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A guide to culturally adapting mental health and addictions programs



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Table of contents

Background	4
How to use this resource	5
Should we adapt this program?	6
Types of evidence	7
Sources of evidence.....	8
How do we adapt this program?	9
What program elements should be adapted?	11
Ecological Validity Model.....	11
Case study: Ecological Validity Model in action	15
Conclusion	17
References	18

Background

Culturally adapted programs are evidence-based programs that have been modified to better fit the needs and preferences of a specific cultural group (Bernal et al., 2009; Booth & Lazear, 2015). Modifications could include changes to reflect differences in language, culture, and values (Bernal et al., 2009).

In culturally grounded programs, a program is developed 'from the ground up' with input from members of the cultural group the program is intended to serve. However, developing a culturally adapted program starts with an evidence-based program. An evidence-based program is an intervention or program that several research studies show to be effective at achieving positive outcomes (Booth & Lazear, 2015).

Emerging evidence suggests that mental health and substance use programs that are culturally adapted may be more effective for racialized children and young people than non-adapted programs (Arora et al., 2021; Steinka-Fry et al., 2017). Historically, evidence-based programs were developed and evaluated with white, middle-class, Western participants (Naeem et al., 2019). These programs may not meet the needs of racialized clients, which can lead to lower rates of enrollment, retention, and satisfaction (Barrera et al., 2017).

There is a lack of current literature on frameworks for culturally adapted programs, and on how to culturally adapt programs. Instead, much of the literature on this topic focuses on the effectiveness of culturally adapted programs already in place. In this resource, we have compiled the existing literature to help your organization culturally adapt evidence-based mental health and addictions programs.



For more information on why cultural adaptation is important and for a glossary of key terms, see our [overview of culturally adapted programs](#).

How to use this resource

This resource is intended for leaders and service providers working in the child and youth mental health and addictions sector who want to learn about the process for adapting evidence-based programs for different cultures. This resource will help you answer three questions:

1. Should we adapt this program?
2. How do we adapt this program?
3. What program elements should be adapted?

Should we adapt this program?

Before starting the adaptation process, you must first determine whether or not your program should be adapted, as not all programs need to be adapted for different cultures. In fact, there are some concerns about culturally adapting evidence-based programs.

First, limited research shows that evidence-based practices are less effective for racialized and minority populations (Lau, 2006). Even though evidence is limited due to an overall lack of research regarding the effectiveness of evidence-based practices for these populations, it still means that we should be cautious before setting out on a lengthy adaptation process. Put simply, if we don't know whether an evidence-based practice is as effective or less effective for the selected cultural group, we may not need to adapt the program.

Second, a focus on culturally adapting evidence-based practices may lead to inappropriate adaptations that could jeopardize the fidelity of the program, which may in turn impact its effectiveness (Lau, 2006).

Third, given the limitless combination of different programs for specific mental health and addictions issues for individual cultural groups, cultural adaptations not based on data may be inefficient and unnecessary (Lau, 2006).

It is important to be selective when choosing which evidence-based programs to adapt. Consider this question: Does the program lead to worse outcomes for the cultural group you want to serve? Adaptation efforts should be focused where they are most needed – for the mental health or addictions issue, program, and population where there is evidence of variability in the effectiveness of the evidence-based practice.

Types of evidence

Three main types of evidence can be used to identify the specific issue, program, and population that may benefit from a cultural adaptation.

1. Differences in engagement rates

- Clients belonging to a cultural group may be less aware that a program is available or be less likely to enter it. There may also be differences in rates of participation and program completion between cultural groups (Barrera & Castro, 2006; Lau, 2006).
- Social validity refers to the acceptability and viability of a program when implemented in a community setting. When a program is not socially valid for a cultural group, members of the group see the treatment as “irrelevant, unhelpful or unacceptable” (Lau, 2006). When a program has low social validity, clients are less likely to enter the program and therefore do not have the opportunity to receive the potential benefits of the program.

2. Differences in risk and resilience factors

- Different cultural groups may have different risk and resilience factors, which may need to be addressed through program adaptations (Lau, 2006).
- For example, higher rates of difficulties with substance use in various Indigenous communities have been linked to individual and intergenerational trauma related to colonialism and experiences of racism and discrimination (Pride et al., 2021). A strong cultural identity has been shown to be protective against substance use challenges (Marsh et al., 2015). When adapting a program for an Indigenous community, a trauma-informed approach co-developed with community members – which aims to strengthen the cultural identity of participants – is needed to address community-specific risk and resilience factors.

3. Differences in treatment outcomes (Barrera & Castro, 2006; Lau, 2006)

- A non-adapted program may be less effective at producing positive treatment outcomes for some cultural groups. In this case, adapting the program may be necessary to ensure equity.
- For example, if members of a cultural group do not experience improved well-being after participating in a program that targets this outcome, the program may need to be adapted to better fit the needs of the group.

Sources of evidence

Is cultural adaptation needed for your program? Several sources of evidence can be used to determine this.

- **Program evaluation or performance measures.** This evidence source is particularly relevant for identifying differences between groups in engagement rates and treatment outcomes.
- **Literature search.** A comprehensive review of the literature can be helpful in identifying risk and resilience factors for specific cultural groups (Castro-Olivo & Merrell, 2012). It can also help you determine if the program has already been adapted for the cultural group you want to reach.
- **Expert consultation.** Speaking with experts in the field can help identify programs that may benefit from a cultural adaptation.
- **Engagement with the intended cultural group.** It is recommended that you engage with members of the cultural group you want to better serve to identify programs that may benefit from a cultural adaptation.

How do we adapt this program?

Risks and protective factors for mental health and well-being will vary for different communities, due to each individual cultural group's common life experiences, social contexts, and cultural norms. When adapting a program to better meet the needs of a particular cultural group, it's necessary to consider that group's specific practices and dynamics.

Community-specific practices and values may not be included in Eurocentric models of psychological research or service provision, which centre on white and middle-class populations (Leong & Lee, 2006; Whitbeck, 2006). Examples include valuing collectivism over individualism, having a self-concept of being interdependent rather than independent, or communicating in a way that prioritizes shared non-verbal context cues or formal relationship protocols instead of informal, individual-focused expression (Leong & Lee, 2006; Whitbeck, 2006).

A cultural group may have many shared values or practices, but there can also be variations from region to region, community to community, or nation to nation (Whitbeck, 2006). An adaptation that works in one community may need to be tailored for another community from the same cultural group.

When considering culturally adapting a program:



Review existing markers of risk and resilience to identify any that may need to be culturally translated to better speak to the experiences of the community (Whitbeck, 2006).



Explore additional unique risks and protective factors the community faces, which the original modality – or Eurocentric developmental or health measures at large – might not address (Leong & Lee, 2006; Whitbeck, 2006). This can be done through literature review and consultation with community experts like Elders, Knowledge Keepers, community leaders, and community members with strong cultural knowledge.



Prioritize collaboration with local community experts to identify the cultural variables to factor into an existing intervention. This can be done alongside your consultations with other experts, like mental health and addictions service providers or researchers. You can also continue to collaborate while you are exploring the literature (Burrow-Sanchez et al., 2011; Whitbeck, 2006).

Whitbeck (2006) highlights the importance of community members being involved in the full scope of a project, from identifying problems to developing and implementing interventions to address them. Involving community members as true collaborators takes time and trust-building (Burrow-Sanchez et al., 2011). When mapping out the timeline and workflow of your adaptation process, consider the existing state of your relationships with community members and how to work together in true partnership. Work may take longer as a result, but partnering with community members through all phases of a project can make the work more responsive to community needs and improve program implementation outcomes.

As you work to culturally adapt a program and begin to offer it in a community, evaluate your processes and results to assess the effectiveness of your adaptations (Burrow-Sanchez et al., 2011; Leong & Lee, 2006; Whitbeck, 2006). These evaluations can reveal further changes you can make to better align the program with the needs of the community.

Some potential things to evaluate include:

- Recruitment and retention of program participants.
- Participant engagement in, and satisfaction with, the program.
- Individual or community outcomes from participation.
- Challenges and successes in facilitating the program.

Why is it called the ecological validity model? Ecological validity is defined as the level of agreement between the properties of the program that the clinician assumes it has and the program as experienced by the client (Bernal et al., 1995). Culturally adapted programs aim to increase the congruence between these two views. In other words, the goal of culturally adapted programs is to increase the ecological validity between the client's experience of how their culture is reflected in a program, and the properties of the program assumed by the clinician (Bernal et al., 1995).

What program elements should be adapted?

Ecological Validity Model

When determining what program elements should be culturally adapted, the Ecological Validity Model (Bernal et al., 1995) can be a useful framework. This model has eight dimensions – language, persons, metaphor, content, concepts, goals, methods and context. These dimensions delineate the program content that should be modified to fit the needs of the cultural group you want to better serve. The dimensions are not mutually exclusive categories, so some components may overlap.



Note: Selecting the metaphors, concepts, content, or other elements being added to or changed in a program will depend on the cultural group the program is being adapted for. It is essential to consult with members of the selected group.

The eight dimensions are outlined below. Each section includes a definition of the dimension and steps you can take to culturally adapt a program, and more details are provided when relevant. We have used examples from the literature to illustrate the eight dimensions.

Language

This dimension refers to considerations related to the language of the program.

- Translate the program (Bernal et al., 1995).
 - If language barriers are negatively impacting treatment delivery, the program language should be changed. This includes translating program materials and hiring staff who speak the language.

- Incorporate culturally sensitive language into the program (Bernal et al., 1995).
 - The language used should align with the preferences of the cultural group being served. Individuals who speak the same language may use different words depending on their dialect, country of origin, and current environment.
- Consider the emotional expression of language (O'Connor et al., 2020).
 - Service providers should understand the typical mannerisms and emotional expressions used by the cultural group being served.

Persons

This dimension refers to client and therapist variables and relationships.

- Match clients with service providers of the same race or ethnicity.
 - Clients seeking mental health services report a preference for service providers of the same race or ethnicity and perceive these service providers somewhat more positively than those of a different race or ethnicity (Cabral & Smith, 2011). However, a meta-analysis of 53 studies found no significant differences in treatment outcomes when clients and services providers were matched by race or ethnicity (Cabral & Smith, 2011).
- Provide training on working with clients of different cultures.
 - For example, your organization can provide cultural humility training or cultural safety training. These enhance understanding of the impact of race and culture on mental health and can help increase a clinician's capacity to address clients' experiences related to racism or discrimination (Maharaj et al., 2021; Rathod et al., 2019).
- Discuss race and racism directly.
 - It may not be feasible or necessary to match clients with a service provider of the same race or ethnicity (Cabral & Smith, 2011). Instead, clients' experiences of race, ethnicity, or racism should be acknowledged and discussed in treatment (Cabral & Smith, 2011; Maharaj et al., 2021; Rathod et al., 2019). When approached in a culturally safe way, addressing race and racism directly can help create a safer space and enhance the therapeutic relationship (Maharaj et al., 2021).

Metaphors

This dimension refers to the use of symbols, stories, and concepts relevant to the selected cultural group.

- Include artwork, objects, or symbols that are familiar to the cultural group (Bernal et al., 1995).
 - These components can be incorporated in the waiting room, in the therapeutic environment, or in program materials.
- Incorporate relevant sayings, expressions, or idioms into the program (Bernal et al., 1995).
 - For example, Chinese young people who participated in a focus group for a cultural adaptation reported that “carrying the weight of the world on your shoulders” was too abstract and exaggerated. A common local expression, “like a ton of invisible pressure falls on you” was used instead (Sit et al., 2020).

Content

This dimension refers to cultural knowledge about values, customs, and traditions – for example, how the selected culture views personal space, gender roles, time, or family.

- Add new content or change content to reflect the values, customs, traditions, and experiences of the cultural group (Castro-Olivo & Merrell, 2012).
 - For example, Chinese young people reported that spending time with family at a picnic was not a common activity in their experience. The adapted intervention was changed to “spending time in a café with friends” as this was a more relevant leisure activity (Sit et al., 2020).
 - Another example is incorporating Indigenous spiritual practices and stories related to healing to address the impact of historical and ongoing colonial and racial trauma (Kirmayer et al., 2003; Menzies, 2008; O’Keefe et al., 2021). Incorporating culture into treatment is an important treatment approach for Indigenous people (Blackdeer, 2023; Marsh et al., 2015).

Concepts

This dimension covers how the problem is conceptualized within the treatment model and how this is communicated to the client.

- Incorporate new treatment concepts relevant to the selected cultural group.
 - For example, if members of the selected group are immigrants, the concepts of acculturative stress or a familial acculturative gap could be incorporated into the program (Castro-Olivo & Merrell, 2012).

- Explain concepts in a way that is consistent with the cultural beliefs of the clients (Bernal et al., 1995).
 - For example, the concept of a headache was not relevant for young people in China who participated in a cultural adaptation focus group. Instead, the concept of “dizziness” was included in the final program, as this term better fit with their experiences (Sit et al., 2020). A second example from this study was the phrase “thoughts go really fast.” This was seen by Chinese young people as a positive reaction and not a symptom, so the wording was changed to “thoughts go very messy” (Sit et al., 2020).

Goals

This dimension refers to the client’s treatment goals as well as those set by the program or the clinician.

- Listen to the client’s goals.
 - The service provider should not make assumptions about what positive outcomes look like for the client. Instead, the client’s personal goals should be used to evaluate whether treatment has been successful (Bernal et al., 1995).
- Align the overarching program goals with the selected group.
 - Goals should align with the values, customs, and traditions of the selected cultural group (Castro-Olivo & Merrell, 2012).
 - When formulating the program goals, consider the level of mental health stigma present in the target cultural group. It may be beneficial to not frame the program as a mental health intervention, in order to increase the uptake of the program (Sit et al., 2020).

Methods

This dimension refers to the way the treatment is delivered, or the therapeutic procedures used to achieve the treatment goals.

- Modify who participates in treatment (Bernal et al., 1995).
 - For example, it may be beneficial to incorporate the entire family into treatment in family-centred cultures.
- Change the schedule for treatment (O’Connor et al., 2020).
 - The timing and length of treatment sessions may need to be modified to better fit the needs of the group.
- Change the treatment location.
 - Some cultural groups may be better served if treatment is offered in their communities or in their homes.

- Modify the modality.
 - Consult with members of the selected cultural group to determine the most appropriate modality (individual treatment versus group-based treatment, in-person versus virtual treatment, instructional versus dialogue-driven methods).

Context

This dimension considers the client's background – their socioeconomic status, social supports, developmental stage, phase of migration, experiences of acculturative stress, experiences of racism, and relationships to their culture of origin.

- Address relevant barriers to participating in the program.
 - For example, in focus groups conducted with Hispanic fathers with low family incomes, fathers reported that lack of time and energy due to long working hours were barriers to participating in a program with their children (O'Connor et al., 2020). Addressing these contextual barriers in a cultural adaptation of the program can help with retention and engagement.
- Add or change content to reflect the context of the selected cultural group.
 - For example, Chinese young people reported not only mental health concerns, but also academic and career concerns. In the culturally adapted program, career development resources were included so that the mental health program reflected the local context (Sit et al., 2020).

Case study: Ecological Validity Model in action

The Strong Teens program is a school-based mental health program that teaches self-awareness, emotion regulation, social awareness, problem-solving, and goal-setting (Castro-Olivo & Merrell, 2012). American researchers have undertaken cultural adaptations of this program to improve the fit for Latino adolescents (Castro-Olivo & Merrell, 2012) and a culturally diverse group of adolescents (Cramer & Castro-Olivo, 2016). The table below shows the adaptations made to the program for these two groups of adolescents.

Dimension	Latinx adolescents	Culturally diverse adolescents
Language	<p>The program was translated into Spanish, as that was the dominant language of the selected cultural group.</p> <p>The name of the program was changed from Strong Teens to Jóvenes Fuertes.</p>	<p>Adolescents were offered the choice of completing the program in English or Spanish.</p>
Persons	<p>The program was delivered by staff who were bilingual or bicultural.</p>	<p>Staff received training in identifying the cultural needs of adolescents and being sensitive to these needs.</p>
Metaphors	<p>Common Latinx metaphors and folktales were incorporated to help connect the skills being taught with the cultural background of the adolescents.</p>	<p>Cultural metaphors of the selected group were used. Also, given the diversity of the group, metaphors that may not be understood by other cultural groups were explained.</p>
Content	<p>The examples used to model social-emotional skills were adapted to reflect the cultural values, customs, and traditions of Latinx immigrant adolescents.</p>	<p>Adolescents were encouraged to consider their own cultural values, language, customs, and traditions when applying social-emotional skills in their everyday lives.</p>
Concepts	<p>New concepts, like acculturative stress and ethnic pride, were added to the program to help link the skills being taught with the lived experience of the adolescents.</p>	<p>New concepts were added to the program.</p>
Goals	<p>N/A</p>	<p>Adolescents set goals for home and school that reflected their cultural values, such as family values.</p>
Methods	<p>The methods of teaching the target skills were modified slightly to reflect cultural concepts like respeto and familismo.</p>	<p>N/A</p>
Context	<p>Culture-specific life and family circumstances were considered, such as immigration status and family acculturation.</p>	<p>Participants were encouraged to consider how their life and family circumstances would impact the at-home application of their new social-emotional learning skills.</p>

Note: Examples are taken from Castro-Olivo & Merrell (2012) and Cramer & Castro-Olivo (2016).

Conclusion

We know that, historically, evidence-based programs were developed and evaluated with white, middle-class, Western participants in mind (Naeem et al., 2019). The lack of focus on the experiences of racialized people can mean evidence-programs don't always meet their needs (Barrera et al., 2017). Cultural adaptation of programs can make them more effective for racialized children and young people than non-adapted programs (Arora et al., 2021; Steinka-Fry et al., 2017). However, before setting out on a lengthy adaptation process, it is important to determine whether the program should be adapted or not. If a cultural adaptation is warranted, engaging community members throughout the adaptation process is essential. When considering how to adapt a program, the Ecological Validity Model (Bernal et al., 1995) can be a useful tool to help identify the various program elements that should be adapted.

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