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The Centre for Applied Research and Evaluation-International Foundation

Global Position Statement:

Culturally Adapted Interventions in Mental Health

Careif is an international mental health charity that works towards protecting and promoting mental health and resilience, to eliminate inequalities and strengthen social justice. Our principles include working creatively with humility and dignity, and with balanced partnerships in order to ensure all cultures and societies play their part in our mission of protecting and promoting mental health and well-being. We do this by respecting the traditions of all world societies, whilst believing traditions can evolve, for even greater benefit to individuals and society.

Careif believes that knowledge should not only be available to those with wealth or those who live in urban and industrialised parts of the world. It considers knowledge sharing to be a basic human right, where this knowledge can change lives and help realise true human potential. Furthermore there is substantial knowledge to be found in the less developed, rural and poorer areas of the world and this is valuable to the wellbeing of people in areas which are wealthier.

This Position Statement aims to highlight the current position and need for culturally adapted interventions and discusses a global call for action to achieve a standardised mechanism to achieve parity of access and outcomes across all cultural groups.

Background

Globalisation has created culturally rich and diverse societies. During the past several decades, there has been a steadily increasing recognition of the importance of cultural influences on life and health. From a social point of view, politics and the media have recognised the rapid social and cultural changes which accompany migration of people and ideas within and between nations.

Societies are becoming multi-ethnic and poly-cultural in nature worldwide, where different groups enrich lives with their unique culture. Each individual is further influenced by their own experiences and

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an amalgamation of the culture of different subgroups which influences their tolerance and expression of psychological distress as well as their help seeking behaviours and pathways into care. Culture also determines the degree of resilience individuals show in dealing with their problems. The concept of culture, and its influence upon individuals, is itself dynamic, and as individuals and societies change, so do the relevant parts of their culture.

Therefore, from a societal perspective, there is a need to improve the cultural competence of health services enabling them to provide evidence based care, unbiased by views about an individual's majority or minority cultural status and influenced only by respect for their values and world view. Cultural competence in services can be nurtured through an instilled awareness of specific cultures and through cultural adaptation of interventions that are evidence based. In this way, services, individuals and their families can draw strength from their cultural background and increase resilience (Rathod et al., 2015).

Most interventions for mental and physical health disorders, as currently delivered, have been criticised as being West-centric and not in tune with varied cultural beliefs. This is one of the reasons why people from diverse cultural backgrounds are often reluctant to work with clinicians, who in turn, often do not have the confidence or the cultural competence to work with people from diverse cultures. The concept of cultural relevance has, thus, become significantly more important.

With the increasing realisation of the need, cultural adaptation of many interventions for mental and physical health problems has begun (Naeem et al, 2010; Rathod et al. 2013) but this has also highlighted the need for guidance and standardisation of the practice of adaptation through building on the evidence.

What is Cultural Adaptation of Interventions?

Cultural adaptation is 'the systematic modification of an evidence-based treatment (EBT) or intervention (EBI) protocol to consider language, culture, and context in such a way that it is compatible with the individual's cultural patterns, meanings, and values' (Bernal, et al., 2009). Cultural adaptation of an EBI would need to incorporate cultural competence, intelligence and cultural sensitivity, as these would guide the adaptation process. Falicov (2009) described cultural adaptations to evidence-based interventions (EBIs) as procedures that maintain fidelity to the core elements of EBI while also adding certain cultural content to the intervention or its methods of engagement. We would also suggest that the success of such an adaptation should emulate, at least, the effectiveness of the original intervention (Rathod et al., 2015).

Evidence of Benefits of Cultural Adaptation

Work on psychological interventions in a range of conditions has concluded that the outcome of the intervention for minority cultural groups is not as good as for the majority populations (Bhugra, 1997; Rathod et al., 2005) in developed countries. Often individuals from minority cultural groups do not engage with clinicians and interventions due to different attributions to illness symptoms that lead to alternative help-seeking behaviours into care. Even when they begin seeking interventions, they may not complete them for the same reasons.

Few evaluations of the effectiveness of interventions have included adequate numbers of non-Western cultural groups (Alvidrez et al., 1996), and few studies report on adaptations of proven interventions for use by culturally distinct populations. For example, Hispanics and Asians are highly under-represented in research samples (Hussain-Gambles et al., 2004; Miranda et al., 2005; Wells et al., 2001), as requirements of English literacy systematically exclude individuals who do not speak English. Even when language is not an issue, clinical trials on psychological interventions generally enrol few minority clients, and analysis of trial results is usually not done separately based on ethnic group (Carroll et al., 2009).

There are therefore few studies of effectiveness of evidence-based interventions in minority groups. The current criteria for judging good research designs may or may not be feasible for research on non-dominant cultural groups and there are no paradigms for developing measures or for interpreting existing measures to incorporate ethnicity and racialized experiences (Helms, 2015). Therefore, the generalization of findings to many ethnic and cultural groups may not be valid or even appropriate. Under representation of minority groups in research samples is a significant concern that prompted the National Institutes of Health (NIH - a part of the U.S. Department of Health and Human Services) to issue a policy in 1994 (updated in 2001 (NIH, 2001)) mandating that ethnic minorities be included in all NIH-funded research. Despite this, over the last 15 years there have been only a few randomised trials that have been able to demonstrate efficacy of psychological interventions in minority groups (Grant et al., 2012; Ingman et al. 2016).

Despite the potential for cultural mismatch to render treatments ineffective, clinicians and researchers are disseminating psychological interventions globally, across widely diverse cultures (Casas, 1988; Chen et al., 2007; Naeem et al., 2010). Sometimes, local adaptations are made based on local cultural knowledge and some have been successful (Carter et al., 2003; Hinton et al., 2004, 2005; Kubany et al., 2003; Patel et al., 2007; Rahman et al., 2008; Rojas et al., 2007).

Evidence suggests that culturally adapted interventions are effective (Griner and Smith, 2006; Benish et al. 2011) and acceptable (Rathod et al, 2010). However, there remains a lack of consistency in these evaluations as there are currently a number of adaptation frameworks and limited understanding of what aspects of the adaptation have worked.

There have been trials conducted in LAMI (Low and Middle Income) countries demonstrating the efficacy of culturally adapted interventions. These include culturally adapting therapy (Naeem et al., 2010) as well as adapting local resources (Rahman et al., 2008). Although these and similar trials have been successful in showing the efficacy of culturally adapted interventions, they have not been formulated in terms of policy on a local, national or regional basis. Since these have not been utilized on a bigger scale, the effectiveness in generalizable terms remains questionable. This therefore means that apart from some scientific applause, the interventions have not been able to show the true impact, that they have potential for.

What CAREIF proposes

There is an urgent need to review the availability of culturally adapted interventions and available adaptation frameworks. Standardised guidelines including lists or catalogues of resources and some measures of effectiveness and acceptability for different adapted interventions are required. This would not only require a series of round table conferences of experts (including experts with lived experience), but also need empowered communities and patient leaders in a social change movement.

International Level

We have to recognize that the world is rapidly becoming truly global and that challenges of intermingling of different ethnicities, nationalities and cultures has to be addressed in a thoughtful and proactive manner. International organisations have the ability to shape the landscape by influencing global policies in health and social care through promoting the need for culturally competent services that deliver culturally adapted interventions and lead to good outcomes and experiences of every individual.

Government and national level

We believe that governments and political leaders play a key role in influencing and celebrating cultural diversity by addressing stereotypes and valuing cultures. A consistent message of the strength in diversity can mitigate the tendency to dehumanize certain cultural groups and promote healthy respect for all cultures. Where necessary, there should be policies to ensure that appropriate services and interventions are made available.

Better information systems would help; for example, national drug approving agencies could set expectations that new drugs should have data on risk benefit ratios for cultural minorities so that prescription decisions could be more data driven.

Local Service level

Systems of health care should know the cultural breakdown of the population they serve and develop culturally informed services that are inviting to minority cultures in their setting.

There should be monitoring systems in place to identify, address and mitigate cultural disparities in provision of care. This should include means to ensure that staff are adequately trained in culturally competent interventions and reduce the likelihood of the differences in outcomes across cultures. Monitoring of outcomes is essential to understand other factors that may be contributing to these differences and make attempts to impact on them.

Cultural literacy and sensitivity of mental health providers

Cultural competency should be required for all providers of mental health care. The elements of cultural competency should at least include an understanding of psychopathology and idioms of distress for individuals of different cultures but certainly should include the population they serve. Clinicians who provide interventions should be competent in providing culturally adapted interventions.

We recognize that all cultures are dynamic, and adapt to their changing circumstances and hence clinicians should keep their knowledge and understanding current through different means.

Concerted research effort to obtain data on cultural minorities

There should be an effort to include individuals from minority cultures in various clinical trials. Research should encourage a separate sub group analysis of various interventions based on cultural subgroups.

Empowerment of communities

There should be recognition of the need for cultural competence for various cultural groups and a comprehensive set of interventions that are needed to address access, outcomes and stigma. In addition to community outreach and education, individuals from particular cultural groups who have dealt with mental illness (individuals with lived experiences) should be used as ambassadors to spread the education and positive message of culturally adapted interventions. A variety of measures are needed including enlisting the help of religious, political and cultural leaders of that group to have an empowered society.

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