/or addictions treatment interventions need to be culturally relevant and sensitive to the unique needs of IRER populations (Hansson et al., 2012; MHCC, 2016).

There are two main approaches to providing culturally sensitive treatment interventions to IRER populations. The first is culturally specific interventions, in which a treatment program is developed with a specific population/group in mind from the outset. The second is culturally adapted interventions, whereby an existing treatment program is modified or tailored to more appropriately meet the needs of a specific population/group. In order for culturally specific and culturally adapted treatment interventions to be effective, it is critical that these interventions are created and implemented in partnership with the community in which they aim to serve (Castro et al., 2010). The involvement of the IRER community has proven to be a critical component to the acceptability and efficacy of culturally specific and/or culturally adapted treatment interventions (Castro et al., 2010). This scoping review will examine the existing literature on the effectiveness of culturally adapted and culturally specific psychotherapeutic interventions to support Converge3 in developing policy recommendations on mental health and/or addiction programs and services for IRER populations living in Ontario.

Definitions of IRER populations

Immigrant	A person who is legally allowed to live permanently in a new country, and were born outside of that country (Statistics Canada, 2013)
Refugee	A person who has left their country due to a justifiable fear of being persecuted in relation to their race, nationality, social group membership, or for political reasons (United Nations High Commissioner for Refugees, 1951)
Ethno-cultural group	A group of people that share common heritage and cultural characteristics (Statistics Canada, 2013)
Racialized	A term now used to replace invalid terms such as "racial minority," "visible minority," "person of colour" or "non-white" (Ontario Human Rights Commission, 2005)

Table adapted from MHCC, 2016

Culture, mental health and addictions

A person's cultural background can influence many aspects of mental health and substance use, including patterns of health care utilization and treatment-seeking behaviours. Culturally-specific concepts, values and beliefs can influence the meaning and priority people attribute to mental illness (Paniagua, 2013). Culture can also influence how people cope and describe their symptoms, as well as how, when, where and if they seek help (National Institute of Mental Health, 2001). It is also important to note that IRER groups are heterogeneous in nature; they are diverse and distinct, and a one-size-fits-all approach to evidence-based interventions may not adequately address their unique needs (MHCC, 2016; Castro et al., 2010).

The culture of the health care system may also influence interactions between service providers and patients/clients, affecting diagnosis, treatment and the organization of services. The absence of culturally relevant treatment interventions can be a barrier to receiving appropriate mental health care for IRER populations, both by making it more difficult for them to access such care and by deterring them from making use of it (MHCC, 2016).

In order to reduce inequities in access and outcomes, mental health and addictions treatment interventions need to be culturally relevant and sensitive to the unique needs of IRER populations. Culturally appropriate interventions can be newly developed for the specific IRER group, or an intervention developed for general population could be modified to be relevant to other populations (MHCC, 2016).

To be effective, it is critical that these interventions are created and implemented in collaboration with the specific population(s) in which they aim to serve. The involvement of the IRER community has proven to be a critical component to the acceptability, relevance and efficacy of both culturally specific and culturally adapted treatment interventions (Castro et al., 2010).

Culturally-specific

Existing research has demonstrated that mental illness and addiction treatment interventions are more successful and have higher retention rates when they are rooted in the clients' culture (Kandel, 1995; Kulis et al., 2007; Shadish et al., 1993). An intervention is said to be culturally-specific when it is created for specific cultural groups from the "ground up," which means starting from the values, behaviours, norms, and worldviews of the populations they are intended for (Marsiglia & Booth, 2013). These treatment interventions take into account deeper contexts of culture, such as the core values that influence how an individual, their support system, and community view mental illness and addictions (Marsiglia & Booth, 2013). Generally, culturally-specific interventions, are designed with a particular culture or community group in mind, with ongoing guidance from the community and in the primary language of the population/cultural group.

The evidence of the effectiveness of culturally-specific treatment interventions is limited. There is a growing trend in evidence-based interventions to be validated through Randomized Control Trials (RCTs) as a gold standard. When an intervention is confirmed through an RCT it means it has undergone vigorous evaluation and sound methodology (Marsiglia & Booth, 2013). Unfortunately, culturally-specific interventions are not tested with RCTs due to a number of barriers. For example, RCTs involve the use of a control group for comparison. The research argues that there are inadequate means of creating a control group that is appropriately "matched" to the treatment group (Beehler et al., 2012).

Okamoto and colleagues (2014) provide a comprehensive review of culturally-specific health prevention interventions. Although their review is not specific to mental health and/or addictions, their findings and definitions are relevant. Culturally-specific interventions are said to develop from the "ground up," taking into consideration the values, norms, and behaviours of the target population, making the intervention familiar to the intended clients (Marsiglia & Kulis, 2009). Okamoto and colleagues argue, "rather than adapting prevention curricular components from one population to another, they build the evidence base within the communities and cultures that are intended to be served" (2014, p. 6).

Compared to culturally adapted interventions, culturally-specific interventions pose unique challenges and limitations. First, generalizability and replication of the intervention to other target populations are generally limited, as culturally-specific interventions are created with one target group in mind. Second, the process of developing culturally-specific interventions assumes that program creators possess the unique competencies required to interpret and translate cultural norms and behaviours into relevant treatment interventions (Okamoto et al., 2014).

The available evidence shows that culturally-specific treatment interventions are likely effective in improving access and outcomes for IRER groups. However, due to the limitations outlined above, more research is needed to validate these approaches.

Culturally adapted

Culturally adapted interventions are existing programs or services that are modified, or tailored, to more appropriately meet the needs of a specific population or group. The process of cultural adaptation

involves reviewing existing interventions to determine cultural relevance and fit, then modifying aspects to be more meaningful and appropriate to the needs of a specific cultural group or community. It is crucial that these modifications are made at every level of mental health treatment delivery to ensure cultural competence, from administration to implementation (Booth & Lazear, 2015). Bernal and colleagues define cultural adaptation of interventions as "the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (2009, p.362).

Cultural adaptations can be informally conducted when practitioners identify a discrepancy between the treatment intervention they are using and the population being served (Botvin, 2004; Castro et al., 2004). The literature suggests that the cultural adaptation of psychotherapy significantly improves treatment outcomes (MHCC, 2016). However, this impact seems to be greater for some populations more than others. A number of reviews have demonstrated that psychotherapies adapted for specific cultural groups are more effective than those targeting heterogeneous (or culturally mixed) groups of participants (MHCC, 2016). If existing evidence-based practices lack cultural appropriateness, certain cultural adaptation would be warranted to ensure it is relevant to the population being served (Kumpfer & Kaftarian, 2000). If these adaptations do not follow a specific adaptation protocol, the integrity and fidelity of the original intervention may be compromised, affecting the overall treatment efficacy (Bridge et al., 2008; Castro et al., 2004).

Culturally adapting evidence-based psychotherapy is an important element in increasing acceptability, satisfaction, and treatment effectiveness for the populations being served (Bernal & Scharrón-del-Río, 2001; Sue, 2003; Castro et al. 2010). These adaptations may involve revisions to modes of treatment delivery, content, and theoretical frameworks. When considering the two positions of presuming original evidence-based interventions are applicable and relevant to all cultural populations and utilizing a culturally specific approach that is uniquely grounded in a particular culture, cultural adaptations can serve as an appropriate concession (Chowdhary et al., 2014). This approach can also help to ensure that cultural adaptations maintain fidelity to the core elements of the original intervention, while adding specific cultural elements to enhance its acceptability and efficacy (Falicov, 2009; Barrera et al. 2013).

There are a number of challenges and limitations of culturally adapted interventions. For instance, there is some debate surrounding the efficacy of culturally adapted psychotherapeutic interventions. Contenders believe adaptations are an effective and continuous process that increase treatment efficacy with a variety of populations (Botvin, 2004; Castro et al., 2004). Others argue that cultural adaptations simply focus on providing methods to *modify* interventions for specific groups, in place of creating and testing culturally specific interventions from the ground up (Kazdin, 1993). If these modifications are not systematic or properly evaluated, they may compromise the fidelity of the original intervention and, therefore, impact efficacy, undermine certain cultural groups, and promote western cultural values in their design (Bridge et al., 2008; Castro et al., 2004, Frable, 1997). Other challenges concerned with culturally adapted evidence-based interventions include whether or not these adaptations are justifiable, effective, and whether within-group cultural variation can be accounted for (Castro et al., 2010).

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Methodology

The first phase of this scoping review consisted of a review of the literature on the effectiveness of culturally adapted and culturally specific mental health and addiction treatment interventions for IRER populations. Two knowledge brokers conducted a search of the literature using two databases, MEDLINE and PsycINFO. The library services at CAMH were also engaged to conduct a search of grey literature.

Scoping review research question:

- What is known from the literature about the effectiveness of culturally adapted mental health and addictions treatment interventions for IRER populations, and treatment interventions that are designed specifically for these groups?

The following search terms were used in each literature search:

Search Terms		
Population	**Intervention**	**Outcome**
• Racialized • Ethnic groups • Ethno-cultural • Ethnocultural • Ethnopsychology • Ethnology • Emigrants and immigrants • Refugees • Visible minority • Newcomers • Linguistic • Cultural diversity • No age restrictions	• Service(s) • Program(s) • Treatment • Therapy • Interventions • Psychotherapy • Therapeutics • Mental health • Mental illness • Mental disorders • Mental health services • Psychiatry • Substance use *disorders • Drug abuse • Substance abuse • Addictions	• Effective • Effective interventions • Effective practices • Effective treatments • Pilot project • Program development • Program evaluation • Treatment outcome • Practice guideline • Guideline • Best practice • Evidence-based • Good practice • Evaluation • Adaptation, psychological • Cultural adaptation • Culturally adapted

The searches were limited to records published in English between 2007 and 2018. The initial literature search identified 3129 records from MEDLINE and 2214 records from PsycINFO. Following the removal duplicates, a total of 4671 records remained for review. Between February and April 2018, two knowledge brokers divided the list of records, reviewed abstracts independently, and consulted with

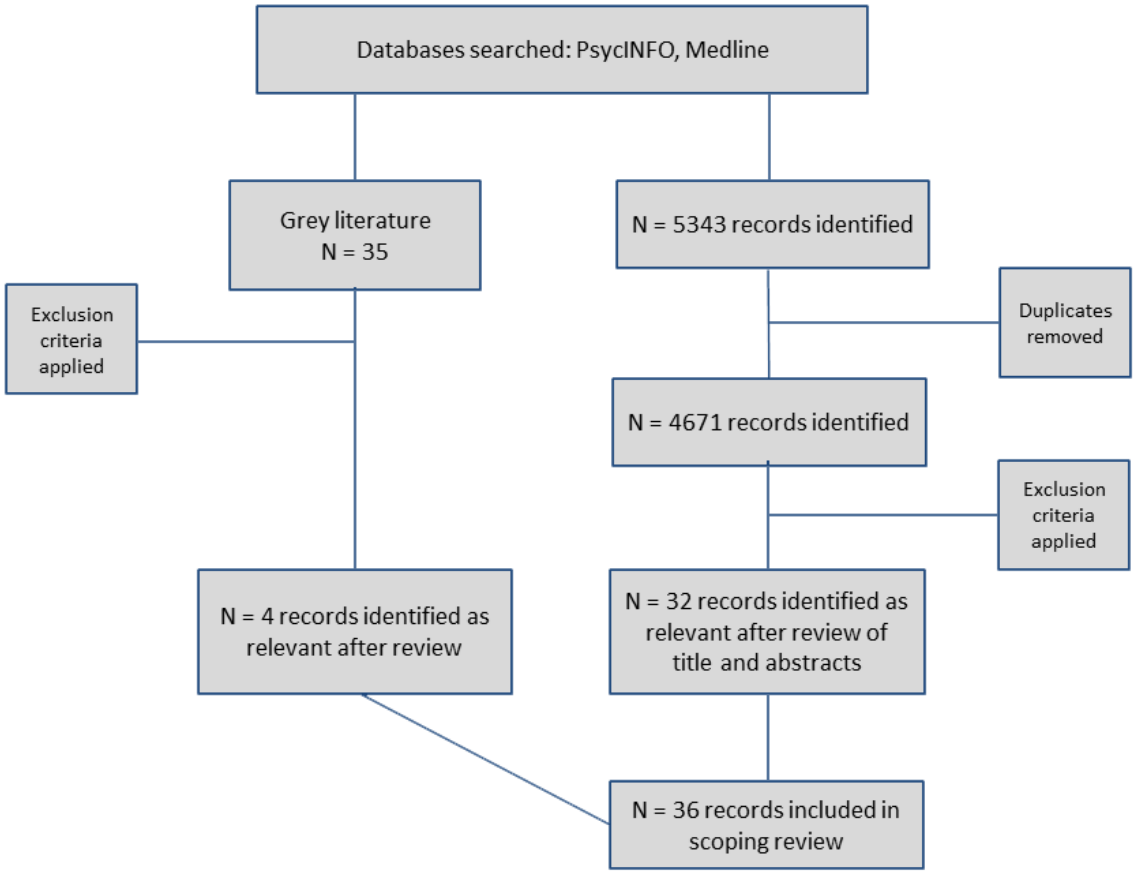
one another if they were uncertain if a record met inclusion criteria. If consensus could not be met, a third party reviewer was available to arbitrate; however, this was not needed. The following inclusion and exclusion criteria was used to in this review:

Inclusion criteria:

- Must include IRER populations
- Must be from a setting similar to Canada (e.g. Australia, New Zealand, U.S., U.K.)
- Must examine culturally adapted or culturally specific mental health and addictions programs and services
- Must be service/treatment focused

Exclusion criteria:

- Indigenous populations
- Francophone populations
- Records that did not report treatment outcomes
- Records that were not published in English



The second phase of the scoping review consisted of synthesizing the literature into a data extraction table, which was completed by two knowledge brokers. The data extraction table organizes the findings by the intervention type, such as whether the intervention was culturally specific or culturally adapted. The third, and final, phase of the scoping review entailed the full narrative of the findings. The narrative of the scoping review was led by one knowledge broker, who received support from the project team where needed.

Review of literature

This scoping review is organized into two main sections based on the approach – culturally specific interventions and culturally adapted interventions. Each section is then sub-divided based on population and type of disorder to establish whether any tends or patterns exist. The sub-sections were selected based on what populations and disorders were pronounced in the literature.

Culturally specific interventions

There are a growing number of empirically tested mental illness and addiction treatment interventions to consider. The following is a summary of six articles found on mental illness and addiction treatment interventions designed and evaluated with specific IRER groups. Five of these articles evaluate specific treatment interventions that have been implemented with IRER populations, while one is a systematic review. The first part of the review will focus on specific IRER populations. These groups include immigrant, refugee and asylum-seeking, Latin American and African American populations. The second portion of this review will focus on the mental illness and/or substance use diagnoses that were prominent in the literature.

Populations

Immigrant populations

Beehler, Birman and Campbell (2012) looked at first and second-generation immigrant children and adolescents experiencing significant trauma. They utilized the *Cultural adjustment and trauma services* (CATS) model amongst a variety of immigrant populations experiencing trauma and/or symptoms of posttraumatic stress disorder (PTSD). The CATS service model is a school-based program that targeted two large school districts in New Jersey, United States. The first school district was based in a secondary school (high school), while the second was in a primary school (kindergarten – grade eight). The 149 participants in the study intervention came from 29 different countries of origin, and spoke 19 different languages (please see Table 3 on page 45 for more demographic details of this sample). The CATS service components included relationship building, outreach services, and comprehensive clinical and case management. Results demonstrated the efficacy of the CATS program in improving overall functioning and symptoms of PTSD. However, different service components affected different student outcomes. For example, supportive therapy showed improvements in overall functioning, but not on symptoms of PTSD. Conversely, service coordination improved symptoms of PTSD, but had no impact on overall functioning. Cognitive behavior therapy (CBT) resulted in improved overall functioning, but only marginally reduced symptoms of PTSD. Trauma-focused CBT was associated with improvements in both overall functioning and symptoms of PTSD.

Refugee and asylum-seeking populations

There were four studies that investigated culturally-specific interventions amongst refugee and/or asylum seeking populations. Two of these studies focused specifically on children and adolescent populations in which school-based interventions were investigated. The *Haven project* was implemented in schools across Liverpool in the United Kingdom, helping refugee children navigate the acculturation

process and overcome traditional barriers to access (Chiumento et al., 2011). Children may be offered individual, group, or family-based therapy depending on their individualized level of need. Unfortunately, this article did not outline what specific refugee populations were targeted in the *Haven project*. Ellis and colleagues (2013) piloted a multi-tiered intervention approach, rooted in Trauma systems therapy (TST), called *Supporting the health of immigrant families and adolescents* (SHIFA). This initiative has a specific focus on Somali refugee youth who have immigrated to the United States (US), supporting them with experiences of trauma in the community, school, and clinical settings. This multi-tiered intervention approach included:

- Tier 1: community resilience building through engagement, education and outreach
- Tier 2: child resilience building through school-based skills groups
- Tier 3: trauma systems therapy (culturally adapted) and school-based skill-building psychotherapy
- Tier 4: trauma systems therapy and home-based care

Youth across all four tiers of the SHIFA model demonstrated improvements in depression and PTSD symptoms. However, these improvements did not differ based on the tier of care a participant received.

Sweet mother is an early-intervention mental health service model for asylum seeking mothers and their babies in the first year of life, which focuses on the attachment between mother and child (Egeland and Erikson, 1993). Research has demonstrated that asylum-seeking women are at an increased risk for developing mental health issues during and following pregnancy (McLeish, 2002). *Sweet mother* offers an attachment-based early intervention to a group of high-risk asylum-seeking mothers. The intervention targeted one cultural group, women from West Africa aged 17-32. Treatment outcome measures were not assessed, however, qualitative analysis demonstrated a positive shift in the quality of attachment between mothers and their children (O'Shaughnessy et al., 2012).

Lastly, Williams and Thompson (2011) conducted a systematic review on the use of community-based, culturally-specific interventions in reducing the psychological impact of trauma amongst refugee populations. All 14 studies in their review consistently demonstrated the efficacy of community-based interventions in improving mental health outcomes among refugee populations. Approximately half the studies focused on adult populations, while the other half were on adolescents. Several themes and considerations emerged from their review, including cultural awareness, language, setting, and post-migration stressors. There were a variety of specific refugee groups that were examined in this review, please review to Table 3 on page 49 for additional demographic details.

Latin American and African American populations

Marsiglia and Booth (2013) reviewed and outlined three culturally specific interventions in their book chapter. One of these interventions, brief strategic family therapy (BSFT), focused on Latin American (US) adolescents with substance use and behavioural disorders. BSFT posits that substance use disorders in adolescents are rooted in dysfunctional family interactions; if the overall functioning of the family improves, then adolescent substance use problems will also be mitigated (Dishion & Andrews,1995 ; Santisteban & Szapocznik, 1994). Research has demonstrated the efficacy of BSFT in engaging and

retaining families in treatment, and reducing substance use in adolescence (Santisteban et al., 1997, 2003).

The second intervention in their review was *Alcohol treatment targeting adolescents in need* (ATTAIN), which focuses on building skills and enhancing motivation, and has been deemed appropriate for culturally diverse populations (Gil, Wagner, & Tubman, 2004). Gil and colleagues (2004) implemented ATTAIN in a juvenile detention centre with both Latin American and African American adolescents. There was a significant decrease in substance use observed, with the most significant differences found in African American participants.

Although Marsiglia and Booth (2013) categorized the aforementioned treatment interventions as culturally-specific, it is unclear from their review how these two interventions were developed specifically for the targeted groups.

Lastly, *Healer women fighting disease* (HWFD) is an integrated substance use and HIV treatment program for African American women. This intervention presents women with pro-health values that are rooted in traditional African culture in order to reduce substance use and promote safer sexual behaviours (Nobles, Goddard, & Gilbert, 2009). HWFD has been shown to be more effective than treatment as usual for enhancing motivation and self-efficacy, reducing depressive symptoms, and promoting safer sexual behaviours. However, the intervention did not improve attitudes towards substance use and self-esteem (Nobles et al., 2009).

Mental illness/substance use diagnoses

This next section of the literature review will focus on the various mental illness and/or substance use diagnoses that were prominent in the literature surrounding culturally specific interventions for IRER populations. These include trauma (and PTSD), mood disorders (specifically depression and/or anxiety-related disorders), and substance use disorders (unspecified).

Trauma/PTSD

Evidence has shown that refugees are at higher risk than the general population for a variety of health problems and disorders including anxiety, depression, PTSD, substance use problems, conduct and eating disorders (Lustig et al., 2004; Ellis et al., 2013). PTSD and depression in refugee children and adolescents are particularly concerning as many refugee children are exposed to violence and stressful experiences before, during, and/or after migration (Ellis et al., 2013). For example, they may experience violence in their home country, acculturation stress, family trauma, and loss. These children and youth also have limited access to mental health services, further compounded by cultural and language barriers (Alegria, Vallas & Pumariega, 2010; Ellis et al., 2013). Despite a very high level of need, very few refugee children and adults receive proper mental health care (Ellis et al., 2010).

School-based interventions have been identified as a potential way to increase access to mental health care for immigrant and refugee children who have experienced trauma (Beehler et al., 2012; Chiumento et al., 2011). The school environment is where adolescent acculturation and adjustment struggles typically unravel, creating an ideal opportunity to intervene. School-based mental health and addiction

initiatives allow treatment to occur within the context of larger systems that either support on inhibit adjustment for immigrant children (Beehler et al., 2012).

Three studies examined school-based mental health interventions for immigrant and/or refugee children experiencing trauma, ranging from age six to 21. The first study (Beehler et al., 2012) examined *Cultural adjustment and trauma services* (CATS), which is a comprehensive school-based mental health program for diverse immigrant students experiencing trauma. It includes relationship building, outreach services, and comprehensive clinical and case management services. The program included the use of cultural brokers and offered training in cultural competence in order to make their services culturally appropriate. Moreover, CATS staff were bicultural and/or bilingual licensed clinicians, many were of immigrant background as well. Unfortunately, no further clarification with respect to how the intervention was culturally-specific was included. Findings suggest that the application of cognitive behavioural therapy (CBT) on immigrant children experiencing trauma had a slight effect on reducing PTSD related symptoms. Some participants received a specialized trauma-focused form of cognitive behavioural therapy (TF-CBT), which not only reduced symptoms of PTSD, but also improved overall functioning. The last group of students in this study received a combination of CBT, TF-CBT, and supportive therapy. These students demonstrated a significant reduction in functional impairment; however, there were no significant reductions in PTSD symptoms.

The second study (Ellis et al., 2013) piloted a multi-tiered intervention approach, with a specific focus on Somali refugee youth who have immigrated to the US. The *Supporting the health of immigrant families and adolescents* (SHIFA) initiative is based on the *Trauma systems therapy* (TST) model. Its aim was to support Somali youth with trauma in community, school, and clinical settings. The SHIFA project demonstrated significant improvements of both PTSD and depression for all participants over time. However, these improvements did not differ based on the tier of care each participant received.

Lastly, Chiumento and colleagues (2011) highlight a multi-agency, school-based mental health service for refugee and asylum seeking children, known as the *Haven project*. The *Haven project* aims to provide mental health services to refugee youth from different backgrounds across seven schools in the United Kingdom (UK). Youth participants responded to the service model positively, preferring to receive mental health services in a school setting compared to a clinical one. The findings highlight the benefit of forging strong bonds between the mental health and education sectors in addressing refugee mental health.

Williams and Thompson (2010) conducted a systematic review, examining the efficacy of community-based interventions in reducing trauma among refugee populations. Several specific interventions were explored, including school-based and play models, home-based individual psychotherapy models, community-based group psychotherapy models, and multifaceted case management models. All interventions shared the common goal of bringing a group of local individuals together, in order to address their own mental health. Most studies demonstrated positive statistical significance in participants who received treatment in their resettled countries or country of origin. Themes of cultural sensitivity, local adaptations to therapy, the use of native languages, and post-migration stressors emerged across the articles.

Mood disorders

The rates of mood and anxiety disorders vary considerably among different IRER populations, which mainly depend on variations in risk and protective factors Moreover, it is important to remember that there are within-and-between-group differences between the different IRER populations (MHCC, 2016). This section of the review will discuss the main findings of culturally-specific treatment interventions that have been utilized to treat mood and anxiety-related disorders with IRER populations. One study focuses on culturally-sensitive treatment for mood and anxiety-related disorders with IRER populations.

Sweet mother is an innovative pilot mental health service for asylum-seeking mothers and their infants in the UK, which explicitly focuses on the attachment between mother and child (O'Shaughnessy et al., 2012). *Sweet mother* aimed to increase infant attachment by increasing maternal sensitivity, altering maternal representations, and increasing social support. The intervention was group-based and consisted of weekly sessions over 21 weeks. Following treatment, mothers described a positive impact on both their own psychological well-being and their infants'. Results also demonstrated a positive shift in the quality of attachment between mother and infant.

Substance use disorders

There is a paucity of research examining culturally specific substance use interventions. One record, by Marsiglia and Booth (2013), examined the effects of culturally specific substance use interventions that targeted the individual and their families. Brief strategic family therapy was a program culturally specific to Latin American adolescents. The treatment, rooted in dysfunctional family interactions, targeted an array of behavioural issues, notably substance use. Overall, the treatment proved to be more effective than comparison groups at reducing substance use, and engaging and retaining families in treatment. However, reducing substance use was only a part of the intervention, while the main focus was on handling adolescent misconduct.

Additionally, Marsiglia and Booth (2013) discussed the *Healer women fighting disease* (HWFD) intervention, which is an integrative intervention that targets both substance use and HIV risk in African American women ages 13-55. Women were presented with pro-health values rooted in traditional aspects of African culture, in order to decrease substance use and HIV risk. Compared to the comparison group, this intervention did not have an impact on drug use, but managed to assist with addressing depressive symptoms in participants.

Lastly, the *Alcohol treatment targeting adolescent need* (ATTAIN) program for Latin American and African American offenders in juvenile detention centres was examined for its effects on substance use treatment (Marsiglia & Booth, 2013). A significant decrease in 30-day substance use was observed in all treatment conditions, with the most dramatic decrease occurring among African American participants. Moreover, participants 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 effective in reducing the number of days of substance use (30-day point prevalence), but no analysis was done comparing the treatment group with control due to a small sample size.

Culturally adapted interventions

There is a growing body of research regarding culturally adapted mental illness and addiction treatment interventions. The following is a summary of 22 articles found on culturally adapted mental illness addiction treatment interventions amongst IRER groups. Twelve of these articles focus on the evaluation of specific culturally adapted interventions that have been implemented with IRER populations, while ten are systematic reviews. The review of culturally adapted interventions will follow the same format as the previous section, by first looking at specific populations and then mental illness and/or substance use diagnoses. The same categorizations exist as the culturally specific interventions review outlined, with a few additions and mixed/unspecified populations.

Populations

This portion of the review will focus on the various populations that were prominent in the literature, including immigrant, refugee and asylum seeking, Latin American and African American populations. Several articles and reviews included mixed populations, as well as samples with unspecified ethnoracial identities.

Immigrant populations

Of the 22 articles included in this section, only eight made particular reference to investigating the effectiveness of culturally adapted mental health and addiction treatment interventions with immigrant populations. Two of these articles looked at immigrant Latin American populations, one looked at African American and Latin American populations in which over half the sample identified as second generation immigrants, and the remaining articles looked at a mix of immigrant populations including individuals that identify as: Chinese, Tamil, Korean, Turkish, Vietnamese, Caribbean, Japanese, and other unspecified groups.

Kanter and colleagues (2010) and Kaltman and colleagues (2016) explored culturally adapted treatment interventions for Latin American immigrant populations in the US. While both studies focused on adult female populations, one focused exclusively on depression (Kanter et al., 2010) and the other on trauma-exposed women with depression and/or PTSD (Kaltman et al., 2016). Kaltman and colleagues (2016) used a combination of behavioural activation, cognitive behavioural therapy, and motivational interviewing in their culturally adapted *Latinas saludables* intervention. Feasibility and acceptability of this intervention was positive, and symptoms of depression and PTSD were reduced from baseline to post-intervention on average. Kanter and colleagues (2010) utilized a culturally adapted behavioural activation intervention at a bilingual (Spanish-English) community mental health clinic. Their results demonstrate the feasibility and effectiveness of the intervention, with approximately half of the participants achieving remission upon completion. However, no follow-ups were conducted.

Ngo and colleagues (2009) examined the efficacy of the *Youth partners in care quality improvement intervention* with a sample of Latin American and African American adolescents. This study supports the value of quality improvement initiatives in addressing ethnoracial disparities in mental healthcare utilization and outcomes. Improvements in depression symptoms were seen for youth in primary care

settings, particularly amongst African American youth. The same trends were seen for Latin American youth, but results were not significant for this portion of the sample.

Chow and colleagues (2011) compared culturally adapted assertive community treatment (ACT) in a sample of immigrant populations at a hospital in Toronto and a community social service agency in Japan. The culturally adapted ACT models demonstrated efficacy in a multicultural client group in Toronto, and a group of Japanese participants in Japan. However, the outcome data was mainly assessed based on decreases in annual number of hospital days and reductions in the number of clients with at least one admission.

Two reviews by Huey and Polo (2008) and Antoniades, Mazza, and Brijnath (2014) demonstrated mixed results when examining cultural adaptations for immigrant populations. Huey and Polo (2008) were not able to show significant improved outcomes, but note that effects were larger when cultural adaptations were compared to no treatment or placebos, versus treatment as usual groups. Antoniades and colleagues (2014) report that cultural adapted interventions tend to improve treatment outcomes. However, methodological issues compromised these results.

Bhui (2010) reviewed the culturally adapted SITARA trial to determine its effectiveness in addressing depression and social isolation in a group of adult Pakistani immigrants, specifically women, in England. The model tested the use of a social intervention (social activities, psychoeducation) and antidepressant medications. At the three-month follow up, participants who received the social intervention alone or the social intervention and medication demonstrated improvements in depressive symptoms, compared to the medication treatment alone. However, at the nine-month follow up no significant differences were found.

Chow and colleagues (2010) evaluated the use of multi-family psychoeducation group (MFPG) to an assertive community treatment (ACT) model in a group of adult Chinese, Tamil, Vietnamese, Korean, and African Caribbean immigrant groups living in Canada. This intervention was effective with culturally diverse populations in reducing family burden, decreased hostility and family conflict, and improved communication between family members. The psychoeducation component was included because increased knowledge in mental illness may help clients and family members to effectively manage expectations, and to look for symptoms of relapse. Their study showed that family members who attended more sessions demonstrated greater reductions in family burden.

Refugee and asylum-seeking populations

Only one study discussed refugee populations, specifically mothers from Afghanistan living in England. In response to community concerns over the use of western-based psychological interventions for refugee populations, Hughes (2014) developed and pilot tested the culturally adapted *Tree of life* school-based group intervention for children and their families. This intervention uses the tree as a metaphor for one's life, with the roots representing cultural and social history, the ground representing current life factors, the trunk of the tress as one's personal strengths and abilities, and the branches of the tree representing hopes and dreams for the future (Hughes, 2014). Although treatment outcomes were not

assessed, qualitative feedback revealed positive experiences felt by participants through taking part in this intervention.

Latin American and African American populations

Six articles looked at Latin American populations, two looked at African American populations, and three looked at Latin American and African American populations together.

Latin American populations

Six studies in this review focused exclusively on Latin American samples; two investigated adolescent Latin American groups, three on adults, and one on families. Burrow-Sanchez and Wrona (2012) and Burrow-Sanchez, Minami, and Hops (2015) investigated culturally adapted cognitive behavioural therapy (A-CBT) for substance use amongst Latin American adolescent populations in the US. Results from both studies report similar acceptance and satisfaction rates for participants in both the standard and adapted treatment conditions. Additionally, participants in both articles demonstrated significant decreases in substance use from baseline to post-treatment. Moreover, substance use outcomes were mediated by two cultural variables, specifically the concepts of ethnic identity and familism.

The studies targeting adult Latin American samples differed in the type of intervention utilized, as well as the mental illness targeted. Kanter and colleagues (2010) conducted a pilot evaluation of a culturally adapted behavioural activation intervention for Latin American adults diagnosed with depression in the US. Their results demonstrate the feasibility and efficacy of this intervention, including treatment retention, adherence, and outcomes. Special attention was paid to specific cultural variables (including familism, personalism, and female and male gender roles), and how they influence behavioural activation. Lee and colleagues (2013) conducted a randomized control trial of culturally adapted verses unadapted motivational interviewing in a sample of Latin American adults exhibiting heavy drinking (defined as 5+/occasion or 14+/week for men; 4+/occasion or 7+/week for women). Their results showed significant decreases in alcohol consumption across both treatment groups, with greater reductions seen in the culturally adapted group at two and six months post-treatment. Lastly, Kaltman and colleagues (2016) evaluated *Latinas saludables*, a CBT-based mental health intervention for Spanish-speaking trauma-exposed Latin American women with a diagnosis of depression and/or PTSD in the US. Preliminary results support the feasibility, acceptance, and safety of the intervention. Additionally, results demonstrated reductions in depression and PTSD symptoms from baseline to post-treatment.

Sparks, Tisch, and Gardner (2013) investigated the efficacy of a family-based intervention (*celebrating families!*), as well as the culturally adapted version of that intervention (*¡celebrando familias!*). *Celebrating families* was delivered in English to both Latin American and non-Latin American families in the US. All families in the program demonstrated improvements in a number of outcome measures (parenting skills, drug and alcohol use, family strength/resilience, etc.). There was no evidence of problems with cultural competency, and Latin American participants demonstrated greater improvements following the program, when compared with non-Latin American participants. *Celebrando familias* was culturally adapted to Latin American populations and delivered in Spanish to monolingual or limited-English families. The adapted program was deemed comparable to the original intervention, and participants reported significant satisfaction. Results demonstrated significant effects

on a number of outcomes, including family function, cohesion, conflict resolution, parental involvement, and a reduction in drug and alcohol use. Both interventions suggest that family-based may be an appropriate substance use intervention for this population.

African American populations

Ward and Brown (2015) evaluated a culturally adapted intervention for African American adults experiencing depression, titled *Oh happy day class* (OHDC). The authors conducted two separate pilots to test the feasibility and acceptability of OHDC, as well as to determine short-term treatment outcomes. Across both pilots, participants demonstrated statistically significant reductions in depression symptoms and reported being very satisfied with the OHDC program. Williams and colleagues (2016) reviewed the existing literature on culturally adapted CBT interventions for African American adolescents. Their review found that culturally adapted CBT is effective in treating a number of mental health disorders amongst adolescent African American samples. Specifically, the adaptations discussed included parental involvement and family-based interventions, empowerment and familial support, understanding the effects of racism, and facilitating a strong, positive ethnoracial identity. Moreover, the authors outlined ten culturally sensitive components that can be incorporated into treatment when working with African American adolescent clients:

1. Inclusion of families
2. Empowerment
3. Ethnoracial-related stressors
4. SES-related stressors
5. Culturally sensitive content
6. Stigma surrounding mental illness
7. Mistrust of research
8. Community / home-based interventions
9. Flexible scheduling
10. Cultural-sensitivity training

Mixed populations

Three articles examined the efficacy of culturally adapted interventions amongst both Latin American and African American samples, all of which focused specifically on adolescent populations. Rue and Xie (2009) reviewed three culturally adapted treatment interventions: storytelling therapy, brief structural family therapy (BSFT), and CBT. Storytelling therapy (or *Cuento therapy*) was examined amongst a group of Puerto Rican children in the US in order to promote self-esteem and emotional well-being. Results found favourable outcomes in the culturally adapted group compared to the treatment as usual group. BSFT model is flexible and focuses on problem solving within the family unit. It has been tested with Latin American and African American samples, demonstrating efficacy in improving conduct, family functioning, and treatment adherence compared to no-intervention control groups. Lastly, authors reviewed culturally adapted CBT amongst Puerto Rican adolescents in the US with depression, and found positive results.

Ngo and colleagues (2009) examined the efficacy of the youth partners in care quality improvement intervention with a sample of Latin American and African American adolescents in the US. The intervention was designed to improve access to care (CBT and medication-based interventions) in primary care settings. African American adolescents in this study demonstrated significant reductions in symptoms of depression and exhibited higher utilization rates at the six-month follow up. These same trends were seen amongst the Latin American adolescents in the sample, though they were not

significant. These results suggest that the intervention acted on different mechanisms across racial-ethnic groups, lending further support to the need for cultural adaptations.

More recently, Steinka-Fry and colleagues (2017) conducted a systematic review to examine culturally sensitive substance use treatment for racial/ethnic minority adolescents. The majority of the samples in this review consisted of Latin American and African American populations, and utilized mostly CBT or family-based interventions. Their results indicate that culturally sensitive treatments may result in significantly larger reductions in substance use following treatment.

Culturally diverse populations or unspecified

Eight articles looked at diverse samples, with some samples with unidentified cultural/ethnic identities. Three of these articles focused on adolescents, one on adults, and four included both adult and adolescent samples.

The articles that focused on adolescent populations demonstrated mixed results. The review by Kataoka and colleagues (2010) found support for culturally adapting treatment interventions amidst a number of mental health and substance-related disorders, across a variety of cultural groups, and utilizing diverse treatment interventions. However, the two studies by Huey and Polo (2008, 2010) were not able to demonstrate improved outcomes from cultural adaptations.

Chowdhary and colleagues (2014) conducted a systematic review of culturally adapted treatment interventions for adults. Their review of 16 studies revealed statistically significant outcomes in support of cultural adaptations amongst a variety of ethnoracial groups, utilizing a variety of interventions.

Lastly, the majority of articles that included both adult and adolescent populations in their reviews all found that culturally adapted interventions led to better treatment outcomes (Kalibatseva & Leong, 2014; Chow et al., 2011; Smith & Trimble, 2016). Antoniades and colleagues (2014) reported improved outcomes for culturally adapted interventions, but were cautiously optimistic in their conclusions. Moreover, Smith and Trimble (2016) caution that the efficacy of culturally adapted mental health interventions appear to be greater in the following conditions:

a) Adult samples (age 35-40 and older)
b) Racially homogeneous (similar) samples
c) Asian American samples
d) Studies involving multiple cultural adaptations (more adaptations result in greater efficacy)

Mental illness/substance use diagnoses

This next section of the review will focus on the different mental illness and/or substance use diagnoses that appeared in the literature amongst IRER populations. These diagnoses include trauma and PTSD, mood disorders (specifically depression and/or anxiety-related disorders), and substance use disorders. Unfortunately, the substance use disorders across all studies were not specific to any one substance, but instead discussed substance use disorders more generally. Additionally, the culturally adapted interventions included two studies that focused on severe/persistent mental illness amongst culturally diverse samples.

Trauma/PTSD

Trauma-related disorders, most notably PTSD, were discussed in four articles. Two of these articles included youth samples, one with adults, and one with families. A review by Kataoka and colleagues (2010) found a number of culturally adapted and sensitive treatments to be effective in treating trauma and PTSD amongst ethnically diverse adolescent samples in the US. Conversely, Huey and Polo (2008) contend that there is not enough evidence to support that culturally adapted interventions lead to better clinical outcomes for ethnically diverse youth. They suggest retaining the intervention in its original form, and applying culturally responsive elements, provided it meets the individual client's needs.

Kaltman and colleagues (2016) examined the efficacy of *Latinas saludables*, a culturally adapted intervention for Latin American women who have immigrated to the US. They report that the intervention was effective at reducing symptoms of depression and/or PTSD in a group of trauma-exposed Latin American immigrant women. Although anecdotal responses were positive, treatment outcomes were not measured.

Lastly, Hughes (2014) indicated that depression and PTSD symptoms were reduced from the baseline to post-intervention, following the implementation of a culturally adapted *Tree of life* intervention to a group of refugee children and families in the UK. The group-based intervention employed a strengths-based method, using the tree as a metaphor for life, enabling participants to develop empowering stories rooted in their social and cultural histories. From this safe space, participants were able to co-develop culturally informed solutions to their problems. Although qualitative data provides support for this intervention, no formal measures were used to determine treatment outcomes.

Mood disorders

The efficacy of culturally adapted interventions in treating mood disorders with IRER populations was examined in ten articles. Three articles focused on adolescents, three on adults, three with both adults and adolescents, and one did not specify the sample.

Overall, eight of the ten articles found culturally adapted interventions to be successful at decreasing symptoms related to depression and/or anxiety (Kalibatseva & Leong, 2014; Kanter et al., 2010; Smith & Trimble, 2016; Ward & Brown, 2014; Antoniades et al., 2014; Kataoka et al., 2010; Ngo et al., 2009; Chowdhary et al., 2014). Most of the articles that investigated anxiety disorders did not indicate what specific anxiety-related disorders were targeted. Only one study mentioned treatments specific to separation anxiety, generalized anxiety, social phobias, and specific phobias (Kataoka et al., 2010). Bhui (2010) found culturally adapted interventions to be effective, but only when combine with anti-depressant treatment. Lastly, Huey and Polo (2008) found no statistical difference between using culturally adapted interventions versus treatment as usual.

Substance use disorders

Eight articles discussed culturally adapted treatments for substance use disorders. Five focused on adolescent populations, one specifically on adults, and two did not specify the population. Aside from

the one study that investigated heavy drinking behaviours (Lee et al., 2013), none of the articles detailed the substance(s) of choice for their samples.

Overall, seven of the eight articles found culturally adapted interventions to have a positive effect on reducing substance use. Strong identification with one's cultural identity and the inclusion of family in treatment contributed to these positive effects (Steinka-Fry et al., 2017; Huey & Polo, 2010; Kataoka et al., 2010; Lee et al., 2013; Burrow-Sánchez et al., 2015; Burrow-Sánchez & Wrona, 2012; Sparks et al., 2013). One study indicated potential best practice steps when adapting an intervention for a specific cultural groups, namely to include the cultural group in stakeholder discussions and for quality improvement purposes and cultural acceptability (Kataoka et al., 2010).

Other

Two studies investigated culturally adapted interventions for IRER populations with severe/persistent mental illness, and three articles discussed culturally adapted interventions on a more general basis without specifying the mental health condition(s) treated.

Chow and colleagues (2011) examined a culturally adapted assertive community treatment (ACT) model amongst a sample of culturally diverse adults in Toronto and Japan. Brief Psychiatric Rating Scale (BPRS) scores significantly decreased from pre-to-post treatment assessment. However, outcome data were largely based on decreases in annual hospital stays (measured in days) reductions in the number of clients with at least one admission. Chow and colleagues (2010) evaluated the use of a multi-family psychoeducation group (MFPG) model to ACT in a sample of ethnoracial diverse adults. Their results demonstrated enhanced familial understanding of mental illness, reduced stress, and less negative feelings towards family members with severe mental illness.

Three articles that discussed culturally adapted mental health and/or addiction treatment interventions with IRER populations, but did not indicate the specific condition(s) being targeted. One record reported insufficient evidence to support the cultural adaptation of psychotherapeutic interventions (Huey & Polo, 2010), however, the other two reported positive effects of using culturally adapted interventions (Rue & Xie, 2009; Williams et al., 2016).

No intervention

Six articles discussed cultural adaptations and cultural competence more generally, without going into detail regarding specific treatment interventions. These articles all provide support to culturally adapting mental health and/or addiction treatment interventions when working with IRER populations, while also demonstrating the need for more rigorous evaluations of these interventions (Janzen et al., 2010; Swift et al., 2015; Substance Abuse and Mental Health Services Administration (SAMHSA), 2017; SAMHSA, 2014; MHCC, 2016; Wellesley Institute, 2016).

A report by the Mental Health Commission of Canada (MHCC, 2016) outlined international evidence on promising practices when working with IRER populations. Authors report the following eight highlights from their review:

1. Cultural competence holds promise, but more rigorous evidence is needed
2. Culturally adapted interventions improve treatment outcomes, but differ across ethnoracial groups
3. Developing specific/integrative-care models for ethnic groups may improve outcomes
4. Culturally adapted interventions for ethnoracial diverse youth appear to be effective
5. Cultural adaptations hold promise for the treatment of substance use disorders
6. There is evidence to support the treatment of refugee populations who have experienced trauma
7. Improvements in care for IRER populations require a structured approach
8. Telecounselling modalities may be a useful alternative to offering treatment to remote populations

Frameworks for cultural adaptations

A number of different frameworks for cultural adaptations of mental health interventions were outlined in the articles reviewed, such as the multidimensional model for understanding culturally responsible psychotherapies (Koss-Chioino & Vargas, 1992), ecological validity framework (Bernal, Bonilla, & Bellido, 1995), and the cultural accommodation model (Leong & Lee, 2006). More recently, Naeem and colleagues (2016) devised and tested a four-step model of cultural adaptation and translated this methodology to a specific treatment (CBT), demonstrating preliminary support for the framework.

Stage 1: Information gathering

Review the literature, consult with subject matter experts, and conduct focus groups with clients, community members, and healthcare providers to gain a better understanding of the problem or concern.

Stage 2: Produce guidelines

Develop guidelines to adapt a particular treatment modality.

Stage 3: Translate and adapt

Culturally adapt treatment materials and procedures.

Stage 4: Field testing

Pilot test the adapted treatment, evaluation, and complete revisions.

Conclusions

It is evident from this scoping review that IRER populations have specific needs when it comes to mental health and/or addictions treatment, which are not always addressed using mainstream interventions. One of the most significant barriers to access and quality care is the cultural incompatibility of existing services. Both cultural adaptations and culturally specific interventions for mental health and/or addiction treatment interventions with IRER demonstrate preliminary evidence for addressing the critical needs of these populations. The literature in this review consistently identified high levels of

acceptability, feasibility, and satisfaction with the intervention. However, there were mixed results when assessing the mental health and/or addiction treatment outcomes. Moreover, various methodological limitations make it difficult to form definitive conclusions. The limitations found in the literature include the use of small sample sizes, the lack of systematic evaluation of treatment outcomes, the reliance on anecdotal feedback, as well as the absence of control groups and randomized controlled trials.

Another significant limitation across these articles is the lack of detail surrounding what elements of the treatment were culturally adapted and/or culturally specific. Amongst the eight articles that examined culturally specific interventions with IRER populations, none discussed the use of a specific framework or culturally specific components used. Moreover, only about half of the articles that examined the efficacy of culturally adapted interventions with IRER populations discussed cultural adaptation frameworks. The most common frameworks cited were the multidimensional model for understanding culturally responsible psychotherapies, the ecological validity framework, and the cultural accommodation model.

Despite these limitations, the literature suggests that culturally relevant treatment interventions are more effective for IRER populations than generic treatment interventions. Furthermore, evidence suggests that culturally adapted psychotherapies improve treatment outcomes, but the impact varies across ethnoracial groups (MHCC, 2016):

- Psychotherapeutic interventions adapted for a specific group are more efficacious than those targeting culturally-mixed groups
- Impact of psychotherapeutic cultural adaptations are greater in adult samples than adolescents

The evidence gathered in this review is unable to address which type of intervention, culturally specific versus culturally adapted, is more effective. Although the amount of literature in this field is growing, it is not enough to draw meaningful conclusions at this time.

Limitations

In addition to the limitations of the various articles outlined in this review, it is important to note a few limitations of this scoping review. The inclusion/exclusion criteria for this scoping review were narrow, thereby limiting the literature included in this review (please see the Methodology section on page 6 for a list of inclusion and exclusion criteria). Although two Knowledge Brokers completed the data extraction for this scoping review independently, each only reviewed half of the literature. It would have been more methodologically sound to have the data extraction results verified by another reviewer. Other limitations include the time constraints of this scoping review, the exclusion of articles published in languages other than English, and the lack of critical appraisal. Generally, however, scoping reviews do not utilize critical appraisals as part of their methodology. Instead, scoping reviews are meant to be broad in scope, compared to the comprehensiveness of a systematic review.

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Appendix A

Table 1: Summary Table – by population

Cultural Identity	# of Articles	Population Type	Type(s) of Cultural Adaptation	Outcomes/Observations
Culturally Specific Interventions				
Various	3 articles looked at culturally specific interventions for various ethnic groups; 2 articles looked at trauma and one looked at substance use.	• Two articles focused on children/youth; one focused on immigrant children from 29 different countries; and the other looked at refugee children, but did not identify their country of origin. • The last article focused on children and adults, and did not state if participants were immigrants or refugees. Nine specific countries of origin were identified, some listed as various/ N/A.	None of these articles detailed what elements of treatment were culturally adapted, or made reference to any frameworks used. 5 articles culturally matched clients and therapists, 2 utilized cultural brokers. The remaining articles state the intervention was "culturally sensitive" but did not detail how.	Studies indicated that results were positive, but additional research is warranted to draw more conclusive recommendations. One article found refugee children are more likely to, and prefer, access to a school-based mental health service compared to visiting a mental health agency.
African	Two articles examined culturally specific interventions for asylum seekers and refugees.	• One article specifically looked at West African new mothers who identified as asylum seekers. • The second article looked at Somali and Somali Bantu refugee youth.		Participants in each generally benefitted from the interventions. In one article West African women felt a closer connection to their babies, and found a safe space to discuss their relationships with their child. The second article indicated that Somali and Somali Bantu youth saw a decrease in PTSD and depression symptoms.
African American	One article focusing on African American women	One article examined substance use and HIV risk among African American women (13-55); there was no indication if women were immigrants, refugees, or born in the U.S.		The program was shown to be more effective than treatment as usual when addressing attitudes towards safer sex, self-efficacy, motivation and depression, but not in attitudes toward drug use and self-esteem.
Latin American	One article focusing on Latin American adolescents	The article examined substance use among Latin American adolescents	None of these articles detailed what elements of treatment were culturally adapted, or made reference to any frameworks used. 5 articles culturally matched clients and therapists, 2 utilized cultural brokers. The remaining articles state the intervention was "culturally sensitive" but did not detail how.	The intervention was found to improve family functioning, identifying repetitive patterns that reinforce the problem, and restructuring the family system. It was also shown to be more effective than comparison group at engaging and retaining families in treatment.
Multiethnic (Latin American and African American)	One article focused on a mix of Latin American and African American youth	The article examined alcohol use among Latin American and African American juvenile offenders.		A significant decrease in 30-day substance use was observed in all treatment conditions, with the most dramatic decrease occurring among African-American participants. 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.
Culturally Adapted Interventions				
Latin American	7 articles focused on Latin American identities	• Two articles identified participants as adult immigrants, with one article focusing on women. • Five articles did not identify participants as immigrants or refugees; however, 1 focused on families, 2 focused on adolescents, and two focused on adults.	Five articles made reference to frameworks of cultural adaptations, mainly the Cultural Accommodation Model (CAM)	All articles demonstrated positive effects on mental illness and/or substance use disorder symptoms. Effects were especially positive when interventions were culturally adapted.

African American	2 articles focused on African American populations	• One article focused on African American youth, some of whom may be immigrants. • The second article focused on African American adults, with no mention of them being immigrants, refugees, or born in the U.S.	One article focused on cultural competence, which is used to adapt various interventions. The second article utilized the Ecological Validity Framework.	The cultural competence intervention did not report on outcomes, but instead provided a summary on different therapeutic styles. The OHDC intervention illustrated the decrease in depression symptoms at multiple follow ups. All participants were satisfied with the intervention.
Afghani	One article looked at Afghani identity	This article focused on refugee children and families.	The "Tree of Life" intervention was adapted as a psychological treatment for trauma.	Qualitative feedback was positive from participants taking part in the group activities.
Pakistani	One article looked at Pakistani identity	This article focused on adult women, but did not state whether they were immigrants, refugees, or born in the U.K.	A culturally adapted social and medication intervention was used to treat depression.	At 3-month follow up the combination therapy (social intervention + medication) was deemed better than anti-depressant therapy alone. However, at 9 months follow up there was no statistically significant findings.
Various	9 articles focused on more than one identity for a culturally adapted intervention.	• Two articles focused on youth and adults from various cultural backgrounds. One specified immigrant populations. • One article focused on immigrants, but did not identify age group. • Four articles focused on youth; 2 articles identified participants as immigrants or refugees. • One focused on immigrant families. • One article focused specifically on adults, but did not identify if they were immigrants or refugees.	A number of frameworks were identified in six of these studies: Ecological Validity Framework, Cultural Accommodation Model, Multidimensional Model for Understanding Culturally Responsible Psychotherapies, and Formative Method for Adapting Psychotherapies.	All articles suggested culturally adapted interventions have a positive effect on participants, particularly with those being treated for substance use and depression. Some adaptions require further research to indicate whether or not they are effective for a homogenous group of participants with different cultural backgrounds or a particular cultural group.
No Intervention				
Various	Four reports and 2 articles focused on applying an adapted intervention on people from various cultural backgrounds	• Two reports looked at adults and children (immigrant and/or refugee). • Two reports looked at adults and children who were immigrant, refugee, and born in the country where an intervention took place. • One article looked at immigrants, but did not specify if the focus was on adults and/or children. • One article looked at college students, but did not specify if they were immigrants, refugees, or born in the country where an intervention took place.	No culturally adapted intervention was discussed.	Each report and article expressed the positive effects related to culturally adapting mental health treatment for immigrants, refugees, and/or people with similar cultural backgrounds who were born in the country where a particular adaption would take place.
Limitations across all				
- No RCTs - No control groups - Small sample sizes - Most did not utilize/detail a framework for adaptations				

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Appendix B

Table 2: Summary Table – by disorder

Disorder	# of Articles	Population	Type(s) of Cultural Adaptation	Outcomes/Observations
Culturally Specific Interventions				
Mood	1 article discussed mood disorders, specifically depression and/or anxiety	Focused on adult populations, specifically on mothers	None of these articles detailed what elements of treatment were culturally adapted, nor made reference to any frameworks used. 5 articles culturally matched clients and therapists, 2 utilized cultural brokers. The remaining articles state the intervention was "culturally sensitive" but did not detail **how**	Identified culturally specific interventions as having positive effects on the mental health of participants.
Trauma	4 articles discussed trauma related issues	3 focused on adolescents, 1 focused on families		All 4 articles identified culturally specific interventions as having a positive effect on decreasing PTSD symptoms. In 1 article the findings illustrate that refugee children are more likely to, and prefer, access to a school-based mental health service compared to visiting a mental health agency.
Substance	1 article discussed substance use disorders	This article discussed adults and adolescents		Overall, evidence-based interventions benefit from cultural adaptations relevant to specific populations being served. If modifications made are not part of a specific adaptation protocol, they risk compromising the overall integrity and efficacy of the original intervention. Moreover, treatments that are tailored to meet specific cultural needs have been shown to have higher retention rates and are, therefore, more successful.
Culturally Adapted Interventions				
Mood	10 articles discussed mood disorders, specifically depression and/or anxiety disorders	3 studies focused on adolescents, 3 on adults, 3 looked at both groups, and 1 did not specify	6 articles detailed culturally adapted elements, and made reference to a framework of adaptation	Overall 8 or the 10 articles found culturally adapted interventions to be successful at decreasing mental illness symptoms. However, these articles noted that this decrease may not be directly due to the intervention itself. Several article indicated potential best practice steps when adapting an intervention for a specific cultural groups.

Trauma	3 articles looked at trauma-related disorders, most notably PTSD	1 focused on families, 1 focused on adults (women); 1 focused on youth	One discussed a framework of adaptation using the Resilient Peer Treatment model. Each detailed culturally adapted elements that were included	One study indicated that a culturally adapted intervention for mother's experiencing trauma was effective; however, no evaluation was conducted. Anecdotal responses were positive. Another study indicated that Depression and PTSD symptoms were reduced from the baseline assessment to the post-intervention assessment. The third study suggested there is no evidence that culturally adapted interventions lead to better clinical outcomes for ethnic youth.
Substance	8 articles discussed culturally adapted treatments for substance use disorders, including alcohol	5 articles focused on adolescent populations, 1 focused on adults populations, and 2 did not specify/ addressed both groups	7 articles detailed culturally adapted elements, and made reference to a framework of adaptation	Overall, 7 of the eight articles found culturally adapted interventions to have a positive effect at reducing substance use. Of these 7, strong identification with one's cultural identity and the inclusion of family in treatment contributed to the positive effects. Specific cultural variables also contributed to the positive effects, other than identifying with one's cultural identity.
Other	2 articles looked at severe/persistent mental illness, 3 articles did not specify the condition(s) being treated	2 articles focused on adolescents, 2 looked at families, and 1 article did not specify	1 article detailed culturally adapted elements, and made reference to a framework of adaptation	Of the articles in this group, 3 out of 5 reported positive effects of using culturally adapted interventions to treat a variety of mental health issues. One article also indicated potential best practice steps when adapting an intervention for a specific cultural groups, namely to include the cultural group in stakeholder discussions and for quality improvement purposes and cultural acceptability.
No Intervention				
These articles (6 in total) discuss cultural adaptations and cultural competence at the high level, without really going into detail regarding specific treatment interventions. However, we felt these articles will still provide value to the scoping review.				
Limitations across all				
- No RCTs - No control groups - Small sample sizes - Most did not utilize/detail a framework for adaptations				

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Appendix C

Table 3: Data Extraction Table

Publication Type	Citation	Study Purpose	Study Location (Country)	Research Design	Intervention Type	Study Population	Outcomes/Findings
Culturally Adapted Treatments							
Journal	Kalibatseva, Z., & Leong, F.T.L. (2014). A critical review of culturally sensitive treatments for depression: recommendations for intervention and research. *Psychological Services, 11*(4), 433-50. DOI: https://dx.doi.org/10.1037/a0036047	To conduct a literature review examining culturally sensitive treatments for depression, and to understand: 1. What factors make treatment culturally sensitive? 2. What types of existing treatments for depression have been adapted and what are the outcomes? 3. What types of client samples have these treatments been tested on? 4. What possible recommendations can be made?	United States	Literature review	Identified 16 studies in total • peer-reviewed articles using PsycINFO • year range not reported (up to Dec 2012)	Overall, the study samples were: • low-income individuals • wide age range (adolescents - elderly) • predominately female • Hispanic American, African American, and Asian American • treatment provided in a number of settings ranging from primary care to outpatient clinics • most studies utilized cognitive-behavioural therapy • there was a mix of group and individual-based therapies	All of the studies that were reviewed demonstrated significant decreases in depressive symptomology post-treatment following cultural adaptations. However, none of the studies reviewed empirically tested whether these treatment effects were related directly to the role of the adaptations. The review found that incorporating culturally-specific values related to interpersonal relationships, family, and spirituality yielded better outcomes. Adaptations that increase the therapeutic relationship/interactions also yielded better treatment retention and outcome. Moreover, adaptations that incorporated culturally appropriate assessment, consideration of client beliefs, as well as destigmatizing the illness all positively contribute to client engagement, retention, and treatment outcome. The authors recommend to review interventions framed within the Cultural Accommodation Model (CAM) of Psychotherapy, which involves 3 key steps: 1. identify the cultural gaps in existing treatment; 2. select culturally specific concepts/models and make necessary treatment adaptations; 3. test the culturally adapted intervention for efficacy.
Journal	Sparks, S.N., Tisch, R., & Gardner, M. (2013). Family-centered interventions for substance abuse in Hispanic communities. *Journal of Ethnicity in Substance Abuse, 12*(1), 68-81. DOI: https://dx.doi.org/10.1080/15332640.2013.759785	The purpose of this article is to review 2 prospective studies of a family-centered substance abuse program, with a focus on the efficacy of this program in Hispanic communities. **Study 1 "Celebrating Families!":** the program was tested in English to Hispanic and non-Hispanic families. Changes compared in parenting skills, family resilience, parent observation of children's behaviour, parent cognitive awareness, and level of alcohol use. **Study 2 "¡Celebrando Familias!":** the program was culturally adapted to Hispanic populations and was tested in Spanish with monolingual and limited-English families.	United States	Semi-Experimental Field Experiment	A 16-week education/support, multi-family, skill building, group-based model	**Study 1** used a convenience sample of existing Celebrating Families! Participants. Five men and 31 women from different ethnicities with at least one parent from each family identified as having substance use disorder. 13 were Hispanic (35.1%), 15 were White (40.5%), and 7 were other minorities (18.9%). 83.8% of participants spoke English. **Study 2** involved the translation and cultural adaptation of Celebrating Families! and was piloted at 3 sites in the U.S. 1. Latin American Community Development Centre; 2. EMQ-Families First; 3. The Mexican American Community Services Agency. A total of 41 monolingual and limited-English, Spanish-speaking parents and 23 bilingual youth ranging in age from 8 to 17 years were included in the sample.	**Study 1:** All participants showed improvement in each of the five measures of effectiveness of Celebrating Families! (parenting skills, drug and alcohol use, family strength/resilience, parent observations of children's behaviours, and parents' social/cognitive skills). There was no evidence of problems with cultural competency. Hispanic participants demonstrated greater changes in the program when compared with non-Hispanic participants, suggesting that a family-centered model may be an excellent substance use related resource for this population. **Study 2:** The success of the culturally adapted, translated program is comparable with the English version. Participants reported significant satisfaction with the pogrom. Results found significant effects on family organization, cohesion, communication, conflict resolution, positive parenting, parental involvement, and a reduction in alcohol and drug use.

Journal	Burrow-Sanchez, J.J., & Wrona, M. (2012). Comparing culturally accommodated versus standard group CBT for Latino adolescents with substance use disorders: a pilot study. *Cultural Diversity & Ethnic Minority Psychology, 18*(4), 373-83. DOI: https://dx.doi.org/10.1037/a0029439	The goal of this pilot study was to evaluate the feasibility and efficacy of a culturally-adapted versus a standard version of an evidence-based cognitive–behavioral substance abuse treatment, in a small sample of Latin American adolescents.	United States	Experimental Pilot study with random assignment	A 12-week group-based CBT model for substance use and dependence, with elements of coping skills training. The culturally-adapted version of the model also included: • changes in treatment content/delivery to integrate culturally-relevant factors for Latin American youth • development of a new module "Ethnic Identity and Adjustment" • revision of other modules to achieve more cultural congruence • increasing therapist contact with parents	35 Latin American adolescents between the ages of 13-18: • 94% were male • 69% were born in the US (most identified as bicultural • most had parents who were born in Mexico (74% of mothers, 88% of fathers) • 69% had annual household incomes of less than $25,000 • most were referred to the treatment through probation officers (71%) • 55% were mandated to treatment • all had to meet DSM-IV-TR criteria for drug use or dependence 18 were randomly assigned to the standard CBT treatment group, and 17 to the culturally-adapted group. 14 participants in each group completed treatment, post-treatment assessment, and 3-month follow-up assessment (high completion rate). All therapists and research assistants were bilingual (English-Spanish).	Participants in each condition performed similarly on feasibility measures, but there were some differences found in substance use outcomes, especially when moderators were considered. Mean substance use scores significantly decreased from pre-to-post-treatment, with slight increases at the 3-month follow-up in both groups. There were significant mean differences between the two treatment conditions on substance use posttreatment, but these differences were only present when moderators were considered. Specifically, with the "ethnic identity" and "familism" moderators. This suggests that Latin American youth in the culturally-adapted CBT treatment who had higher levels of ethnic identity and familism reported larger decreases in substance use following treatment, when compared to the standard treatment. Pilot study results are encouraging and suggest that individuals who identify as an ethnic minority may benefit from culturally-adapted treatments. However, attention must be paid to the specific cultural variables that may influence outcomes in the targeted group, beyond simply race or ethnicity.

Journal	Chow, W., Shiida, M., Shiida, T., Hirosue, A., Law, S., Leszcz, M. & Sadavoy, J. (2011). Adapting ACT to serve culturally diverse communities: a comparison of a Japanese and a Canadian ACT team. *Psychiatric Services, 62*(8), 971-4. DOI: https://dx.doi.org/10.1176/ps.62.8.pss6208_0971	To evaluate the efficacy and fidelity of 2 culturally-adapted Assertive Community Treatment (ACT) programs; the first in Mount Sinai Hospital in Toronto, and the second the KUINA Center in Japan. The purpose is to determine whether the successful outcomes of ACT could be reproduced in the two diverse settings.	Canada and Japan	Semi-Experimental Field experiment	Cultural adaptations to the ACT model were made by both settings, in accordance with their specific target groups. Adaptations included enhanced family support and treatment, culturally/linguistically-matched staff when possible, culturally informed therapy, cultural assessments, culturally matched housing and community support.	66 patients were recruited from Mount Sinai Hospital • 71% male • 30% Chinese, 12% Tamil, 9% Vietnamese, 7% Caribbean, 8% other • 75% diagnosis of schizophrenia, 18% schizoaffective, 6% bipolar 40 patients from the KUINA Center in Japan • 80% male • 100% Japanese • 80% schizophrenia, 5% schizoaffective, bipolar, depression	Fidelity ratings (as per Dartmouth Assertive Community Treatment Fidelity Scale) - 4.5 in Toronto, 3.9 in Japan. Both settings observed over 90% satisfaction levels. The culturally adapted ACT models were shown to be effective in a multicultural client group in Toronto, and an Asian client group in Japan. However, the outcome data were based on decreases in annual number of hospital days and reductions in the number of clients with at least one admission. Brief Psychiatric Rating Scale (BPSR) scores significantly decreased from pre-to-post admissions.
Journal	Kanter, J.W., Santiago-Rivera, A.L., Rusch, L.C., Busch, A.M., & West, P. (2010). Initial outcomes of a culturally adapted behavioral activation for Latinas diagnosed with depression at a community clinic. *Behavior Modification, 34*(2), 120-44. DOI: https://dx.doi.org/10.1177/0145445509359682	To develop and pilot test a cultural adaptation of behavioural activation treatment for a group of Latin American clients with depression and determine the feasibility and efficacy.	United States	Experimental Pilot study with random assignment	Culturally adapted behavioural activation treatment. Treatment length was 12 sessions over/up to 20 weeks.	20 participants total. 10 randomly assigned to treatment as usual, and 10 randomly assigned to the culturally adapted behaviour activation treatment. Both men and women were recruited, but only women ended up in the treatment group. Average age of 40, most from Mexico (60%), Puerto Rico (30%), US (10%).	Results provide preliminary support for the feasibility and effectiveness of culturally adapted behavioural activation for Latin American clients in a community setting. Results showed positive outcomes for treatment adherence, retention, and outcomes. However, the limitations of this study make it difficult to conclude and generalize these findings (small sample size of 10, no comparison group used). The control group (treatment as usual) experienced a very high drop-out rate; only one person completed the treatment, more than half dropped out before session 4.
Book Authored Book	Smith, T.B., & Trimble, J.E. (2016). Culturally adapted mental health services: An updated meta-analysis of client outcomes. Smith, T.B. (Ed), & Trimble, J.E. (Ed). *Foundations of multicultural psychology: Research to inform effective practice,* pp. 129-144. Washington, DC: American Psychological Association. DOI: http://dx.doi.org/10.1037/14733-007	To examine the efficacy of culturally-adapted treatments versus treatment as usual in a variety of different cultural groups.	United States and Canada	Review	Analyzed data from 79 studies identified. Search criteria included: studies conducted in US and Canada; evaluated clients' experiences in mental health services that were adapted based on culture, race, or ethnicity; studies that used a control group, quasi-experimental, or experimental research design.	Subjects in the included studies tended to be either youth/adolescents or middle-aged adults. Asian Americans and Latin Americans were the two most common groups in the studies, with African Americans and Native American Indians being included in only a small number of studies. The types of cultural adaptations varied substantially across all studies, and included: inclusion of cultural content and values; providing treatment in the clients' preferred language; racial/ethnic matching; modifications to the treatment delivery method, etc.	Generally speaking, the studies all made attempts to cultural adapt treatment *without* adhering to best practices. On average, culturally adapted treatments resulted in better outcomes when compared with treatment as usually. However, the findings across studies were highly variable, and results highlight the fact that some culturally adapted treatments are more preferable to others. Moreover, some culturally adapted treatments are *about as effective as* or *worse than* treatment as usual. Treatments were particularly effective when based on clients' goals, informed by cultural contexts, and provided in clients' preferred language. The effectiveness of culturally adapted mental health treatments had been found to be greater amongst: (a) adults between the ages of 35-40, (b) samples that were racially homogeneous, (c) Asian American clients, and (d) studies involving multiple cultural adaptations (more cultural adaptations means more effective treatments). Limitations: publication bias, small sample sizes

Journal	Ward, E.C., & Brown, R.L. (2015). A culturally adapted depression intervention for African American adults experiencing depression: Oh Happy Day. *American Journal of Orthopsychiatry, 85*(1), 11-22. DOI: http://dx.doi.org/10.1037/ort0000027	To pilot test a culturally adapted depression intervention called "Oh Happy Day Class," designed for African American adults experiencing major depressive disorder (MDD).	United States	Semi-Experimental Field experiment (pilot test)	Both Pilot I and Pilot II used the same intervention. The "Oh Happy Day Class" was culturally adapted from the Coping with Depression course. It is grounded in social learning theory and uses a psychoeducational format. The treatment uses CBT and a support group format plus psychoeducation. The weekly sessions are 2.5 hours over 12 weeks.	Participants were referred to the study through local health clinics serving African American clients in the Midwest area (US). **Pilot I** (15 total): • African American • Women only • Age 60+ • mild-moderate depression **Pilot II** (35 total): • African American • Men and women • Ages 30-60 • mild-moderate depression	**Pilot I:** • Depression symptoms decreased significantly across all time points (week 6, week 12, 3-month follow up). • Quality of life (as measured by physical health outcomes) showed significant decreases from baseline to week 6, but no difference at other time points. **Pilot II:** • Depression symptoms decreased significantly across all time points (week 6, week 12, 3-month follow up). • Quality of life (as measured by physical health outcomes) remained unchanged All participants reported high satisfaction rates with the treatment.
Journal	Burrow-Sanchez, J.J., Minami, T., & Hops, H. (2015). Cultural accommodation of group substance abuse treatment for Latino adolescents: Results of an RCT. *Cultural Diversity and Ethnic Minority Psychology, 21*(4), 571-583. DOI: http://dx.doi.org/10.1037/cdp0000023	This randomized trial was conducted to compare the efficacy of an evidence-based standard cognitive behavioural treatment (S-CBT) to a culturally adapted version (A-CBT) with a sample of Latin American adolescents primarily recruited from the juvenile justice system.	United States	Experimental Pilot study with random assignment	Participants were randomly assigned to 1 of 2 groups: 1. standard CBT for substance abuse 2. culturally adapted CBT for substance abuse Both delivered in a group format; 12 weekly 1.5 hour sessions. Cultural adaptations included: • changes in treatment content/delivery to integrate culturally-relevant factors • development of a new culturally relevant content • increasing therapist contact with parents	70 Latin American youth • between ages of 13-18 (mean age 15) • 90% male • meet DSM-IV diagnosis for substance abuse or dependence • self-identified at Latin American • 61.4% born in US • majority of parents born in Mexico (74.3% mothers, 81.4% fathers) • annual household income of less than $25,000 36 assigned to standard CBT, 34 assigned to culturally adapted CBT	Adolescents in both conditions decreased the number of days of substance use across study time-points, indicating that the culturally-adapted treatment did not go above and beyond treatment as usual. However, treatment outcomes were moderated by ethnic identity and parental familism. For Latin American adolescents with a lower commitment to their ethnic identity in the standard treatment reported the lowest mean number of substance use days post-treatment and at the 3-month follow-up. This was followed by those with higher commitment to their ethnic identity in the adapted treatment group. This suggests that certain subgroups of Latin American adolescents may experience better outcomes when the treatment is congruent with their level of ethnic identity. A similar moderator effect was found for substance use outcomes in relation to parent familism scores.
Journal	Antoniades, J., Mazza, D., & Brijnath, B. (2014). Efficacy of depression treatments for immigrant patients: Results from a systematic review. *BMC Psychiatry, 14,* 176-88.	This review aimed to identify and evaluate the effectiveness of depression Interventions specifically directed towards first-generation immigrant populations.	United States	Systematic review	Systematic review of peer-reviewed original research published in English between 2000 and 2013 that investigated depression interventions in first generation immigrants. Used Medline, PsycINFO, EMBASE, Cochrane, CINAHL, and Web of Knowledge databases.	Limited to study participants 18 and older, first-generation immigrants, diagnosis of depression.	CBT and behavioural activation therapies showed reductions in depressive symptoms, especially when these interventions were culturally adapted. Problem solving based interventions improved depressive symptoms with and without cultural adaptations. Collaborate care and physical exercise-based interventions did not significantly improve depression symptoms.

Journal	Hughes, G. (2014). Finding a voice through 'The Tree of Life': A strength-based approach to mental health for refugee children and families in schools. *Clinical Child Psychology and Psychiatry, 19*(1), 139-153. DOI: http://dx.doi.org/10.1177/1359104513476719	To develop and pilot test a cultural adaptation of the "Tree of Life" group intervention for children and families in schools. The groups were developed in response to a concern of the utility of western-based psychological treatments for refugee populations.	UK (London)	Semi-Experimental Field experiment	Group-based program that employs a strength-based narrative methodology, using the "tree of life" as a metaphor to help parents and children develop empowering stories about their lives. The group met weekly over 5 weeks, led by a facilitator, interpreters, and an Afghani link worker.	A group of 9 Afghani mothers who were concerns about their children's' "difficult behaviour," recruited from schools in the London Borough of Camden.	The "tree of life" uses the tree as a creative metaphor for people to map out their lives. The roots signify one's cultural and social history, which can include drawings of where they came from, family origins, religion, etc.. The ground beneath the tree signifies the features of their current lives, such as where they live, what they are doing now, and so on. The trunk of the tree contains the person's strengths and abilities. Lastly, one's hopes and dreams for the future are drawn through the branches of the tree. Through a process of narrative questioning, people are invited to tell their story. Initially, the mothers in the group found it difficult to map out their trees. With the help of the interpreters and other group members, the women were able to draw their trees and share their stories with one another. Evaluation of this group was difficult, as standard evaluation tools were not appropriate given the limited English these women spoke. Qualitative feedback was provided through individual interviews. The responses from participants highlight the positive experience people felt through taking part in the groups.
Journal	Lee, C.S., Lopez, S.R., Colby, S.M., Rohsenow, D., Hernandez, L., Borrelli, B., & Caetano, R. (2013). Culturally adapted motivational interviewing for Latino heavy drinkers: Results from a randomized clinical trial. *Journal of Ethnicity in Substance Abuse, 12*(4), 356-373. DOI: http://dx.doi.org/10.1080/15332640.2013.836730	This article has two purposes. The first, to culturally adapt a motivational interviewing intervention for a group of Latin American participants in order to reduce heavy alcohol use and related problems. Second, to pilot test this culturally-adapted treatment and compare treatment outcomes with an unadapted MI intervention for a group of Latin American participants.	United States	Experimental Pilot study with random assignment	**Unadapted MI**: manualized single 1.5 hour session **Culturally adapted MI:** manualized single 1.5 hour session. Cultural adaptations included addressing the social context of drinking and acculturation stressors that influenced drinking behaviour. For both treatments, follow-ups were conducted at 2 and 6 months post treatment.	Participants were recruited through the community via ads. 57 participants (26 in the adapted group, 27 in the unadapted group): • met criteria for hazardous drinking (definition included) • ages 18-61 (average age of 35) • Hispanic nationality • proficient in English (to examine effects of treatment separate from translation) • 54.7% were men, 52.9% were born in US • 87.3% met criteria for possible alcohol use disorder	Participants in both groups reported fewer days of heavy drinking and fewer alcohol-related consequences following the treatment. However, there were greater reductions in alcohol-related consequences among participants in the culturally adapted group, with reductions continuing up to the 6-month follow up period. Both groups reported equally high levels of satisfaction and treatment engagement.

Journal	Kataoka, S., Novins, D.K., & DeCarlo Santiago, C. (2010). The practice of evidence-based treatments in ethnic minority youth. *Child and Adolescent Psychiatric Clinics of North America, 9*(4), 775-789. DOI: http://dx.doi.org/10.1016/j.chc.2010.07.008	To review and discuss culturally adapted interventions for psychotic disorders among ethnic minority children	United States	Literature review	The review examined interventions for various psychotic disorders: • Depression - CBT, interpersonal therapy, youth partners in care (CBT-based), attachment-based family therapy. • Anxiety - CBT, anxiety management, study skills training. • PTSD- trauma-focused CBT, child centered therapy, parent psychotherapy. • Conduct disorders - multisystemic therapy, coping power (CBT-based). • Substance use disorders - multisystemic therapy, multidimensional family therapy, CBT, adolescent/peer group therapy, multifamily educational interventions, adolescent reinforcement approach.	Ethnic minority youth/adolescents from African American, Latin American and Caucasian populations.	Evidence-based psychotherapies can be used effectively in minority populations of youth/adolescents, so long as the following suggested guidelines are considered: **1. Partnership First** - Collaborate with local stakeholders in the community who have knowledge and experience working with ethnic minority populations. This can lead to treatment retention, greater access to services, and engagement of ethnic minority populations. **2. Choosing what to implement** - Each evidence based therapy needs to be assessed in light of resources, cultural acceptability. It is better to choose evidence-based therapies even if they have not been tested on an ethnic minority population, instead of an effective intervention that is not rooted in evidence. There must be some fidelity to the original treatment model after it has been culturally adapted. **3. Consider system issues before implementation** - Update of interventions will vary based upon setting. Identify where an ethnic minority population may have easier access to services and consider implementing the intervention there (e.g. church versus a health centre). **4. Monitor implementation of intervention and tailor as needed** - Continue to evaluate and refine the intervention after it is implemented, as it may not work as effectively as it should from the start. Include the population for whom the intervention is for in quality improvement discussions to help adapt it effectively.
Book	Huey, S.J.Jr., & Polo, A.J. (2010). Assessing the effects of evidence-based psychotherapies with ethnic minority youths. Weisz, J.R., Kazdin, A.E. [Ed]. *Evidence-based psychotherapies for children and adolescents., 2nd ed,* pp. 451-465. New York, NY, US: Guilford Press.	To examine: 1. The efficacy of evidence based therapies with minority youths. 2. If treatments are just as efficacious between minority youths and European Americans. 3. What adaptations are made to evidence based therapies based on the needs of minority youth and are they effective. 4. What evidence based therapies exist that engage minority youth in mental health treatment.	United States	Book Chapter	Many treatment interventions were considered based upon the disorder of the youth: • **ADHA** - behavioural therapy, • **Anxiety** - anxiety management, group CBT. • **Conduct** problems - anger management group, assertive training, attribution training, CBT, coping power, multisystemic therapy, BSFT, child-centred therapy, problem solving. • **Depression** - CBT, interpersonal psychotherapy. • **Substance** use problems - multisystemic therapy, MDFT. • **Suicidal** behaviour - multisystemic therapy. • **Trauma** - individualized assistance, resilient peer treatment, school-based CBT, TF-CBT. • **Mixed**/comorbid problems - multisystemic therapy.	American ethnic minority youth 18 years old or younger, who have preexisting behavioural and emotional problems. • African American • Latin American • Mixed/other ethnicity	There are a number of evidence based therapies available for minority groups, especially African American and Latin American communities. There isn't enough evidence to support the cultural adaptation of these therapies, as minority groups had similar outcomes as European Americans when used.

Journal	Bhui, K. (2010). Culture and complex interventions: Lessons for evidence, policy and practice. *The British Journal of Psychiatry, 197*(3), 172-173. DOI: http://dx.doi.org/10.1192/bjp.bp.110.082719	To evaluate if the culturally adapted STIARA trial is effective at addressing depression in Pakistani women, compared to anti-depressant based treatment.	United Kingdom	Experimental Cluster randomized pilot study	A culturally adapted social intervention, which consisted of socialized group activities.	Socially isolated Pakistani women	To be effective at treating depressive symptoms, the social intervention should be combined with anti-depressant therapy. At 3 months follow up the combination therapy was deemed better than anti-depressant therapy alone. However, at 9 months follow up there was no statistically significant findings. The social intervention may be beneficial to facilitating easier access to anti-depressant therapy by reducing the stigma associated with it.
Journal	Chow, W., Law, S., Andermann, L., Yang, J., Leszcz, M., Wong, J., & Sadavoy, J. (2010). Multi-family psycho-education group for assertive community treatment clients and families of culturally diverse background: A pilot study. *Community Mental Health Journal, 46*(4), 364-371. DOI: http://dx.doi.org/10.1007/s10597-010-9305-5	To explore the acceptance and effectiveness of a time-limited Multi-Family Psycho-education Group (MFPG) program with Assertive Community Treatment (ACT) clients and family members from two ethno-cultural minority groups; Chinese and Tamil.	Canada	Semi-Experimental Field experiment (pilot test)	Multi-Family Psycho-education Group interventions were used. Staff implementing the intervention modified aspects of the intervention to meet the ethno-cultural needs of the study populations.	Two cohorts with a combined size of 14 Assertive Community Treatment Team clients and 20 family members participated in the study: new cohort of Chinese ethnicity (7 clients and 11 family members) and one cohort of Tamil ethnicity (7 clients and 9 family members).	MFPG was effective in reducing stigma, family perceptions of mental health as being a burden. Increases in knowledge and acceptance of mental health maintenance positively changed beliefs about treatment: medication use and identifying mental health symptoms.
Journal	Rue, D.S., & Xie, Y. (2009). Disparities in treating culturally diverse children and adolescents. *Psychiatric Clinics of North America, 32*(1), 153-163. DOI: http://dx.doi.org/10.1016/j.psc.2008.11.001	To illustrate the underutilization and under-treatment of racial and ethnic children and adolescents. To discuss culturally adapted interventions and culturally competent clinicians as it relates to the treatment of racial and ethnic children and adolescents.	United States	Descriptive study	Cuento/Storytelling Therapy (Puerto Rican children) - telling of heroic characters from folk tales to children at risk for emotional and/or behavioural issues. Brief Structured Family Therapy (Hispanic/African American/Puerto Rican) - works with well-defined hierarchies in family structure to affect youth conduct, family functioning and treatment adherence. CBT & Interpersonal Psychotherapy (IPT) (Puerto Rican) - effective at decreasing symptoms of depression compared to wait-list control group. Aspects CBT appealed to populations: didactic orientation, classroom arrangement, active interventions by therapist, focus on the present, problem solving, and concrete techniques. IPT focuses on the present and interpersonal conflicts related to family and themselves.	African American and Puerto Rican children and adolescents	Storytelling interventions had a positive effect in children with emotional or behavioural problems compared to other groups. Brief Structured Family Therapy showed promising results in terms of improving youth conduct, family functioning, and treatment adherence compared to the controlled group. CBT and IPT adapted for Puerto Rican youth was effective at decreasing depressive symptoms.

Journal	Ngo, V.K., Asarnow, J.R., Lange, J., Jaycox, L.H., Rea, M.M., Landon, C., Tang, L., & Miranda, J. (2009). Outcomes for youths from racial-ethnic minority groups in a quality improvement intervention for depression treatment. *Psychiatric Services, 60*(10), 1357-1364. DOI: http://dx.doi.org/10.1176/appi.ps.60.10.1357	To evaluate a quality improvement intervention on youth from racial-ethnic minority groups.	United States	Experimental Randomized control trial	Quality improvement interventions that included: master's- or doctoral-level care managers who supported primary care providers with patient evaluation, education, medication, and psychosocial treatment and linkage to specialty mental health services; training for care managers in manualized CBT for depression; and patient and provider choice of treatment modalities (CBT, medication, combined CBT and medication, care management follow-up, and referral).	325 youth aged 13-21 years old with depressive symptoms who spoke English. Youth were from Latin American, African American and Caucasian backgrounds.	Positive effects were seen in African American youth with a decline in depressive symptoms post-intervention. Latin American youth the only positive effect was an increase in satisfaction with care. There were no intervention effects for Caucasian youth.
Book	Williams, M.T., Chapman, L.K., Buckner, E.V., & Durrett, E.L. (2016). Cognitive behavioral therapies. Breland-Noble, A., Al-Mateen, C.S., Singh, N.N. [Ed]. *Handbook of mental health in African American youth*. pp. 63-77. Cham, Switzerland: Springer International Publishing.	To review the literature pertaining to CBT among African American youth, incorporate the socio-historical context of the African American experience, **identify existing culturally conscious CBT approaches that are effective with African** American youth, explore factors contributing to attrition among African American youth, and to highlight the need for further research in this population.	United States	Book Chapter	Culturally adapted CBT - which included parental involvement/family-based intervention, empowerment utilizing familial support, understanding the impact of racism, and facilitating positive ethnoracial identity development.	African Americans	The chapter did not report on effectiveness of adapted CBT interventions, but rather provided a summary of different therapeutic styles.
Journal	Steinka-Fry, K.T., Tanner-Smith, E.E., Dakof, G.A., & Henderson, C. (2017). Culturally sensitive substance use treatment for racial/ethnic minority youth: A meta-analytic review. *Journal of Substance Abuse Treatment, 75,* 22-37. DOI: http://dx.doi.org/10.1016/j.jsat.2017.01.006	To address this gap in the literature by synthesizing the current available research evidence on the effects of culturally sensitive substance use treatment for racial/ethnic minority adolescents.	United States and Canada	Meta-analysis	Interventions included: group CBT, family or multiservice one on one or in a group, group counselling, multiservice CBT and family and one on one, brief strategic family therapy, Family/multiservice with counseling, MET/CBT & skills training, CBT.	Interventions had to have a sample of 90% racial/ethnic minority youth between ages 12-18 (at least 68%); no participant could be over 20 years old.	Overall, culturally sensitive treatments had a positive effect on reducing substance use. However, there was quite a bit of heterogeneity amongst studies.
Journal	Huey, S.J.Jr., & Polo, A.J. (2008). Evidence-based psychosocial treatments for ethnic minority youth. *Journal of Clinical Child and Adolescent Psychology, 37*(1), 262-301. DOI: http://dx.doi.org/10.1080/15374410701820174	To synthesize literature focused on efficacious treatments for ethnic minority youth, particularly those treatments meeting criteria as EBTs.	United States	Literature review	Culturally adapted interventions reviewed include: Fostering Individual Assistance Program Resilient Peer Modeling, Child-Centred Play, CBT, Multisystemic Therapy, Attributional Intervention, Counselor and Peer-Led Assertive Training, Multidimensional Family Therapy, Family Effectiveness Therapy, Coping Power	Youth 18 years old or younger with behavioural or emotional problems (Ethnic Minorities and European Americans)	There is no evidence to suggest the adapted interventions reviewed lead to better clinical outcomes for ethnic youth. Suggestions to keep the intervention in its original form and apply culture responsive elements; and allow the treatment provider to tailor an interventions, but so far as it meets the individual client's needs.

Journal	Kaltman, S., Hurtado de Mendoza, A., Serrano, A., & Gonzales, F.A. (2016). A mental health intervention strategy for low-income, trauma-exposed Latina immigrants in primary care: A preliminary study. *American Journal of Orthopsychiatry, 86*(3), 345-54.	To develop and preliminarily evaluate a mental health intervention for trauma-exposed Latin American immigrants with depression and/or PTSD for primary care clinics that serve the uninsured.	United States	Semi-Experimental Field experiment (pilot test)	Individual history sharing session (90 mins) with behavioural activation and motivational interviewing. 5 group sessions (90 mins each) with behavioural activation and other cognitive techniques.	28 female Latin American immigrants who showed symptoms of at least one: depression, traumatic event exposure, and/or PTSD.	The individual session may lead to women attending and staying in group treatment. Depression and PTSD symptoms were reduced from the baseline assessment to the post-intervention assessment. Two-thirds of the participants who started the intervention with a presumptive diagnosis of depression no longer met that criterion at the post-intervention assessment. These findings must be interpreted with caution in the absence of a control group.
Journal	Chowdhary, N., Jotheeswaran, A.T., Nadkarni, A., Hollon, S.D., King, M., Jordans, M.J.D., Rahman, A., Verdeli, H., Araya, R., & Patel, V. (2014). The methods and outcomes of cultural adaptations of psychological treatments for depressive disorders: a systematic review. *Psychological Medicine, 44*(6), 1131-46. DOI: https://dx.doi.org/10.1017/S0033291713001785	To review cultural adaptations of psychological treatments for depressive disorders used on ethnic minorities in Western countries, and any adaptations for depressive disorders in non-Western countries.	United States and Europe	Systematic Review	Culturally adapted interventions included: CBT, psychoeducation, IPT, art group therapy, cognitive therapy, and collaborative stepped care programming.	Diverse populations of ethnic minority adults (19+) with depressive symptoms.	All but 2 studies indicated that culturally adapted psychological treatments are effective at reducing depressive symptoms. Many aspects of the PTs were found to be 'universally' applicable, and did not require adaptation; also the framework and theory of the treatment including treatment phases remained unchanged, respecting the theoretical core of the original PT. Adaptations reflected efforts to enhance the acceptability of the PTs as opposed to adaptations of core content, thus maintaining fidelity to the original PT.
Treatments Developed for a Specific Culture/Ethnic Group							
Journal	Beehler, S., Birman, D., & Campbell, R. (2012). The Effectiveness of Cultural Adjustment and Trauma Services (CATS): generating practice-based evidence on a comprehensive, school-based mental health intervention for immigrant youth. *American Journal of Community Psychology, 50*(1-2), 155-68. DOI: https://dx.doi.org/10.1007/s10464-011-9486-2	The purpose of this study is to determine the efficacy of Cultural Adjustment and Trauma Services (CATS), a comprehensive school-based mental health program for diverse immigrant students experiencing trauma.	United States	Semi-Experimental Field experiment	An array of clinical services including CBT, supportive therapy, and coordinating services were provided to all students. An evidence-based intervention for trauma (TF-CBT) was implemented with a subset of students.	Services were offered across two school districts in the US. A total of 1,043 students were offered services from CATS. Of these students: 894 received outreach services only, 149 enrolled in clinical services (demographic info. collected for this sample only): • 94 female, 55 male • from 29 different countries • spoke 19 difference languages • 50% born outside of US; 45% born in US to immigrant parents; 5% born in US to US-born parents • experienced an average of 4 types of trauma (all but 15 experienced 2 or more) • 90 received outreach services prior to enrollment • 113 received CBT, 82 psychoeducation, 95 supportive therapy, 50 TF-CBT	Supportive therapy provided improvements in functional impairment, but not PTSD symptoms. Service coordination provided improvements in PTSD symptoms, but not functional impairment. CBT services resulted in improved functioning, and was slightly effective in reducing PTSD symptoms. TF-CBT was associated with improvements in both functional impairment and PTSD symptoms. Functional impairment decreased as a result of greater accumulation of supportive therapy, TF-CBT, and CBT. Interaction of these 3 services was significant, suggesting that students receiving a greater combination of these services experienced greater reductions in functional impairment. Symptoms of PTSD decreased as a result of greater accumulation of TF-CBT and coordinating services. CBT services resulted in slightly significant improvements in PTSD. The interaction of these services were not significant, therefore providing these treatments in combination was not better than providing them alone.

Book Edited Book	Marsiglia, F.F., & Booth, J. (2013). Empirical status of culturally competent practices. Vaughn, M.G. [Ed], & Perron, B.E. [Ed]. *Social work practice in the addictions,* pp. 165-181. New York, NY: Springer Science + Business Media.	To outline empirical validity of culturally adapted treatments and various culturally specific interventions.	United States	Review	N/A - review. Methodology of review not outlined in chapter.	Specific population details were not outlined for majority of review. Review of programs designed for specific cultural groups, including: Latin American and African American.	Overall, evidence-based interventions benefit from cultural adaptations relevant to specific populations being served. If modifications made are not part of a specific adaptation protocol, they risk compromising the overall integrity and efficacy of the original intervention. Moreover, treatments that are tailored to meet specific cultural needs have been shown to have higher retention rates and are, therefore, more successful.
Journal	O'Shaughnessy, R., Nelki, J., Chiumento, A., Hassan, A., & Rahman, A. (2012). Sweet Mother: Evaluation of a pilot mental health service for asylum-seeking mothers and babies. *Journal of Public Mental Health, 11*(4), 214-228. DOI: http://dx.doi.org/10.1108/17465721211289392	This paper aims to describe and evaluate an innovative pilot mental health service ("Sweet Mother") for asylum seeking mothers and their babies in their first year of life.	United Kingdom	Semi-Experimental Field Experiment	Sweet Mother advocates a community approach emphasizing clients' strengths and potential, while focusing on the context of their lives. This intervention explicitly focuses on the attachment between mothers and babies, aimed to increase security of the infant's attachment by increasing maternal sensitivity, changing maternal representations, and increasing social support. The intervention was group-based, guided by two psychologists, and included volunteers for social and emotional support. Group sessions were 2 hours, every week over 21 weeks.	Asylum-seeking women and their babies, specifically women from West Africa. Women were between the ages 17-32, and all babies were under 6 months of age (3 of which were not yet born at the time of recruitment). Women were recruited through referrals of women attending maternity units, asylum screening centers, and mental health services in the Liverpool area (UK).	Results revealed a number of key themes: the importance of group relationships, importance of feeling safe, talking about parenting practices across cultures, having time for psychoeducation, and having the opportunity to reflect of mother-baby relationships. Overall evaluation results were positive with women viewing their experiences as positive for both their own psychological well-being and their babies. Results from CARE-Index analysis also provide support for a positive shift in the quality of attachment relationships between mothers and babies.
Journal	Chiumento, A., Nelki, J., Dutton, C., &Hughes, G. (2011). School-based mental health service for refugee and asylum seeking children: Multi-agency working, lessons for good practice. *Journal of Public Mental Health, 10*(3), 164-177. DOI: http://dx.doi.org/10.1108/17465721111175047	To highlight a multiagency, school-based mental health service for refugee and asylum seeking children, the Haven Project.	United Kingdom	Semi-Experimental Field Experiment	The Haven project began in 2003 and aims to provide therapeutic support for refugee and asylum seeking children in schools across Liverpool. Specialist skills involve the use of Narrative Exposure Therapy and Children's Accelerated Trauma Therapy for children suffering from symptoms of PTSD. The Haven works weekly in 7 core schools offering targeting input to education settings with high prevalence of refugee children. The program capitalized on the schools role in facilitating access to mental health services.	Refugee children and young people in schools across Liverpool.	The findings illustrate that refugee children are more likely to, and prefer, access to a school-based mental health service compared to visiting a mental health agency. Multiagency links help facilitate a mutual understanding of working in the interest of the children in improving refugee children's mental health.

					Children may be offered individual, group or family-based therapy ranging from brief to more long-term support.		
Journal	Williams, M.E., Thompson, S.C. (2011). The use of community-based interventions in reducing morbidity from the psychological impact of conflict-related trauma among refugee populations: A systematic review of the literature. *Journal of Immigrant and Minority Health, 13*(4), 2011, 780-794. DOI: http://dx.doi.org/10.1007/s10903-010-9417-6	To review the efficacy of community-based interventions in reducing impacts of psychological trauma among refugee populations.	Varied (see study population for details)	Systematic Review	9 databases searched (Cochrane, Health and Medical Complete, Health and Society, JAMA, Meditext, MEDLINE, PILOTS, PsycINFO, PubMed), as well as Google Scholar. Total articles included in review: 26 Inclusion: • population was refugees (vs voluntary migrants) • mental health was primary focus • intervention accessed community-based supports • results were noted and discussed • articles published in English between 1994-2009	In general, the study populations targeted a particular age group of refugees; some were focused on adults, others on children. 8 studies took place in developing counties (not named), while the rest were in developed countries (Canada, US, UK, Australia). A variety of treatment approaches were assessed: CBT, group therapy, art and play, outreach, individual therapy, school-based therapy.	In general, community-based mental health services proved valuable in improving mental health outcomes among refugee populations. The results were positive and statistically significant in most studies. However, additional research is needed in order to draw more conclusive results and recommendations for best practices. Themes of cultural sensitivity, local adaptations to therapy, the use of native languages, and post-migration stressors emerged across the articles.
Journal	Ellis, B.H., Miller, A.B., Abdi, S., Barrett, C., Blood, E.A., & Betancourt, T.S. (2013). Multi-tier mental health program for refugee youth. *Journal of Consulting & Clinical Psychology, 81*(1), 129-40.	To pilot test a multi-tier mental health program for refugee youth.	United States	Semi-Experimental Field experiment (pilot test)	Interventions were broken into tiers: **Tier 1:** community resilience building through engagement, education & outreach. **Tier 2:** child resilience building through school-based skills groups. **Tier 3:** trauma systems therapy (culturally adapted), enduring/understanding phase school-based skill-building psychotherapy. **Tier 4:** trauma systems therapy, surviving and stabilizing phase home-based care.	30 middle school students who were wither Somali (60%) or of Somali Bantu ethnicity (40%). 63.3% of participants were male, while 36.7% were female.	Project SHIFA shows significant improvements in symptoms of both PTSD and depression for all participants over time.
No Interventions							

Report	Mental Health Commission of Canada. (2016). The Case for Diversity: Building the Case to Improve Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Populations, Ottawa, ON: Mental Health Commission of Canada.	To build the case for improving mental healthcare for Canada's IRER populations.	Canada, United States, United Kingdom, and Australia	Scoping Review	Looked at programs, policies, treatments and supports that have the capacity to effectively address disparities in service delivery for IRER populations that have been culturally adapted or reach these populations in rural/remote locations.	Immigrant, refugee, ethno-cultural, and racialized populations in Canada, the United States, United Kingdom and Australia.	International research demonstrates that targeted, culturally-adapted programs and psychotherapies can help reduce overall costs. Furthermore, programs that take into consideration the diversity of their participants are beneficial because they increase client satisfaction and compliance and produce better health outcomes. Ultimately, by working to reduce disparities in access to services, the appropriateness of services used and mental health outcomes, Canada can reduce overall system costs.
Report	Wellesley Institute. (2016). Thriving Together: A Scoping Review of Interventions to Improve Refugee Social Capital and Health. Toronto, ON: Wellesley Institute.	To identify interventions that have improved aspects of refugee social capital resulting in subsequent improved health amongst these populations.	Canada, United States, United Kingdom, Australia	Scoping Review	Focused on interventions that specifically improved the social capital and health outcomes of refugees in high-income countries.	Refugees in high-incomes countries.	Improving the quality and quantity of relationships for refugees with each other, and amongst other populations in high-income countries can improve emotional health. Two interventions showed the ability to increase to existing social capital that refugees had established in their countries of origin. Sense of belonging demonstrated strong ties to well-being outcomes.
Report	Substance Abuse and Mental Health Services Administration. (2014). Improving Cultural Competence. Treatment Improvement Protocol (TIP) Series No. 59. HHS Publication No. (SMA) 14-4849. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA).	To assist readers in understanding the role of culture in the delivery of behavioral health services (both generally and with reference to specific cultural groups).	United States	Guide	Focused on a variety of culturally congruent interventions for various cultural groups. Counseling was a broad intervention that was adapted based on the population, and included individual, family, and group counseling, and motivational interviewing.	This guide looked at a range of cultural groups in the United states: African Americans, Asian Americans (including Native Hawaiians and other Pacific Islanders), Latin American, Native Americans (i.e., Alaska Natives and American Indians), and White Americans.	The development of cultural competence can have far-reaching effects not only for clients, but also for providers and communities. Cultural competence improves an organization's sustainability by reinforcing the value of diversity, flexibility, and responsiveness in addressing the current and changing needs of clients, communities, and the healthcare environment.
Report	Substance Abuse and Mental Health Services Administration. (2017). Advancing Best Practices in Behavioral Health for Asian American, Native Hawaiian, and Pacific Islander Boys and Men. HHS Publication No. (SMA) 17-5032. Rockville, MD: SAMHSA.	To summarize "best practices" and expert consensus on culturally appropriate approaches, treatment modalities and effective tools in working with this population.	United States	Briefing Document	This brief highlighted a variety of interventions that promote the behavioural health of the identified population. Interventions were culturally-centered and addressed disparities in health (including mental health treatment).	This brief focused on Asian Americans, Native Hawaiians, and Pacific Islander boys and men.	Providing effective services for AANHPI boys and men requires bringing together cultural, ethnic, racial and gender-specific knowledge and practice to an understanding of behavioral health. It draws upon and requires integrating clinical, service, system and social justice perspectives and interventions. In this sense, it is not easy work.
Journal	Swift, J.K., Callahan, J.L., Tompkins, K.A. , Connor, D.R., & Dunn, R. (2015). A delay-discounting measure of preference for racial/ ethnic matching in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 52*(3), 315-20. DOI: https://dx.doi.org/10.1037/pst0000019	To examine treatment preferences of racial/ethnic minority participants for 4 different methods of addressing culturally-related variables in psychotherapy: 1. work with a therapist with high cultural competence 2. work with a therapist with the same race/ethnicity as their own (cultural matching) 3. receive culturally-adapted treatment 4. work with a therapist who is part of an racial/ethnic group, but not the same group as the participant	United States	Descriptive (survey)	**Delay-discounting method:** Participants were asked to complete 4 delay-discounting scenarios. When reviewing each scenario, participants were asked how much they were willing to sacrifice in treatment efficacy in order to ensure that the culturally-relevant variables presented in each scenario	**Group 1: College students/non-clients:** 331 college students recruited from 2 Universities in separate regions of the U.S. Mean age approx. 21, 68.1% were female. Participants self-identified as: African American (28.4%); Latin (37.8%); Multiracial (13%); Asian American (17.2%); American Indian/Alaska Native (2.7%); Other (0.9%) **Group 2: current clients:** The 20 college students who reported current use of psychotherapy were included in this sample. Plus, a nation-wide sample of 77 self-reported racial/ethnic	On average, participants in both samples were willing to sacrifice 8-32% in treatment efficacy in order to ensure that the 4 culturally-relevant variables were present in their treatment. Participants from both samples preferred working with a culturally-competent therapist and receiving culturally-adapted treatment at a much higher rate than being matched to a therapist based on race/ethnicity (in both samples). Strength of preference was stronger for: • the current clients sample compared to the college student/non-client sample. • participants who had a stronger identification with their racial/ethnic minority culture

						minority individuals who reported current use of psychotherapy (recruited using Amazon's Mechanical Turk survey system) were included.	
Journal	Janzen, R., Ochocka, J., Jacobson, N., Maiter, S., Simich, L., Westhues, A., & Fleras, A. (2010). Synthesizing culture and power in community mental health: An emerging framework. *Canadian Journal of Community Mental Health, 29*(1), 51-67. DOI: http://dx.doi.org/10.7870/cjcmh-2010-0005	To explore, develop, pilot and evaluate the most effective ways to provide mental health services for culturally diverse populations.	Canada	Descriptive (focus group, interview, survey)	No intervention was used. The review attempted to develop a framework in which to deliver culturally appropriate interventions to address mental health in ethnic minority communities.	Stakeholders included members of five cultural-linguistic groups: Punjabi Sikh, Mandarin Chinese, Somali, Spanish Latin American, and Polish; service providers within the community mental health system; provincial umbrella organizations in both the mental health and immigrant settlement sectors; and members of a multidisciplinary, multi-university research team.	The approach to develop a framework to provide mental health services allowed for cultural linguistic communities to have a voice and say in their own care. They discussed the barriers to accessing mental health services and how their values may play a role in this. Often, stigma in many communities proved to be a key barrier to accessing services, as well as a lack of knowledge about these services. Some advancements in mental health services, such as competency training and flexibility in language use were seen as positive, but not comprehensive.

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