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Summary Report of a Rapid Review

Guidance and an associated action plan to improve access to, and provision of, psychological interventions for people from Black, Asian and minority ethnic communities

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1.0 Executive Summary

The aim of this rapid review is to identify research and guidance on the provision of psychological therapies for members of Black, Asian and minority ethnic communities. These will be used to provide a set of good practice guidelines to improve access to, and the quality of, psychological interventions and build upon and enhance the guidance already provided in Matrics Cymru and Matrics Plant. The review process identified an initial body of 4,379 research papers and grey literature sources (e.g., professional guidelines, government reports). From these, 232 articles were identified as suitable for full text review and after this process was complete there were 19 papers included in this rapid review.

The data suggested that clients from Black, Asian and minority ethnic communities may experience higher rates of mental health difficulties associated with several key predisposing factors. These include socio-economic circumstances (e.g., living in deprived areas), the client's immediate context (e.g., uncertainty regarding repatriation or asylum/refugee processes), and systemic issues related to mental health access and treatment. Here, there are specific issues relating to referrals, such as navigating complex systems, longer waiting times for clients from Black, Asian and minority ethnic backgrounds (e.g., waiting for interpreters to be arranged or clients not being taken off the waiting list by practitioners), and service policies (e.g., placing clients at the bottom of the waiting list if they decline an offered slot, or not allowing for additional time during interpreter-mediated therapy).

In addition, despite the need and potential benefits of psychological therapies, clients from Black, Asian and minority ethnic communities tend to be underrepresented and have poorer access to interventions of this type. Furthermore, when they do access psychological therapies, there tends to be higher non-completion rates and poorer outcomes.

Research evidence indicates that poorer access and outcomes are related to a number of barriers:

- **Client-facing or community-facing barriers,** such as individual or community-based stigma about mental health problems or community-based mistrust about mental health services, reluctance to engage with them, and concerns about the implications of engagement.

- **Organisational or service-based barriers,** such as service pathways to referral being challenging to navigate (Harwood et al., 2023; Mind, 2010; Mind, 2013; Lawton et al., 2021 & Beck & Naz, 2019) or longer waiting times for members of these communities (Memon et al., 2016; Costa, 2022 & Faheem, 2022),

- **Therapist-facing barriers,** such as therapists being avoidant or anxious about discussing pertinent aspects of the client's culture or identity or a lack of training in culturally adapted therapies, in part due to core training not addressing this topic or a lack of Continuing Professional Development.

- **Therapeutic approach barriers,** for example, the generic application of a Western, individualistic therapeutic approach without consideration of the client's culture, background, or identity.

A number of studies in this review have described attempts to address these issues with the development and piloting of culturally sensitive or culturally adapted psychological therapies:

- **Culturally sensitive psychological therapies** tend to look much more like the psychological therapy provided to majority service users, but with adaptations made on a case-by-case basis by therapists, service users, or interpreters. For instance, when helping a client increase their activity levels, including activities that are culturally appropriate and in keeping with their identity.

- **Culturally adapted psychological therapies** involve retaining the active components of the psychological therapy while incorporating elements of the distinct and culturally mediated aspects of the way that mental health problems are expressed and understood. For instance, exploring and integrating cultural norms and behaviour into psychological therapy for a community group.

The available research indicates both culturally sensitive and culturally adapted psychological therapies have shown positive results in terms of accessibility, appropriateness, acceptability and outcomes. It is of note however, that there is still limited research on the efficacy of such interventions across distinct cultural communities. The literature also supports the utilisation of more community based collaborative approaches to service development to remove access barriers and improve outcomes. On the basis of this rapid review, we suggest eight recommendations to assist in the provision of psychological interventions for diverse cultural groups (see page 32 for full details).

1. Therapists and service leads should consider adopting existing models for developing culturally appropriate interventions. For example, Bernal et al's ecological model for the cultural adaptation of psychotherapeutic interventions (Bernal, Bonilla, & Bellido, 1995).

2. Therapists should adopt a collaborative, 'knowledge exchange' approach to intervention when a client's cultural background is unfamiliar to them.

3. Imagery, proverbs, metaphor, stories, and other narratives can be utilised as important tools for clients to vocalise and understand their experiences and distress, and somatisation of distress is also more likely in some ethnic groups.

4. Therapists should establish the client's perspective on their safety, both physical (e.g., fear of harm, repatriation) and psychosocial (e.g., stigma, confidentiality) as a key feature of therapy.

5. Community stakeholders (e.g., faith leaders, third sector organisations) should be involved in discussions about developing and delivering interventions.

6. There should be utilisation of tools to facilitate a culturally-minded approach to practice and research. For example, the template to guide the development of a culturally adapted or culturally sensitive psychological therapy (Fig 2, p33).

7. A culture of evidence-based practice and practice-based evidence should be embedded across the full scope of mental health services.

8. Guidelines such as the Medical Research Council framework for developing and evaluating complex interventions for diverse cultural groups, should be utilised when evaluating service provision.

2.0 Introduction / Background Rationale

There is a large body of evidence to suggest that there are healthcare inequalities experienced by individuals within the Black, Asian and minority ethnic communities, and this is also apparent within mental health service provision. Wales is no exception, with such issues being identified here. For example, the Wales Centre for Public Policy states that; 'Racial and ethnic minority people in Wales experience disparities in mental health and wellbeing and access to mental health care, particularly among refugees and asylum seekers' (Policy Briefing March 2021: www.wcpp.org.uk). There is certainly a need to address these disparities, and the Welsh Government is committed to ensuring that health care is equitable for all (Anti Racist Wales Action Plan Anti-racist Wales Action Plan | GOV.WALES). One particular issue of concern relates to access to, and the provision of, psychological interventions to those from ethnic minority communities. The current report has a focus not only on conceptualising the nature and extent of this problem, but also on reviewing good practice guidelines from a variety of sources in order to inform provision within Wales.

2.1 Diversity within Wales

To understand the Welsh context, it may be beneficial to explore the demographics within our nation. The most recent census data reveals a rich tapestry of diversity, emphasizing the nation's multicultural fabric and its evolving demographic landscape (ONS, 2023).

For instance, in terms of high-level ethnic group categories, the percentage of the population who identified as:

- "White" ethnic groups was 93.8%
- "Asian, Asian British or Asian Welsh" ethnic groups was 2.9%
- "Mixed or Multiple ethnic groups" was 1.6%
- "Black, Black British, Black Welsh, Caribbean or African" was 0.9%
- "Other ethnic groups" was 0.9%

Language diversity is another prominent aspect highlighted by the census. In Wales, 96.7% of usual residents spoke English or Welsh as their main language. The remainder selecting a variety of other language, with the top 10 most spoken being Polish, Arabic, Romanian, Bengali, all other Chinese, Portuguese, Spanish, Bulgarian, Italian and Turkish to mention a few.

In terms of high-level religious categories, the percentage of the population who identified as:

- No religion - 46.5%
- Christian - 43.6%
- Muslim - 2.2%
- Buddhism - 0.3%
- Hinduism - 0.4%

- Other religious group - 0.7%
- Not stated - 6.3%

Attempting to summarise all aspects of diversity identified in the census is not feasible within this introduction; however, we would encourage individuals to explore the comprehensive census report for a detailed and thorough understanding of the diverse demographics encompassing ethnicity, language, religion, and nationality in Wales.

2.2 Lower Access and Outcomes Rates to Psychological Therapies

There is a lack of research into the access and outcome rates for clients from Black, Asian and minority ethnic communities for psychological therapy services in Wales. This is not uncommon within the UK as there is also a notable lack of research on access and outcomes to psychological therapies for Black, Asian and minority ethnic clients and communities in Scotland and Ireland, highlighting the need for further investigation and understanding in these regions. However, for the purposes of this rapid review, the data from NHS England and the Talking Therapies (IAPT) initiative provides some useful insights and inferences from a similar context.

Data from England shows clients from diverse backgrounds tend to have lower access rates, lower completion rates and poorer outcomes within IAPT services than White British clients (Baker & Kirk-Wade, 2023). This trend is true across the years as individuals who identified as White British were more likely to complete treatment and improve than those from any other background between 2018-2019 (Ahmad et al., 2021). Poorer outcomes were reported for clients from Yemini, Pakistani and Somali backgrounds (Arafat, 2021) and women of Pakistani backgrounds (Kapadia et al., 2017). In addition, clients from Black Caribbean, Black Other and White Other groups were more likely to be referred to other services than be treated within IAPT (Harwood et al., 2021). Bhavsar et al. (2021) noted that individuals residing in the UK for less than 10 years are less likely to engage with IAPT services, even after accounting for factors such as English proficiency or reason for moving.

Whilst these trends may be associated with a variety of causes, Rathod et al., (2015) highlight the risks of clients disengaging or having poorer outcomes when psychological therapies are continually delivered in a generic way as it creates a perception or experience that their culture or they themselves are not understood. Moreover, delivery of psychological therapies in a manner that doesn't account for clients' culture and identity could obstruct the process of change especially if the therapists' explanations are contradictory or not acceptable to the client's cultural model (Jameel et al., 2022). For example, something that might seem simple such as enquiring about 'going out for a drink on Friday night' would be outside of some clients' experience or the teachings of their faith, and therefore could run the risk of alienating those clients.

While the focus of certain results or discussions may predominantly revolve around England, it is important to recognise that many findings and observations in the context of healthcare, history, and other areas can often be applicable to Wales as well. Even though these are distinct healthcare systems with variations in policies and practices, England and Wales share a significant amount of context and a shared history that make it possible to draw parallels between the two countries.

2.3 Provision of Culturally Appropriate Psychological Therapies

Given the crucial role that psychological interventions play in mental health care, there is a need to identify inequalities in access, appropriateness, acceptability and outcomes for such interventions within Black, Asian and minority ethnic communities.

Within England, The Black, Asian and minority ethnic Positive Practice Guide (Beck et al., 2019) encourages services and clinicians to proactively work to address such issues through service level changes, outreach, audits, developing staff and ensuring culturally appropriate psychological therapies.

In contrast, the provision of psychological interventions in Wales for adults is guided by Matrics Cymru which was designed to assist planning and delivering evidence-based psychological therapies within local authorities and health boards in Wales, including commissioned third sector and independent sector services. It provides guidance to support greater quality and consistency in the delivery of psychological therapy across Wales. Matrics Plant has been designed for practitioners working in psychological services for children, young people and families to assist in the development, planning and delivery of a Wales wide approach to providing psychological services to children, young people and their families. This requires an evidence-based theoretical framework to guide the provision of a range of interventions, in addition to the delivery of direct therapy specific interventions. Both guidance documents acknowledge the important of equitable provision and the need for reasonable adjustments. However, what is currently unclear is whether the recommended range of psychological interventions are accessible and appropriate for mental health service users and families from BAME communities. There is a clear need to supplement current best practice guidelines in Wales with data relating to these minority communities.

2.4 Aims of the Rapid Review

The purpose of the current project is to review existing research and good practice guidelines in relation to psychological therapies for Black, Asian and minority ethnic communities. This will be used to provide a set of good practice guidelines to inform the Matrics Cymru and Matrics Plant national guidance for the delivery of psychological interventions.

2.5 An Important Note about Terminology

The terminology we use when talking about race and ethnicity can have real world impact and an influence on policy. Therefore, due consideration is being given to the language and terminology being used within this report. There is a recognition that terms such as Black, Asian and minority ethnic communities may be unhelpful for some (Milner & Jumbe, 2020); however, alternative terms used to describe racially minoritised populations may not provide a term that conveys the multiple facets of diversity or may not be in common usage (Lawton et al, 2021).

Therefore, in this rapid review, whenever possible, specific language will be utilised to describe ethnic, religious, or linguistic groups to which we refer. We will only resort to using collective terminology when there is a legitimate need to do so, such as when summarising studies which use such terms, e.g., BAME to describe Black, Asian and minority ethnic communities. In instances requiring collective terminology, our decisions will always be guided by the context at hand, and we will refrain from adopting a generic term. If the context does not provide a decisive direction, we will interchangeably use collective terms such as 'Black and minority ethnic,' 'ethnic minority,' or 'Black,

Asian, and minority ethnic.' This approach acknowledges the fact that no single term is universally suitable for all our stakeholders and serves to uphold the dignity of individuals and communities. We urge practitioners, researchers, and all other stakeholders in mental health in Wales to be mindful of the terminology they use to describe people from different ethnic, cultural, and faith groups and to consult groups and individuals about the preferred terminology, where possible.

In addition, consideration has been given to the terminology used to describe individuals accessing psychological therapies. Various terms are in common usage, and the terminology is widely debated with no universally accepted term (Simmons et al., 2018). Commonly used terms include "experts by experience," "those with lived experience," "patients," "clients," "service users," "citizens," and many others. However, some alternative terms may not be in common usage or adequately convey the diverse spectrum of individuals engaging with psychological therapies. Therefore, throughout this review, these terms will be employed interchangeably to encompass the diverse spectrum of individuals involved in therapeutic interventions, irrespective of the specific terminological choice utilized.

3.0 Research Methodology

This was a rapid review although elements of systematic review methodology were applied. A rapid review is best described as a brief synthesis and judgement of available research evidence related to a specific question or questions, which is appropriate for studies aiming to identify the trends and patterns accompanied by cautious interpretations (Booth, 2015). Rapid reviews are inherently more susceptible to bias than full systematic reviews, however the risk of bias in this review was minimised through:

- Stage 1 – Development of a search protocol in collaboration with the expert reference group.
- Stage 2 – Literature search and initial screening.
- Stage 3 – Full text screening of studies identified in stage 2.
- Stage 4 – Data extraction and quality assessment of studies retained after stage 3.
- Stage 5 – Synthesis of results and report including guidelines for inclusion in the existing Matrics documents.
- Stage 6 – Feedback to PHW and presentation of a final report including consideration of recommendations for next steps in Wales including a draft action plan.

3.1 Rapid Review Protocol

As this is a rapid review, we did not seek to pre-register the protocol; however, the protocol has been developed according to the Prospero gold standard guidelines for transparency and minimisation of the risk of bias in systematic reviews as set out below.

Review question

1. The rapid review aims to provide up-to-date evidence on accessibility, appropriateness, acceptability and outcomes of psychological therapies for those from Black, Asian and minority ethnic communities.

2. The review aims to provide evidence of both good practice and barriers to good practice.

3. The evidence will be narratively synthesised to provide recommendations for future guidelines for gold standard provision.

Search strategy

Garritty et al. (2021) recommend limiting rapid review searches to the 3 main databases (i.e., MEDLINE, CENTRAL, and EMBase), only supplementing the searches with additional, specialised, databases if necessary. We chose to search MEDLINE (via PubMed) and EMBASE, as well as some psychology/social science databases (i.e., PsycINFO, PsychArticles, Psychology database, Academic Search Complete, & ASSISA) because we expected these to be appropriate for our specific topic.

Grey literature searches were conducted through the following databases:

- BASE - https://www.base-search.net/
- CADTH - https://www.cadth.ca/about-cadth
- CORE - https://core.ac.uk/
- EThOS - https://ethos.bl.uk/Home.do
- TRIP Database - https://www.tripdatabase.com/Home

Hand Searches were also carried out: e.g., reference sections of identified studies, National Institute for Health and Care Excellence (NICE), Professional bodies such as the British Association for Behavioural and Cognitive Psychotherapies (BABCP), British Association of Counselling and Psychotherapy (BACP) and the British Psychological Society (BPS).

Search Terms

The databases were searched using predefined terms relating to the inclusion and exclusion criteria that have been predetermined for this rapid review using the PICOS formula (see appendix 1). Key terms were combined using the Boolean operators "AND", "OR" and 'NOT". In addition, due to the ubiquity of some search terms (mental health, intervention, culture), an additional parameter was placed on the searches, that being that the search only returns papers that include the search terms in either their title, abstract, or keywords.

Furthermore, we utilised valuable insights and knowledge of key stakeholders, to not only direct us towards pertinent grey literature sources but also to contribute to the process of refining and enhancing our search terms. These comprised of an Expert Reference Group made of clinicians and members of the Welsh Government and Wales Alliance for Mental Health Ethnic Minorities task and finish group, and the NHS Wales Executive.

Types of studies included:

- All study designs were included
- Papers must be available in English
- Studies must relate to individuals from Black, Asian and minority ethnic (sometimes referred to as BAME) communities
- Studies must be reporting on evidence based psychological interventions
- Grey literature

Condition or domain being studied

Accessibility, appropriateness and effectiveness of psychological intervention services for individuals from Black, Asian and Ethnic Minority backgrounds.

Participants/population

Participants will be members of Black, Asian and Minority Ethnic communities, or the grey literature guidance refers to members of Black, Asian, or Minority ethnic communities. Any gender and all ages (e.g., child, adolescent, adult, older adult) were included.

The search terms included: (BAME OR BME OR "{GLOBAL MAJORITY}" OR "{Racial minority}" OR racial* OR Minorit* OR "{ETHNIC MINORITY POPULATION}" OR ETHNIC* OR "{Diverse population}" OR "{ethnic minority}" OR Indian OR Pakistani OR Bangladeshi OR "Sri Lankan" OR Asian OR "south Asian" OR BSA OR "British south Asian" OR "south east Asian" OR Caribbean OR "African Caribbean" OR Irish OR Chinese OR Refugee OR Asylum* OR Gyps* OR Roma* OR Traveller OR Japanese OR Malaysia* OR Indonesia* OR Arab* OR Nepal* OR Iran* OR African OR Albania* OR Iraq* OR Afghan* OR Syria* OR Somali* OR Polish OR Palestin* OR Sudanese OR Yemeni OR Egyptian OR Vietnamese OR Black OR "mixed heritage" OR "{mixed race}" OR "{mixed ethnicity}" OR "{displaced people}").N.B, please see appendix a for full search strategy.

Intervention(s), exposure(s)

Psychological interventions incorporated evidence-based approaches (e.g., psychological therapies, counselling, psychological interventions, Cognitive Behavioural Therapy: CBT).

Comparator(s)/control

N/A

Context

Any level of healthcare (e.g., primary, secondary, & tertiary).

Geographical context: only research based in the United Kingdom was included due to potential generalisability issues owing to cultural and Health Service differences between the U.K. and other countries.

Main outcome(s)

Reporting on factors relating to the accessibility, appropriateness, acceptability and/or outcomes of psychological interventions for Black, Asian, or Minority ethnic populations.

Measures of effect

N/A

Additional outcome(s)

N/A

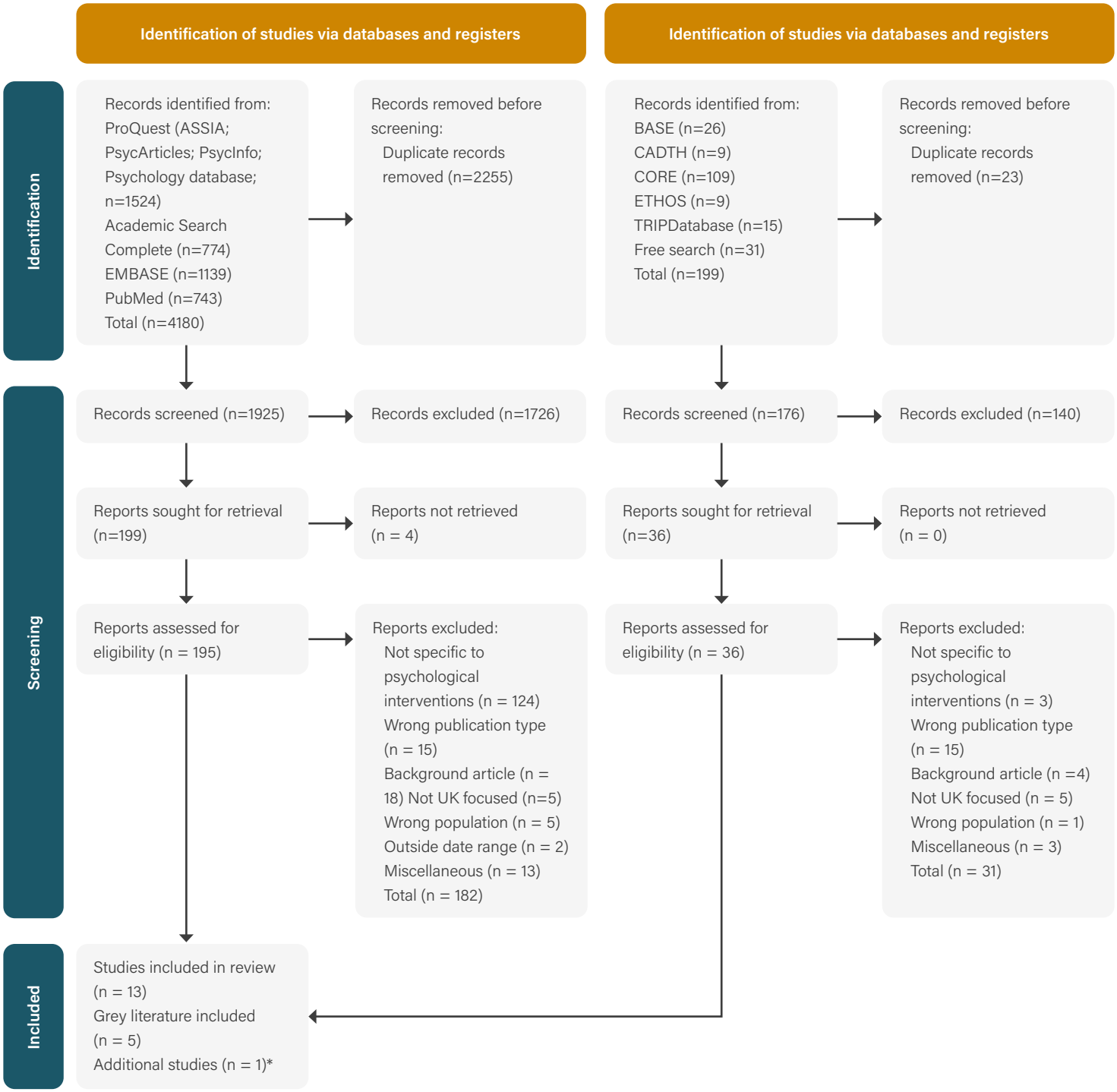
Additional terms

Terms related to mental health and well-being were also incorporated to further limit the search results to relevant papers.

Data selection and coding

Retrieved papers were entered into endnote to remove duplicates and then exported to Rayyan (a software platform for carrying out systematic reviews). The reviewers (TK, JM, SG, DL, PT, BJ, GRD) independently carried out the title and abstract screening, removing studies that did not meet the inclusion criteria. Following this, the full-text screening took place, and papers were evaluated against a predefined checklist and papers that did not meet this checklist were excluded. At all stages papers were evaluated by two reviewers. When a disagreement arose, the reviewers discussed the divergence until agreement was reached.

Figure 1. Prisma Flow Diagram:* this depicts the stages of extraction from initial searches, through to the number of studies included in the final rapid review.



*One member of the study team read a case-study article and subsequently located the empirical article where the intervention referenced in the case-study was developed.

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit: http://www.prisma-statement.org/

3.2 Data synthesis

Information on data extraction, synthesis and quality assessment / risk of bias.

Data extraction

Important data from each source was extracted to inform the quality assessment process. This included details of the:

1. Title, authors, date of publication and journal or report (grey literature).
2. Aims and objectives.
3. Method (design, control, randomisation (if applicable).
4. Population (recruitment and inclusion criteria).
5. Intervention (theoretical rationale, procedure, delivery, and setting).
6. Outcomes and conclusion country of origin, type of study, participants.
7. Methodology, intervention features and results.

See appendix 2 for the full data extraction table.

Risk of Bias (Quality assessment)

Following data extraction, risk of bias (quality assessment) was carried out. This followed the method outlined in the MIXED METHODS APPRAISAL TOOL (MMAT; Hong et al., 2018). This tool is designed to support critical appraisal of studies included in a review where there are qualitative, quantitative, and mixed methods studies. As the current review extracted a mix of qualitative research, randomised controlled trials, non-randomised studies, quantitative descriptive studies, and mixed methods studies, this tool was appropriate to facilitate our critical quality appraisal of the studies. Detailed coverage of the MMAT is available in the MMAT manual, which is available via this link: http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/127916259/MMAT_2018_criteria-manual_2018-08-01_ENG.pdf)

In line with the MMAT, when starting the review for each paper, regardless of methodological approach, the reviewer first considered and answered 'Yes', 'No', or 'Can't tell' to two screening questions: 1) whether there are clear research questions and 2) whether the collected data addressed the research question. The MMAT advises that further evaluation is not appropriate or feasible if the answer to either of those questions is 'No' or 'Can't tell' because such a paper is unlikely to be presenting an empirical research study. No papers in the present review were rated as 'No' or 'Can't tell' on those questions. The subsequent questions for reviewers to consider in their quality assessment differed depending on the methodology of the paper in question. For example, qualitative study assessment criteria involved considerations such as whether this approach was appropriate for the research question, and whether the interpretations were substantiated by data. Randomised controlled study criteria included questions enquiring about randomisation, blinding, and group equivalence at baseline. Non-randomised study questions enquired about the representativeness of the sample, the completeness of outcome data, the presence of and confounders. Quantitative descriptive study questions enquired about sampling

strategy, nonresponse bias, and the appropriateness of analyses. Finally, for mixed-methods studies, questions enquired about the integration of methods and results, and whether the qualitative and quantitative elements of the study adhered to the quality criteria of their respective traditions.

NB: Our search indicated that research into access to, and provision of, psychological interventions to people from Black, Asian and minority ethnic communities contains many qualitative and exploratory studies. There are several studies that would not be rated as good or fair according to the risk of bias criteria but still contain valuable information that will contribute to recommendations for good practice. Therefore, we did not exclude studies based on the outcome of the risk of bias assessment. Instead, we have commented on their limitations and raised points for caution in interpretation, where appropriate.

Strategy for data synthesis

Our data extraction demonstrated that a quantitative analysis of the findings was not possible due to the heterogeneity of the included studies. Instead, a formal descriptive/narrative synthesis of the studies is provided based upon the main outcomes of the extracted papers.

4.0 Results

4.1 Study Characteristics

The 19 studies included in this review consist of 1 guidance document and 18 empirical studies. Of the 18 empirical studies, 14 were focused on clients, 2 focused on therapists, 1 was a scoping / rapid review and 1 focused on clients, family members, advocates and professionals. Detailed tables representing these subsets of studies are provided in the Appendices (see pages 53-94). Table 1 below presents the 19 studies, followed by: 1) summaries of the findings from the qualitative research and the quality of that research, and 2) summaries of the findings from the quantitative research and the quality of that research.

Table 1: Key Characteristics of the Included Studies

Author, Date	Study Design & Population	Research Aims/Focus	Main Outcomes
Bahu, M. (2019)	Pre test post test Comparison over time. Non randomised. Clients	Evaluate culturally adapted cognitive therapy group programme for Tamil refugees and asylum seekers in the Wandsworth IAPT (Improving Access to Psychological Therapies) service	A positive change in the wellbeing of participants was indicated by a reduction in the severity of negative thinking for all metrics
Coelho et al (2022)	Rapid Scoping Review of published qualitative research	To describe the nature and scope of qualitative research about the experiences of children and young people from ethnic minority backgrounds in seeking or engaging with mental health services	Identified barriers to receiving help include: lack of awareness/knowledge of MH conditions and their causes; lack of trust in care professionals; lack of information about services; social stigma; culture/community/religion as specific reasons for not seeking help
De la Cruz et al. (2015)	Pre test post test. Quasi-experimental. Non randomised. Clients	The aim of this naturalistic study was two-fold. First, to compare the clinical characteristics of a sample of White vs. non-White children and adolescents with Obsessive Compulsive Disorder (OCD) treated at a national specialist clinic in the UK. Second, to test whether the outcomes of a multimodal, evidence-based treatment for OCD (CBT with or without SRI medication) were comparable in both groups.	The clinical presentation was similar in White and non-White patients. Both groups received a similar number of CBT sessions and similar proportions were on concomitant SRI medication. Both groups improved similarly with treatment and similar proportions were classed as responders and remitters. Youths from ethnic minorities with OCD were indistinguishable from their White counterparts in nearly every respect and responded equally well to evidence-based treatment.
Durà-Vilà et al. (2013)	Prospective study, Quasi-experimental. Non randomised. Clients	Investigate whether the background and living situation for young refugees differed according to the duration of settlement; secondly, to investigate the importance of duration of settlement on the level of psychological distress and treatment uptake and progress. The third aim was to investigate the outcomes of psychological interventions	A comparison of the teachers' and parents' mean Strengths and Difficulties Questionnaire (SDQ) scores of the study's young refugee sample and a national study representative of Great Britain as a whole showed that young refugees have higher scores in total problem and all subscales' scores than the British scores.

Author, Date	Study Design & Population	Research Aims/Focus	Main Outcomes
Edge et al. (2018)	Mixed Methods Feasibility Study Clients	To describe the development, implementation and acceptability of a Culturally adapted Family Intervention (CaFI) for African-Caribbean people diagnosed with schizophrenia and their families.	CaFI, as delivered by the team, was acceptable to service users and family/FSMs in terms of both content and session length. Delivery was acceptable across community and in-patient settings; delivery was acceptable by both psychologists and non-psychologists (but non-psychologists may require more training to improve experience for family/FSMs
Faheem (2023a)	Qualitative interviews and thematic analysis Therapists	To explore whether practitioners working for Improving Access to Psychological Therapies (IAPT) services are culturally competent to deal with the needs of diverse communities	Out of sixteen participants, only nine therapists received one-day formal training throughout their therapeutic career, whilst seven reported receiving no cultural competence training at all. Overall, three themes were generated: **Theme 1: Encountering cultural dissonance within therapy.** **Theme 2: Challenges in making cultural adaptations to therapy.** **Theme 3: Identifying cultural competency needs.** Subthemes included cultural expression of distress; patient therapeutic expectation; recognising cultural challenges beyond the therapy room; service users' therapeutic expectations; and the challenges therapists encountered trying to explain Western notions of therapy
Faheem, (2023b)	Qualitative interviews Reflexive Thematic Analysis N=9 Past clients	To explore whether evidence-based psychological interventions offered by IAPT services are suitable to the needs of BAME communities	Whilst most service users did not fully recover, they found therapy useful and would recommend it to others. Three over-arching themes were generated: **Theme 1: Recognising cultural dissonance within therapy.** **Theme 2: Developing cultural competency.** **Theme 3: The road to recovery**
Golker & Cioffi (2021)	Qualitative interviews and thematic analysis Therapists N=5	(1) To explore how CBT therapists work with the religious beliefs and practices of Orthodox Jewish clients. (2) To discover the challenges faced by Orthodox Jewish clients when accessing psychological treatment. (3) To consider the ways in which CBT can be culturally adapted to meet the needs of the Orthodox Jewish community	Analyses yielded 4 main themes with 12 sub-themes **Theme 1: Cultural understanding:** Role of culture; Individual experience. **Theme 2: Confronting shame:** Combating stigma; Normalising therapy; Heightened confidentiality. **Theme 3: Building trust:** Suspicious attitudes; Cultural sensitivity; Therapeutic relationship. **Theme 4: Religious beliefs:** Religious compatibility; Incorporating religious teachings; Scrup¬ulosity; Rabbinic guidance.

Author, Date	Study Design & Population	Research Aims/Focus	Main Outcomes
Gurpinar-Morga et al. (2014)	Qualitative, phenomenological, and idiographic design. Clients N=5	Gain insight into the views and experiences of BME young people accessing mental health services regarding ethnicity and the ways in which they feel it may be important to the therapeutic relationship. Participants had received CBT	**Theme 1: Impact of client ethnicity on relationships and sense of self: understanding the presenting difficulties.** Therapists must acknowledge the potential role of ethnicity in clients' presenting problems, but they must not assume it will be relevant to all clients. **Theme 2: Talking about ethnic differences: establishing the foundations or testing them?** Clients want to acknowledge ethnic differences between themselves and the therapist. They do not want them to be ignored. Acknowledging these differences can aid the therapeutic relationship. **Theme 3: Implications of having an ethnically dissimilar therapist.** The ethnicity of the therapist may be less important than their personality and general demeanour. **Theme 4: Expectations of an ethnically similar therapist.** Participants expected that having an ethnically similar therapist would make it easier to open up to them and the therapist would be more likely to understand their difficulties.
Hammad et al. (2020)	Service evaluation of 2 coproduced interventions using a mixed methods design Clients Group 1 – 10 participants Group 2 – 6 participants	1) To try to understand and address the barriers encountered by a group of MENA origin Muslims in accessing mental health services. 2) To co-produce a culturally appropriate therapeutic group intervention utilising culturally appropriate modes of coping with trauma and loss that is responsive to the needs pf the Grenfell affected MENA Muslim communities. 3)To assess the impact and participant experience of the interventions.	**Intervention 1** encouraged engagement and retention of participants with negative attitudes toward therapy and challenged the stigma attached to mental health and help seeking. Participants reported positive changes in attitudes toward therapy and went on to access individual therapy and their children in need also accessed therapy. The findings suggest that the intervention fostered building of trust, greater awareness of mental health, improved emotional regulation, strengthening of social support networks, reduced social isolation, and the activities promoted wellbeing. **Intervention 2** improved psychological wellbeing, emotional expression, and emotional regulation, recovery/healing, behavioural activation, resilience, the strengthening of social support networks, personal growth, and coping with trauma and bereavement. The intervention was found to reduce social isolation and distress including Grenfell related distress
Jidong et al. (2022)	Randomised Controlled feasibility trial Clients	Whether 'Learning Through Play in combination with Culturally adapted Cognitive Behaviour Therapy' is acceptable and culturally appropriate for treating maternal depression compared with 'Psychoeducation' in British mothers of African and Caribbean decent	The culturally adapted therapy group showed higher acceptability, feasibility and satisfaction levels than the psychoeducational group) (NB: no inferential statistics applied)

Author, Date	Study Design & Population	Research Aims/Focus	Main Outcomes
King & Said (2019)	Pre test post test Comparison over time. Non randomised. Clients N=14	To evaluate acceptability and suitability of a psychological skills (CBT based) group developed for unaccompanied asylum-seeking and refugee young people using routine outcome monitoring, attendance data and feedback from young people	Attendance over 35 weeks was 65% Qualitative feedback was positive Outcome data appear positive but were incomplete and measures used might not be appropriate for the specific client group
Masood (2015)	Qualitative interviews Thematic analysis Clients N=17	To assess the acceptability and overall experience of the Positive Health Programme (culturally adapted CBT) by British South Asian mothers	Barriers to attendance & engagement included: lack of support from husbands; childcare & transport difficulties; domestic chores Positives included: facilitators spoke Urdu; group sessions empowering Overall, intervention appears acceptable to target population
Mir et al (2015)	Qualitative interviews Thematic Analysis Clients, therapists, other health professionals	1. Develop a faith-sensitive adaption of Behavioural Activation for Muslim clients and 2. Test the feasibility and acceptability of the adapted intervention.	The adapted intervention may be more appropriate for Muslim patients than standard therapies and is feasible in practice Core elements of the BA model were acceptable to Muslim patients. Religious teachings could potentially reinforce and enhance BA strategies and concepts were more familiar to patients and more valued than the standard approaches Therapists needed more support than anticipated to implement the intervention
Phillips & Andriopoulu (2022)	Qualitative interviews Thematic Analysis Clients	To gain an understanding of the experiences of SA women who have used MH services; to explore how culturally sensitive services were and the impact of this upon experiences; and to provide recommendations regarding how services can best meet the needs of SA women and be sensitive to cultural differences.	Analysis yielded an overarching theme of "degree of understanding" and three main themes: "shared background and understanding" "humanity" and "cultural factors" Recommendations are entirely co-produced with participants and include: be understanding; improve diversity training; work with and learn from experts; incorporate faith; and be proactive practitioners
Phiri et al. (2023)	A non-randomised quantitative study, comparison over time Clients	To investigate the feasibility and acceptability of a culturally adapted, CBT-based, third-wave therapy manual using the Comprehend, Cope, and Connect approach with individuals from a diverse population presenting to primary and secondary healthcare services	Hospital Anxiety and Depression Scale (HADS) depression, HADS anxiety scores, and CORE (Clinical Outcomes in Routine Evaluation) total score and WHODAS (World Health Organization Disability Assessment Schedule) significantly reduced from baseline. Overall, the experience of treatment was independent of the changes in the outcome measures
Rathod et al. (2013)	Randomised Controlled Trial (RCT) Clients	A culturally adapted form of CBT was used to treat minority groups (Black British, Black Caribbean, African Caribbean, Pakistani & Bangladeshi) presenting with psychosis.	Post-treatment, the intervention group showed statistically significant reductions in symptomatology on overall Comprehensive Psychopathological Rating Scale scores. The adapted CBT was viewed positively.

Author, Date	Study Design & Population	Research Aims/Focus	Main Outcomes
Rathod et al. (2019)	Guidance document	Discusses the process, foci and framework of cultural adaptation of CBT.	Describes an evidence-based framework for adapting CBT for individuals from non-Western cultures that will benefit clinicians who practise CBT and individuals from different cultural backgrounds.
Vincent et al. (2013)	Qualitative interviews Interpretative phenomenological analysis Clients	This study considers the acceptability of Trauma Focused CBT for asylum-seekers with PTSD by exploring their experiences of this treatment.	All participants described finding TFCBT extremely difficult, but most participants also reported benefits. Factors impeding engagement with therapy included: uncertainty about the future/fear of repatriation; perceived powerlessness of the therapist to help; lack of progress; negative implications of accepting past trauma; perceiving attending therapy as failure Factors encouraging engagement included: having extensive difficulties; belief that disclosing trauma would aid recovery; trusting therapists' professional skills. Importance of the therapeutic relationship was highlighted. E.g. practical support from therapists was valued because it indicated 'genuine care'

4.2 Summary of Findings from Qualitative Research

Ten of the included studies utilised qualitative methodologies. The majority of these used structured or semi-structured interviews with two utilising focus groups. Populations included adults, young people and children. Some studies focused on communities from a specific ethnic background, others included many cultural identities. There was a range of methods of analysis of the qualitative data, including thematic, reflexive thematic, phenomenological and idiographic analyses. Some studies focused on client and/or therapist experiences of receiving or delivering psychological therapy, including barriers to receiving or seeking help. Others explored views on adaptation of standard therapies in terms of content and acceptability. There was an emphasis on co-production to varying extents, from co-designing group interventions to co-producing recommendations based on study findings. Stakeholders involved in co-production included service users, families, therapists and other health professionals, and community members. Three studies included user feedback on novel culturally adapted interventions. One study was a rapid scoping review of qualitative studies on the experiences of young people in accessing mental health services.

Overall, the findings confirmed that there are a range of individual, service and community barriers to accessing and engaging with psychological therapies. Several useful suggestions to overcoming the challenges of culturally adapting therapies emerge, for example identifying cultural competencies. Talking about ethnic differences in therapy sessions was deemed by service users as very important to the therapeutic relationship. Adapted group therapy was rated positively by clients. This mode of delivery was felt to be empowering, helped to reduce feelings of stigma and increased understanding of the purpose of psychological interventions.

4.3 Quality of Qualitative Research

Overall, our quality appraisal of the extracted qualitative studies (using the MMAT) was positive, with most studies fully meeting the required standard for using appropriate methodology for the research question under consideration and interpreting results from the substantive data collected. Qualitative approaches to research questions can produce rich data that gives an in-depth understanding of often complex issues. This is particularly important where new or adapted therapeutic interventions are being considered. We refer at various points in this report to the Medical Research Council (MRC) framework for the Development and Evaluation of Complex Interventions (Campbell et al., 2000; Craig et al., 2008; Skivington et al., 2021). Evidence from experts by experience, including the examples of co-production that we have noted, is critical to the process of development, evaluation and refinement of the steps involved in this framework. However, caution must be exercised when considering the generalisability of these qualitative findings in isolation.

There are several caveats that should be highlighted when interpreting the qualitative findings. A number of these are noted by the authors. Most of the studies involved small numbers of participants. Whilst this is not unusual in qualitative research and can be justified through reaching 'data saturation' (e.g., Braun & Clarke, 2021b) or accessing under-researched populations or groups, the rigour of the findings may be undermined. Many of the extracted studies included a narrow demographic of participants that might not be generalisable to other groups. Examples include British born, English speaking teenagers; well-educated English speakers from health and psychology backgrounds; and participants from a narrow geographical area of the UK. Some studies asked participants to reflect on therapy received in the past, which could produce recall bias. In two studies, post intervention interviews were conducted by intervention group facilitators which could influence participant responses.

4.4 Summary of Findings from Quantitative Research

Fewer than 50% (n=8) of the extracted studies used quantitative methods to evaluate research questions relevant to people from Black, Asian, or Minority ethnic backgrounds. Three of these considered the acceptability and/or feasibility of culturally adapted therapies (2 x CBT based; 1 x family intervention); two evaluated culturally adapted cognitive therapy; one evaluated a CBT-based, third-wave therapy manual and considered the acceptability; and two investigated mental health characteristics and outcomes in ethnic minority groups.

Broadly speaking, the acceptability and feasibility studies demonstrated that culturally adapted therapies were acceptable and feasible. The intervention evaluation studies suggested that cultural adaptations to psychological therapies led to improved treatment outcomes. For example, improvements on validated questionnaires such as the Hospital Anxiety and Depression Scale (HADS), the Strengths and Difficulties Questionnaire (SDQ) or the CORE (Clinical Outcomes in Routine Evaluation) questionnaire. Benefits were also seen on other relevant outcomes, such as attitudes to therapy, distress, isolation, satisfaction and attendance. One of the Mental Health characteristics studies suggested that young refugees had considerable mental health needs. The other study suggested similar characteristics between OCD patients from white and non-white backgrounds. There is considerable variation in the methodological quality of the extracted studies.

4.5 Quality of Quantitative Research

Two of the extracted quantitative studies had the evaluation of acceptability and feasibility as their primary focus. For example, establishing whether content and session length were acceptable, and/or evaluating attrition, engagement, or attendance. Only one of those studies, and one of the remaining 6, were randomised controlled trials. Those two studies compared a culturally adapted intervention against Treatment as Usual, or Psychoeducation. Other than that, studies were non-randomised, either evaluating change over time or were quasi-experimental (groups were based on pre-existing characteristics such as refugee status, or ethnicity).

Properly powered (i.e., appropriate number of participants to detect significant differences that do exist) randomised controlled trials (RCTs) of new or adapted interventions are a gold standard of evidence used to evaluate the effectiveness of a target intervention. Ideally, such RCTs should test the culturally adapted intervention against a comparable intervention, or an alternative type of intervention with known benefits for those participants, and a treatment as usual and/or waiting list control group (to detect if the target intervention was better than nothing, or what participants would usually receive). None of the quantitative studies we extracted had such a set of control arms. In the two RCTs we extracted, the control arms comprised of Treatment as Usual (which the authors acknowledge would vary across the sites involved in the RCT) or psychoeducation (including group therapy around child and maternal difficulties, which was not stated to be culturally sensitive or culturally adapted). Different control arms could feasibly lead to greater or lesser differences against the target intervention, depending on the extent to which they are naturally or deliberately culturally adapted or culturally sensitive. It would be unsurprising if a very different or entirely culturally insensitive intervention was inferior to the target intervention, for example. Consideration of, and full definition of the control arms of intervention studies is important to determine not only their therapeutic effectiveness and cultural relevance, but also their practicality and cost-effectiveness compared to the target intervention arm.

Our conclusion from our synthesis of the quantitative data is that the low level of experimental rigour in our extracted studies is an indication that research into culturally adapted and culturally sensitive interventions is, sadly, in its infancy. We can conceptualise the state of research in this domain by relating it to a gold standard for intervention development and evaluation, known as the Medical Research Council (MRC) framework for the Development and Evaluation of Complex Interventions (Campbell et al., 2000; Craig et al., 2008; Skivington et al., 2021). Complex interventions are those which involve numerous client, therapist, and context variables that can interact to influence the effectiveness of an intervention, and culturally adapted interventions certainly represent such complexity. The MRC framework advocates a systematic, iterative process of intervention development and evaluation, from initial conceptualisation to full implementation of the finished product. In between those stages, they recommend that qualitative (e.g., focus groups /interviews with intended recipients of the proposed intervention and practitioners), pilot studies (to calculate effect sizes, define the intervention elements, and decide on appropriate control arms) and fully powered RCTs should be used, in that sequence, to develop a "continuum of increasing evidence" (Campbell et al., 2000) for the effectiveness of the intervention. Should problems be evident at any stage, the developers should consider altering the intervention and returning to an earlier stage of evaluation.

The study methodologies, both qualitative and quantitative, in the current rapid review are best understood as 'modelling' and 'exploratory trials', as described in the MRC framework, and are thus in keeping with the 'bottom up' and iterative processes advocated by this framework. Once intervention developers have developed sufficient evidence indicating the potential for their

interventions to have benefits for those of Black, Asian and Minority ethnic people, we would expect the literature to reflect this by the publication of more high quality RCT evidence, and subsequent systematic reviews and meta-analyses of the effectiveness of culturally relevant interventions against appropriate controls. In short, we would expect the quality of quantitative evidence to improve in the future, and a systematic review and meta-analysis of the evidence would then be appropriate.

4.6 Additional Good Practice Guidance Sources

Numerous sources of information (e.g., existing guidelines) have been found during this search, which are beyond the scope of this review. These contain important information about issues facing those of Black, Asian, or minority ethnic background in mental health services. These sources include some relating to services outside of Wales, but the recommendations and discussions will be of interest and relevance to clinicians and their clients in Wales. Clinicians should therefore familiarise themselves with these sources. Links and references for these sources are provided in Appendix h, page 95.

4.7 Narrative Synthesis of Findings

The studies included in the rapid review revealed important findings regarding access, acceptability, and outcomes of psychological therapies for clients from Black, Asian, and minority backgrounds, including the incorporation of cultural healing practices.

a) Access and Engagement

Qualitative findings identified various barriers to accessing and engaging with existing psychological therapies. These barriers can be classified as client-facing, community-facing, service-facing, therapist-facing, and contextual barriers. Client-facing barriers involved practical difficulties such as lack of awareness about available services, challenges related to childcare or transportation costs. Community-facing barriers included culturally bound shame, stigma surrounding mental health, and a lack of trust in professionals. Service-facing barriers encompassed limited resources and training for modifying therapies, as well as a lack of access to interpreters. Therapist-facing barriers involved discomfort or avoidance in discussing cultural factors and a need for self-reflection. Contextual barriers were related to environmental circumstances, such as uncertainty regarding repatriation or asylum/refugee processes. By addressing these barriers and implementing modifications to psychological therapies, accessibility improved for clients from Black, Asian, and minority backgrounds. These modifications had positive effects, including openness to new ideas and behaviours, trust in therapists, and signs of progress. They also positively impacted the community by combating stigma, normalising therapy, increasing awareness of mental health problems, and ensuring confidentiality. Service factors that facilitated access included providing necessary resources, offering appropriate training, providing supervision or cultural consultancy, and ensuring access to interpreters. Despite potential discomfort, therapists inquiring about clients' culture, being open about cultural differences, and discussing experiences of racism were valued and contributed to positive engagement. Lastly, recognising and addressing contextual barriers through problem-solving or collaboration with other agencies had a positive impact.

b) Acceptability

Other qualitative findings emphasized the positive influence of modifying psychological therapies to better suit clients from Black, Asian, and Minority Ethnic communities. Participants expressed a desire for psychological support that they could relate to, highlighting the importance of incorporating their language, faith, and culture into the intervention. Participants also valued being able to express themselves in their mother tongue. Culturally informed content in therapy led to positive learning experiences, increased confidence, and empowerment among participants. Cultural understanding, including awareness of cultural norms and religious practices, was crucial for therapy. Cultural sensitivity, including modest dressing and interaction, was seen as essential for acceptability. Building trust and developing a strong therapeutic relationship were also emphasized. Incorporating religious or spiritual beliefs into therapy was generally seen as compatible and beneficial, but therapists should be cautious in distinguishing between normative religious practices and psychopathological behaviour. Collaboration with religious leaders was recommended to address the religious needs of clients. Delivering therapy in accordance with cultural norms and traditions helped reduce stigma and shame associated with mental health and accessing therapy. Group therapy sessions decreased social isolation and loneliness, leading to increased communication among group members outside of sessions. The acceptability of therapy was influenced by the clients' ethnic background and the match between the client and therapist. Some participants preferred an ethnically similar therapist for easier communication and understanding, while others expressed concerns about judgment and confidentiality. These findings highlight the significance of cultural and linguistic needs, religious beliefs, trust-building, and therapist-client matching in enhancing the acceptability of therapy.

c) Outcomes

Qualitative findings regarding outcomes demonstrated positive effects of psychological therapies for Black, Asian, and Minority Ethnic communities. Participants reported a reduction in mental health symptoms, improved emotional management, better understanding of grief and trauma, achieving valued goals, and increased psychological well-being. Overall, participants had a positive perception of therapy, with some variance in the amount of focus on culture or religion desired by clients. These findings collectively demonstrate the effectiveness of tailored interventions for minority populations and the need for therapists to consider cultural practices, individual needs, and adequate support to achieve positive treatment outcomes and address mental health disparities. By recognising and incorporating the unique experiences and perspectives of diverse populations, mental health interventions can be more inclusive, accessible, and effective.

4.8 Modifying Psychological Therapies to Cater to The Needs of Clients From Black, Asian, and Minority Ethnic Communities.

a) Culturally Adapting vs Culturally Sensitive Psychotherapy

Even though the terms are often used interchangeably, it can be helpful to consider these as different approaches to modifying psychological therapies to better meet the needs of clients from Black, Asian and Minority Ethnic Communities (Beck et al., 2019). Culturally adapted psychotherapies and culturally sensitive psychotherapies differ in their specific focus and methods.

Culturally Adapted psychological therapies involves retaining the fundamental components of the psychological therapy while integrating the distinctive and culturally influenced aspects of how mental health issues are expressed and comprehended (Beck, 201). Such adaptations are made to make the psychological therapy more suitable and effective for individuals from diverse cultural backgrounds. This involves tailoring therapeutic techniques, content, language, and delivery formats to align with the cultural values, beliefs, and practices of the client group. The adaptation process may also involve incorporating culturally relevant examples, metaphors, and activities into the therapy sessions. The goal of culturally adapted therapy is to enhance the accessibility and relevance of the treatment for clients from different cultural backgrounds, thereby improving outcomes. For example, a group intervention specifically developed and delivered for a particular community group that integrated cultural influence.

On the other hand, Culturally Sensitive psychological therapy tends to look much more like the psychological therapy as provided to majority service users, but with modifications made on a case-by-case basis by therapists, service users or even interpreters (Beck, 2016). This emphasises the importance of cultural awareness and understanding in the individual therapeutic relationship. It involves recognising and respecting the cultural perspectives and experiences of the client, while actively avoiding stereotypes and biases. Culturally sensitive therapists strive to create a safe and inclusive environment where clients feel understood, validated, and empowered. They may engage in ongoing self-reflection, education, and training to enhance their cultural competence and responsiveness. For example, within individual therapy with a client respecting the client's background, guarding against generalisation or biases, adjusts the therapeutic relationship to suit the client and ensures the process / interventions are consistent with the clients' background.

Regardless, whether approaching it as culturally adaptive or culturally sensitive, the rapid review highlighted some common focus of modifications. These included modifying the delivery approach, involvement of significant others, empowering client and significant others, conceptualisation of presenting problem, therapeutic modality, therapy content, staff knowledge and integrating culturally influenced aspects of mental health.

For the purposes of this report, we have summarised the findings into separate domains of modifications of psychological therapies. It is important to note that these domains are not mutually exclusive. In fact, therapy modifications often overlap and can address multiple domains simultaneously. For example, it may incorporate modifications to the delivery, the therapy content, staff knowledge and degree to which we integrate culturally influenced aspects of mental health.

b) Delivery

Modifying psychological therapies by changing delivery elements can enhance accessibility, acceptability, and effectiveness for clients from Black, Asian and Minority Ethnic Communities. Such modifications may include whether delivered as a group versus individual sessions, choice of therapist, language in which sessions are delivered, locations, formality of the setting and even pathways to treatment.

Due to the history and theoretical underpinnings of some psychological therapies, they are often delivered individually for adults or provided to nuclear families for children and young people. However, offering the choice of therapy in group formats, including significant others, extended family members, or members of the community, can be more appealing to clients from diverse backgrounds. It may create a sense of community and support as clients can connect with others who may share similar experiences or challenges. This can reduce feelings of isolation and provide

a space for validation and understanding. Clients may feel more comfortable expressing themselves and exploring their concerns, knowing they are not alone in their struggles. When delivered culturally, adaptive group therapy can create a safe and supportive environment where individuals can connect with others, the development of sense of community, a sense of cultural pride and greater cohesion. This fosters a sense of belonging and validation, addressing the unique challenges faced by communities or more collectivistic communities.

Another aspect of delivery may include matching therapists with clients, when appropriate, to enhance cultural understanding and facilitate a stronger therapeutic alliance. Matching therapists from similar ethnic or cultural backgrounds can help create a safe and comfortable environment for clients, where they feel understood and validated. Therapists who share similar cultural backgrounds can better comprehend the unique experiences, values, and challenges faced by clients from these communities, thereby fostering a deeper connection and facilitating effective therapy. However, this may not be true for all clients as there may be times client actively wish to see therapists from different backgrounds. For instance, where clients may be speaking about topics deemed culturally inappropriate, where there are concerns about culturally based judgements or even concerns about confidentiality within a small community group.

Language plays a crucial role in therapy accessibility, acceptability, and outcomes. Providing therapy in the client's preferred language or offering interpreter services ensures effective communication and understanding. By removing language barriers, therapy becomes more accessible and inclusive, allowing clients to fully engage in the therapeutic process. Equally, for those clients who are accessing therapy in English, consideration about language could mean a more nuanced modification of languages and using descriptions and terminology that are acceptable. For instance, rather than using clinical terminology such as depression, some client might resonate more with idioms of distress such as feeling down or dragged down.

The location of therapy sessions also plays a vital role in accessibility, acceptability, and outcomes. Offering therapy in convenient locations, such as community centres or places of worship, can help overcome logistical and transportation challenges. Equally, some settings may be more culturally appropriate or relevant which may influence the degree to which some clients may wish to engage. This approach acknowledges and respects the lived experiences of clients, making therapy more acceptable and accessible to them.

Reflecting on and modifying pathways to psychological therapy can make it more accessible to clients from diverse backgrounds. Traditional therapy pathways may not always align with the unique cultural values, beliefs, and help seeking behaviours of individuals from different backgrounds as these typical rely on GP referral. By offering flexible and customizable pathways, therapy can be tailored to meet the specific needs of clients or communities. This may include incorporating referral routes, pathways that don't rely on GPs alone, link work with community groups, culturally specific promotions or outreach and even having information about services in community venues. Adapting pathways to therapy acknowledges and respects the diverse backgrounds of clients, creating a more inclusive and accessible therapeutic experience.

c) Modality

Modifications may focus on the choice of modality as a means to enhance accessibility, acceptability, and effectiveness for clients from Black, Asian and Minority Ethnic Communities. The results from the rapid review were from a range of existing psychological therapies such as CBT, counselling, and more integrative therapeutic approaches (drawing on community psychology,

CBT, relational, interpersonal, narrative, expressive, humanistic therapies) and also developing and piloting new psychological therapies co-created with the community or faith groups. This is a means to modify the therapeutic approach offered to better suit clients from Black Asian and minorities background.

One approach is to incorporate culture into existing therapy models, which involves modifying therapeutic techniques, content, and delivery to align with the cultural values, beliefs, and experiences of these populations. This can include using culturally relevant metaphors, incorporating traditional healing practices, and addressing specific cultural stressors. Additionally, ensuring the therapy is delivered in a culturally sensitive manner, with therapists who have knowledge and understanding of diverse backgrounds, can enhance the therapeutic alliance and increase client engagement.

An alternative is developing new approaches specifically for clients from Black, Asian, and minority backgrounds. This involves recognising the unique experiences and cultural contexts of these populations and tailoring therapeutic approaches accordingly. To achieve this, it is essential to engage in community-based participatory research, involving members from these communities in the development and refinement of therapeutic interventions. Collaborating with community leaders, organisations, and advocates from these backgrounds can also inform the development of culturally appropriate therapies. By collaboratively identifying cultural strengths, values, and preferences, therapists can design interventions that resonate with clients and address their specific needs. Incorporating culturally relevant techniques, such as storytelling, expressive arts, or religious / spiritual practices rooted in cultural traditions, can enhance therapy's acceptability and effectiveness.

d) Therapy content

Another domain of modifications focussed on the content of the psychological therapies. Existing therapeutic modalities were utilised and modified to enhance accessibility, acceptability, and outcomes, while staying consistent with the underlying psychological therapies' modality. Various techniques were employed, including psychoeducation, exposure response prevention, problem-solving, signposting, stress management, cognitive restructuring, contingency planning, worry management, distress tolerance, active listening, contingency planning, highlighting available resources, celebrating successes, family interventions, safety and stabilisation, active listening, and guided discovery, were applied. In addition to this, careful consideration was given to what would constitute culturally appropriate behavioural tasks or homework. Regardless of the content that was selected, it was modified to align with the clients' preferences, goals, cultural norms, values, customs, and traditions. Collaborative efforts were made to tailor the therapy content appropriately and ensure its acceptability. The review indicated that incorporating these modifications and promoting collaboration, therapy was made more accessible, acceptable, and effective for clients from diverse backgrounds.

e) Involvement of significant others

Psychological therapies can be modified to enhance accessibility, acceptability, and effectiveness for clients from Black, Asian, and minoritized backgrounds by adjusting the involvement of significant others. This might include engaging community leaders, promoting parental involvement, incorporating family systems, and drawing on teachers and school systems in the therapeutic process.

By involving various significant others such as community leaders, therapists can tap into culturally specific knowledge and resources to create a more culturally relevant and acceptable therapy experience. Parental involvement plays a crucial role in the therapeutic journey as parents can provide valuable insights into the client's background and cultural context. Additionally, training and consultation with teachers can be beneficial in creating a supportive environment for the client both within and outside the therapy setting. Liaison with other agencies, such as schools or community organisations, allows for a comprehensive and holistic approach to addressing the client's needs.

Modifications in the involvement of significant others can take various forms. Firstly, it is important to raise the significant others' ability and confidence in recognising and managing psychological distress, as well as making appropriate referrals when necessary. Education about the mental health system, culturally specific models of mental illness, and medication effects is essential for clients, caregivers, and therapists to develop a shared understanding and promote effective collaboration.

Moreover, addressing conflicts within families and between caregivers and healthcare professionals is crucial in fostering a supportive and cohesive therapeutic environment. By involving families in therapy sessions and empowering them to provide support at home through homework tasks, the therapeutic impact extends beyond the therapy room. This involvement within the wider community not only benefits the client but also promotes acceptance of interventions and services in the broader community.

In summary, modifying psychological therapies to be more accessible, acceptable, and effective for clients from Black, Asian, and minoritized backgrounds involves adjusting the involvement of significant others. By engaging community leaders, promoting parental involvement, incorporating children and families, and establishing collaboration with teachers and other agencies, therapists can create a culturally sensitive and supportive therapeutic environment. This approach enhances the client's outcomes and acceptance of therapy within their immediate network and the wider community. However, it is important to note that the degree and nature of involvement will be informed through collaborative discussions and decision-making.

f) Empowerment

Psychological therapies can be modified to make them more accessible, acceptable, and effective for clients from Black, Asian, and minoritized backgrounds through the lens of empowerment. Empowerment entails providing individuals and communities with the degree of autonomy and self-determination necessary to address systemic inequalities and challenges. In therapy, this can be achieved by recognizing the impact of systematic disempowerment and working towards supporting clients in reclaiming their power and agency.

One way to empower clients is by involving them in the development of therapy plans through collaborative work, ensuring their goals and aspirations are acknowledged and prioritised. Raising awareness plays a crucial role in empowerment, where clients, carers, and communities are educated about the mental health system, culturally specific models of mental illness, and the effects of medications. By improving communication and advocacy skills, clients are better equipped to navigate interactions with mental health services and assert their needs effectively.

Recognising the care burden and the possibility of clients caring for their carers is another aspect of empowerment. Therapists can emphasise the rights and responsibilities of carers, fostering a supportive environment that acknowledges their contributions. Additionally, addressing systematic inequalities involves acknowledging the impact of racism and providing resilience-building strategies to help clients navigate such experiences.

Therapeutic techniques such as problem-solving booths, exploring strengths, understanding hopes, and proud moments can further contribute to empowerment. By supporting clients in developing resilience and enhancing their sense of self-worth, therapy becomes a space for building strength and personal growth (For instance, in Hammad et al. (2020), the interventions specifically focused on these topics, or Edge et al. (2018) took a recovery-based approach that considered strengths and resources).

In summary, modifying psychological therapies to be more accessible, acceptable, and effective for clients from Black, Asian, and minoritized backgrounds involves an emphasis on empowerment. Through collaborative therapy planning, education, addressing systematic disempowerment, and fostering resilience-building techniques, therapy can empower clients to assert their autonomy, address inequalities, and promote positive change in their lives and communities.

g) Conceptualisation of presenting problems

Modifying psychological therapies to make them more accessible, acceptable, and effective for clients from Black Asian and minoritised backgrounds may involve adjusting how distress is conceptualised.

For some, this might involve considering diagnostic criteria, through a culturally sensitive lens. It recognizes that the manifestation and expression of symptoms may vary across different cultural contexts. For example, across many cultures, physical symptoms are the most common presenting feature and more likely to be expressed than psychological symptoms. Therefore, by acknowledging cultural nuances and understanding the ways in which mental health problems are understood within specific cultural frameworks, therapists can tailor their interventions accordingly.

In addition to diagnostic criteria or presenting problem, therapists should be aware of culturally bound understandings of mental health problems. This means acknowledging that certain symptoms or experiences may be attributed to cultural factors or specific cultural beliefs. By taking these factors into account, therapists can gain a more comprehensive understanding of the client's distress and work collaboratively to develop culturally appropriate treatment strategies.

Furthermore, it is essential to formulate the client's problems as a variety of presenting issues rather than relying solely on a single diagnostic category. This approach allows for a more nuanced exploration of the client's experiences, taking into consideration the influence of culture, identity, and social context. By adopting a broader perspective, therapists can address the complexity of the client's concerns and tailor interventions that resonate with their unique needs.

h) Integrating cultural components

Psychological therapies can be modified to be more accessible, acceptable, and effective for clients from Black, Asian, and minoritized backgrounds by incorporating specific cultural components into therapy sessions. This includes incorporating traditions, norms, imagery, proverbs, metaphors, and stories that are culturally relevant and meaningful to the clients. By incorporating these cultural components, therapy can enhance shared understanding and engagement. Cultural narratives help bridge the gap between the clients' lived experiences and the therapeutic concepts, making them more relatable and applicable to their specific cultural context. Imagery, for example, can be used to create visual representations that align with clients' cultural backgrounds and beliefs, making the therapeutic process more relatable and accessible. Traditions and norms can be integrated

to establish a sense of familiarity and comfort, providing a foundation for trust and openness in therapy.

Recognising and addressing experiences of racism is another crucial aspect of making therapy more accessible and effective for clients from Black, Asian, and minoritized backgrounds. Therapists must acknowledge the impact of racism on clients' mental health and well-being and create a safe and supportive environment for discussing these experiences. Experiences of discrimination and racism have a cumulative effect and are associated with mental health difficulties. Therefore, therapists can begin by actively listening to clients' experiences of racism, validating their emotions, and providing a space for them to express their thoughts and feelings. By acknowledging the reality of racism and its effects, therapists can validate clients' lived experiences and foster a sense of trust and understanding. This may involve discussing the impact of racism on self-esteem, identity development, and relationships. Therapists can help clients develop coping strategies to navigate and respond to racism, empowering them to assert their agency and challenge discriminatory practices.

Cultural humility is essential in addressing experiences of racism. Therapists should continuously educate themselves about systemic racism, cultural diversity, and the historical context of oppression. This knowledge helps therapists better understand the unique challenges faced by clients from diverse backgrounds and guides them in providing culturally sensitive and appropriate interventions. In addition to individual therapy, group therapy can provide a supportive environment for clients to connect with others who have similar experiences. Group therapy can offer a sense of belonging, validation, and community support, which can be particularly beneficial when addressing experiences of racism.

It is also essential for therapists to understand and respect clients' models of illness, cultural beliefs, and values regarding health and well-being. By incorporating culturally relevant models of illness or health, therapists can ensure that the therapeutic process aligns with clients' cultural perspectives and experiences. This may involve exploring clients' cultural beliefs about the causes of mental health issues, their understanding of symptoms, and their preferred methods of healing or seeking support. Therapists can engage in culturally sensitive dialogue with clients to gain insights into their cultural models of illness or health. This includes actively listening to clients' narratives and acknowledging the influence of culture, spirituality, and community on their well-being. By understanding these cultural perspectives, therapists can tailor interventions and treatment plans that are meaningful and relevant to clients' experiences. Ultimately, a shared collaborative understanding can be reached that incorporates clients' and more clinical understandings.

When assessing functioning or the impact of presenting problems, considering cultural markers of functioning is important. Therapists can take into account the unique cultural norms, values, and expectations that shape clients' experiences and behaviours. This involves recognising that different cultures may have diverse ways of defining and evaluating mental health and well-being. Therapists should be attentive to how cultural factors, such as collectivism, respect for authority, family dynamics, and acculturation stress, may influence clients' psychological functioning. To effectively consider cultural markers of functioning, therapists can engage in culturally sensitive assessments that explore the impact of culture on clients' lives. This may involve asking questions about cultural identity, experiences of discrimination or racism, family.

i) Supporting therapists

Psychological therapies can be modified to make them more accessible, acceptable, and effective for clients from Black, Asian, and Minoritised Background by therapists actively developing their knowledge. This may involve seeking knowledge about the clients / local communities, their cultures, religions, as well as the issues of racism and discrimination. As well as knowledge of how to modify psychological therapies to make them more culturally appropriate. As well as staff self-reflection to minimise the risk of intervening based on assumptions or biases influencing on the therapy.

It is vital for therapists to actively expand their knowledge and understanding of diverse cultures, including their norms, traditions, and values. By immersing themselves in learning about different cultural backgrounds, therapists can provide therapy that is culturally sensitive and responsive to the unique needs of their clients. Also expanding knowledge of challenging social contexts influenced by prejudice, discrimination, and systemic inequalities.

Furthermore, when therapists enquire about client cultures and influences on therapy, they can better recognise the impact of cultural factors on their clients' psychological well-being. Cultural beliefs, values, and traditions shape individuals' identities, worldview, and coping strategies. By having a deep understanding of these cultural influences, therapists can tailor their interventions to align with their clients' cultural needs. This not only improves the effectiveness of therapy but also helps clients feel seen, heard, and validated in their cultural identities. By integrating culture into therapy, therapists facilitate a more comprehensive and inclusive approach that acknowledges the interconnectedness between a person's cultural background and their mental health.

Historically, core therapeutic training for therapists has paid minimal attention to modifying therapies to ensure they are acceptable, accessible, and beneficial for Black, Asian, and other minoritized communities. There is still work to be done to fully integrate cultural sensitivity and competence into therapeutic training. This will ensure therapists are better equipped to understand and address the unique needs and experiences of clients from diverse cultural backgrounds. They possess the knowledge and skills to modify therapeutic approaches and interventions to align with clients' cultural values, beliefs, and norms. This ensures that therapy is relevant, meaningful, and effective for clients, leading to better outcomes.

Finally, therapists and services may inadvertently perpetuate stereotypes, engage in micro-aggressions, or overlook the cultural factors influencing clients' experiences. This can lead to harm and re-traumatisation for clients, further exacerbating their mental health struggles. Supervision and self-reflections help therapists develop the awareness and sensitivity needed to avoid these pitfalls and ensure that therapy is affirming and supportive. Therapists can be supported through self-reflection and supervision to minimise the micro and macro aggressions. Therapists engage in self-exploration to identify and challenge any preconceived ideas that may hinder their ability to provide culturally sensitive therapy. This self-awareness allows therapists to approach therapy with an open mind, free from biases and stereotypes.

5.0 Conclusions

The overall conclusions of this rapid review of the literature are as follow:

1. A number of barriers have been identified, some of these are client facing (e.g., stigma or mistrust of services), some are service facing (e.g., complex pathways), and some are therapist facing (e.g., avoidance).

2. There is often a generic application of a therapeutic approach without consideration of client background or adaptation to better suit people of Black, Asian, or Minority Ethnic background.

3. Where psychological therapies have been appropriately adapted, these show positive outcomes. However, a particular cultural adaptation cannot be understood as a set of changes that will be relevant to every client, group, or community. Instead, adaptations must vary according to the needs and preferences of different ethnic, faith, and/or cultural backgrounds.

4. Consideration of language barriers in therapy is critical. Not only might interventions be delivered through the medium of an interpreter, with the obvious implications of the sensitive nature of the communications, but language and cultural barriers might also affect the patient reported outcome measures. Patients and clients might not fully relate to measures developed by and for English speaking, White Western populations if the language and terminology used, and the life-experiences and priorities are different to those from other ethnic backgrounds.

5. Imagery, proverbs, metaphor, stories, and other narratives can be important tools for clients to vocalise and understand their experiences and distress, and somatisation of distress is also likely in some ethnic groups. Such approaches to mental health are likely to impact across the whole set of processes involved in the clinical cycle.

6. The client's perspective of their safety, both physical (e.g., fear of harm) and psychosocial (e.g., stigma) can undermine treatment effectiveness. Furthermore, some physical threats (e.g., racial attack, repatriation) or psychosocial threats (e.g., community stigma) may be greater threats to clients from some ethnic, cultural, or faith backgrounds than others.

7. Some ethnic, cultural, or faith backgrounds have a more collectivist philosophy towards life and wellbeing than is the case in others. In collectivist societies, family and community are an important part of the client's identity and the involvement of the family and community can be a central component influencing the effectiveness of the intervention.

8. As with White individuals, Black, Asian, and Minority Ethnic individuals seeking help for mental health issues can have other characteristics that might lead to marginalisation in society. Although beyond the scope of this review, the evidence suggests that characteristics such as religious faith, sexual orientation, refugee/asylum status, learning disability etc., could confer additional disadvantage in mental health settings.

6.0 Recommendations for Guidelines for Inclusion in the Existing Matrics Documents

1. **Therapists and service leads should consider adopting existing models for developing culturally appropriate interventions,** such as 'bottom-up' models (e.g., Hwang, 2009) and/or top-down (e.g., Bernal, Bonilla, & Bellido, 1995). Bottom up or 'formative' methods involve collaboration with community stakeholders to develop ideas to adapt the therapy, and involves five phases that target developing, testing, and reformulating therapy modifications. Bernal et al's 'top-down' Ecological Validity Model includes eight dimensions important in cultural adaptation, for example, offering therapy in the client's preferred language matching client and therapist on salient variables to enhance therapeutic alliance and applying cultural knowledge about traditions, customs, and values.

2. **Therapists should adopt a collaborative, 'knowledge exchange' approach to intervention when a client's cultural background is unfamiliar to them,** to ensure that cultural, spiritual and community factors valued by the client are considered within the intervention processes and that the intervention tasks are adapted appropriately (e.g., socialising on Friday nights might be inappropriate for some clients).

3. **Imagery, proverbs, metaphor, stories, and other narratives can be important tools for clients to vocalise and understand their experiences and distress, and somatisation of distress is also more likely in some ethnic groups.** Therapists should allow space and time at every stage in the clinical cycle for clients to communicate their needs and preferences, using the narrative that is most comfortable for the client.

4. **Therapists should establish the client's perspective on their safety, both physical (e.g., fear of harm, repatriation) and psychosocial (e.g., stigma, confidentiality)** and prioritise enhancing safety, in line with the recommendations of Herman (1992) to increase the likelihood that the effectiveness of therapy is not undermined by a client's sense of threat. Clinicians should also be mindful of the potential for other factors (e.g., faith, sexuality, learning disability) that could negatively affect a client's sense of safety and hinder the extent to which clients access and benefit from the interventions they provide.

5. **Community stakeholders (e.g., faith leaders, third sector organisations) should be Involved in discussions about developing and delivering interventions.** However, be mindful that clients might welcome or conversely worry about community knowledge and involvement in mental health provision and reassure those who are concerned about the potential for negative consequences.

6. **There should be utilisation of tools to facilitate a culturally-minded approach to practice and research.** This could involve the adaptation or development of tools to facilitate routine consideration of the unique characteristics, needs, preferences, and cultural contexts of clients and communities. Please see our own example below (Fig. 2). Modifications are not universally applicable because clients and communities are not homogenous, and this tool will help clinicians to confirm the appropriateness of their intervention in the context in which it will be used. To use the tool, firstly consider whether the aim is to deliver a culturally adapted or culturally sensitive psychological therapy and secondly consider the foci of the adaptations.

7. A culture of evidence-based practice and practice-based evidence should be embedded across the full scope of mental health services. These should include audit, research, service evaluation, intervention development, clinical practice, and commissioning of services. This approach will help to build the evidence base of efficacy and effectiveness (including cost effectiveness) by providing clear data about the acceptability, accessibility, outcomes, engagement, and retention associated with culturally adapted and culturally sensitive interventions.

8. Guidelines such as the Medical Research Council framework for developing and evaluating complex interventions (Campbell et al., 2000; Craig et al., 2008; Skivington et al., 2021), should be used to guide the methodological approaches used in intervention development and evaluation. Complex interventions are those where numerous facets (e.g., number of components, range of behaviours, expertise and skills required, numbers of groups and settings, context, or flexibility) affect the assessment of process and outcomes. This framework emphasises the dynamic and adaptive nature of the systems in which an intervention might be employed. The guidelines also emphasise that consideration should be made of the extent to which interventions are "implementable, cost effective, transferable, and scalable in real world conditions" as well as effective and that this needs collaboration with relevant stakeholders. The MRC guidelines advocate an iterative process of development that covers 1) identification of the intervention 2) feasibility 3) evaluation, and 4) implementation with the involvement of stakeholders and appropriate modification at each stage.

Figure 2. Example template to guide the development of a culturally adapted or culturally sensitive psychological therapy.

		1) Is the aim to deliver a psychological therapy that is culturally adapted or culturally sensitive?	
		Culturally Adapted	Culturally Sensitive
2) What will be the focus of the modifications?	What will be the focus of the modifications?		
	Modality		
	Therapy content		
	Significant others		
	Empowerment		
	Conceptualisation of distress		
	Integrating cultural components		
	Supporting staff		

7.0 Concluding Thoughts

By implementing these recommendations, mental health service provision will move more towards the routine creation of an inclusive and culturally appropriate therapeutic environment that addresses the unique needs of all clients. It is important to foster an ongoing philosophy of education, self-reflection, and collaboration with communities in mental health services in order to continuously improve cultural competence and responsiveness in therapy. Ultimately, the goal is to enhance the accessibility, acceptability, and effectiveness of psychological therapies for clients, thus leading to improved outcomes and well-being.

8.0 Glossary of Terms

In this section, you will find definitions and explanations of key terms relevant to the subject matter of this report. This glossary is designed to assist you in navigating through the various terms, acronyms, and language used throughout the document. We encourage you to refer to this glossary whenever you encounter an unfamiliar term or acronym. By doing so, you will be able to delve deeper into the subject matter and engage with the report on a more comprehensive level.

Table 2: Glossary of Terms

Term	Definition
Anxiety Disorders	An umbrella term to describe a group of mental health conditions characterized by excessive worry, dread, fear, or apprehension.
BABCP	British Association for Behavioural and Cognitive Psychotherapies. A professional organisation that accredits cognitive behavioural therapists and promotes ethical practice and standards in CBT in the UK.
BACP	British Association for Counselling and Psychotherapy. One of the professional organisations that accredits counsellors / psychotherapists and promotes ethical practice in the UK.
Black, Asian, and Minority Ethnic	A term that refers to individuals and communities who are of Black, Asian, or other minority ethnic backgrounds.
Boolean Operators	Words used as conjunctions to combine or exclude keywords in a search, resulting in more focused and productive (e.g., AND, OR, NOT).
BPS	British Psychological Society. A professional organisation that accredits psychologists and promotes psychological research, education, and practice.
CBT Therapist	A mental health professional trained in delivering cognitive-behavioural therapy, an evidence-based therapy approach for a range of mental health problems.
Cognitive Behavioural Therapy	A psychological therapy approach that focuses on the relationship between thoughts, emotions, and behaviours to help individuals manage their psychological difficulties or mental health problems.
Community Mental Health Workers	Professionals who provide mental health support and services within local communities. This ranges from psycho-social interventions, support, and advocacy, to enable people to manage the social factors in their lives e.g., relationships, housing, and employment.
Counselling	A talking therapy that involves a trained counsellor listening to you and helping you find ways to deal with emotional issues. Typically involves exploring and addressing personal issues and challenges.

Term	Definition
CPD	Continuing Professional Development. Activities and learning undertaken by professionals to enhance their knowledge, skills, and expertise.
Data Extraction	The process of systematically retrieving relevant information from research studies or other sources to enable synthesis and summary of key information.
Diagnostic Assessment	An evaluation conducted to determine the presence, nature and impact of a specific mental health condition or disorder. Focused on identifying if a group of symptoms are present or absent in someone's life.
Depression	A mental health problem characterised by depressed mood and loss of enjoyment in activities.
Eating Disorders	An umbrella term to describe a group of mental health disorders characterized by disturbances in eating behaviours and body image.
Ethnicity	A term that refers to the social and cultural characteristics, backgrounds, or experiences shared by a group of people. These include language, religion, beliefs, values, and behaviours that are often handed down from one generation to the next.
Evidence-Based Practice	The integration of the best available research evidence with clinical expertise and patient preferences to inform decision-making in healthcare.
GAD	Generalised Anxiety Disorder. A common anxiety condition characterized by persistent and excessive worry and anxiety.
Grey Literature	Information produced which may not be formally published or widely accessible through traditional publishing channels.
Hand Searches	The process of manually searching through reference lists, conference proceedings, or other sources to identify relevant research or information.
Heterogeneity	The dissimilarity or diversity or variability of participants, interventions, or outcomes within a group of studies or data.
Homogenous	Refers to a state or condition in which a group or sample is similar or uniform in terms of certain characteristics. It implies that the individuals within the group share common traits, attributes, or conditions, making them more alike and less diverse.
Matrics Cymru	Matrics Cymru is a structured guide to assist planning and delivering evidence-based psychological therapies within local authorities and health boards in Wales, including commissioned third sector and independent sector services. It is the result of collaborative working between service user and carer representatives.
NICE	National Institute for Health and Care Excellence. A UK organisation that provides evidence-based guidance and recommendations for healthcare practice. An executive non-departmental public body of the Department of Health and Social Care in England
Non-Randomised Study	A study design in which participants are not randomly allocated to different groups or conditions.
OCD	Obsessive-Compulsive Disorder. A mental health condition characterized by recurrent unwanted thoughts (obsessions) and repetitive behaviours (compulsions).
Panic Disorder	A mental health condition characterized by recurring and unexpected episodes of intense fear or discomfort, known as panic attacks.
PHW	Public Health Wales. The national public health agency in Wales, an organisation responsible for protecting and improving the health and well-being of the population in Wales.
PICO	An acronym used in evidence-based practice to formulate research questions, representing Population, Intervention, Comparison, and Outcome.
Practice-Based Evidence	Evidence derived from clinical practice and real-world settings, providing insights into the effectiveness and outcomes of specific interventions.
Presenting Problem	Presenting Problem: The main issue or concern that a person seeks help or psychological therapy for.

Term	Definition
Psychoeducation	The provision of education and information to individuals and their families about mental health conditions and treatment options.
Psychological Therapies	Various therapeutic approaches aimed at improving mental health and well-being, often involving talking therapies and interventions.
PTSD	Post-Traumatic Stress Disorder. A mental health condition that is characterised by nightmares, flashbacks and other symptoms associated with reliving a traumatic event.
PWP	Psychological Wellbeing Practitioner. A role within the UK IAPT initiative, involved in delivering low-intensity interventions to support individuals with mental health problems such as depression and anxiety.
Quality Assessment	The evaluation of the quality and reliability of research studies or evidence using specific criteria or standards. Focusing on the methodological quality, and rigor of the trials or studies included in a review.
Randomised Controlled Trials	Research studies that randomly assign participants to different groups or conditions to evaluate the effects of interventions or treatments.
Rapid Review	A condensed and expedited form of systematic review that aims to provide timely evidence synthesis.
Schizophrenia	A mental health condition characterised by symptoms such as hallucinations, delusions, disorganized thinking / speech, diminished emotional expression, and impaired social functioning.
Search Protocol	A predefined plan or strategy outlining the steps and criteria for conducting a systematic search of literature or information sources.
Search Strategy	The systematic plan or approach used to identify relevant studies or information for a research review.
Social Phobia	A mental health condition characterized by an intense fear of social situations or being scrutinized by others.
Stakeholders	Individuals or groups who have an interest, involvement, or influence in a particular area.
Substance Abuse	The harmful or excessive use of drugs or other substances that negatively impact an individual's health, functioning, or well-being.
Systematic Reviews	Comprehensive and rigorous reviews of research evidence that follow predetermined methods to synthesize and evaluate available studies.
Talking Therapies (IAPT)	A program in England developed to improve the delivery of, and access to, evidence-based, NICE recommended, psychological therapies for depression and anxiety disorders within the NHS.
Treatment As Usual	The standard or usual care provided to individuals in a particular healthcare setting or context.

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12 APPENDICES

Appendix a

Final search strategy for ProQuest (ASSIA, PsycArticles, PsycInfo, & Psychology database)

Date conducted: 14/03/23

#	Search terms
1	title(BAME OR BME OR "{GLOBAL MAJORITY}" OR “{Racial minority}” OR racial* OR Minorit* OR "{ETHNIC MINORITY POPULATION}" OR ETHNIC* OR "{Diverse population}" OR "{ethnic minority}" OR Indian OR Pakistani OR Bangladeshi OR "Sri Lankan" OR Asian OR "south Asian" OR BSA OR “British south Asian” OR “south east Asian” OR Caribbean OR “African Caribbean” OR Irish OR Chinese OR Refugee OR Asylum* OR Gyps* OR Roma* OR Traveller OR Japanese OR Malaysia* OR Indonesia* OR Arab* OR Nepal* OR Iran* OR African OR Albania* OR Iraq* OR Afghan* OR Syria* OR Somali* OR Polish OR Palestin* OR Sudanese OR Yemeni OR Egyptian OR Vietnamese OR Black OR “mixed heritage” OR “{mixed race}” OR “{mixed ethnicity}” OR “{displaced people}”)
2	title,abstract,if("{PSYCHOLOGICAL THERAPY}" OR "{PSYCHOLOGICAL INTERVENTION}" OR “{cognitive behavioural therapy}” OR CBT OR COUNSELLING OR THERAP* OR "{MENTAL HEALTH SERVICE}" OR "Community psychology" OR "{Evidence based psychological intervention}" OR "{Evidence based therapy}" OR Psychotherap* OR "{psychological service}" OR "{psychosocial therapy}" OR "{psychosocial intervention}" OR Service* OR “{talking therapy}” OR “{narrative exposure therapy}” OR net OR “{talking treatment}” OR Treatment)
3	title,abstract,if(ACCESS* OR OUTCOME* OR ACCEPT* OR Appropriat* OR "{service user satisfaction}" OR engage* OR “drop out” OR “{service use}” OR recover* OR "reliable change" OR adher* OR nonadher* OR attend* OR Utili* OR Usage OR uptake OR need OR "best practice" OR “good practice” OR Enable* OR barrier OR facilitat* OR use* OR obstacle OR help N/2 seek* OR "care path" OR “care pathway” OR pathway OR aware* OR “{patient satisfaction}” OR communication N/2 barrier* OR communication N/2 facilitat* OR Attrition OR effective* OR efficac* OR participation OR Experience OR cultur* N/2 barrier* OR “{cultural adaptation}” OR “{cultural sensitivity}” OR “{Cultural responsiveness}” OR “{Cultural competence}” OR Cultur* OR adapt* OR sensitiv* OR responsive* OR Competen* OR “Cultural humility” OR Cultur* N/2 knowledge OR transcultur* OR translat* OR interpret* OR language* OR impact* OR Discriminat* OR Support* OR Racism OR Issue* OR Satisf* OR Admission OR Provision)
4	title,abstract,if(“Mental health” OR “mental well-being” OR “mental wellbeing” OR “mental illness” OR “{mental disorder}” OR “{common mental health problems}” OR “{complex mental health problems}” OR Anxiety OR Depress* OR panic* OR phobi* OR agoraphobi* OR GAD OR “{generalised anxiety disorder}” OR OCD OR “{obsessive compulsive disorder}” OR suicid* OR psychosis OR schizophrenia OR schizoaffective OR PTSD OR “{post-traumatic stress disorder}” OR “{posttraumatic stress disorder}” OR stress OR distress OR “{eating disorder}” OR “{mood disorder}” OR “{substance-related disorder}” OR dementia OR ADHD OR “attention deficit” OR Trauma OR “{personality disorder}” OR “Psychological health” OR “psychological well-being” OR “psychological wellbeing” OR “{psychological illness}” OR “{psychological disorder}” OR Autism OR “emotional well-being” OR “emotional wellbeing” OR condition* OR “{psychological conditions}” OR “{mental conditions}” OR “{psychosocial conditions}” OR “feeling low” OR “feeling down” OR Sad OR Sadness OR unhapp* OR “no motivation” OR “low motivation” OR Wellbeing OR Well-being OR Somatic OR Bipolar)
5	title,abstract,if(gb OR "g.b." OR britain* OR british* OR uk OR "u.k." OR “{united kingdom}” OR england* OR "{northern Ireland}" OR “{northern irish}” OR scotland* OR scottish* OR wales OR "south wales" OR welsh*)
6	title,abstract,if("new england" OR "new south wales" OR "british columbia")
7	1 AND 2 AND 3 AND 4 AND 5 NOT 6
8	Databases: Applied Social Sciences Index and Abstracts (ASSIA), PsycArticles, PsycInfo, & Psychology Database
9	Filter: English language

Appendix b

Data extraction table

First reviewer:	**Independently reviewed by (reviewer 2):**
Date:	**Date:**
	Decision on extraction: ▪ No changes required ▪ Changes required (outline below)
Reviewer 2 feedback:	
Is the paper being Excluded: (Yes) (No)	
Reason for exclusion by reviewer 1 (if applicable): **Reviewer 2:** (agree) (disagree)	
Citation:	

Study methods

Type of publication: (Scientific or grey literature)
Country of origin
Aims of the study or aims of the grey literature document (e.g., inform professionals)
Study design
Type of psychological intervention under consideration If applicable, what cultural adaptions have been made to the intervention?
Target population (Who are the findings intended to generalise to?)
Participant inclusion/exclusion criteria
Participant characteristics (e.g., [1] number, [2] clinicians or service users, [3] ethnicity, [4] proportion of the sample from the BAME community, [5] percentage of males, [6] mean age and S.D., & [7] type of mental health issue under consideration and its severity

Outcome measures

Do outcomes relate to [1] access, [2] acceptability, [3] appropriateness, or [4] outcomes? (Multiple answers are allowed) And what construct was used to infer the outcomes? (e.g., 'outcomes' = changes in anxiety, appropriateness = attendance data or appropriateness ratings)
Measurement tool used to capture each outcome (are they reliable and valid?) or qualitative data collection method (is this method and the data source used appropriate to address the research question?)
Type of statistical test or qualitative analysis used

Results	Describe (Page/para/fig)
Key findings (Please support the findings with quantitative analysis/outcome OR quotes/text extracts for qualitative findings).	
Key recommendations (From grey literature guidance documents or recommendations from empirical studies)	
Have co-variates been addressed? (for quantitative analysis)	
Level of credibility for each qualitative finding ([1] unequivocal = findings are directly inferred from the data, and not open to challenge, [2] credible = interpretations that are plausible in light of the data or theoretical framework, [3] not supported = when 1 or 2 do not apply, findings not supported by the data)	
Key limitations (as noted by authors or as noted by the study team)	
Notes:	

Appendix c Table of Characteristics of Empirical Research Focused on Clients

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Data collected	Main Findings
1. Bahu, M. (2019)	N=16 Male n=4 and Female n=12 Adults: Mean age = 32 (SD not reported)	Tamil (100%)	Grief Worry Rumination Panic attacks Anxiety PTSD	Qualitative feedback PHQ9 (Depressive symptoms) GAD7 (Generalised anxiety symptomology) Phobia Scale (Phobia symptomology) Employment Status (Employment) WSAS (Functioning) IES-R (PTSD Symptomology)	Quantitative Reduction in the severity of symptoms for all measures. These changes were statically significant using Wilcoxon signed-rank tests for the PHQ9, GAD7 and IESR with $p<0.001$ Effect size calculations indicate a high effect size and significant clinical change. Qualitative Theme-Identity: Individual/cultural and collective Theme–benefits from interventions that were used in the group Theme–concerns about diagnosis and measures because of stigma, concepts of mental illness and utility of measures Theme–improvements to the group such as being outside or more session

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Data collected	Main Findings
2. Durà-Vilà et al. (2013)	N=102 Male n=75 Female n=27 Children and young people Mean age=10.1 (SD not reported)	Middle Eastern countries (44%) African countries (27%) European countries (22%) Other countries (7%)	Did not include psychiatric diagnostic assessments Range of disorders included: Depression PTSD	SDQ (Strengths and Difficulties Questionnaire)	The more recently arrived refugees had significantly higher levels of close exposure to war and violence, were more likely to have suffered separation from immediate family and to have insecure legal status. Those refugees settled longer were significantly more likely to be referred because of conduct problems while there was a trend in recent arrivals to present with internalizing pathologizing Community based mental health services for young refugees appeared effective significant improvement was found in SDQ scores for the subgroup (n = 24) who took up the treatments offered The only significant differences observed in treatment modalities were that those who have been in the country more than two years were more likely to receive individual treatment and those more recently arrived were more likely to have had no face to face contact with service
3. Edge et al. (2018)	N=31 Male n=21 and Female n=10 Adults Mean age=43 (SD=13.77)	Afro-Caribbean descent born in England (70.97%) Afro-Caribbean Born in Caribbean (19.35%) No data available (9.67%)	Schizophrenia	Feedback forms Semi-structed interview Working Alliance Inventory	Twenty-four out of the 26 family units (92%) that commenced CaFI completed all 10 sessions. Those who completed treatment as a proportion of those who consented was 77.42% (24/31). The mean number of sessions attended by family units (i.e. the service user, relative/FSM or both) was 7.90 (SD 3.96 sessions) out of 10. It proved feasible to collect a range of other outcome data at baseline, post intervention and at 3 month follow up
4. Faheem, (2023)	N=9 Male n=1 Female n=8 Adults: Mean age= 33 (SD 5.74)	Pakistani (44.4%) Bangladeshi (11.1%) Chinese (11.1%) Arab (22.2%) Chinese (11.1%)	Depression Anxiety disorders	Qualitative data from semi structured interviews	Three over-arching themes were generated: 1. Recognizing cultural dissonance within therapy. Made up of subtheme of Therapeutic expectations, therapeutic guilt & conflicting cultural identities 2. Developing cultural competence. Made up of building therapeutic trust, Exploring patient culture within therapy 3. the road to recovery. Made up of Challenges with therapeutic engagement & evaluating therapeutic effectiveness

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Data collected	Main Findings
5. Gurpinar-Morga et al. (2014)	N=5 Male n=1 Female n=4 Children and Young People Age range 16-18 (mean & SD not reported)	Black or minority ethnic groups (100%)	No disorder specified but under the care of specialist adolescent mental health services	Qualitative - interviews	Four over-arching themes were generated: Theme 1: Impact of client ethnicity on relationships and sense of self: understanding the presenting difficulties. Therapists must acknowledge the potential role of ethnicity in a client's presenting problems, but they must not assume it will be relevant to all clients. It's important to recognise that a client's ethnicity may play more of a prominent role in their disorder when the presenting problems include relationship difficulties or when the client has two parents of different ethnicities and feels forced to choose between them. Theme 2: Talking about ethnic differences: establishing the foundations or testing them? Clients want to acknowledge ethnic differences between themselves and the therapist. They do not want them to be ignored. Acknowledging these differences can aid the therapeutic relationship. The clients also believed this conversation should happen early on in therapy. Even if the therapist feels uncomfortable talking about these topics, discussing them with the client will still be beneficial (see below). Clients may sometimes feel uncomfortable discussing ethnicity. The therapist should prompt this conversation in an empathetic and sensitive manner if the client does not initiate the conversation. However, it's important to recognise that not all clients feel the same way – not all of them will want to discuss ethnic differences between themselves and the therapist. The timing, sensitivity, and context of the conversation about client and therapist ethnicity is crucial. This conversation should be used to develop formulations of client's difficulties and it was generally thought this conversation should happen towards the start of therapy (As pointed out by Unmair in the above quotes – PG 718). However, not all participants felt the same, they thought the conversation should take place after the rapport is established; it should not be used to build rapport. Moreover, a clear rationale should be provided for the conversation, so that the client is aware of the reasons for discussing their ethnicity. Theme 3: Implications of having an ethnically dissimilar therapist The ethnicity of the therapist may be less important than their personality and general demeanour. During the initial contacts, most clients were apprehensive about the ability of an ethnically dissimilar therapist to understand their difficulties. If therapists are able to effectively demonstrate a level of understanding of the client and their ethnicity, this can facilitate the

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Data collected	Main Findings
					therapeutic relationship and also aid client's recovery (by coming up with suitable techniques the client can use to overcome their issues – e.g., based on religion). Ethnic differences between the client and therapist can still present as a barrier to engagement for some and can hamper motivation during sessions. Theme 4: Expectations of an ethnically similar therapist Participants expected that having an ethnically similar therapist would make it easier to open up to them and the therapist would be more likely to understand their difficulties. Some participants also felt an ethnically matched therapist would make more assumptions about the client because they would believe the shared beliefs and ethnicity would automatically equate to shared experiences.
6. Hammad et al. (2020)	N=16 All Female Adults Intervention 1 n=10 Age range=36-83 (Mean and SD not reported) Intervention 2 n=6 Age range=41-84 (Mean and SD not reported)	British Middle Eastern and North African Muslims (100%)	Did not include psychiatric diagnostic assessments Range of difficulties included: Bereavement PTSD Displacement from home	Semi-structured focus group	Intervention 1 The first service evaluation found that the Hand of Hope therapeutic group intervention encouraged engagement and retention of MENA-origin Muslim participants who previously held negative attitudes toward therapy and challenged the stigma attached to mental health and seeking therapy. The large majority of participants reported positive changes in their attitudes toward therapy and went on to access individual therapy and their children in need also accessed therapy. The findings suggest that the intervention fostered stabilization, building of trust, greater awareness of mental health, improved emotional regulation, strengthening of social support networks, reduced social isolation, and the activities promoted wellbeing. Intervention 2 The second service evaluation found that the Hand of Hope therapeutic group intervention improved psychological wellbeing, mood, emotional expression, and emotional regulation and promoted positive emotional states (e.g., happiness, relaxation), recovery/healing, behavioural activation, resilience, the strengthening of social support networks, personal growth, and coping with trauma and bereavement. The intervention was found to reduce social isolation and distress including Grenfell related distress

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Data collected	Main Findings
7. Jidong et al. (2022)	N=16 All Female Adults Age range=20-55 (Mean and SD not reported) Intervention 1 (LTP+CaCBT): Learning Through Play plus Culturally adapted CBT n=13 Intervention 2 (control group): Psychoeducation n=13	African/ Caribbean origin	Maternal Depression	PHQ GAD7 Qualitative – Focus Group	Depression (PHQ) LTP+CaCBT group: baseline=3.00, end of intervention (EOI)=1.00, 3 months=1.00, 6 months=.00. Control group: baseline=3.00, EOI=.500, 3 months= 1.00, 6 months = 3.00 Thus, while the control group reported better initial changes in depression, they were not sustained. Median scores of the intervention group at 6 months indicates no depression, compared to the control group which where the score is the same as the baseline score in both groups (I.e., 3.00). Anxiety LTP+CaCBT: baseline=3.00, EOI=1.00, 3 months=1.00, 6 months=1.00. Control group: baseline=3.00, EOI=1.00, 3 months=1.00, 6 months=3.00. Scores were similar between groups at the end of intervention and at 3 months, but whereas the decrease was sustained at 6 months in the intervention group, there was an increase in anxiety back to baseline levels in the control group at 6 months. Attrition There was high participant retention (>95% retention) across the 12 sessions of LTP+CaCBT. Less than 50% of control group participants contributed data for analysis. Acceptability 85.7% of the LTP+CaCBT group rated the intervention as 'very useful' or 'extremely useful', compared to 83.3% of the control group Effectiveness 100% of the CBT group rated the intervention as very or extremely effective compared to 66.7% of the control group Intrusiveness All participants in both groups rated the intervention they received as at least somewhat or extremely comfortable, but more control group participants said their intervention was 'extremely comfortable' (33.3% vs 14.3%). Quality All participants in both groups rated the intervention they received as at least somewhat or extremely good. However, more of the LTP+CaCBT participants said their intervention was extremely good (42.9% vs 33.7%).

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Data collected	Main Findings
					Satisfaction All participants in both groups said they were at least somewhat or extremely satisfied, but more participants in the LTP+CaCBT group said they were extremely satisfied with the intervention they had received (42.9% vs 16.7%). Would they recommend to others? All participants receiving LTP+CaCBT would probably or definitely recommend the intervention, compared to 83.3% of the control group participants. 16.7% of participants in the control group would 'probably not' recommend it. Overall, the LTP+CaCBT intervention seems more appealing than the control intervention on all criteria other than 'intrusiveness' Qualitative Three main themes were generated: Theme1: 'Positive learning experience underpinned by culturally-informed content' Theme 2: Enlightenment following limited awareness Theme 3: Quality training underpinned by e-convenience.

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Data collected	Main Findings
8. King & Said (2022)	N=14 Males n=13 and Female n=1 Children and Young People (Unaccompanied asylum-seekers) Mean age = 16.36 (SD=0.93)	Afghanistan (35.71%) Ethiopia (21.42%) Sudan (35.71%) Somalia (7.14%)	Did not report on specific mental health issues. Participants were not limited to those with formal diagnoses	Attendance rates Feedback from participants CGSRS SDQ Child Revised Impact of Events Scal (CRIES-8)	Symptoms of PTSD were monitored using the Child Revised Impact of Events Scale 8-item version (CRIES-8;); however, this was completed at later stages in the group and was not used to monitor group outcomes. The reliable change index was used to determine whether change in scores between pre-intervention and a review at 35 weeks was deemed to be a statistically reliable change, beyond that which could be accounted for by measurement error. Using normative data for the SDQ, it was calculated that statistically reliable change at the 5% significance level was indicated by a score change greater than 6.32. Of the eight people for whom paired data were available, four showed a reliable improvement in scores on the SDQ. One person was just below the statistically reliable threshold for improvement. No young people showed a deterioration. The clinical threshold for identifying the presence of a psychiatric disorder for the self-report SDQ is a score of 18. At baseline, four of the young people for whom data were available (N=10) scored above the clinical threshold on the SDQ. At the review time point, one of the young people for whom data were available (N=12) scored above the clinical threshold. Cohen's d for SDQ data was calculated to be 1.08, representing a large effect size. A discrepancy was identified between the total difficulties scores for young people on the SDQ and the difficulties identified on the CRIES-8. At baseline, of the six young people who completed the CRIES-8, all scored above the clinical cut-off of 17. One young person completed the Child PTSD Symptom Scale for DSM-5 (CPSS-V; Foaet al.,2018) instead of the CRIES-8 and scored 59 at baseline, which is above the clinical cut-off score of 31. At the review time point, seven of the young people for whom data were available (N=10) scored above the clinical threshold on the CRIES-8

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Data collected	Main Findings
9. Masood et al. (2015)	N=16 All Female Adults Age ranged from 20-45 (Mean and SD not reported)	Pakistani (88.24%) Indian (5.88%) Bangladeshi (5.88%)	Postnatal depression	Qualitative Interviews	Five themes were derived, relating to access, acceptability, appropriateness, and outcomes. Theme 1: Barriers to attendance and commitment: Restrictions from their husbands who didn't understand the need for the support group Absence of childcare Transport availability, cost Difficulty completing homework because of domestic responsibilities Theme 2: Understanding of cultural and linguistic needs Group facilitators were of South Asian origin and spoke Urdu – this was positive But some could not read the handout in English Facilitators understood the SA socio-cultural dynamics, and they were good listeners Theme 3: Participation in group sessions This was viewed positively because participants can share experiences. Theme 4: Feeling confident and empowered These feelings were enhanced. Theme 5: Suggestions for improvement Therapy needs to be longer term GP's and nurse practitioners need culture specific training
10. Mir et al., (2015)	Study 2 N=19 Male n=5 and Female n=14 Adults Age range= 23–56 years (Mean or SD not reported)	All self-identified as Muslim Pakistani backgrounds (89.47%) African backgrounds (5.26%) Indian backgrounds (5.26%)	Depression	Qualitative Interviews	Three main themes were derived from the data: Theme 1; relevance of the Behavioral Activation model. Therapists generally followed the Behavioral Activation model but some struggled to suggest specific activities to clients, preferring a more exploratory approach. Clients confirmed the acceptability of the Behavioral Activation model but critiqued the exploratory approach taken by some therapists. These patients would have preferred more practical advice about potentially helpful activities. One participant felt a more concrete application of Behavioral Activation would have helped her. "I just did not understand the process….they could have said anything such as 'perform your prayers' […] but they did not say anything like that. […] When you speak to someone, they should suggest something to overcome those problems. It's one's choice whether to take the advice or not, but at least you have peace of mind that there is something that can be done to resolve the issues, there is some way out to those problems"

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Data collected	Main Findings
					Theme 2: Social context Patients and therapists spoke of the value of involving their families in raising the awareness of depression and improving communication and support. Despite this, some patients were worried about their relatives contradicting them, and losing their privacy. Furthermore, some family members did not want to be involved and some therapists were also averse to family member involvement. Reasons included a lack of training, their own role, and the potential for patients to be disempowered. Some patients said they had not been given an option to involve their families. Theme 3: patient-therapist matching Findings reinforce findings from study 1 on patient-therapist matching, which had yielded mixed findings. Some participants felt that matching could lead to openness and quicker development of trust. However, some felt that patients may fear being judged and have concerns around confidentiality. Patients highlighted potential language barriers and anxieties that might arise when discussing problems with non-Muslim therapists and how these might reinforce negative perceptions of the Muslim community. Understanding and respect for Islam were important to patients along with a genuine acceptance that such an approach was potentially helpful to patients. "The person ought to be genuine, that is the biggest thing. That is my question: that a person should be genuine. You cannot just bring anybody to do it." BN, male, 48, Punjabi speaker "The person fears that they might think what kind of Muslims are these? [.] if I had discussed [failure to remain clean and to pray] with some non-Muslim [...] I mean, such things, if they are discussed with them, I feel ashamed" BL, male, Punjabi speaker ""Religion should be made part of therapy; it is a very important and good thing, but my point is the therapist should be Muslim; he/she would understand our values better. She was English, I think it was [therapist name]; she perhaps can learn about it, get trained but she won't be able to go in depths of it." GN, female, 40, Urdu speaker

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Data collected	Main Findings
					Theme 4: religion and therapy Some participants said the therapy paid less attention to religion than they had expected. Most therapists recognised the benefits of discussing religion, but many lacked the confidence to do so. Assessment of therapy adherence revealed that therapists had generally delivered Behavioral Activation in accordance with the adherence criteria, as described in Mir et al. (2012)), but religious beliefs mentioned by patients were not always followed up, and neither was the use of religion as a resource always explored. Qualitative feedback from therapists highlighted barriers such as unfamiliarity with Islam and worries that patients would know more than them or would feel patronised. Some therapists suggested the manual should include a therapist script to support sensitive engagement. Those who had delivered the therapy reported their confidence increased with practice, suggesting confidence is linked to normalising such discussions Patients felt the therapists who lack knowledge of Islam should discuss religion in order to understand it. Both religious and non-religious clients were recruited. One participant said he wondered whether he was being punished in some way. However, he hadn't discussed this thought with his therapist. Overall, findings suggest that religion should be explored in terms of its 'positive coping' functions (Pargament et al., 2001)" A values assessment tool was seen as useful by patients, but it was introduced later than recommended because of limited time and it was experienced as difficult for therapists in the context of a short intervention. Patients were extremely positive about a self-help booklet they had received, describing it as 'brilliant', 'very helpful', 'really good', and feeling 'excited' and 'reassured' that potential support from Islam was acknowledged: "She gave me a leaflet with all hadeeths [Prophetic teachings] on it, it was brilliant. I knew half of them, but the other ones I didn't know. I even got them checked out by my friend of mine and he said. 'look', you know, 'they're authentic you know, it's right." NL, male, 46, English speaker The booklet's relevance to therapy was not well-explained, however, meaning that participants were not able to fully understand the links between the two. One participant, who dropped out after three sessions, did not receive the booklet and felt 'it would have been useful'; another received the English version although her first language was Urdu.

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Data collected	Main Findings
					Therapists felt 'uncomfortable' and unsure how to use the booklet and would have liked scripts in the therapist manual to introduce the resource. Three of the therapists said that having less knowledge of Islam than patients would be a barrier to offering the resource and another reported a patient being offended at a non-Muslim therapist offering the booklet. One therapist felt her own Christian identity made the booklet difficult to accept and she preferred to ask patients about Qur'anic teachings rather than refer to those within the booklet. However, patients said unfamiliarity with Islam should not stop therapists from offering the booklet or using the teachings to negotiate goals Theme 5: impact of therapy Most patients were positive about Behavioral Activation and said that unfamiliarity with Islam should not stop therapists from offering the booklet or using the teachings to negotiate goals. Patients reported achieving valued goals such as restarting a business, performing prayers, learning more about Islam, reciting scriptures, spending time with children and walking outdoors. One patient who had been offered for counselling would have preferred to carry on with Behavioral Activation. Participants who withdrew did so because they were too busy and did not feel any benefit (3), they wanted the therapist to focus more on religion (1) or thoughts (1), session times clashed with a social group (1), they wanted to deal with problems within the family first (1) or that therapy had provided closure (1). Overall, the results suggest that therapists and patients need more support to deliver and engage with this intervention.
11. Phillips & Andriopoulu (2022)	N=16 All Female Adults Age range=19-48 (Mean and SD not reported)	Pakistani (31.25%) British Indian (43.75%) Indian–Gujarati (6.25%) Indian–British Citizen (6.25%) Indian–Punjabi (6.25%) Bangladeshi British (6.25%)	Eating Disorders PTSD Depression Childhood Sexual abuse Anxiety Relationship difficulties Substance Abuse	Qualitative - semi-structured interviews	Three main themes and a number of subthemes were derived from the data: Theme 1: Shared background and understanding Theme 2: Humanity Subtheme a): Assumptions and stereotypes in therapy Subtheme b) Experiences of judgemental and non-judgemental practitioners Subtheme c) Some participants felt practitioners lacked the ability or willingness to see them as individuals Subtheme d) Power dynamics were strongly influenced by the humanity of practitioners and their understanding

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Data collected	Main Findings
					Theme 3: Importance and influence of cultural factors Subtheme a) Cultural pressures felt by participants and the impact they may have upon the experiences of services e.g., Pressure on women Subtheme b) Inherent link between family and culture and the impact of practitioners' understanding and sensitivity to family values. Subtheme c) The importance of faith, its relationship with mental health and the sensitivity of practitioners Subtheme d) Benefits of sharing languages with practitioners
12. Phiri et al. (2023)	N=32 Male n=5 and Female n=27 Adults Mean age=34.8 (SD not reported)	Black African (6%) Black Caribbean (12%) Black Other (9%) Indian (21%) Bangladeshi (3%) Chinese (9%) Other Asian (6%) Other/mixed (32%)	Depression Schizophrenia Generalised anxiety disorder Social phobia PTSD OCD Mixed depression and anxiety	HADS BSI WHO Core PEQ	Findings indicated that this culturally adapted, CBT-based third-wave therapy manual intervention was effective for minority groups. Findings indicated moderate effect sizes for improvements over time. Repeated measures of analysis of variance: HADS depression: $F(2, 36) = 12.81$, $P < 0.001$, partial $\eta 2 = 0.42$ HADS anxiety: $F(2, 26) = 9.93$, $P < 0.001$, partial $\eta 2 = 0.36$; CORE total score: $F(1.25, 18.72) = 14.98$, $P < 0.001$, partial $\eta 2$ WHODAS: $F(1.29, 14.18) = 6.73$, $P < 0.001$, partial $\eta 2 = 0.38$ PEQ responses were positive
13. Rathod et al. (2013)	N=33 CaCBTp (n=16) TAU (n=17) Male n=20 and Female n=13 Children and Young People Mean age=33.5 (SD= 11.60)	African Caribbean (27%) Black African (15%) Mixed race (30%) Pakistani (18%) Bangladesh (6%) Iranian (3%)	Schizophrenia Psychosis	CPRS MADRAS Schizophrenia Change Rating Scale Brief Anxiety Rating Scale PEQ	Positive mean differences indicated a positive result for CaCBTp over TAU. Post-treatment, the intervention group showed statistically significant reductions in symptomatology on overall CPRS scores, CaCBTp Mean (SD)=16.23 (10.77), TAU=18.60 (14.84); p=0.047, with a difference in change of 11.31 (95% CI: 0.14 to 22.49). Post treatment, mean (SD) total insight scores were: CaCBTp 10.23 (3.49) and TAU 11.07 (3.70). At six months follow-up the mean total insight scores were: CaCBTp Mean (SD)=10.14 (3.32) and TAU=11.06 (2.90). Insight domains 2 (acceptance of illness) and 3 (re-labelling of psychotic experiences) when adjusted for baseline scores post-treatment were statistically significant at p 0.001 and p 0.001 respectively, a 0.11 unit improvement in CaCBTp when compared to TAU

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Data collected	Main Findings
					Medication: Analyses of medication was calculated in terms of Chlorpromazine equivalents at baseline: CaCBTp group M (SD)=407.30 (392.62) and TAU group 502.54 (544.59). Two participants were on both 1st and 2nd generation antipsychotics: CaCBTp (n=1) and TAU (n=1). Participants on Clozapine constituted 18% of the sample. At six months follow-up, the mean medication change for the TAU group was M (SD)=2.29 (1.10) and CaCBTp group 3.13 (0.61) a statistically significant difference between the two groups:β=−0.83; p 0.001. Post-treatment, overall satisfaction with treatment experience was based on PEQ item 10 (PEQ) (n=14), M (SD)=4.36 (1.082) (88.2% CI; 3.71 to 4.71). Overall satisfaction was significantly correlated with the number of sessions attended (r=0.563; p=0.003). PEQ items 10 (How satisfied are you with the overall experience of using this service: CaCBTp?) and 8 (How involved were you with important decisions about your care/treatment?) were significantly correlated (r=0.563;p=0.003). There was a strongly significant correlation between PEQ items 10 and 5 (How satisfied are you with therapist that treated you?) (r=0.78; p0.001). Males had a slightly higher satisfaction than females (M=4.50 vs. M=4.17) p=0.58 although not statistically significant. Overall satisfaction was associated with accessibility, type of therapy, therapist and involvement in decision-making process
14. Vincent et al. (2013)	N=7 Male n=4 and Female n=3 Adult asylum seekers Mean ages not reported	Barundi (42.85%) Sudan (28.57%) Afghanistan (14.29%) Zimbabwe (14.29%) Iraq (14.29%)	PTSD	Qualitative: Semi-Structured schedule	Findings suggest that fear of repatriation can negatively affect engagement in Trauma Focused CBT (TFCBT). Therapists and patients were aware they had no control over the clients' asylum status and thought that engagement in therapy was undermined by the "perceived powerlessness of the therapist or therapy" (p.7) in this regard. Also, given the magnitude of their experiences, participants did not fully believe that therapy would overcome their distress, and therefore were unsure about engaging in therapy. It is possible that the clients do not feel safe, effectiveness of TFCBT for asylum seekers. Six super-ordinate interlinking themes are discussed: Theme 1: Staying where you are versus engaging in therapy Theme 2: Experiences encouraging engagement in therapy Theme 3: Experiences impeding engagement in therapy Theme 4: Importance of the therapeutic relationship Theme 5: Losing oneself Theme 6: Regaining life

Appendix d: Table of Studies of Cultural Adaptations of Therapies

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Treatment Cultural Adaptations
1. Bahu, M. (2019)	N=16 Male n=4 and Female n=12 Adults: Mean age = 32 (SD not reported)	Tamil (100%)	Grief Worry Rumination Panic attacks Anxiety PTSD	**CBT (Group)** Culturally adapted CBT group programme to support Tamil clients who presented with severe anxiety and depression due to trauma. Modification to location, pathways and actively engaging with community leaders Therapy plans were developed through collaborative work with the clients and was discussed in detail to establish the goals of therapy. Content from a variety of Cognitive Behavioural Therapy approaches and focusing on a variety of presenting problems focused on creating safety, anxiety, worry, panic management, understanding trauma and trauma reactions. Specific cultural components in activities, and use culturally relevant imagery, proverbs, metaphor and stories in treatment so the clients could make sense of what was being offered. Input was included from the Tamil community leaders, members and clients
2. Durà-Vilà et al. (2013)	N=102 Male n=75 Female n=27 Children and young people Mean age=10.1 (SD not reported)	Middle Eastern countries (44%) African countries (27%) European countries (22%) Other countries (7%)	Did not include psychiatric diagnostic assessments Range of disorders included: Behaviour disorders Depression PTSD	**Direct therapeutic work** to the children and families, training & consultation with teachers to raise competence in the recognition and management of children's psychological distress, and appropriate referral. It was delivered by community-based child and adolescent mental health professionals. A variety of flexible treatment and management options were available: ▪ Liaison with other agencies ▪ Problem-solving and practical help ▪ Individual psychotherapy based on narrative work, supportive treatments, family therapy and cognitive therapy. With varying degrees of adapting content. Interpreter was provided when it was necessary.
3. Edge et al. (2018)	N=31 Male n=21 and Female n=10 Adults Mean age=43 (SD=13.77)	Afro-Caribbean descent born in England (70.97%) Afro-Caribbean Born in Caribbean (19.35%) No data available (9.67%)	Schizophrenia	**Culturally adapted family intervention (CaFI)**. This was based on a family intervention for schizophrenia: Service user assessment: ▪ Explore the role of racism in past experiences with mental health services. ▪ Consider culturally relevant models of health and illness. ▪ Be aware of culturally relevant markers of functioning, such as food. ▪ Take a future-focused recovery-based approach in assessing strengths and resources ▪ Explore family structure and dynamics, acknowledging potential tension. Psychoeducation (renamed as "shared learning"): ▪ Focus on knowledge exchange between clients, therapists, and carers.

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Treatment Cultural Adaptations
				▪ Acquire culturally appropriate knowledge. ▪ Educate clients, carers, and therapists about the mental health system, culturally specific models of mental illness, and medication effects. ▪ Improve communication and advocacy skills to enhance interactions with mental health services. Stress management and coping: ▪ Address conflicts within families and between carers and healthcare professionals. ▪ Recognize the care burden and the possibility of clients caring for their carers. ▪ Emphasize carers' rights and responsibilities. ▪ Include relapse prevention, crisis planning, and developing positive coping strategies. Problem-solving and goal-planning: ▪ Current model deemed good by focus group and conference. ▪ Additional considerations include contingency planning, highlighting resources, and emphasizing progress rather than failure. ▪ Celebrate successes along the journey to acknowledge even small steps.
4. Faheem, (2023)	N=9 Male n=1 Female n=8 Adults: Mean age= 33 (SD 5.74)	Pakistani (44.4%) Bangladeshi (11.1%) Chinese (11.1%) Arab (22.2%) Chinese (11.1%)	Depression Anxiety disorders	**Group CBT, CBT, and Counselling** Did not report on specific adaptations, rather have reported on clients' experiences of treatment and whether evidence based psychological interventions are suitable to the needs of BAME. communities
5. Gurpinar-Morga et al. (2014)	N=5 Male n=1 Female n=4 Children and Young People Age range 16-18 (mean & SD not reported)	Black or minority ethnic groups (100%)	No disorder specified but under the care of specialist adolescent mental health services	**CBT** Doesn't specify adaptation. Explored views and experiences of BME young people who have accessed a Mental health service.

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Treatment Cultural Adaptations
6. Hammad et al. (2020)	N=16 All Female Adults Intervention 1 n=10 Age range=36-83 (Mean and SD not reported) Intervention 2 n=6 Age range=41-84 (Mean and SD not reported)	British Middle Eastern and North African Muslims (100%)	Did not include psychiatric diagnostic assessments Range of difficulties included: Bereavement PTSD Displacement from home	**The Hand of Hope therapeutic group interventions** adopted an integrative therapeutic approach utilizing community psychology, cognitive-behavioural aspects, relational/interpersonal, narrative, expressive/ humanistic therapies, and Western group therapy principles. The first group intervention consisted of eight once weekly two-hour sessions and ran from April to June 2018. The group sessions focused on the cultural healing practices/collective cultural coping strategies: group cooking and communal gatherings over food and oral storytelling The second group intervention involved nine weekly 90-minute sessions and ran from April to June 2019, 22 months after the Grenfell Tower fire. The second coproduced Hand of Hope therapeutic group intervention was run in partnership with NHS GHWS (adults service) and a third sector organization. The group was coproduced and co-facilitated by the first and third author. The group requested to focus on their religion, the seerah, stories of the prophets, and to engage in traditional arts. Participants requested informal, culturally appropriate faith informed. therapeutic interventions delivered in Arabic. A combination of bottom-up (Hwang, 2009) and top-down (Bernal, Bonilla, & Bellido, 1995) approaches were used to create a culturally appropriate intervention. Hwang's (2009) formative method for adapting psychotherapy (FMAP) utilizes a bottom-up approach consisting of collaborating with community stakeholders to develop ideas to adapt the therapy, and involves five phases that target developing, testing, and reformulating therapy modifications. Bernal and colleagues (1995) outline an Ecological Validity Model consisting of eight dimensions of culturally adapting interventions for ethnic minority groups using a top down approach: a) language (e.g., offering therapy in the client's preferred language); b) persons (e.g., matching client and therapist on salient variables to enhance therapeutic alliance, such as culture/race/language); c) metaphors (e.g., use of cultural expressions and concepts); d) content (e.g., applying cultural knowledge about traditions, customs, and values); e) concepts (e.g., intervention concepts consistent with culture); f) goals (e.g., support of client's desired outcomes); g) methods (e.g., cultural enhancement of intervention methods); and h) context of the intervention/services (e.g., considering impact of client's socio-political economic context). The Hand of Hope therapeutic group interventions were informed by Herman's (1992) three phase (non-linear) model of trauma recovery. The first phase of recovery involves safety and stabilization (e.g., stabilizing symptoms and building trusting relationships). The second phase involves remembrance and mourning (e.g., expressing emotional impact of and processing trauma and loss). The third phase focuses on reconnection (e.g., reintegration and reconnecting with people, meaningful activities, and other aspects of life).

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Treatment Cultural Adaptations
				A community psychology approach was adopted that aimed to meet the mental health needs of ethnic minority and faith groups that were not engaging with mental health services by trying to address the reported barriers to improve access, and improve service user experience by coproducing and tailoring therapeutic interventions to meet their cultural and faith needs following collective trauma and loss
7. Jidong et al. (2022)	N=16 All Female Adults Age range=20-55 (Mean and SD not reported) Intervention 1 (LTP+CaCBT): Learning Through Play plus Culturally adapted CBT n=13 Intervention 2 (control group): Psychoeducation n=13	African/ Caribbean origin	Maternal Depression	**Learning Through Play (LTP)** Described as "...a culturally relevant pictorial calendar activity for mothers, depicting eight successive stages of child development from birth to 3 years. The pictures have been adapted to reflect African/ Caribbean culture so the participants could relate well to the calendar. The calendar is accompanied by a manual with a step-by-step guide for facilitators." CBT techniques of active listening, changing negative thinking, guided discovery (i.e., questioning style to both gentle probe for health beliefs and stimulate alternative ideas), culturally appropriate behavioural tasks and homework. Participants are further educated (noting traditional values and cultural beliefs) about maternal depression and anxiety, correlates and management, social support and practical advice on accessing appropriate healthcare. These cultural adaptions were informed by the 'patient and public involvement (PPI) event' and 'Focus group participatory action research (FG-PAR)', conducted with African and Caribbean mothers, caregivers, clinicians and clinical researchers. It is claimed these groups helped with co-adaption which used culturally relevant case examples and pictorial illustrations. It might also be worth noting, LTP+CaCBT was conducted in a group-based environment. Although this was not noted as a specific cultural adaption, the authors noted how "the scope of group-integrated intervention addressed the instrumental role of collectivism in African and Caribbean parenting culture.' So, the group element of the therapy may be a relevant adaption to consider when evaluating the intervention.
8. King & Said (2022)	N=14 Males n=13 and Female n=1 Children and Young People (Unaccompanied asylum-seekers) Mean age = 16.36 (SD=0.93)	Afghanistan (35.71%) Ethiopia (21.42%) Sudan (35.71%) Somalia (7.14%)	Did not report on specific mental health issues. Participants were not limited to those with formal diagnoses	**CBT based psychological skills group.** Encompassing a range of interventions from first wave, second wave and third wave CBT approaches. These were focused on three themes of physical health needs, emotional wellbeing and resilience building. Adaptations ▪ Overall adaptation in content and amalgamation of approaches and interventions ▪ Initial focus on physical health as this is a presenting concern. ▪ Psychoeducation on diet, routine and the importance of physical health ▪ Introducing strategies to respond to difficulties falling asleep and difficulties staying asleep applicable to UASC.

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Treatment Cultural Adaptations
				▪ Supporting engagement with the group by meeting with each young person to assess their unique mental health needs as well as how they felt about attending a group and whether they had any concerns. ▪ Issues related to power, racism and status were acknowledged and emphasis was placed on collaboration and certain interventions within the group also took on a more explicit empowerment aim. ▪ Language needs analysis was carried out as part of the initial assessment for the group, allowing clients to state their preferred spoken language and dialect. Using interpreters (up to 5) enabled the provision of an equitable and accessible service. ▪ Less content was planned for each group session to account for the increased amount of time required to support interpretation. ▪ The final consideration was being mindful of the needs of the group as young people. Adaptations were made for the content to be more user-friendly and interesting and to be delivered in a manner that considered young people's developmental stage. Content Physical health needs ▪ The importance of physical health ▪ Sleep hygiene and psychoeducation ▪ Sleep guides ▪ Routines ▪ Yoga Emotional wellbeing ▪ Values, goal setting ▪ Identifying emotions, emotions in the body ▪ The fight/flight/freeze response ▪ Function of emotions ▪ Managing overwhelming emotions: DBT-informed ▪ self-soothing and distress tolerance ▪ Cycles of avoidance ▪ Grounding and memories ▪ Three affect-regulation systems (CFT) ▪ Soothing rhythm breathing, safe place imagery. ▪ Hot cross bun and stress ▪ Managing worries and thoughts ▪ Relaxation and mindfulness exercises

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Treatment Cultural Adaptations
				Resilience-building and empowerment ▪ Strengths ▪ Problem-solving booths ▪ London/home – getting used to somewhere new, transitions. ▪ Racism ▪ Tree of Life ▪ Something I am proud of ▪ Hopes
9. Masood et al. (2015	N=16 All Female Adults Age ranged from 20-45 (Mean and SD not reported)	Pakistani (88.24%) Indian (5.88%) Bangladeshi (5.88%)	Postnatal depression	**Culturally adapted CBT called the Positive Health Programme or PHP.** There are no details of this intervention here other than: ▪ The programme was designed to be delivered to groups of participants using the cognitive behavioural model. ▪ The manual assisted programme, tailored to the cultural needs of British Pakistani women, was developed by our group and initially feasibility tested for a PhD project. ▪ It consisted of 12 weekly group sessions delivered over 3 months. The manual is organized into 9 distinct sections.
10. Mir et al., (2015)	Study 2 N=19 Male n=5 and Female n=14 Adults Age range= 23–56 years (Mean or SD not reported)	All self-identified as Muslim Pakistani backgrounds (89.47%) African backgrounds (5.26%) Indian backgrounds (5.26%)	Depression	**Behavioral Activation** An existing BA manual was used as the basis of the adaptation. Much of the manual remained unchanged, and care was taken to maintain the integrity of the basic mechanism of BA, namely, activating the client to increase contact with positive reinforcement. Regarding social context, the link between the abovementioned environmental stressors and depression was described in detail in a new section in the manual. Therapists were encouraged to target adverse social circumstances through activation assignments, consistent with the patient's goals and readiness to address these issues. The manual also explained and differentiated between cultural and religious influences on the experience of depression in Muslim populations. In addition, therapists were encouraged to increase their knowledge of Islam and convey a message of understanding and social inclusion to counter the adverse social context. Therapists were encouraged to accept patients' religious and health beliefs without judgement and to promote BA's basic idea of activating personally meaningful behaviours, whatever the perceived cause of depression. The manual also encouraged therapist self exploration about preconceived ideas that might lead to stereotyping and prejudice. A reference list of relevant social organisations and religious experts that therapists could potentially consult was included in the manual; however, findings suggested a need for more research on collaboration with faith healers, given reports of exploitation (Dein et al., 2008). The adapted manual, therefore, promoted collaboration but suggested that therapists work with professionals, such as NHS chaplains, when possible.

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Treatment Cultural Adaptations
				Given the mixed findings on patient–therapist matching, the adapted intervention promoted professionalism, a non-judgemental approach and some knowledge of Islam was placed above shared identity as the most important therapist attribute. At the same time, offering a choice of therapist, where possible, was also recommended to accommodate potential patient concerns. The adaptations to the BA manual to support engagement with religious practice were somewhat novel and will be described in detail. First, the manual advised therapists to assess patient religiosity and tailor the intervention to individual patient needs, depending on level of religiosity and religious identity. Whilst the therapy was always seen as 100% BA, the extent to which religious behaviour and beliefs were addressed would depend on how important these were to each patient. Assessment of patient values is part of standard BA; however, a specific values assessment tool (adapted from Walser and Westrup (2007)) was included in the manual to facilitate the process and support therapist identification of religious and other important values. The adapted manual included suggestions for religious activities and encouraged therapists to treat such activity in line with the BA model by scheduling and structuring the behaviour on a case-by-case basis. Where patients' ambivalence about religion contributed to depression, therapists were encouraged to signpost patients to individuals with expertise in Islamic teachings from the list of local resources provided, and to consult experts themselves where necessary. To increase patient and therapist awareness of and access to Islamic teachings as appropriate, a self-help booklet (Shabbir et al., 2012) was developed in English and Urdu, inspired by other research on mental health in Muslim communities (Maan, 2010), and with input from advisory group members and a Muslim clinical psychologist. The booklet avoided sectarian differences and religious teachings that could support negative interpretations of depression or induce guilt. Therapists were advised to only offer the booklet to patients who had identified religion as an important value. The resource was presented as enhancing, rather than substituting for, BA approaches and therapists were encouraged to discuss and draw on the content during sessions, if appropriate. The final content of the adapted intervention differed from the original manual in terms of an introduction outlining the need for the adapted therapy; additional resources in the form of a values assessment tool, the self-help booklet and a list of local religious groups and experts; guidance for therapists on how to engage with Muslim patients to treat depression and understand the social context in which these patients live.

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Treatment Cultural Adaptations
11. Phillips & Andriopoulu (2022)	N=16 All Female Adults Age range=19-48 (Mean and SD not reported)	Pakistani (31.25%) British Indian (43.75%) Indian–Gujarati (6.25%) Indian–British Citizen (6.25%) Indian–Punjabi (6.25%) Bangladeshi British (6.25%)	Eating Disorders PTSD Depression Childhood Sexual abuse Anxiety Relationship difficulties Substance Abuse	**A range of talking therapies** Doesn't specify interventions but describes a range of talking therapies (including counselling & Cognitive Behavioural Therapy) accessed from primary, secondary and charity mental health service.
12. Phiri et al. (2023)	N=32 Male n=5 and Female n=27 Adults Mean age = 34.8 and SD not reported	Black African (6%) Black Caribbean (12%) Black Other (9%) Indian (21%) Bangladeshi (3%) Chinese (9%) Other Asian (6%) Other/mixed (32%)	Depression Schizophrenia Generalised anxiety disorder Social phobia; PTSD OCD Mixed depression and anxiety	**CBT-based, third-wave therapy manual** The adaptation facilitated the inclusion of family members and careers to be involved in the therapy; allowed for the somatic conceptualisation of emotional issues and teaching stories Spirituality and religion, where relevant, are integral to all versions of Comprehend, Cope, and Connect (CCC). The manual developed this aspect further to meet the needs of a diverse population. In many ethnic minority cultures, the family is the nucleus within households and communities, so incorporating this core value with ensure more efficacious treatment outcomes. Families are able to provide support within therapy sessions, at home with homework tasks, but also within the wider community promoting positive outcomes for the patient and acceptance of such interventions and services in the wider community. Similarly, ethnic minority groups hold various spiritual and religious values which greatly impact understanding of psychopathology and influence help-seeking behaviours. It is important to understand these elements as they greatly impact values and beliefs, and these are the concepts of wellness explored within therapy. Culturally adapted CCC used in the current study is an abridged version of standard CCC offered in IAPT therapy at the moment.
13. Rathod et al. (2013)	N=33 CaCBTp (n=16) TAU (n=17) Male n=20 and Female n=13 Children and Young People Mean age=33.5 (SD= 11.60)	African Caribbean (27%) Black African (15%) Mixed race (30%) Pakistani (18%) Bangladesh (6%) Iranian (3%)	Schizophrenia Psychosis	**CBT for Psychosis (CaCBTp)** Doesn't detail in this paper, but principles underlying the cultural adaptation are published (Rathod et al., 2010).

Author, date	Sample size Gender Age	Ethnicities / Country of origin (% of total sample)	Disorder	Treatment Cultural Adaptations
14. Vincent et al. (2013)	N=7 Male n=4 and Female n=3 Adult asylum seekers Mean ages not reported	Barundi (42.85%) Sudan (28.57%) Afghanistan (14.29%) Zimbabwe (14.29%) Iraq (14.29%)	PTSD	**Trauma Focused Cognitive Behavioural Therapy (TFCBT)** involved focusing on traumatic events and their meaning, through imaginal reliving (Ehlers and Clark, 2000) and/or adapted testimony within a CBT framework (see Grey and Young, 2008). All participants had previously received a phased approach to treatment, with Cognitive Behavioural Therapy based psychoeducation and symptom management, involving activity scheduling or anxiety management, being provided before TFCBT. The median number of therapy sessions received was 8 (range 7–20). The median number of TFCBT sessions was 3 (range 2–10). TFCBT involved imaginal reliving for four participants, adapted testimony within a CBT framework for one participant, and a combination of adapted testimony and imaginal reliving for two participants. For asylum-seekers it seems reasonable to assume that the possibility of repatriation and further trauma would contribute to a sense of serious current threat and may undermine the effectiveness of TFCBT. Indeed, there is some evidence that fear of repatriation contributes to the risk of ongoing PTSD (Steel et al., 2006) Adaptations relevant to asylum seekers as recommended by NICE are based on the work of Herman (1992). 1) Establish safety; addressing primary needs, such as accommodation, benefits, family separation, physical problems; and establishing a trusting therapeutic relationship. 2) Once a sufficient sense of stability and security has been established then the use of TFCBT may be considered to treat persisting PTSD. 3) Help clients to reconnect with their communities and rebuild their lives. The concern is whether it is possible for asylum-seekers to achieve a sufficient degree of stability and security to engage in and benefit from TFCBT (given a potential fear of repatriation)

Appendix e: Table of Key Characteristics of Empirical Research Focused on Therapists

Author, date	Sample size Gender Age	Ethnicities / Country of origin/ Religious affiliation (% of total sample)	Role	Data collected	Main Findings
1. Faheem, (2023)	N=9 Male n=1 Female n=8 Adults: Mean age= 33 (SD 5.74)	Pakistani (44.4%) Bangladeshi (11.1%) Chinese (11.1%) Arab (22.2%) Chinese (11.1%)	Trainee PWP (12.5%) Qualified PWP (18.8%) CBT therapists (68.8%)	Qualitative – semi-structured interviews	Out of sixteen participants, only nine therapists received one-day formal training throughout their therapeutic career, whilst seven reported receiving no cultural competence training at all. Theme 1: Cultural dissonance encountered during therapy. ▪ Sub-theme describes the cultural expressions of distress that were discussed during therapy. ▪ Subtheme describes service users' therapeutic expectations and the challenges therapists encountered trying to explain Western notions of therapy. ▪ Sub-theme describes cultural challenges beyond the therapy room that had both implicit and explicit implications for BAME service users e.g., family dynamics. Theme 2: Challenges in making cultural adaptations to therapy. ▪ Sub-theme describes the conflict therapists encountered in adhering to treatment fidelity and making cultural adaptation. ▪ Sub-theme describes the challenges therapists experienced in getting appropriate culturally adapted resources. ▪ Sub-theme describes the challenges therapists encountered when working with interpreters. ▪ Sub-theme describes the challenges therapists encountered in helping BAME service users achieve recovery. Theme 3: Identifying cultural competency needs. ▪ Sub-theme describes therapists' self-reflections about their cultural knowledge and understanding. ▪ Sub-theme describes the innate responsibility that was placed on BAME therapists to serve ethnic minority communities and the implications that this had for practice. ▪ Sub-theme describes the importance of cultural competency training and good supervision to support therapists to work effectively with BAME service users.

Author, date	Sample size Gender Age	Ethnicities / Country of origin/ Religious affiliation (% of total sample)	Role	Data collected	Main Findings
2. Golker & Cioffi (2023)	N=5 Male n=3 Female n=2 Age range= 33-67 (Mean or SD not reported)	Identified as Jewish sub-types (80%) Secular Jewish (20%)	Trainee PWP (12.5%) Qualified PWP (18.8%) CBT therapists (68.8%)	Qualitative – semi-structured interviews	Participants' responses yielded four themes as well as 12 sub-themes: Theme 1: Cultural understanding: Role of culture; Individual experience. The importance of therapists being aware of the cultural norms and religious practices of the Orthodox Jewish community. This was perceived to be a key factor in the ability of therapists working with Orthodox Jewish clients. Role of culture: Therapists believe that the cultural differences of the Orthodox Jewish community do not justify adopting an entirely different approach to their CBT treatment. This is in line with the recent finding that CBT is an efficacious clinical treatment for Orthodox Jews suffering from anxiety and depression disorders, even without adopting major cultural adaptations throughout treatment (Rosmarin et al., 2019) As CBT has been founded on individualistic assumptions, there is a potential risk of focusing solely on the individual without viewing them in their broader context (orthodox Jewish communities primarily collectivistic societies in which the cultural and religious values and practices of the community have a substantial influence on the lives of individuals). Individual experiences: Although, there is a substantial variation within the Orthodox Jewish community in terms of the strictness of their religious observance and their attitudes towards engagement with secular culture. Confronting shame: Combating stigma; Normalising therapy; Heightened confidentiality. The feeling of shame that Orthodox Jews can experience when seeking psychological treatment for a mental health condition. Combating stigma: There was widespread agreement from participants that the Orthodox Jewish community has made considerable progress to promote mental health within the community. Normalising Therapy: Even though the mental health stigma has subsided within the Orthodox Jewish community, individuals experienced considerable shame when accessing psychological support. Heightened confidentiality: Several therapists mentioned that Orthodox Jewish clients are particularly secretive about the fact that they have sought psychological help for a mental health condition. They may fear community

Author, date	Sample size Gender Age	Ethnicities / Country of origin/ Religious affiliation (% of total sample)	Role	Data collected	Main Findings
					members finding out that they are accessing psychological support or that their therapist would disclose personal information to their rabbi or community leaders. Theme 2: Building trust: Suspicious attitudes; Cultural sensitivity; Therapeutic relationship. The necessity for therapists to elicit the trust of their clients. Suspicious attitudes: When engaging with a therapist from a different cultural and religious background, Orthodox Jewish clients may fear that their therapist will not approve of their way of life, or even attempt to influence or change their religious beliefs. belonging to a different community can evoke mistrust from Orthodox Jewish clients, and even slight discrepancies between the religious practice of the therapist and client can evoke mistrust. Cultural sensitivity: Given the suspicious attitudes of Orthodox Jews towards mental health professionals, therapists are advised to be sensitive to the cultural and religious needs of this client group. E.g., 'modesty' is an important religious and cultural value for Orthodox Jews, CBT therapists are recommended to dress and interact modestly to facilitate culturally sensitive treatment with this client group; refrain from utilising resources or ideas which conflict with the religious beliefs of the Orthodox Jewish community; that therapy resources presented to the client are approved by a rabbi beforehand; a secular therapist can be viewed as a 'messenger of God', a prestigious title meaning 'a conduit of God's will' when they demonstrate genuine respect for Orthodox Jewish religious beliefs and practices. Therapeutic relationship: Several participants described the importance of developing a strong therapeutic alliance with Orthodox Jewish clients to gain their trust. a CBT therapist can gain the trust of their Orthodox Jewish clients by demonstrating that they are a member of the Orthodox Jewish community. Theme 3: Religious beliefs: Religious compatibility; Incorporating religious teachings; Scrupulosity; Rabbinic guidance. How therapists approach the religious beliefs of their Orthodox Jewish clients. Religious compatibility: Overwhelmingly, therapists believed that the CBT approach was compatible with Orthodox Jewish beliefs and teachings.

Author, date	Sample size Gender Age	Ethnicities / Country of origin/ Religious affiliation (% of total sample)	Role	Data collected	Main Findings
					Religious teachings: Several therapists found it beneficial to explain CBT concepts or principles to Orthodox Jewish clients using Jewish teachings. Scrupulosity: Orthodox Jews will often present mental health difficulties related to their religious beliefs and practices. For therapists, it was important to make the distinction between normative Orthodox Jewish beliefs and practices, and psychopathological behaviour. Rabbinic guidance: Some therapists highlighted the importance of working collaboratively with a rabbi to deliver therapy that meets the religious needs of the Orthodox Jewish community.
3. Mir et al., (2015)	Study 2 N=19 Male n=5 and Female n=14 Adults Age range= 23–56 years (Mean or SD not reported)	All self-identified as Muslim Pakistani backgrounds (89.47%) African backgrounds (5.26%) Indian backgrounds (5.26%)	Community mental health workers (31.03%) BA/intercultural therapy academics (20.69%) Clinical Psychologists (17.24%) Muslim service users (13.79) Service managers (10.34%) GPs (6.9%)	Qualitative Interviews	Four primary themes identified within data: Theme 1: Core elements of the BA model were acceptable and a potential good fit for Muslim patients. This was largely because key informants felt the model's straightforward behavioural focus linked to patient values resonated with Islamic. Theme 2: Importance of social context. This is largely as respondents commented upon links between depression and environmental stressors affecting Muslim populations e.g., discrimination, social exclusion, high levels of unemployment, poverty and poor health. Theme 3: Patient–therapist matching if appropriate for the client. Evidence was mixed about the need for patient–therapist matching. Some reported patients could potentially develop trust and openness more quickly with matched therapists and experience less need to explain and justify their values and behaviour. On the other hand, some key informants reported that patients had fewer fears of being judged and fewer teachings and concerns about confidentiality when practitioners did not share the patients' background. Theme 4: Religion and therapy. The importance of openness to, and specific inclusion of, religious teachings and an 'Islamic way of life,' which is often linked by patients to good health was emphasised by a number of key respondents. Presenting therapeutic goals through the framework of Islamic teachings was considered by many key informants to be an important means of adapting BA. A range of Islamic teachings was identified as promoting 'positive religious coping' such as resilience, hope, making sense of experience and increased self-esteem. Core elements of the BA model were acceptable to Muslim patients. Religious teachings could potentially reinforce and enhance BA strategies and concepts

Author, date	Sample size Gender Age	Ethnicities / Country of origin/ Religious affiliation (% of total sample)	Role	Data collected	Main Findings
					were more familiar to patients and more valued than the standard approaches. Patients appreciated therapist professionalism and empathy more than shared religious identity but did expect therapist acceptance that Islamic teachings could be helpful. Patients were generally enthusiastic about the approach, which proved acceptable and feasible to most participants; however, therapists needed more support than anticipated to implement the intervention.

Appendix f: Table of Key Characteristics of Guidance Documents

Author, date	Focus	Basis of Adaptations	Summary of recommendations or adaptations
Rathod et al. (2019)	How to culturally adapt CBT to clients from non-Western background	Refers to several cultural adaptation framework /models, including: 1) The ecological validity model for cultural adaptation. This framework consists of eight elements: language, persons, metaphors, content, concepts, goals, methods, and context (e.g., Bernal, 1995) 2) Surface structure adaptations and deep structure adaptations (e.g., Resnicow and colleagues (2000) 3) integrative and multi-dimensional cultural accommodation model (Leong and Lee (2006) The authors state that the models have limitations in relation to cultures other than Asian and Hispanic groups	(1) Culturally adapted CBT shows better results in individuals from different cultural groups. (2) Adaptation of therapy requires a robust methodology. (3) Every individual has a unique culture that is influenced by their wider culture, sub-culture and further developed through unique life experiences. (4) There must be flexibility in applying the culturally adapted therapy, and clinicians should be aware of their biases, and propensity to stereotype when working with people from minority groups adaptation in our work has focused on three fundamental areas of delivery, which we refer to as the 'Triple-A' principle: I. Awareness of relevant cultural issues and preparation for therapy. This can be further subdivided into: a) Culture and culture-related issues including religion and spirituality, family and community, and language and communication. b) System and environmental aspects including individual capacity and circumstances, systems of support, services, and help seeking pathways into care. c) Cognitive biases and unhelpful beliefs that are directly related to the problem and its treatment. II. Assessment and engagement. III. Adjustments in therapy

Appendix g: Table of Key Characteristics of Scoping Reviews

Author, date	Sample Size [dates of data collection]	Target Population	Research Aims	Summary of Findings
Coelho et al. (2022)	26 studies included. [Between 2012 to 2022]	Children and young people from ethnic minority backgrounds with mental health problems	To describe the nature and scope of qualitative research about the experiences of children and young people from ethnic minority backgrounds in seeking or obtaining care or support for mental health problems	Lack of awareness and knowledge about some mental health issues/conditions, sometimes including under-appreciation of the seriousness and misunderstanding of the causes of the conditions, both of which could deter care-seeking. Lack of trust in care professionals, potentially due to perceptions of services or professionals operating in a way that is not culturally sensitive and/or past experiences of feeling let down by services. Note that, among refugees or asylum seekers, this distrust had different root causes (such as fear of links to the justice/asylum system and language differences) and different manifestations (such as resistance to paper form-based assessment or therapy exercises). Lack of awareness/lack of information about available services and support for mental health difficulties. Social stigma – either self-perceived by the young person and/or embedded in and related to the services and institutions providing care. Culture-, community- and religion-specific reasons for either hiding/suppressing the admission of having mental health difficulties, or for seeking support from informal or alternative sources rather than mainstream mental health services. Differing expectations about mental resilience and levels of ease in talking about problems between different ethnic groups, and between boys/young men and girls/young women within particular ethnic groups.

Appendix h: Good practice guidance sources

Authors:	Good practice guidance sources
American Psychological Association	**Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations** https://www.apa.org/pi/oema/resources/policy/provider-guidelines
Barnett, Jeffrey E;	**Culturally Sensitive Treatment and Ethical Practice** https://www.apadivisions.org/division-31/publications/articles/maryland/barnett-ethical.pdf
Beck, Andrew; Naz, Saiqa; Brooks, Michelle; Jankowska, Maja;	**IAPT Black Asian and Minority Ethnic Service User Positive Practice Guide** https://babcp.com/BAME-Positive-Practice-Guide
British Association for Behavioural & Cognitive Psychotherapies	**BABCP Equity, Equality, Diversity and Inclusivity Statement** https://babcp.com/EDI
British Psychological Society	**Working with interpreters: Guidelines for psychologists** https://explore.bps.org.uk/content/report-guideline/bpsrep.2017.inf288
Care Quality Commission	**Culturally appropriate care - Care Quality Commission** https://www.cqc.org.uk/guidance-providers/adult-social-care/culturally-appropriate-care
Edwards, Amy; Santhosh, Sindhu; Kunorubwe, Taf;	**Cultural Change in IAPT - A Work in Progress** https://www.researchgate.net/publication/360826626_Cultural_Change_in_IAPT_-_A_Work_in_Progress
Haque, Farzana; Thapa, Binita; Kunorubwe, Taf;	**Reflections on Cultural Competence Training in IAPT** https://www.researchgate.net/publication/355406161_Reflections_on_Cultural_Competence_Training_in_IAPT
Kunorubwe, Taf; Edwards, Amy; Santhosh, Sindhu;	**The Struggles of Working in a Culturally Competent or Culturally Sensitive Way within IAPT - Part 1** https://www.researchgate.net/publication/363847761_The_Struggles_of_Working_in_a_Culturally_Competent_or_Culturally_Sensitive_Way_within_IAPT_-_Part_1
Kunorubwe, Taf; Edwards, Amy; Santhosh, Sindhu;	**The Struggles of Working in a Culturally Competent or Culturally Sensitive Way within IAPT - Part 2** https://www.researchgate.net/publication/366445851_The_Struggles_of_Working_in_a_Culturally_Competent_or_Culturally_Sensitive_Way_within_IAPT_-_Part_2
NICE	**NICE: Innovative ways of engaging with Black and Minority Ethnic (BME) communities to improve access to psychological therapies** https://www.nice.org.uk/sharedlearning/innovative-ways-of-engaging-with-black-and-minority-ethnic-bme-communities-to-improve-access-to-psychological-therapies
Patient and Carer Race Equality Framework	**Patient and Carer Race Equality Framework (PCREF) at South London and Maudsley** https://slam.nhs.uk/pcref
TADF	**Developing Racial-Cultural Competence: A Call to all therapists** https://tadf.co.uk/2022/12/08/developing-racial-cultural-competence-a-call-to-all-therapists/

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