November 2022

An overview of culturally adapted programs

Knowledge Institute
on Child and Youth Mental Health and Addictions

Suggested citation

Erbach, M., Danseco, E. & Porath Eves, A. (2022). An overview of culturally adapted programs. Knowledge Institute on Child and Youth Mental Health and Addictions. cymha.ca/equity

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Introduction

This overview of culturally adapted programs will address the following:

- What are culturally adapted programs?
- Why are they important?
- What are key issues to consider when adapting programs?
- What other terms are used in this field?

This document will be useful for agency leaders and service providers who want to ensure their programs and services are appropriate and responsive to the needs of racialized children, young people and their families.

Why focus on culturally responsive programs?

What is culture?

There are hundreds of definitions of the word culture (Kroeber & Kluckhohn, 1952). Modern definitions typically emphasize shared values, beliefs and behaviours transmitted from one generation to the next (Matsumoto, 1996). Culture is dynamic and changes across individuals within groups and across time (Matsumoto, 1996).

What are culturally adapted programs?

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 to programs may reflect differences in language, culture, historical context and values (Bernal et al., 2009).

Here are some important points about culturally adapted programs.

- The program being adapted must be evidence-based. Evidence-based programs are interventions that have been shown, in several research studies, to be effective at achieving positive outcomes (Booth & Lazear, 2015).
- Program content and service delivery should be adapted to meet the unique needs and preferences of the specific cultural group. Program content is the substance of the program (the "what"), while service delivery is the process of administering the program (the "how").
- The adapted program must be tailored to a specific cultural group with shared norms, language, traditions or religion.

Why are culturally adapted programs important?

We are more diverse than ever.

Canada's population is increasingly diverse. From 2011 to 2016, the proportion of people living in Canada who reported being a visible minority increased from 19.1% (Statistics Canada, 2011) to 22.3% (Statistics Canada, 2017a). Ontario is even more diverse than the national average, especially among children and young people. In 2016, more than one in three Ontarians under the age of 25 reported being a visible minority (Statistics Canada, 2017a).

The term "visible minority" is often used in government reports and refers to "'persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour" (Statistics Canada, 2017b). The term "racialized" refers to people affected by racial discrimination or racism based on skin colour, religion, language or country of origin (Souissi, 2022). "Racialized" is often used when examining racism and equity (Cokley, 2007).

Racialized children and young people face a number of unique challenges when it comes to mental health services. Here are some examples.

- Factors that disproportionately affect racialized communities, like poverty and geographic barriers, can make it more difficult to access mental health care (Fante-Coleman & Jackson-Best, 2020; Nowrouzi et al., 2015).
- Racialized communities may experience mistrust of healthcare professionals due to historic injustices (Fante-Coleman & Jackson-Best, 2020; Nowrouzi et al., 2015), which can decrease the likelihood of these communities accessing mental health care.
- When racialized children and young people do access services, they can face difficulties finding care that recognizes the intersecting identities and oppressions they experience (Fante-Coleman & Jackson-Best, 2020).

Programs were not designed for racialized communities.

Despite Canada's diverse population and the different needs of children and young people, most evidence-based programs are based on a Western worldview and developed and evaluated with white, middle-class participants (Naeem et al., 2019). This can result in program content and materials that do not meet the needs and values of clients (Barrera et al., 2017). Researchers theorize that non-adapted programs have a poor "fit," resulting in lower rates of enrollment, retention and satisfaction in racialized populations (Barrera et al., 2017). Most concerning is that the lack of diversity in evaluation studies may mean the effectiveness of these programs is not generalizable to other populations. The scarcity of research also means we do not understand how non-white, non-middle-class children and young people experience these programs (Naeem et al., 2019).

Racialized children and young people have higher levels of exposure to

racism (Alegria at al., 2010), which may not be addressed in traditional evidence-based programs. Service providers may avoid discussing their clients' experiences of racism out of fear of saying the wrong thing. They may also feel these experiences are not relevant for their clients' mental health concerns (Rathod, et al., 2019). However, when experiences of culture and racism are not discussed, racialized children and young people may feel dissatisfied and that their needs are not being met (Rathod, et al., 2019).

People from racialized communities report different mental health and substance use outcomes.

Mental health and substance use outcomes vary significantly between groups of racialized children and young people (Mental Health Commission of Canada [MHCC], 2016). However, when racialized populations are combined into one group and compared with white populations, contrasting outcomes between different cultures are lost. Here are a few examples.

- Black children and young people are more likely to be over- or under-medicated and improperly diagnosed than white children (Fante-Coleman & Jackson-Best, 2020).
- East Asian communities reported more discrimination and worse mental health during the COVID-19 pandemic than white populations (Wu et al., 2020).
- Indigenous young people in Canada are more likely to use tobacco, alcohol and cannabis than non-Indigenous young people (Sikorski et al., 2019).

When looking at mental health outcomes in racialized children and young people, it is helpful to consider social determinants of health. Social determinants are social factors that can either increase or decrease a young person's risk of developing mental health or substance use problems (MHCC, 2016). Examples include income, education, culture, age, discrimination, language, economic inequality and food security (Hansson et al., 2009; Lund et al., 2018). Racialized communities are more likely to be exposed to social determinants that increase their likelihood of developing mental health or substance use problems (MHCC, 2016). Increased exposure to social determinants also increases the risk of poor outcomes from mental health treatment.

Culturally adapted programs may improve mental health and substance use outcomes.

There is promising evidence suggesting that culturally adapted mental health programs (Arora et al., 2021) and substance use programs (Steinka-Frey et al., 2017) are more effective for racialized children and young people than non-adapted programs. However, the evidence is not strong enough to demonstrate that culturally adapted programs are always superior.

Certain programs with certain adaptations for certain cultural groups have been shown to be effective, but some research has found no significant differences in outcomes (e.g. Burrow-Sanchez et al., 2015). However, some studies that found no differences in outcomes have reported improved retention or participant satisfaction (Gainsbury et al., 2017). This can indirectly influence the effectiveness of an intervention. Lower drop-out rates mean that children and young people are more likely to receive the full benefits of the program.

In a recent systematic review of 52 studies, Arora and colleagues (2021) found the following:

- Programs adapted for a specific culture were more effective at improving mental health outcomes than programs adapted for more than one cultural group.
- There is a link between a greater number of adapted program components and improved mental health outcomes.

The findings from the literature should be considered within the context of two important limitations.

1. There is far more research on culturally adapted programs for adult populations. More research, including systematic reviews, is needed on young people.
2. There is a lack of rigorous research on culturally adapted programs. Studies comparing adapted and non-adapted programs are needed to better determine the effectiveness of culturally adapted interventions in improving mental health and substance use outcomes for children and young people. Also needed are more rigorous, mixed methods studies using both qualitative and quantitative approaches and explaining how and why culturally adapted programs work.

Culturally adapted programs improve equity.

Culturally adapted programs are an important aspect of improving mental health and addictions services. Implementing these programs is a concrete way to improve access, utilization and mental health outcomes for racialized children and young people in Ontario (Kirmayer & Jarvis, 2019).

Achieving equity requires identifying and addressing unfair barriers to opportunity. Equity can be defined as both a process and an outcome. As a process, equity can be achieved in many ways, such as co-developing with communities the policies and practices that impact their lives, or applying an equity lens or framework to programs and services. As an outcome, equity is the absence of differential outcomes based on social, economic, demographic or geographic characteristics. It is important to note that equity is not the same as equality.

Cognitive behavioural therapy for Indigenous young people

Cultural factors can impact the effectiveness of evidence-based programs. One example is cognitive behavioural therapy (CBT) for Indigenous young people with anxiety (Nowrouzi et al., 2015). This example demonstrates how cultural adaptations could help modify content and delivery to make programs more effective.

CBT is a highly effective treatment for anxiety disorders in young people. Some elements of CBT align with the culture of certain First Nations groups. For instance, both CBT and First Nations' perspectives see the mental, physical and emotional components of health as being intertwined. However, other elements of CBT clash with First Nations' perspectives — like the emphasis on structured, written exercises when First Nations culture involves more oral traditions and narrative elements. CBT may be more effective for First Nations young people if its content is adapted to better align with their culture.

Additionally, young people in First Nations communities may be more likely to experience factors that affect treatment delivery, like poverty, foster care and distrust of healthcare employees due to historical injustices. To increase the effectiveness of CBT, Elders and other community members could work with program developers to improve service delivery and ultimately improve mental health outcomes for Indigenous young people.

What are key issues in developing culturally adapted programs?

In their seminal article, González Castro and colleagues (2010) explored key issues and challenges that must be considered when culturally adapting an evidence-based program.

Challenges in defining the cultural group

When adapting a program, the specific cultural group must be defined. This can be difficult, given the overwhelming number of definitions of "culture." Nonetheless, it is important to identify the target cultural group and not the ethnicity, nationality or race. These terms are not synonymous and should not be used as a proxy for culture. For example,

Black communities in Canada are diverse, representing people from 125 countries with cultural practices and values from Africa, the Caribbean or the United States (Ottawa Public Health, 2020). Adapting a generic program for Black children and young people would be unwise given the variations in cultural practices.

Additionally, population segmentation may be required to narrow a group to a smaller, homogenous subcultural group (Resnicow et al., 2000). For example, instead of adapting a program for First Nations children, it may be more appropriate to adapt a program for children of a specific First Nations tribe.

It may also be necessary to take an intersectional lens and define the cultural group based on multiple shared factors, including ethnicity, nationality, religion, socioeconomic status, immigration status, and any special identity. For example, racialized young people in the juvenile justice system are likely to share developmental experiences such as disrupted families and incarceration. These young people form a subcultural group based on their shared experiences and developmental trajectories, even though they may have diverse ethnicities and nationalities. A culturally adapted program for racialized young people in the youth justice system may be more beneficial than a program adapted for a specific ethnicity.

Challenges in ensuring cultural relevance

The program must be relevant to the cultural group. If not, the retention rates may be low and the program will be less effective. To develop a culturally relevant program, the developer must have a "deep structure" understanding of the specific culture (Resnicow et al., 2000). In other words, the adaptation team must have a solid understanding of the cultural, social, historical, environmental and psychological forces influencing mental health outcomes of the specific culture (Resnicow et al., 2000). Incorporating deep structure factors, like the client's perception of the cause of their mental health condition, can increase the relevance of the program. Members from the cultural group, such as cultural knowledge brokers, can help adapt the content ("the what") and the process ("the how") of the program (Kirmayer & Jarvis, 2019; O'Keefe et al., 2021).

Challenges in maintaining effectiveness

An important challenge when considering culturally adapted programs is the "fidelity-adaptation dilemma." This term refers to differing points of view among researchers regarding the best way to maintain program effectiveness. Fidelity refers to the degree to which an intervention is implemented as originally intended (Carroll et al., 2007).

On the fidelity side of the conflict, some researchers argue that evidence-based interventions work best when administered according to the original design, as the procedure has been tested and validated. On the adaptation side, researchers believe interventions are more effective when they have been modified to be culturally relevant and fit the needs of a specific cultural group.

Both viewpoints have sound merits, and so program developers should aim to strike a balance: culturally adapted programs should be modified to meet the unique needs of a population while maintaining the core components that made the original program effective.

There are also concerns regarding the effectiveness of the adaptation. While efficacy measures how well an intervention works under ideal circumstances (like a highly controlled research study), effectiveness refers to how well the intervention performs in the real world. Culturally adapted programs must be shown to be effective and not merely efficacious.

Additionally, when reporting the effectiveness of interventions, it is crucial to specify which cultural groups the intervention has been shown to be effective for. A statement such as "Program X is effective for producing Y outcomes" is essentially meaningless, as it does not specify who the program has been designed for. A more useful statement would be "Program X has been shown to be effective for producing Y outcomes for Z populations."

Glossary

Many terms are used to describe how culture is addressed in mental health and addictions programs. Terminology in this field is inconsistently defined and constantly evolving. Some researchers have offered definitions and differentiations (see Curtis et al., 2019 and Resnicow et al., 2000), but there are no standard and universally agreed-upon definitions. Certain terms, like culturally responsive and culturally adapted, are treated as synonyms by some researchers but not by others. There can be also contradictory views for the same term, such as cultural competency being seen as a characteristic of individuals (e.g. Bernal et al., 2009) or as a term that applies to programs and organizations (e.g. Cross et al., 1989, Curtis et al., 2019).

In this glossary, we present one definition for each term, noting similarities, issues and the historical context when applicable. This glossary should be treated as a guide that aims to clarify some of the differences between terms. Our goal is for you to feel more confident in selecting an appropriate term for a given situation, knowing that there is no one "right" answer.

Terms to describe individuals

Cultural awareness: Acknowledging that cultural differences exist between people from different cultures, as well as recognizing your personal values and biases (Darroch et al., 2017; Sue et al., 2009).

- To demonstrate cultural sensitivity or cultural humility, you must be culturally aware.
- Typically, definitions of cultural awareness do not require service providers to act in a specific manner. Having an awareness of similarities and differences between people is enough to be deemed culturally aware.
- Cultural awareness emerged as a concept in the 1960s. It gave rise to other terms discussed in this glossary, such as cultural competence, cultural safety and cultural humility (Shepherd, 2019).

Cultural sensitivity: Being aware of cultural differences and acting with respect toward other cultures.

- Sometimes this term is viewed similarly to cultural awareness, although it could be argued that being culturally sensitive requires service providers to go one step further. In addition to being aware of cultural differences, culturally sensitive individuals modify their actions to be respectful (Darroch et al., 2017).
- While many researchers (see Curtis et al., 2019) apply this term to individuals, Resnicow and colleagues (2000) believe this term refers to programs.

Cultural competency: Combines an awareness and knowledge of cultural differences with the skills to provide effective care to diverse populations (Curtis et al., 2019).

- There are many similarities between definitions of cultural sensitivity and cultural competency.
- There are countless definitions of cultural competency (Curtis et al., 2019; Sue et al., 2009), and almost all involve an internal and an external component. To be culturally competent, an individual must:
  - have knowledge of cultural differences (internal).
  - exhibit certain behaviours or skills, like respect (external).
- Some researchers believe that cultural competence is linked to service providers (e.g. Bernal et al., 2009), while others use a definition that evaluates the cultural competency of systems or organizations (e.g. Cross et al., 1989, Curtis et al., 2019).
- A common criticism is that achieving cultural competency is often seen as a static outcome (Kumagai & Lypson, 2009). Opponents of cultural competency ask, "Can you ever be fully competent in another person's culture?"

In addition to being aware of cultural differences, culturally sensitive individuals modify their actions to be respectful.

Cultural humility: Involves three factors: "a lifelong commitment to self-reflection and self-critique"; remedying the power imbalances present in client-provider interactions; and developing partnerships for advocacy (Tervalon & Murry-Garcia, 1998; Waters & Asbill, 2013).

- This term originated in the landmark article by Tervalon and Murray-Garcia (1998).
- The first factor of cultural humility emphasizes that service providers must be humble, flexible and open-minded (Foronda et al., 2015; Tervalon & Murry-Garcia, 1998).
- The second component refers to client-centred care. To be culturally

Attaining cultural humility is not a goal but a continual process (Miller, 2009) in which service providers are always growing and learning from their clients.

humble, service providers must recognize that the client is the expert on themselves and is a capable partner in the client-provider relationship (Tervalon & Murry-Garcia, 1998).

- Terms like "culturally competent" or "culturally aware" have been criticized as they imply there is an endpoint (Tervalon & Murry-Garcia, 1998). Attaining cultural humility is different, in that it is not a goal but a continual process (Miller, 2009) in which service providers are always growing and learning from their clients.

Cultural safety: Focusing on the client's feelings of safety by addressing power imbalances and the effects of colonialism in the healthcare system (Downing et al., 2011). Culturally safe service providers engage in personal reflection to understand their own culture and how it may manifest in their interactions with clients (Downing et al., 2011).

- Cultural safety is a concept originating from Indigenous nurses in New Zealand (Churchill et al., 2020).
- Leaders envision a continuum that moves toward cultural safety (Ramsden, 1992). Previous concepts of cultural awareness, cultural sensitivity and cultural competency have been criticized for promoting stereotyping, normalizing the "othering" of racialized communities and de-emphasizing the structural oppressions influencing mental health outcomes (Churchill et al., 2020). Cultural safety is seen as the next step in providing better, more equitable mental healthcare services.
- Like cultural humility, cultural safety centres on the client. The service provider does not determine safety. Instead, the client decides whether their cultural identity has been protected and whether they feel safe (Downing et al., 2011).

Terms to describe programs

Culturally responsive program: A program that focuses on critical reflection and collaborative relationships between service providers and clients (Smith et al., 2021; Sundar et al., 2012).

- This approach originated in the education sector (Villegas & Lucas, 2002).
- "Culturally responsive" is a broad term that focuses on relationships rather than specific program components or processes. While there are certain characteristics that define culturally responsive programs, these characteristics could be present in both culturally adapted and culturally grounded programs (see definitions, below). We see culturally responsive as an umbrella term.

- Some key characteristics of culturally responsive programs:
  - An affirming attitude toward people of all cultures (Sundar et al., 2012; Villegas & Lucas, 2002).
  - Service providers seeing themselves as responsible for improving equity (Sundar et al., 2012; Villegas & Lucas, 2002).
  - A focus on self-reflection and learning from clients (Smith et al., 2021).

- In keeping with the focus on collaborative relationships and self-reflection, related terms include cultural humility and cultural safety (Smith et al., 2021).

Culturally adapted program: An existing evidence-based program that has been systematically modified to be more relevant to a specific cultural group (González Castro et al., 2010).

- Similar terms include culturally sensitive, culturally appropriate and culturally informed. If any of these terms are used in reference to a program, it means the program has been adapted in some way to better fit the needs of a specific cultural group.

Culturally grounded program: A novel program co-developed with members of the relevant cultural group (González Castro et al., 2010; Lauricella et al., 2016).

When looking at making adaptations to programs, it is helpful to envision a spectrum. At one end, there are culturally adapted programs, and on the other, culturally grounded programs. Differences between the two terms are summarized in the table below. Even though we are presenting the differences, these concepts are not mutually exclusive. Elements of both approaches can be used when making program modifications that increase relevance for racialized communities.

Comparison item	Culturally adapted programs	Culturally grounded programs
Definition	Modifications are made to an evidence-based program to be more relevant to a specific cultural group (Booth & Lazear, 2015; González Castro et al., 2010)	A new program is co-developed from inception to implementation with members of the target cultural group (González Castro et al., 2010; Lauricella et al., 2016)

Program type	Existing program	Novel program
Approach	“Top down”	“Bottom up” or “ground up”
Cultural relevance	May not be as relevant for the specific cultural group	High degree of social and cultural validity, or “fit”
Effectiveness	Interventions are based on a program that has already been tested and validated, so there is evidence to support their effectiveness	Because the program is newly designed, determining effectiveness will be a lengthy process

References

Alegria, M., Vallas, M., & Pumariega, A. (2010). Racial and ethnic disparities in pediatric mental health. *Child and Adolescent Psychiatric Clinics of North America, 19(4), 759–774.*

Arora, P. G., Parr, K. M., Khoo, O., Lim, K., Coriano, V., & Baker, C. N. (2021). Cultural adaptations to youth mental health interventions: A systematic review. *Journal of Child and Family Studies, 30(10), 2539–2562.*

Barrera, M., Berkel, C., & Gonzalez Castro, F. (2017). Directions for the advancement of culturally adapted preventive interventions: Local adaptations, engagement, and sustainability. *Prevention Science, 18(6), 640–648.*

Bernal, G., Jimenez-Chafey, M. I., & Rodriguez, M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice, 40*(4), 361–368.

Booth, C., & Lazear, K. (2015). *Cultural adaptation.* The Cultural & Linguistic Competence Hub of the Technical Assistance Network for Children's Behavioral Health.

Burrow-Sánchez, 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.

Carroll, C., Patterson, M., Wood, S., Booth, A., Rick, J., & Balain, S. (2007). A conceptual framework for implementation fidelity. *Implementation Science, 2*, 40.

Churchill, M. E., Smylie, J. K., Wolfe, S. H., Bourgeois, C., Moeller, H., & Firestone, M. (2020). Conceptualising cultural safety at an Indigenous-focused midwifery practice in Toronto, Canada: Qualitative interviews with Indigenous and non-Indigenous clients. *BMJ Open, 10*, e038168.

Cokley, K. (2007). Critical issues in the measurement of ethnic and racial identity: A referendum on the state of the field. *Journal of Counseling Psychology, 54*(3), 224–234.

Cross, T., Bazron, B., Dennis, K., & Isaccs, M. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed.* Georgetown University Child Development Center.

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S. J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health, 18(1), 1–17.*

Darroch F., Giles, A., Sanderson, P., Brooks-Cleator, L., Schwartz, A., Joseph, D., & Nosker, R. (2017). The United States does CAIR about cultural safety: Examining cultural safety within Indigenous health contexts in Canada and the United States. *Journal of Transcultural Nursing,* 28(3), 269–277.

Downing, R., Kowal, E., & Paradies, Y. (2011). Indigenous cultural training for health workers in Australia. *International Journal for Quality in Health Care, 23*(3), 247–57.

Fante-Coleman, T., & Jackson-Best, F. (2020). Barriers and facilitators to accessing mental healthcare in Canada for Black youth: A scoping review. *Adolescent Research Review, 5*(2), 115–136.

Foronda, C., Baptiste, D.-L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing, 27*(3), 210–217.

Gainsbury, S. M. (2017). Cultural competence in the treatment of addictions: Theory, practice and evidence. *Clinical Psychology and Psychotherapy, 24(4), 987–1001.*

González Castro, F., Barrera, M., & Holleran Steiker, L. K. (2010). Issues and challenges in the design of culturally adapted evidence-based interventions. *Annual Review of Clinical Psychology, 6*, 213–239.

Hansson, E., Tuck, A., Lurie, S., & McKenzie, K. (2009). *Improving mental health services for immigrant, refugee, ethno-cultural and racialized groups: Issues and options for service improvement.* Mental Health Commission of Canada.

Kirmayer, L. J., & Jarvis, G. E. (2019). Culturally responsive services as a path to equity in mental healthcare. *HealthcarePapers, 18(2), 11–23.*

Kroeber, A. L., & Kluckhohn, C. (1952). Culture: A critical review of concepts and definitions. *Papers. Peabody Museum of Archaeology & Ethnology, Harvard University,* 47(1), viii, 223.

Kumagai, A. & Lypson, M. (2009). Beyond cultural competence: Critical consciousness, social justice, and multicultural education. *Academic Medicine, 84*(6), 782–787.

Lauricella, M., Valdez, J. K., Okamoto, S. K., Helm, S., & Zaremba, C. (2016). Culturally grounded prevention for minority youth populations: A systematic review of the literature. *Journal of Primary Prevention, 37(1), 11–32.*

Lund, C., Brooke-Sumner, C., Baingana, F., Baron, E. C., Breuer, E., Chandra, P., Haushofer, J., Herrman, H., Jordans, M., Kieling, C., Medina-Mora, M. E., Morgan, E., Omigbodun, O., Tol, W., Patel, V., & Saxena, S. (2018). Social determinants of mental disorders and the Sustainable Development Goals: A systematic review of reviews. *The Lancet Psychiatry, 5*(4), 357–369.

Matsumoto, D. (1996) *Culture and Psychology. Brooks/Cole.*

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.*

Miller S. (2009). Cultural humility is the first step to becoming global care providers. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 38*(1), 92–93.

Naeem, F., Phiri, P., Rathod, S., & Ayub, M. (2019). Cultural adaptation of cognitive–behavioural therapy. *BJPsych Advances, 25*(6), 387–395.

Nowrouzi, B., Manassis, K., Jones, E., Bobinski, T., & Mushquash, C. J. (2015). Translating anxiety-focused CBT for youth in a First Nations context in northwestern Ontario. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 24*(1), 33–40.

O'Keefe, V. M., Cwik, M. F., Haroz, E. E., & Barlow, A. (2021). Increasing culturally responsive care and mental health equity with Indigenous community mental health workers. *Psychological Services, 18*(1), 84–92.

Ottawa Public Health. (2020). *Mental health of Ottawa's Black community.*

Ramsden, I. (2002). Cultural safety and nursing education in Aotearoa and Te Waipounamu. [Doctoral dissertation, Victoria University of Wellington].

Rathod, S., Phiri, P., & Naeem, F. (2019). An evidence-based framework to culturally adapt cognitive behaviour therapy. *The Cognitive Behaviour Therapist, 12, 1*–10.

Resnicow, K., Soler, R., Braithwaite, R. L., Ahluwalia, J. S., & Butler, J. (2000). Cultural sensitivity in substance use prevention. *Journal of Community Psychology, 28*(3), 271–290.

Shepherd, S. M. (2019). Cultural awareness workshops: Limitations and practical consequences. *BMC Medical Education, 19(1), 1–10.*

Sikorski, C., Leatherdale, S., & Cooke, M. (2019). Tobacco, alcohol and marijuana use among indigenous youth attending off-reserve schools in Canada: Cross-sectional results from the Canadian student tobacco, alcohol and drugs survey. *Health Promotion and Chronic Disease Prevention in Canada, 39(6–7), 207–215.*

Smith, P., Rice, K., Usher, K., & Schutte, N. (2021). Cultural responsiveness for mental health professionals working with Aboriginal and Torres Strait Islander clients: A concept analysis. *Australian Psychologist, 56*(6), 446–457.

Souissi, T. (2022). Racialized Minorities. In The Canadian Encyclopedia.

Statistics Canada. (2011). *Immigration and ethnocultural diversity in Canada.*

Statistics Canada. (2017a, November 1). *Immigration and ethnocultural diversity highlight tables.*

Statistics Canada. (2017b, October 25). *Visible Minority and Population Group Reference Guide: Census of Population, 2016.*

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.

Sue, S., Zane, N., Hall, G. C. N., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525–548.

Sundar P., Todd S., Danseco E., Kelly L.J. & Cunning S. (2012). Toward a culturally responsive approach to child and youth mental health practice: Integrating the perspectives of service users and providers. *Canadian Journal of Community Mental Health, 31(1), 1*–15.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humanity versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor & Underserved, 9*(2), 117–125.

Villegas, A. M. & Lucas, T. (2022). Preparing culturally responsive teachers: Rethinking the curriculum. *Journal of Teacher Education, 53*(1), 20–32.

Waters, A. & Asbill, L. (2013, August). Reflections on cultural humility. American Psychological Association.

Wu, C., Kennedy, E. B., Wilkes, R., Columbia, B., Qian, Y., & Columbia, B. (2020). *Acute discrimination and East Asian-white mental health gap during COVID-19 in Canada. Unpublished manuscript.*

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