GUIDANCE REPORT

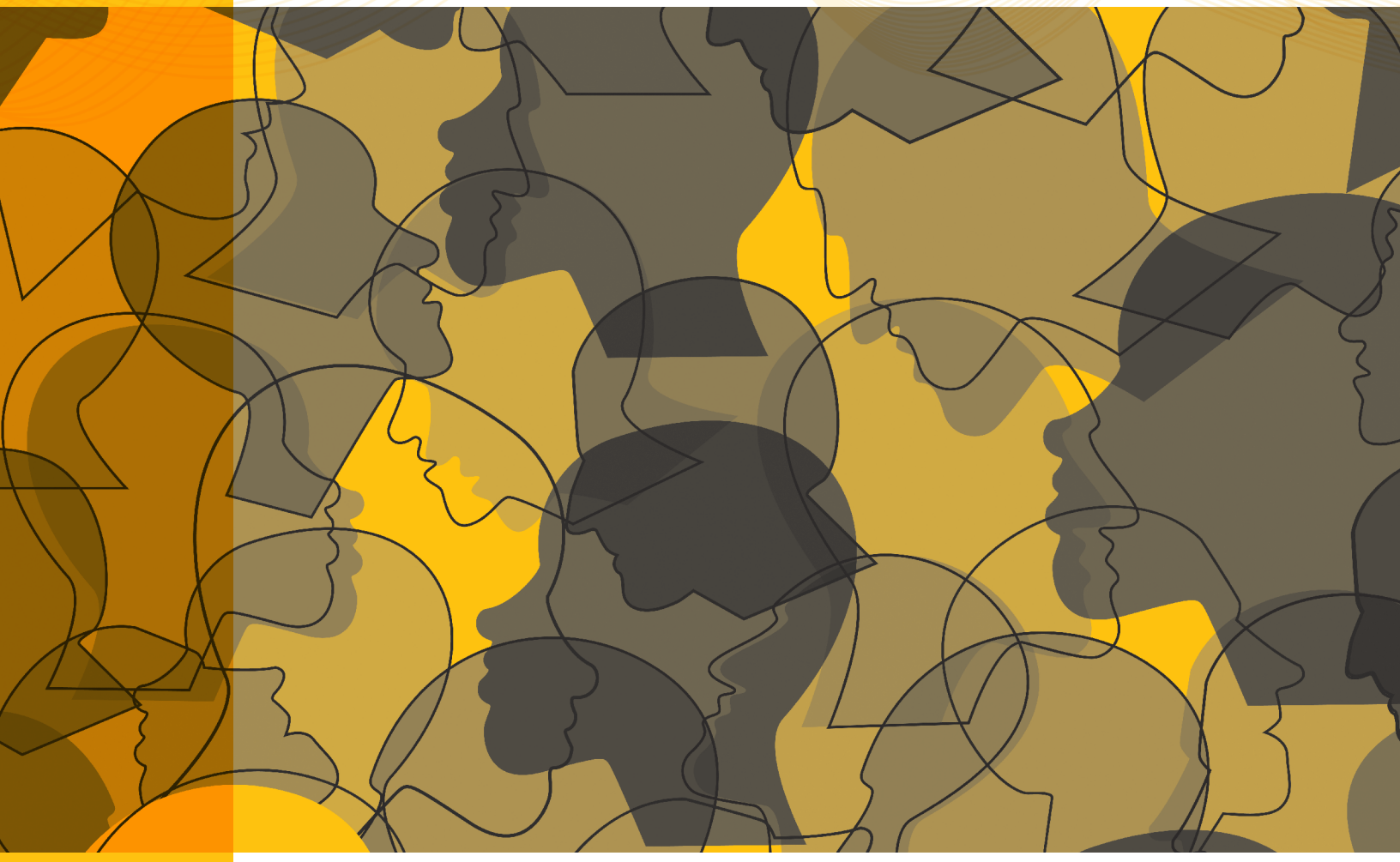
August 2019

Converge3

Integrating health, economic and equity evidence to inform policy

Mental Health and Substance Use Treatment Interventions for Immigrant, Refugee, Ethno-Cultural and Racialized (IRER) Populations in Ontario

A Converge3 Guidance Report



About this Report

This report was prepared by Converge3. We appreciate the participation of Ontario citizens and other health system stakeholders in a knowledge user dialogue that informed the report. Converge3 receives funding from the Province of Ontario. The views expressed in this report are those of Converge3 and do not necessarily reflect those of 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 Ontario Ministry of Health.

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Contents

Key findings

The population of Ontario is diverse, made up of over 200 ethnic groups. Some of these groups experience a disproportionate burden of mental health and substance use problems. We use the term IRER to refer to people who belong to an immigrant, refugee, ethno-cultural or racialized group. People who belong to IRER groups are more likely than other Ontarians to experience poverty and other social factors that contribute to mental health problems. IRER populations also access services for mental health and substance use less frequently than the general population and often receive poorer quality of care.

While people who belong to IRER groups experience many barriers to accessing services for mental health and substance use, one of the most significant is that current services are not culturally relevant or sensitive to their needs. There are two main approaches to providing culturally sensitive treatment interventions to IRER populations:

- **Culturally specific** interventions refer to treatment programs that are developed for a specific population or group from the outset.
- **Culturally adapted** interventions refer to modification or tailoring of existing treatment programs to more appropriately meet the needs of a specific population or group.

To review this evidence and discuss its implications for Ontario, Converge3 identified the following policy research question in consultation with stakeholders: ***What is known about the effectiveness of culturally adapted and culturally specific mental health and substance use treatment interventions for IRER populations?***

Converge3 commissioned the Provincial System Support Program at the Centre for Addiction and Mental Health (CAMH) to conduct a review of the literature which is published as a Converge3 evidence report entitled: *Mental Health and Substance use Treatment Interventions for Immigrant, Refugee, Ethno-Cultural and Racialized (IRER) Populations in Ontario: Scoping Review*.

Converge3 also held a knowledge user dialogue with policy-makers, service providers and people with lived experience to give participants an opportunity to contribute to a broader understanding of the evidence and to provide insights based on their context and experiences.

Based on the literature review and knowledge user dialogue, Converge3 identified the following policy areas for consideration by stakeholders involved in the planning or provision of mental health and substance use services for IRER populations:

- There is a need for both culturally specific and culturally adapted mental health and substance use interventions for IRER populations.
- The evidence is insufficient to provide strong guidance when selecting between culturally specific and culturally adapted interventions.
- School-based culturally specific programs show promise for delivering mental health services to immigrant and refugee youth.
- Both culturally specific and culturally adapted substance use services show promise.
- Family and peer-based interventions may be particularly important for some ethno-cultural groups.
- Both culturally specific and culturally adapted

There is a need for both culturally specific and culturally adapted mental health and substance use interventions for IRER populations

interventions would benefit from integrating a strong evaluative component.

- Adaptation frameworks and identification of successful methods can help guide program design and implementation.

Introduction

The population of Ontario is diverse, made up of over 200 ethnic groups. Some of these groups experience a disproportionate burden of mental health and substance use problems. This occurs for many reasons, including racism and social isolation. Some people come to Canada after having traumatic experiences and may develop post-traumatic stress disorder (PTSD).

We use the term IRER to refer to people who belong to an immigrant, refugee, ethno-cultural or racialized group (see page 4 sidebar for definitions). This report does not address Indigenous or Francophone populations. People who belong to IRER groups are more likely than other Ontarians to experience poverty and other social factors that contribute to mental health problems.[1] IRER populations also access services for mental health and substance use less frequently than the general population and often receive poorer quality of care.[2]

While people who belong to IRER groups experience many barriers to accessing services for mental health and substance use, one of the most significant is that current services are not culturally relevant or sensitive to their needs.

Culturally specific concepts, values and beliefs can influence the meaning and priority people give to mental illness. Culture can influence how people describe their symptoms, how they cope with mental illness, and how, when, where and if they seek help. It can also have an impact whether people continue in care after they are connected to a provider. As a result, mental illness and substance use treatment interventions are more successful and have higher retention rates when they are rooted in the culture of the clients receiving the services.[3,4] However, IRER groups

About Converge3 Guidance Reports

Converge3 guidance reports address specific topics by combining policy research with contextual and experiential evidence. The reports are intended to support evidence-informed policy and are developed using a multi-step process:

Determining the policy question
Policy research questions are identified through ongoing consultation with the Ontario Ministry of Health and Long-Term Care, the Ontario Ministry of Children, Community and Social Services and other health system stakeholders including patients and members of the public.

Gathering the evidence
Converge3 commissions policy research from Ontario-based research institutes. This research is published as separate evidence reports and informs the development of our guidance reports.

Engaging stakeholders
Evidence reports and draft guidance reports are used by stakeholders in knowledge user dialogues to gather perspectives and feedback, which are incorporated into the final reports.

Disseminating findings
All reports are shared through the Converge 3 website (converge3.ca) to inform a wide range of stakeholders with an interest in contributing to stronger health policy in Ontario.

IRER populations access services for mental health and substance use less frequently than the general population and often receive poorer quality of care.

are diverse and may have distinct needs; an approach that is culturally appropriate for one group may not be appropriate for another. [5]

There are two main approaches to providing culturally sensitive treatment interventions to IRER populations:

- **Culturally specific** interventions refer to treatment programs that are developed for a specific population or group from the outset.
- **Culturally adapted** interventions refer to modification or tailoring of existing treatment programs to more appropriately meet the needs of a specific population or group.

The optimal mix of culturally specific and culturally adapted interventions for IRER populations is unknown. To explore this question and to discuss the implications for Ontario, Converge3 identified the following policy research question in consultation with stakeholders:

What is known about the effectiveness of culturally adapted and culturally specific mental health and substance use treatment interventions for IRER populations?

Previous reports

A report by the Mental Health Commission of Canada[2] reviewed international evidence on promising practices when working with IRER populations and highlighted the following:

- Cultural competence holds promise, but more rigorous evidence is needed.
- Culturally adapted interventions improve treatment outcomes, but their effectiveness differs across ethnic and cultural groups.

Definitions

An **immigrant** is a person who was born outside of Canada and is now a legal permanent resident of Canada. In Ontario, immigrants make up 29.1% of the population[6].

A **refugee** is person who has left their home country due to a justifiable fear of being persecuted because of their race, nationality, social group membership, or for political reasons

A person in an **ethno-cultural** group, whether an immigrant or born in Canada, shares common heritage and cultural characteristics with other people in that group.

A person is **racialized** through a complex process by which their ethno-cultural group becomes designated as being of a particular "race" and, on that basis, is subjected to differential or unequal treatment. The term "racialized" replaces outdated terms such as "racial minority," "visible minority," "person of colour" or "non-white." Among Ontarians, 28.9% identify as a member of a racialized group, including both immigrants and people born in Canada[6].

Mental illness and substance use treatment interventions are more successful and have higher retention rates when they are rooted in the culture of the clients receiving the services

- Developing specific/integrative-care models for ethnic groups may improve outcomes.
- Culturally adapted interventions for ethnic and racially diverse youth appear to be effective.
- Cultural adaptations hold promise for the treatment of substance use disorders.
- Evidence supports providing mental health treatment to refugee populations who have experienced trauma.
- Improvements in care for IRER populations require a structured approach.
- Tele-counselling may be a useful approach for offering treatment to IRER populations in remote areas.

Gathering the evidence

To inform this guidance report, Converge3 commissioned the Provincial System Support Program at the Centre for Addiction and Mental Health (CAMH) to conduct a scoping review of the literature on culturally appropriate mental health and substance use treatment interventions for IRER populations. The scoping review was conducted with a librarian and followed best practices for such reviews.

The findings of this review are summarized in this guidance report and published in the evidence report available on our website (converge3.ca) or by following this link: *Mental Health and Substance use Treatment Interventions for Immigrant, Refugee, Ethno-Cultural and Racialized (IRER) Populations in Ontario: Scoping Review*.

Articles included in the Evidence Report

The following eligibility criteria were used in the scoping review:

Inclusion Criteria
- Must include IRER populations
- Must be from a setting similar to Canada (e.g., Australia, New Zealand, U.K., U.S.)
- Must examine culturally adapted or culturally specific mental health and substance use 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

IRER groups are diverse and may have distinct needs; an approach that is culturally appropriate for one group may not be appropriate for another

Knowledge user dialogue

In addition to commissioning policy research, Converge3 incorporates the perspectives of stakeholders in order to interpret and apply that evidence. To gather these perspectives, Converge3 held a knowledge user dialogue with policy-makers, service providers, researchers and people from IRER populations with experience accessing mental health and substance use treatment services in Ontario. We provided participants with a draft of this guidance report as the basis for a facilitated discussion about the available evidence and potential policy options and considerations. This discussion was an opportunity for participants to contribute to a broader understanding of the evidence and to provide insights based on their context and experiences. The dialogue followed the Chatham House Rule to enable a full and open discussion.

What we learned: A summary of the commissioned policy research

The scoping review identified 36 records, 32 from Medline or PsycINFO and 4 from the grey literature. Common study limitations included small sample sizes, the lack of systematic evaluation of treatment outcomes, the reliance on anecdotal feedback and the absence of control groups. No study rigorously evaluated interventions by randomizing individuals to different types of programs.

Culturally specific interventions

A culturally specific intervention is created for a specific cultural group beginning with the values, behaviours, norms and worldviews of the population for which it is intended. Generally, culturally specific interventions are designed with ongoing guidance from the specific community and in the community's primary language.

The studies on culturally specific interventions were conducted predominantly in the United Kingdom and the United States and none used a specific framework or culturally specific components. Four studies focused on immigrant or refugee populations and included interventions such as:

- comprehensive clinical and case management within a school-based program for immigrant children;
- community resilience building, child resilience building and culturally specific trauma systems therapy with both school-based psychotherapy and home-based care for Somali refugee youth in the United States;
- early-intervention mental health services for asylum-seeking West African mothers aged 17–32 and their babies in the first year of life; and
- brief strategic family therapy for Latin American adolescents in the United States with substance use and behavioural disorders.

One study reported on an alcohol treatment program with Latin American and African American adolescents in a juvenile detention centre, and another reported on an integrated substance use and HIV treatment program with values rooted in traditional African culture for African American women. A systematic review summarized 14 studies conducted prior to the six aforementioned studies. The studies included in that systematic review used community-based, culturally specific interventions to reduce the psychological impact of trauma among diverse refugee populations.

The studies reviewed reported outcomes for the following culturally specific interventions:

- **School-based interventions:** The results indicate that culturally specific school-based interventions (including cognitive-behavioural therapy and trauma-focused cognitive behavioural therapy) have the potential to reduce both PTSD-related and depressive symptoms and to improve functioning. Play-based therapies also show promise. Youth responded positively to culturally specific service models, preferring to receive mental health services in a school setting rather than a clinical one. Cultural sensitivity was achieved through using cultural brokers, training in

Culturally specific school-based interventions have the potential to reduce both post-traumatic stress disease-related and depressive symptoms and to improve functioning

cultural competence, local adaptations to therapy and offering services in the clients' primary languages.

- **Services for young mothers:** Culturally specific services targeting young mothers with mood disorders demonstrated a positive shift in the quality of attachment between mothers and their children.

- **Substance use services:** Culturally specific services for addressing substance use have been evaluated in Latin American and African American populations. The evidence is limited because interventions were sometimes offered as a component of broader interventions (such as family therapy) and sometimes were not rigorously evaluated. Two studies demonstrated decreased substance use while one did not; however, the intervention that did not decrease substance use did show an improvement in depressive symptoms. Of the programs reporting positive results, one was a program for Latin American and African American offenders in juvenile detention centres that was associated with decreased substance use 30 days after the program was completed. Notably, participants with higher reported levels of ethnic pride and orientation reported fewer days of alcohol consumption post-treatment.

Culturally adapted interventions were feasible, acceptable and associated with positive experiences.

Culturally adapted interventions

A culturally adapted intervention builds on existing interventions, making changes to ensure cultural relevance and fit. All levels of the intervention (from administration to implementation) may be modified or tailored to be more meaningful and appropriate to the needs of a specific ethno-cultural group or community. Such changes can address issues such as language, context of the intervention, modes of treatment delivery, content and theoretical frameworks.

The review identified 22 studies on culturally adapted mental illness and substance use treatment interventions among IRER groups. Twelve studies focused on the evaluation of specific culturally adapted interventions that have been implemented with IRER populations, while ten were systematic reviews. Eight made reference to particular immigrant populations – two included immigrant Latin American populations and one included African American and Latin American populations in which most participants identified as second-generation immigrants (children of immigrants). The remaining studies included a mix of immigrant populations, including individuals that identified as Chinese, Tamil, Korean, Turkish, Vietnamese, Caribbean, Japanese and other groups. The quality of the evidence was mixed, as many studies had limited follow-up or did not have comparator groups. About half of the studies used a cultural adaptation framework; the most common were the multidimensional model for understanding culturally responsible psychotherapies, the ecological validity framework and the cultural accommodation model.

The following themes emerged from a review of the studies:

- **Interventions were feasible and acceptable:** Most studies indicated that culturally adapted interventions were feasible, acceptable and associated with positive experiences. In a study of a school-based intervention among a refugee population, participants reported positive experiences. In studies with Latin American populations, there were similar acceptance and satisfaction rates for participants in both the standard and adapted treatments.

- **Cultural variables played a role:** Cultural variables, including factors such as ethnic identity and the prioritization of family, may be important for understanding how interventions are effective in specific contexts. For example, a study with African Americans found that treatments were more likely to be effective if they incorporated parental involvement and family-based interventions, addressed empowerment and familial support, addressed the effects of racism, and facilitated a strong, positive ethno-cultural identity. Some studies that included mixed ethno-cultural groups suggested that the ways in which interventions were most effective differed across ethno-cultural groups.

- **Adaptation may be most effective for some groups:** Two reviews demonstrated mixed results when examining the effectiveness

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of cultural adaptations for immigrant populations. A review of cultural adaptation for adolescents showed mixed efficacy while a review of culturally adapted treatment interventions for adults shoed more consistent results. In that review, there were a variety of ethno-cultural groups and interventions had positive outcomes. Studies that included both adult and adolescents also reported culturally adapted interventions led to better treatment outcomes. One review identified that cultural adaptation was most successful for people age 35-40 and older, for Asian Americans, and for groups that were ethno-culturally homogeneous. Interventions tended to be most effective when they included multiple, rather than one, cultural adaptations.

The studies reviewed also addressed the use of culturally adapted interventions for specific conditions:

- **PTSD:** There is limited evidence for culturally adapted interventions for the treatment of PTSD, particularly among youth. PTSD treatment interventions for families and for women show promise but evaluations were limited.

- **Depression and anxiety:** There is mixed evidence regarding culturally adapted interventions for treatment of depression and anxiety. While eight of ten studies found culturally adapted interventions to be successful at decreasing symptoms, one study found culturally adapted interventions to be effective only when combined with anti-depressant medication, and a review found no statistically significant difference between using culturally adapted interventions and treatment as usual.

- **Substance use:** There is consistent evidence that culturally adapted interventions have a positive effect on reducing substance use, with seven of eight studies reporting an effect. Strong identification with one's cultural identity and the inclusion of family in treatment contributed to these positive effects.

- **Mental illness:** There is limited evidence that culturally adapted services may increase the effectiveness of assertive community treatment models for individuals with severe and persistent mental illness.

What we learned: A summary of our knowledge user dialogue

Participants endorsed the need for both culturally specific and culturally adapted mental health and substance use programs for IRER populations. They also strongly endorsed the need for programs to address cultural norms, beliefs and values. For example, a program may be more acceptable to certain communities if it uses non-pharmaceutical approaches or strategies that acknowledge the use of traditional medicines.

Participants recognized that evidence for specific programs or interventions may be weak, but encouraged decision-makers to adopt a broad view of what constitutes evidence, including Ontario-specific community experiences.

Participants noted that programs should directly address stigma toward mental illness, which may be strong in some cultures. They suggested that when stigma is a major concern, culturally specific programs may be more effective than culturally adapted programs, particularly if community-based education is integrated into the program. They also suggested that family psychoeducation can be very helpful in addressing stigma.

Participants also stressed the need to recognize the diversity of experiences within seemingly similar IRER populations. For example, the African Diaspora community is diverse and services targeted to some members of the community may not be relevant for others.

Participants felt that family-based treatment interventions are well matched to culturally specific approaches, including involvement of the extended family. Family-based programs may be most effective when delivered within community-based settings.

What we need to know

Participants identified several additional areas of research needed to identify optimal culturally specific or culturally adapted interventions for IRER populations.

- Many participants noted the importance of cost-effectiveness and suggested that culturally adapting an existing program – if one exists – may be less expensive than developing a new culturally specific program. Formal cost-effectiveness analyses may help to guide such resource allocation decisions.
- Participants noted that no studies in the evidence review directly addressed the role of religion. They noted that culturally-adapted interventions that address religion could significantly improve the delivery of culturally appropriate mental health services, but can also be a significant barrier to families accepting mental health issues and mental health care. They noted this as an important area for additional research.
- Several participants noted that the role of telemedicine in delivering services both culturally adapted and culturally specific services has yet to be fully explored in Ontario. Telemedicine may be particularly important for individuals who live in communities where there are few other members of their ethno-cultural group.

Programs should directly address stigma toward mental illness, which may be strong in some cultures. When stigma is a major concern, culturally specific programs may be more effective than culturally adapted programs,

On the subject of evaluation, participants noted that several evaluation and adaptation frameworks have been published and implemented, including some that are Ontario-specific.

Implementation considerations

Participants identified several aspects of both culturally specific and culturally adapted interventions that are important when implementing these programs for IRER populations in Ontario.

Several participants noted a potential conflict in implementing mental health and substance use programs that stress features such as patient empowerment and community engagement. Program administrators should consider how such features could conflict with some cultural norms—such as respecting one's elders and deferring to authority — and how to adapt these features accordingly.

Participants noted that many members of IRER communities often access health care first through primary care clinics, particularly when seeking services in their original language. However, many clinics lack cultural training and have inadequate resources to provide social supports, referrals and follow-up. Care providers who do not have cultural training may misdiagnosis a culturally appropriate response to stress as a mental illness, with deleterious consequences for individuals and for the health care system. There is also a need to better inform newcomer populations of the availability of settlement services, which can determine a client's needs, address distress, and provide referrals for specific mental health issues.

Participants noted that implementation of both culturally specific and culturally adapted interventions for immigrants and refugees should consider how recently people in the program came to Canada and the need to integrate programs with settlement services for recent newcomers. Similarly, refugee claimants in different sponsorship programs (government-sponsored, privately sponsored and blended visa refugees) may have very different needs. Second generation immigrant communities may benefit from programs that stress cultural affirmation, such as instilling pride in the traditions of an ethno-cultural group.

Participants stressed the central importance of having language services available, including in smaller communities, and the value of having service providers who are familiar with the culture of their clients. When such providers are not available, implementation strategies might include incorporating peer workers from the same cultural communities or providing clients with access to providers from other racialized or ethnic communities who are generally sensitive to culturally defined needs.

Participants urged greater investment in peer and informal caregiver support for both culturally adapted and culturally specific programs. Peer support can assist in building resiliency by changing a client's narrative from one centred on a mental health diagnosis to one that stresses perseverance through challenging and unique circumstances.

Participants noted concerns about the resources allocated to school-based interventions, with social workers and school psychologists often shared between multiple schools and a lack of

Participants urged greater investment in peer and informal caregiver support for both culturally adapted and culturally specific programs. Peer support can assist in building resiliency.

culturally competent service providers within schools.

Finally, participants suggested there is also a need to more effectively integrate health and social services across sectors and to coordinate care across agencies that serve similar populations.

Guidance for implementing culturally appropriate interventions

Through our evidence review and knowledge user dialogue, Converge3 identified the following policy areas for consideration by stakeholders involved in the planning or provision of mental health and substance use services for IRER populations:

- **There is a need for both culturally specific and culturally adapted mental health and substance use interventions for IRER populations.**

  The available evidence indicates that both culturally specific and culturally adapted interventions are more likely to be effective for IRER populations than standard programs, suggesting that each of these approaches has a potential role in service delivery. However, the approaches also have distinct limitations. Culturally specific interventions may be difficult to replicate across programs and populations, such that programs may not be as effective when applied in different contexts than those in which they were originally studied Culturally They also require specific skills, cultural competencies and community partners to interpret and translate cultural norms and behaviours into treatment interventions. Culturally adapted interventions may be of limited relevance for certain IRER populations, particularly if they are very different from groups in which the intervention has previously been developed or applied. Thus, funders will need to recognize that the evidence base for most interventions is limited, whether culturally specific or culturally adapted.

  Participants in the knowledge user dialogue urged decision-makers to accept many different forms of evidence when making decisions, including local experiences. Decision-makers were encouraged to recognize that generalizing evidence to new populations and settings requires careful extrapolation beyond available evidence. The evidence review emphasized that culturally adapted interventions are most successful when they are customized for specific ethno-cultural groups. Participants in the knowledge user dialogue emphasized the need to recognize the diversity of cultures and experiences, such as how the specific needs of refugee claimants may differ by sponsorship category.

- **The evidence is insufficient to provide strong guidance when selecting between culturally specific and culturally adapted interventions.**

  The scoping review found no direct comparisons of culturally specific and culturally adapted mental health and substance use interventions for IRER populations. Decision-makers designing and implementing a new intervention could base their consideration on specifics of the population, the intervention and the specific mental health or substance use problem being addressed. Participants in the knowledge user dialogue stressed the importance of addressing stigma in the diagnosis and delivery of mental health and substance use services. They noted that culturally specific interventions, including community-based and family-based programs, may be particularly effective in meeting this objective.

Both culturally specific and culturally adapted interventions were successful in decreasing substance use in selected communities. Such programs may be particularly relevant for individuals who strongly identify with their ethno-cultural group.

- **School-based culturally specific programs show promise for delivering mental health services to immigrant and refugee youth.**

  The most consistent evidence for culturally specific interventions relates to school-based interventions, including cognitive-behavioural therapy and trauma-focused cognitive behavioural therapy for PTSD-related and depressive symptoms among immigrant and refugee youth populations. School-based interventions were often more acceptable to youth than clinic-based interventions. In the Ontario context, culturally specific interventions may be most feasible in areas with large immigrant or refugee populations. Participants in the knowledge user dialogue noted that, in Ontario, social workers and school psychologists are often shared between multiple schools and that culturally competent service providers within schools are often not available.

- **Both culturally specific and culturally adapted substance use services show promise.**

  The scoping review found several studies of both culturally specific and culturally adapted interventions that were successful in decreasing substance use in selected ethno-cultural communities. The evidence suggests that such programs may be particularly relevant for individuals who strongly identify with their ethno-cultural group.

- **Family and peer-based interventions may be particularly important for some ethno-cultural groups.**

  Families are central to how many ethno-cultural groups conceptualize and cope with illness. Several of the culturally specific and culturally adapted interventions identified in the review emphasized the role of family. This can happen in several ways, including prioritizing family considerations in therapy, providing family-based interventions and integrating family support. Participants in the knowledge user dialogue noted that family-based programs may be most effective when delivered within community-based settings. While peer-based support was not identified as a strong component in the evidence review, participants in the knowledge user dialogue strongly urged greater investment in such support in both culturally adapted and culturally specific programs. They also advocated for additional research in this area.

- **Both culturally specific and culturally adapted interventions would benefit from integrating a strong evaluative component.**

  The scoping review found that most culturally specific and culturally adapted interventions had not been rigorously evaluated. The result is both an unmet need for mental health and substance use therapies and a significant evidence gap. Furthermore, interventions will need to be adapted to new contexts, which further underscores the need for ongoing

Interventions need to be adapted to new contexts, which underscores the need for ongoing evaluations; these are likely to benefit greatly from involvement of community members.

evaluation. Finally, there is very little evidence on the long-term effects of interventions or whether interventions can be sustained over time. For all of these reasons, strong evaluative components should be planned alongside implementation. Such evaluations are likely to benefit greatly from involvement of community members. Participants in the knowledge user dialogue noted that several evaluation frameworks have been published and implemented, including some that are Ontario-specific.

- **Adaptation frameworks and identification of successful methods can help guide program design and implementation.**

  The scoping review found that few interventions were designed based on adaptation frameworks, although several have been described in the literature. The review also identified several methods that have been associated with successful implementation of both culturally specific and culturally adapted interventions. These include: providing training in cultural competence and cultural sensitivity, adapting implementation to local context, ensuring that treatments are delivered in culturally sensitive ways, offering services in clients' primary languages and incorporating multiple cultural adaptations where possible. Participants in the knowledge user dialogue noted that several adaptation frameworks are available, including several that have been used in Ontario. Participants also stressed the central importance of having language services available, including in smaller communities.

Next steps

Converge3 provides stakeholders with options and considerations that are evidence-based with a consideration of economic and equity implications. Stakeholders, whether internal to government or from the broader IRER community, will decide which strategies are best aligned with their interests. As such, Converge3 presents stakeholder feedback but does not endorse or recommend any specific strategy.

Stakeholders should also recognize that while some strategies can be implemented relatively easily, others will require additional analyses and careful consideration to determine costs, feasibility and acceptability. Converge3 welcomes the opportunity to work with stakeholders to examine all options more fully, including options that we may have missed in this report. Our goal is to contribute actively to evidence-informed decision making that improves health and equity for all Ontarians while increasing efficiency within the health care system.

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