

EVIDENCE-BASED RESOURCE GUIDE SERIES

# Adapting Evidence-Based Practices for Under-Resourced Populations



**SAMHSA**  
Substance Abuse and Mental Health  
Services Administration

# Adapting Evidence-Based Practices for Under-Resourced Populations

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## Abstract

Tailoring care, programs, and services to the cultural, social, gender, and other socio-demographic contexts of individuals served yields positive outcomes.<sup>1</sup> Communities and individuals benefit when they receive behavioral health services that are clinically proven effective, equitable, and culturally appropriate.

This guide focuses on the process of adapting evidence-based practices (EBPs) for under-resourced populations who experience obstacles in obtaining healthcare services because of their socio-demographic characteristics, and the research supporting such adaptations. The guide provides examples of research on adapted EBPs for mental health and substance use disorders for clients with a wide range of demographic characteristics.

The guide provides considerations and strategies for community leaders and advocates, behavioral health practitioners, administrators, and organizational decision-makers.

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<sup>1</sup> Lee, S. J., Altschul, I., & Mowbray, C. T. (2008). Using planned adaptation to implement evidence-based programs with new populations. *American Journal of Community Psychology*, 41, 290-303. <https://doi.org/10.1007/s10464-008-9160-5>



**MESSAGE FROM THE ASSISTANT SECRETARY  
FOR MENTAL HEALTH AND SUBSTANCE USE,  
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

As the Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the head of the Substance Abuse and Mental Health Services Administration (SAMHSA), I am pleased to present this new resource: *Adapting Evidence-Based Practices for Under-Resourced Populations*.

SAMHSA is committed to improving prevention, treatment, and recovery support services for individuals with mental illnesses and substance use disorders. SAMHSA's National Mental Health and Substance Use Policy Lab developed the Evidence-Based Resource Guide Series to provide communities, clinicians, policy makers and others with the information and tools to incorporate evidence-based practices (EBPs) into their communities or clinical settings. As part of the series, this guide aims to inform behavioral health practitioners and other interested parties and stakeholders about the process of culturally adapting evidence-based practices for under-resourced populations. On the care continuum, although this guide focuses predominantly on adapting treatment EBPs, the adaptation process outlined in the guide is applicable to any EBP in behavioral health, including prevention, treatment, and recovery practices for substance use and mental health.

This guide and others in the series address SAMHSA's commitment to behavioral health equity, including providing equal access for all people to evidence-based prevention, treatment, and recovery services regardless of race, ethnicity, religion, income, geography, gender identity, sexual orientation, and disability. Each guide recognizes that substance use disorders and mental illness are often rooted in structural inequities and influenced by the social determinants of health. Behavioral health practitioners and community stakeholders must address health equity as a strategy for improving individual and population health.

Increasing robust inclusion of under-resourced populations in clinical trials and health research is a key goal to mitigating disparities. Simultaneously adapting evidence-based practices, while retaining core practice components, can help mitigate the disparities too often seen in behavioral health outcomes for these populations. This guide discusses the different types of adaptations and key steps in the adaptation process. I encourage you to use this guide to ensure that all populations benefit from culturally appropriate and clinically effective care.

**Miriam E. Delphin-Rittmon, PhD**

Assistant Secretary for Mental Health and Substance Use  
U.S. Department of Health and Human Services

# Evidence-Based Resource Guide Series Overview

The Substance Abuse and Mental Health Services Administration (SAMHSA), specifically its National Mental Health and Substance Use Policy Laboratory (Policy Lab), is pleased to disseminate information on evidence-based practices (EBPs) and service delivery models.

The Evidence-Based Resource Guide Series is a comprehensive set of modules with resources to improve health outcomes for people at risk for, experiencing, or recovering from mental health and/or substance use disorders. It is designed for practitioners, administrators, community leaders, health profession educators, and others considering an intervention for their organization or community.

Expert panels of federal, state, and non-governmental participants provide input for each guide in this series. The panels include accomplished researchers, educators, service providers, community members with lived experience, community administrators, and federal and state policy makers. Members provide input based on their lived expertise, knowledge of healthcare systems, implementation strategies, EBPs, provision of services, and policies that foster change.

A priority topic for SAMHSA is ensuring that behavioral health services reach under-resourced populations for prevention, engagement, early intervention, treatment, and recovery. Additionally, President Biden's Executive Order 13985: *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government* directs federal agencies to evaluate whether their policies produce racially inequitable results when implemented and to make the necessary changes to ensure underserved communities are properly supported. Implementation of evidence-based policies, programs, and practices can reduce the impacts of mental health and substance use disorders for individuals and communities. However, implementation and uptake of EBPs can be challenging for states, tribes, communities, and organizations.<sup>2</sup> Nationally, EBPs are reported to be only a small fraction of the prevention, treatment, and recovery programs that behavioral health programs implement.<sup>3,4</sup> In addition, an EBP must be adapted to the cultural norms and values of the group to whom practitioners deliver it. As a result, individuals in need of certain behavioral health services do not always receive the benefit of EBPs. This guide reviews the diverse types of cultural adaptations, the process for adapting EBPs

<sup>2</sup> Walker, S.C., Whitener, R., Trupin, E. W., & Migliarini, N. (2013). American Indian perspectives on evidence-based practice implementation: Results from a state-wide Tribal mental health gathering. *Administration and Policy in Mental Health and Mental Health Services Research, 42*, <http://doi.org/10.1007/s10488-013-0530-4>

<sup>3</sup> National Research Council and Institute of Medicine. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington, D.C.: National Academies Press.

<sup>4</sup> Glasgow, R. E., Vinson, C., Chambers, D., Khoury, M. J., Kaplan, R. M., & Hunter, C. (2012). National Institutes of Health approaches to dissemination and implementation science: Current and future directions. *American Journal of Public Health, 102*(7), 1274–1281. <https://doi.org/10.2105/AJPH.2012.300755>

to serve under-resourced populations, and the research supporting such adaptations.

Implementing new programs and practices requires a comprehensive, multi-pronged approach. This guide

is one piece of an overall approach to implement and sustain change. Readers are encouraged to review the [SAMHSA website](#) for additional tools and technical assistance opportunities.

***Behavioral health equity** is the right to access high-quality and affordable healthcare services and supports for all populations, including Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. As population demographics continue to evolve, behavioral healthcare systems will need to expand their ability to fluidly meet the growing needs of a diverse population. By improving access to behavioral health care, promoting quality behavioral health programs and practice, and reducing persistent disparities in mental health and substance use services for under-resourced populations and communities, recipients can ensure that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with promoting access to high-quality services, behavioral health disparities can be further mitigated by addressing social determinants of health, such as social exclusion, unemployment, adverse childhood experiences, and food and housing insecurity.*



# Content of the Guide

This guide contains a foreword (FW) and five chapters (1–5). Each chapter is designed to be brief and accessible to community leaders and advocates, behavioral health practitioners, administrators, researchers, organizational decision-makers, and others working to meet the needs of individuals at risk for, experiencing, or recovering from a mental health or substance use disorder.

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## **FW Evidence-Based Resource Guide Series Overview**

Introduction to the series.

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### **1 Issue Brief**

This chapter provides definitions of evidence-based practice adaptation, reasons for adapting EBPs, comparing fidelity versus fit, and different levels and types of cultural adaptations.

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### **2 What Research Tells Us**

This chapter highlights research on adaptations of EBPs and describes the steps in the process of adapting an EBP.

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### **3 Guidance for Adapting EBPs**

This chapter provides best practices for adapting EBPs and then implementing the adapted practice.

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### **4 Examples of Cultural Adaptations of EBPs**

This chapter highlights three examples of organizations developing and implementing adapted EBPs for under-resourced populations in their communities.

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### **5 Resources for Evaluation and Quality Improvement**

Guidance and resources for documenting and evaluating the process of adapting an EBP and the implementation of the adapted practice.

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## **FOCUS OF THE GUIDE**

Tailoring care, programs, and services to the cultural, social, gender, and other demographic contexts of individuals served yields positive outcomes. Communities and individuals benefit when they receive behavioral health services that are clinically proven effective, equitable, and culturally appropriate.

This guide describes various types of cultural adaptations of EBPs for under-resourced populations and the multiple steps in the adaptation process. The guide also focuses on research supporting such adaptations.

The guide does not focus on a sole behavioral health outcome or a specific under-resourced population. Instead, it details the adaptation process practitioners can tailor and implement for their individual programs. This guide is intended to be broad and provide information for practitioners across both the mental health and substance use disorder fields.

On the care continuum, this guide focuses predominantly on adapting treatment EBPs, although the adaptation process that this guide describes is applicable to any EBP in behavioral health, including prevention, treatment, and recovery practices for substance use and mental health.



## Issue Brief

Health inequities adversely affect under-resourced communities and are reflected across a number of physical and [behavioral health](#) outcomes.<sup>1</sup> Under-resourced communities are defined population groups that experience greater obstacles to health, based on characteristics such as, but not limited to, race, ethnicity, religion, income, geography, gender identity, sexual orientation, and disability. While recent data suggest that prevalence of mental health and substance use disorders are generally *not* higher for under-resourced racial groups, people in these groups are less likely to seek or receive treatment services.<sup>3-4</sup> In another example, a 2015 survey of transgender adults found that 7 percent of transgender adults had attempted suicide in the past year and 40 percent in their lifetime, compared to 0.6 and 4.6 percent of the general U.S. population.<sup>6</sup>

**Health inequities** are differences in health status or in the distribution of health resources among different population groups, arising from the social conditions in which people are born, grow, live, work, and age.<sup>2</sup>

**Structural racism** is defined as a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity.<sup>5</sup> It remains a root cause of persistent health disparities in the United States.

Clinical research shows that evidence-based practices (EBPs) improve behavioral health outcomes for children, adolescents, and adults.<sup>7-8</sup> However, for an EBP to be effective for a population with whom it was not tested, it must be adapted to the cultural norms and values of the group to whom it is to be delivered.<sup>9</sup> Additionally, there is often a “know-do” gap, with an estimated time frame of 17 years between the development of an EBP to its optimal implementation in communities of need.<sup>4</sup>

**Evidence-based practices** are interventions for which there is consistent scientific evidence showing that they improve client outcomes.<sup>10</sup>

Often, the demographic characteristics of participants in research on an EBP are different from those of the population that hopes to benefit from its implementation<sup>17</sup>; demographic characteristics include social and cultural factors. Under-resourced communities are commonly underrepresented in the research that tests the efficacy of substance use and mental health prevention and treatment EBPs.<sup>8, 18</sup> Further, as few EBPs have been adapted to under-resourced populations, there is limited implementation of EBPs with these populations.<sup>19</sup>



Historically, under-resourced populations are excluded from clinical trials and large studies in health research.<sup>11</sup> Research cites multiple reasons for this exclusion<sup>12</sup>: mistrust and fear or exploitation experienced by some under-resourced populations; shortage of researchers who themselves identify with and represent the under-resourced populations and who could help address some of the trust issues; and logistical barriers potential participants face, such as inflexible schedules and lack of transportation. As a result of this exclusion, clinicians find it hard to apply lessons from health research to the under-resourced populations in their care.

The optimal solution to this problem would be to tackle the above barriers and increase diversity in health services research.<sup>13</sup> This change needs to be deliberate, systemic, and pervasive throughout the research enterprise. Until such a shift happens, cultural adaptation and/or tailoring of EBPs are valuable and empirically sound approaches to treating behavioral health concerns of under-resourced populations.<sup>14</sup> The cultural adaptation of EBPs allows a practitioner to integrate cultural competence into therapy.<sup>15</sup> Cultural adaptation serves as a “unifying bridge” between practitioners who uphold the need for new treatment approaches for the behavioral health issues of under-resourced populations and those who recommend that existing treatment methods should be tested, unchanged, with these populations.<sup>16</sup>



This chapter:

- Defines adaptation
- Discusses why practitioners<sup>5</sup> should adapt EBPs for under-resourced populations
- Examines the distinction between [fidelity](#) and fit
- Describes the different levels and types of cultural adaptations

**Culture** is a broad, multi-dimensional construct, influenced by the context of social norms and experiences. Culture refers to integrated patterns of human behavior that include the language, spirituality, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.<sup>22</sup>

**Cultural competence** is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals, enabling them to work effectively in cross-cultural situations.<sup>23</sup>

Five essential elements contribute to the ability of a system, institution, or agency to become more culturally competent:

1. Valuing diversity
2. Having the capacity for cultural self-assessment
3. Being conscious of the dynamics inherent when cultures interact
4. Having knowledge of institutionalized culture
5. Having the knowledge and capacity to adapt service delivery that reflect an understanding of cultural diversity

**Cultural adaptation** is the systematic modification of an EBP’s protocol and/or content to consider language, culture, and context such that it is compatible with the client’s cultural patterns, meanings, and values.<sup>24</sup>

**Cultural integrity** is the practice of respecting and honoring the ownership of materials, traditions, and knowledge of a particular culture or community.<sup>25</sup>

<sup>5</sup> The terms *provider* and *practitioner* are used throughout this guide to refer to individuals providing services. The specific term depends on context. Similarly, for simplicity, *client* is used throughout this guide to refer to individuals receiving behavioral health services. The authors recognize that while some professional roles or settings may use this term exclusively, other organizations, professional roles, or settings may use the term patient or other term.

# What Does Adaptation Mean?

Adaptation of an EBP involves making changes to better fit the needs of the population being served without negatively affecting, removing, or changing key or core implementation elements.<sup>20</sup> Core elements are defined as “the essential program components that are believed to make an EBP effective and that should be kept intact to maintain intervention effectiveness.”<sup>21</sup> Examples of adaptations include, but are not limited to, additions, deletions, or modifications of non-core program components; changes in content; and changes in who delivers the EBP and how the practitioner engages with clients.<sup>4</sup> Outcomes measured with consistently applied adaptations can help ensure the ongoing effectiveness of specific EBPs within the populations being served. Adaptation of an EBP can occur within the context of implementation science and/or cultural adaptation.

Only the **non-core elements** of the EBP can be adapted. Further, adapting an EBP does not automatically make the adaptation an EBP. Rigorous evaluation discussed in [Chapter 5](#) is required to establish the evidence for the adaptation.

## Implementation Science View of Adaptation

Implementation science is defined as “the scientific study of the methods to promote the systematic uptake of clinical research findings and other EBPs into routine practice and hence improve the quality and effectiveness of health care.”<sup>26</sup> Implementation science defines adaptation as “a process of thoughtful and deliberate alteration to the design or delivery of an intervention, with the goal of improving its fit or effectiveness in a given context.”<sup>27</sup> Improving fit includes ensuring cultural relevance. [Cultural integrity](#) in the adaptation of an EBP increases the likelihood of equitable implementation and desired outcomes.

Behavioral health practitioners may also adapt an EBP organically to suit the individual needs of a particular client. While this is a form of adaptation, it is not the focus of this guide.

In 2013, the U.S. Department of Health and Human Services Office of Minority Health (OMH) released the enhanced [National Standards for Culturally and Linguistically Appropriate Services \(CLAS\) in Health and Health Care](#), originally developed in 2000, to provide a blueprint for individuals and healthcare organizations to implement CLAS.<sup>29</sup>

The National CLAS Standards are intended to advance health equity, improve quality, and eliminate healthcare disparities. The standards are based on principles of respect and responsiveness and include a principal standard: *Providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs*. They also include standards in three additional categories: governance, leadership, and workforce; communication and language assistance; and engagement, continuous improvement, and accountability.

Further, in 2021, the Substance Abuse and Mental Health Services Administration (SAMHSA) and OMH published a [Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care](#), which describes strategies for the behavioral health community to provide CLAS.<sup>30</sup>

## Cultural Adaptation of EBPs

Cultural adaptation of EBPs refers to modifying existing programs to best suit the worldviews (i.e., attitudes, values, stories, and expectations about the world) of specific populations, cultures, and/or communities.<sup>24</sup> It can help to address social, cultural, demographic, and other contextual differences between the community in which the EBP was tested and the community in which the EBP will be implemented.<sup>8</sup>

Cultural adaptation often is aimed at increasing the cultural sensitivity of the EBP. Cultural sensitivity is the extent to which the ethnic and cultural characteristics, experiences, norms, values, behavioral patterns, and beliefs of a population, as well as relevant historical, environmental, and social forces, are incorporated into the design, delivery, and evaluation of targeted health promotion materials and programs.<sup>28</sup>

## Why Adapt EBPs for Under-Resourced Populations?

Adapting an EBP can improve the overall effectiveness of that EBP for the specific population with which it will be implemented. Culturally tailored EBPs can be more effective than those developed for a general population,<sup>30</sup> and studies comparing adapted and non-adapted versions of substance use and mental health EBPs have likewise found that cultural adaptation can increase efficacy and effectiveness.<sup>31</sup>

For adaptation of an EBP to be successful, it should happen within the broader context of addressing **systemic inequities**. The adaptation content and process should recognize and be informed by knowledge of the effects of racism, historical discrimination, minority stress, and other **structural forms of oppression** experienced by the under-resourced populations.<sup>33-34</sup>

Without cultural adaptation, implementing EBPs that have been supported solely by research with advantaged populations may result in ineffective or even harmful results,<sup>8</sup> including increasing health disparities.<sup>32</sup>

A final consideration is that, practically speaking, developing a new EBP is a massive undertaking, often requiring years of human and financial resources. In comparison, adapting an EBP for a new population allows practitioners to draw on existing evidence and work from an established EBP, including any training, fidelity support, or documentation already available.

## Fidelity vs. Fit

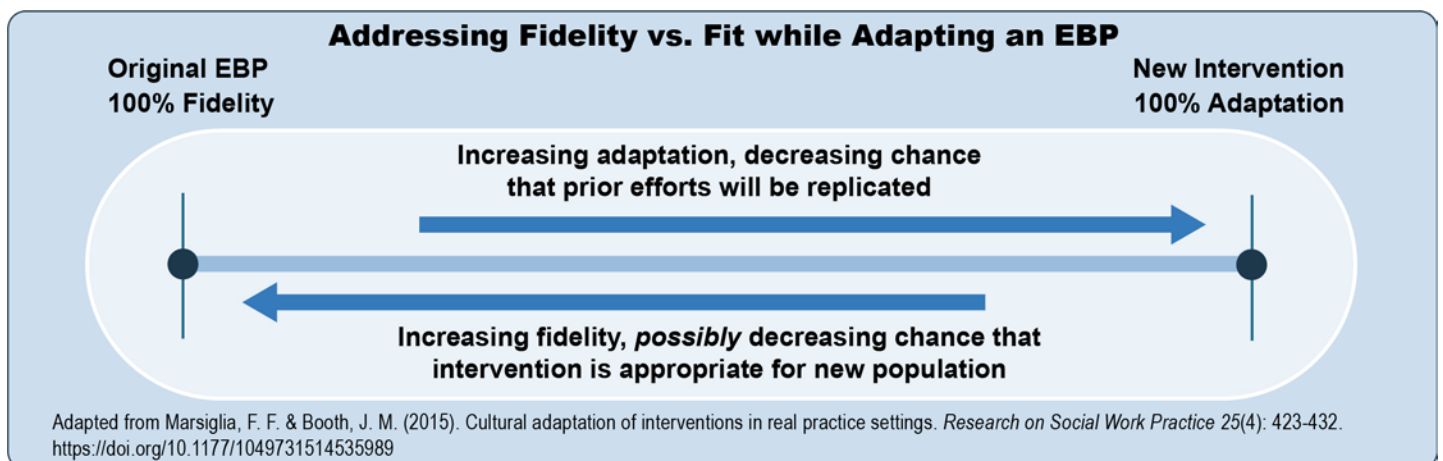
Historically, researchers and program developers have been hesitant to encourage deviations from the researched, manualized forms of EBPs. They tend to emphasize implementing EBPs with high fidelity and minimal change. Those who advocate strict adherence to an EBP's original design and delivery assume that deviations will reduce efficacy and result in suboptimal outcomes, compared to the research evidence.<sup>35</sup>

**Fidelity** has been defined as the extent to which an intervention was delivered as conceived and planned, to arrive at valid conclusions concerning its effectiveness in achieving the target outcomes.<sup>35</sup>

**Fit** refers to how well a program matches, or is appropriate for, the community, organization, [stakeholders](#), and potential participants.<sup>36</sup>

However, this “one size fits all” approach does little to address the concerns that some EBPs are not culturally appropriate or a good “fit” for under-resourced communities. Imposing EBPs when they do not consider the perspectives of a new population may result in clients' lack of interest or engagement in the treatment program.<sup>4</sup> In addition, encouraging strict fidelity to the EBP during implementation limits both a practitioner's ability to be culturally appropriate and the opportunity for practitioners and researchers to learn from cultural adaptations that may actually improve outcomes.<sup>37-38</sup>

Also, it is essential to distinguish between **cultural adaptation**—purposeful modification of the program — and **lack of fidelity**—unplanned modifications in program content and delivery because of barriers, such as time constraints, inappropriate training, or poor preparation.<sup>37</sup>



For these reasons, fidelity and cultural adaptation should not be considered as either-or choices.<sup>37</sup> Both maintaining fidelity and adapting the EBP can and should occur. Recent theories of cultural adaptation suggest that if program implementers modify an EBP in a systematic way without compromising its “core components,” they can maximize benefits for a given population.<sup>31, 35, 39</sup> Implementation with fidelity to the original EBP and complete adaptation are two ends of a continuum; an effective, adapted EBP lies somewhere between the two.

Maintaining an appropriate balance between fidelity and cultural adaptation is a complex but key aspect in tailoring EBPs for new populations. The process of cultural adaptation should be systematic and well-documented and done in dialogue with the EBP developers, who can help ensure the maintenance of core components. When the adapted EBP maintains the key components of the original EBP, it can reasonably be expected to deliver similar positive outcomes. Continued evaluation and research of the adapted EBP can lend further support for its use with the new population and potentially other under-resourced communities, as well.<sup>24</sup>

## What Are the Different Levels of Cultural Adaptation?

Cultural adaptation can be made at various levels—practitioner, program, and organizational.

- At the *practitioner* level, an organization needs to consider the cultural understanding of the participant-facilitator relationship required for successful implementation of the practice.<sup>40</sup>
- At the *program* level, an organization may tailor the modes in which the EBP is delivered—for example, delivering an EBP online to increase access for clients, providing additional training to the practitioners to bring a person-centered approach to their work,<sup>19</sup> or changing the examples/stories practitioners use during therapy sessions to ensure cultural relevance.
- At the *organizational* level, cultural adaptation might involve taking a closer look at the organizational culture (e.g., policies, leadership support) and its alignment with the norms and culture of the population of focus.

## What Are the Different Types of Cultural Adaptation?

The following elements are typically considered when culturally adapting an EBP and play a role in determining the balance between fidelity and fit<sup>24, 41</sup>:

- **Content:** What is being delivered? How does the EBP align with the cultural norms of the population of focus?
- **Implementation:** Who delivers the EBP and what additional training do they need? How is the EBP being delivered? How long is the program? What is the dosage of the EBP? Where is the EBP delivered?

Organizations should adapt an EBP with input from various stakeholders and members within the community where the organizations will implement it. Organizations should engage stakeholders at every step in the adaptation process. [Chapter 2](#) elaborates on the process involved in cultural adaptation of EBPs and presents a model for adaptation based on the following steps:

1. Engage the community and define the issue
2. Assess organizational capacity and readiness
3. Review EBPs, choose one, and re-assess the organizational capacity
4. Select non-core components that can be modified and adapt the EBP
5. Train staff and test adapted materials
6. Implement the adapted EBP and evaluate implementation and outcomes
7. Assess and make further adaptation



## What Research Tells Us

Evidence-based practices (EBPs) improve behavioral health outcomes for specific populations when the content and implementation of the EBP is made culturally relevant.<sup>30, 42-44</sup> This process of cultural adaptation includes modifying the EBP to meet the cultural norms and values of the group to whom practitioners deliver it.<sup>5</sup> Adaptation of an EBP does not automatically make it evidence-based; rigorous evaluation and testing of the adapted model (described throughout the guide) is required.

**Cultural adaptation** is the systematic modification of an EBP's protocol and/or content to consider language, culture, and context such that it is compatible with a client's cultural patterns, meanings, and values.<sup>15</sup>

This chapter discusses research on adaptations of treatment EBPs, although the outlined adaptation process is applicable to any EBP in behavioral health, including prevention, treatment, and recovery practices for substance use and mental health. The first section describes the process of adapting an EBP. The second section illustrates the process using examples of adaptations for three EBPs: cognitive behavioral therapy (CBT), motivational interviewing (MI), and dialectical behavior therapy (DBT). These EBPs were specifically selected, based on a thorough literature review and input from a technical expert panel (TEP) brought together for this guide. While research on EBP adaptations is

limited, researchers have studied adaptations of these three practices more than for other EBPs ([Appendix 2](#) provides background information on these EBPs, with accompanying information on the process of adaptation).

The adaptation examples include a wide range of mental health and substance use outcomes in various populations. This guide is not limited to certain outcomes or populations; it provides practitioners with best practices they can use to adapt and implement non-core components of an EBP for their client population.

For the discussed adapted EBPs, studies only indicate an *association* between the outcomes reached and the modification made to the EBP. In most cases, a *causal* relationship between the two cannot be established because:

1. The studies do not use suitable methods to infer causality, such as randomized controlled trials (RCTs) or quasi-experimental designs (QEDs).<sup>45</sup>
2. Adaptations or types of adaptations are not examined individually, but rather combined and collectively examined in the same study. For example, studies often compare an adapted EBP to a control (no intervention) or minimal treatment control group, which only informs research on whether the adapted intervention as a whole works; it does not identify whether specific parts of the adapted intervention had meaningful effects.

**Association** is evidence demonstrating a *statistical relationship* between an intervention and outcomes measured in the study's sample population. An association may or may not have clinically relevant meaning. Association is *not* causation.

**Causal impact** is evidence demonstrating that an intervention *causes* or is *responsible for* the outcomes measured in the study's sample population.

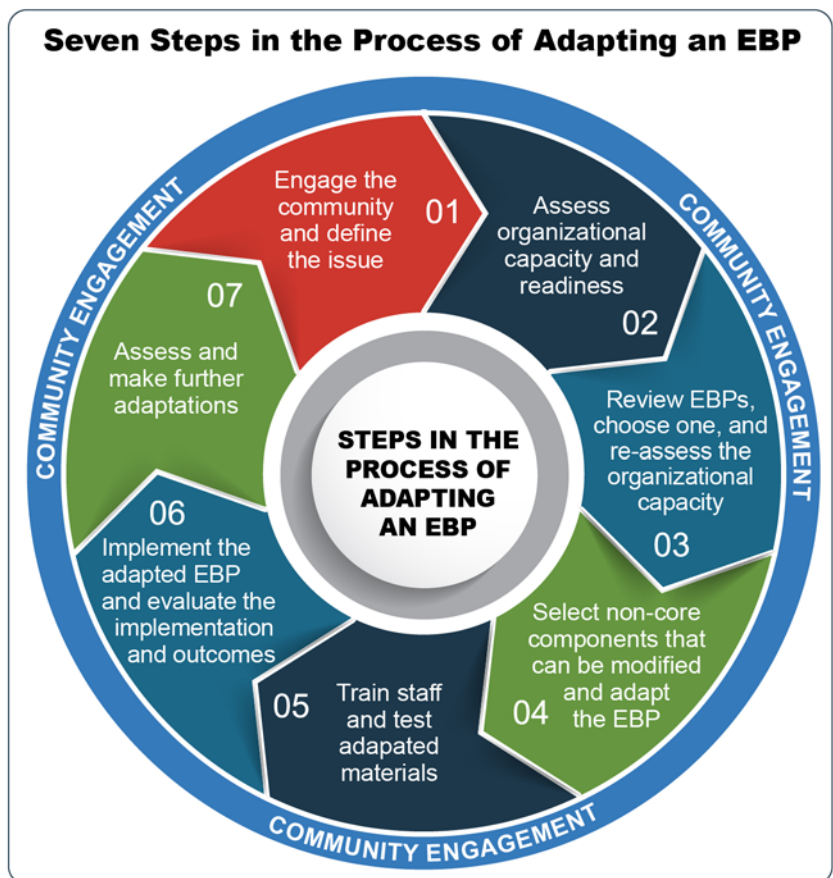
Additionally, most studies of adapted EBPs have not looked at whether cultural adaptations that explicitly address historical racism and oppression are more effective than cultural adaptations that do not. In one study that asked this question, researchers found that health outcomes were differentially improved when adaptations addressed systemic oppression directly.<sup>46</sup> The behavioral health field would benefit from experimental research on specific adaptations of behavioral health programs and practices and their use with particular populations.

## Cultural Adaptation Process

Multiple frameworks describe the necessary steps to adapt an EBP. Most common among these frameworks are:

- [Cultural Adaptation Process Model](#)<sup>47</sup>
- [ADAPT model](#)<sup>48</sup>
- [ADAPT ITT Framework](#)<sup>49</sup>
- [M-PACE](#) (Method for Program Adaptation through Community Engagement)<sup>50</sup>
- [Planned Adaptation](#)<sup>51</sup>
- [Integrated Strategy for Cultural Adaptation of Interventions](#)<sup>24</sup>

Although the steps in each model's adaptation process differ, common themes emerge. Below is a description of the comprehensive process based on these common themes, also depicted schematically.



### Step 1. Engage the community and define the issue

- Engage all [stakeholders](#) within the community.
- Understand the community's cultural beliefs, values, needs, and expectations. Keep an open mind and listen carefully, acknowledging that unless you are part of a given community, you will never know it like the stakeholders know it. Within appropriate boundaries, stakeholders should include children and adolescents when adapting EBPs for those populations.
- Understand the historical discrimination, injustices, and contextual adversity issues affecting the population of focus.
- Work with stakeholders to identify and define the problem at hand.

### Step 2. Assess organizational capacity and readiness

- Assess the capacity of one's organization to implement an EBP, including available resources (e.g., funding, physical space, staff time, and staff experience).
- Assess the organizational readiness for adapting and implementing the intervention.

### Step 3. Review EBPs, choose one, and re-assess the organizational capacity

- a. Identify potential EBPs through a literature search.
- b. Review EBPs with all stakeholders to understand how an EBP's objectives align with the needs of the population for which you are adapting.
- c. Understand the goals of and implementation strategy for each EBP being considered.
- d. Assess the fit between community norms and those underlying each EBP to gauge its acceptability to the community.
- e. Identify the core components of the EBPs that are critical to maintaining program [fidelity](#).
- f. Re-assess the organizational capacity and choose the most applicable EBP based on information collected thus far.

### Step 4. Select non-core components that can be modified and adapt the EBP

- a. Once an EBP has been selected, use information gathered from community assessment and stakeholder consultation to identify content and implementation modifications.
- b. Document what was adapted and the rationale for the adaptations, to create a record available for review by administrators, funders, evaluators, and other organizations.

### Step 5. Train staff and test adapted materials

- a. Increase organizational capacity for the adapted intervention (i.e., hiring staff and providing ongoing training on key components of adapted intervention).
- b. Pilot the adapted intervention with representatives from the intended service population to better understand potential challenges and/or mismatch of assumptions between the adapted EBP and the target community.
- c. Test intervention materials considering reading level (Grade 5 reading level is preferred<sup>90</sup>), comprehension, language, and usability.
- d. Revise as needed.

### Step 6. Implement the adapted EBP and evaluate implementation and outcomes

- a. Implement the intervention while ensuring adherence to the core components of the original intervention.
- b. Consider the contextual/environmental issues that could affect the implementation (e.g., advocating for the under-resourced population and active case management).
- c. Evaluate the implementation: document EBP delivery, assess adherence to fidelity, track participant outcomes, and gather participant feedback.
- d. Continually assess implementation of the EBP's core components to ensure fidelity.

### Step 7. Assess and make further adaptations

- a. Based on the evaluation data, make any necessary additional adaptations that continue to be culturally tailored or relevant to the population of focus.
- b. Repeat steps 3 through 5, above, as appropriate.



It is essential to highlight certain guardrails about the above adaptation process:

- **The process of cultural adaptation described above is not always linear.** Organizations should always begin with community engagement and continue this engagement throughout the process. Individual organizations can change the sequence of next steps based on data gathered from the community during the previous steps.
- **The process of cultural adaptation is iterative.** Cultural adaptations occur in many ways. For example, sometimes adaptations are made to the content or implementation of a specific EBP. In other cases, adaptations focus on changing the organizational culture and are holistic, resulting in all EBPs that organization delivers reflecting this cultural approach.
- **It is critical to engage stakeholders and experts throughout the process.** Organizations should engage stakeholders and community members early and throughout the seven steps of the adaptation process.
- **Fidelity and fit are both important considerations during the adaptation process.** There is often a tension between maintaining *fidelity*—the idea that EBPs should be delivered with adherence to original models—and *fit*—the idea that EBPs should be adapted to reflect the cultural values and norms of the client and address issues of systemic racism and discrimination. However, well-executed cultural adaptations of EBPs can be respectful of both perspectives and still achieve desired outcomes.<sup>52</sup>
- **Adaptations are planned and systematic.** Cultural adaptations cannot be spontaneous and need to be planned and systematic to be effective.
- **Evaluation of the adaptation is extremely important.** Organizations need to evaluate the adaptation and consider collaboration with researchers to expand awareness of the new model. Evaluation will assess effectiveness, safety, and adherence to the adaptation's original intention. Testing and evaluating will also confirm that the EBP adaptation does not lead to unintentional harm to the population with whom organizations implement it.

In the comprehensive process of cultural EBP adaptation described above, step 4 involves decisions about which non-core components can and should be adapted. The following section elaborates on this step's execution.





# Selecting Non-Core Components to Adapt

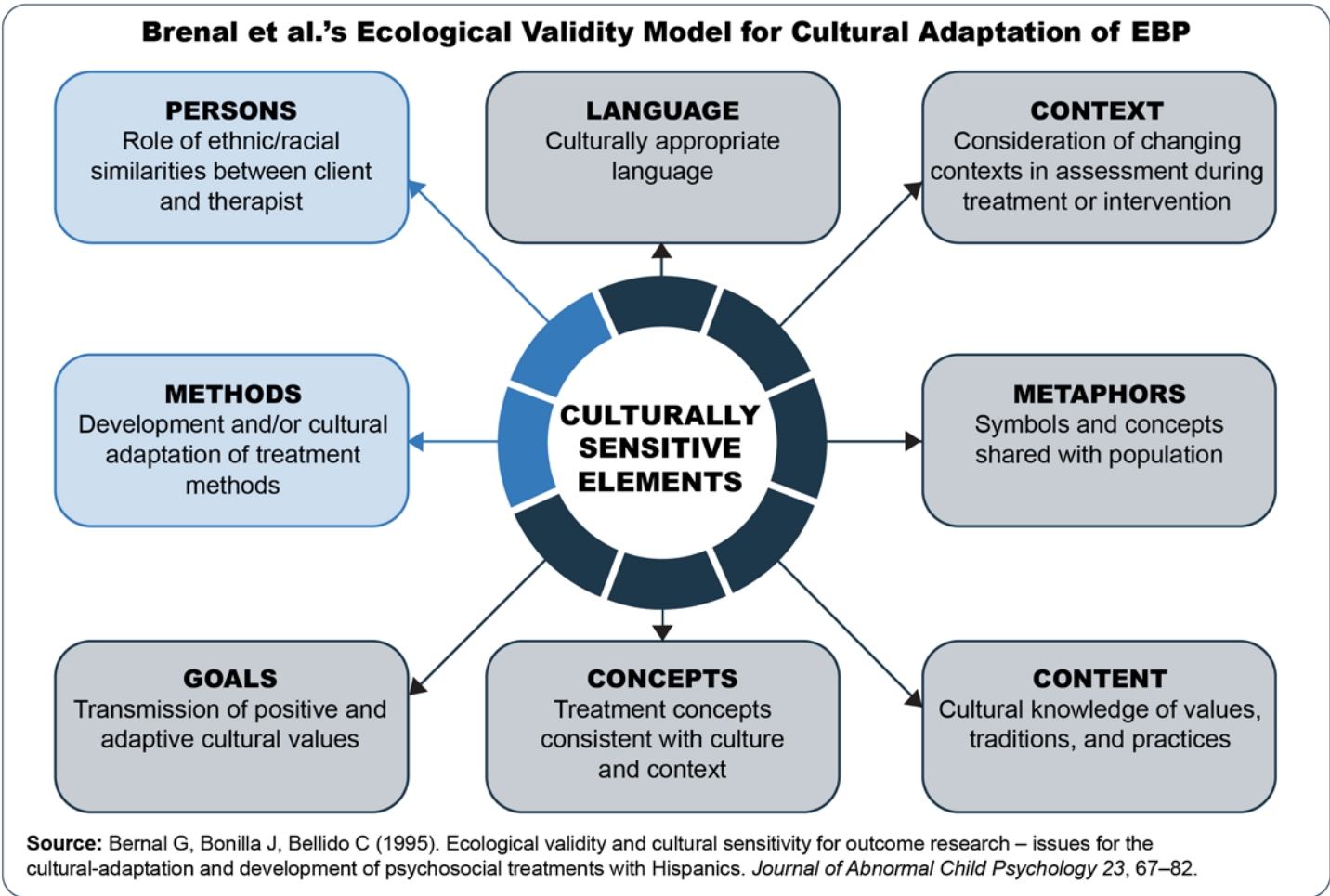
Bernal et al. (1995) presented one of the earliest theoretical frameworks on adapting an existing EBP to a specific community or population.<sup>53</sup> They argued that bringing a culturally sensitive perspective increases the ecological validity of the treatment. The framework includes eight dimensions of adapting an EBP to bring in the lens of cultural sensitivity (see graphic). These eight dimensions overlap with and influence the expression of other dimensions.

**Ecological validity** is the generalizability of study findings or therapy situations to the participant's real-life settings.<sup>54</sup>

The eight elements can be categorized into two areas of adaptation:

1. **Content** (adaptation of *what* information is delivered)
2. **Implementation** (adaptation of *how* information is delivered)

Content-related adaptations are shown in grey; implementation-related adaptations are in blue. Each adapted EBP can include adaptations in one or both areas. The studies examined for this guide adapted EBPs for different populations and sought to change behavior related to several outcomes.



Study	EBP	Population	Outcome	Content Adaptation	Implementation Adaptation
<a href="#">Lee et al. (2013)</a> <sup>55</sup>	MI	Latino adults	Alcohol consumption	✓	✓
<a href="#">Venner et al. (2016)</a> <sup>56</sup>	MI	Native American Tribal adults	Substance use	✓	✓
<a href="#">Hanson et al. (2017)</a> <sup>57</sup>	MI	American Indian women	Alcohol consumption in pregnancy	✓	
<a href="#">Golin et al. (2007)</a> <sup>58</sup>	MI	People living with HIV/AIDS	Safe sex	✓	
<a href="#">Cheng &amp; Merrick (2016)</a> <sup>59</sup>	DBT	Chinese American adult case study	Eating disorder and depression	✓	
<a href="#">Mercado &amp; Hinojosa (2017)</a> <sup>60</sup>	DBT	Latina woman case study	Anxiety and depression		✓
<a href="#">Ross et al. (2007)</a> <sup>61</sup>	CBT	Lesbian, gay, bisexual, and transgender (LGBT) adults	Depression	✓	
<a href="#">Paris et al. (2018)</a> <sup>62</sup>	CBT	Latino adults	Substance use	✓	
<a href="#">Hwang et al. (2015)</a> <sup>63</sup>	CBT	Chinese American adults	Depression	✓	
<a href="#">Kohn et al. (2002)</a> <sup>64</sup>	CBT	African American women	Depression	✓	
<a href="#">Kuhajda et al. (2011)</a> <sup>65</sup>	CBT	Low literacy rural populations	Chronic pain	✓	✓
<a href="#">Kananian et al. (2020)</a> <sup>66</sup>	CBT	Afghan refugees	Posttraumatic stress disorder (PTSD)		✓
<a href="#">Bahu (2019)</a> <sup>67</sup>	CBT	Tamil refugees	Trauma and well-being		✓



## Content Adaptation

Content adaptation involves increasing the EBP's cultural relevance by tailoring the content to the audience, which is by adding cultural elements, substituting non-core elements, or reordering program elements.<sup>68</sup> Content adaptation also may involve including metaphors or references appropriate to that population.

Examples of content adaptation include:

- Lee et al. (2013) used **culturally adapted MI** for reducing **alcohol consumption** and related problems among **Latino adults**.<sup>55</sup> The adaptation included expanding the focus of MI from the individuals and their drinking contexts to the individuals' broader cultural and social contexts, and how they might affect drinking behavior. The adaptation included discussion of additional stressors stemming from experiences of discrimination and acculturation. Acknowledging these important aspects of the social context enhanced the client's feeling of being understood and helped improve the therapist-client relationship.
- While implementing **MI** as a treatment for **substance use disorder outcomes** within a **Southwest tribe**, Venner et al. (2016) used culturally consistent greetings and introductions that involved the spiritual aspect of social interactions.<sup>56</sup> The adaptation also included a discussion of how the counselor and client may be related by clan. The use of spirituality and relationships with the extended family and the community helped enhance motivation for behavioral change.
- Hanson et al. (2017) implemented a version of CHOICES (Changing High-risk Alcohol Use and Increasing Contraception Effectiveness Study), which is an **MI-based EBP**, focused on pre-conception prevention of **alcohol-exposed pregnancy**, adapted for **American Indian women**.<sup>57</sup> The adapted curriculum included local images and pictures. Providers shared alcohol consumption data relevant to the community and information on birth control measures available at local clinics. Finally, they modified the readability level by editing specific words on some surveys in the curriculum.
- During their development of Start Talking About Risks (STAR), an **MI-based safer sex counseling program for people living with HIV/AIDS**, Golin et al. (2007) refined their resources and materials using feedback from interviews and meetings conducted with a community advisory board.<sup>58</sup> As an example, providers used appropriate photographs to reflect clients' diversity.
- While using a cultural adaptation of **DBT** for an **international student** from China with an **eating disorder, depression, and cultural adjustment issues**, Cheng & Merrick (2016) included topics from the client's social-cultural framework, such as understanding of attachment, obligation to family, child-parent relationship, separation-individuation, and interdependence.<sup>59</sup>
- With the goal of improving treatment for **LGBT** people with **depression**, Ross et al. (2007) adapted the existing **CBT** protocol for Mind Over Mood<sup>69</sup> to address homophobia, biphobia, and transphobia and associated structural oppression.<sup>61</sup> Wherever deemed appropriate, providers contextualized group discussion within an anti-oppression framework; for example, practitioners discussed how stereotypes of LGBT relationships may affect the way clients view their own relationships. The providers added sessions specifically related to the coming-out process and to internalized homophobia, biphobia, and transphobia to discuss how these experiences and feelings may impact an individual's depression.
- Paris et al. (2018) delivered a culturally adapted **computer-based CBT** program focused on reducing **substance use** for **Latino adults**.<sup>62</sup> The providers retained CBT skills and strategies from the base intervention—CBT4CBT<sup>70</sup>—and adapted its modularized approach to use a Latin American television soap opera (telenovela) format highlighting culturally relevant experiences, such as immigration-related family separation. In addition, the adapted program emphasized Latino cultural values, such as respect (*respeto*), family orientation (*familismo*), and the value of interpersonal relationships (*personalismo*).

- Using a community-based participatory (CBP) approach, Hwang et al. (2015) adapted and implemented a **CBT** program for **Chinese American adults** with **depression**.<sup>63</sup> The adapted program integrated cultural metaphors and symbols, as well as philosophical teachings that were identified during pre-implementation focus groups. Therapy placed a greater emphasis on goal-setting and problem-solving than the original CBT intervention, and addressed traditional Chinese conceptions of mental illness and stigma.

**Community-based participatory (CBP) approach** upholds the engagement and participation of those who are affected by the issue or problem at hand and recognizes and appreciates the unique strengths and resources each stakeholder contributes to the process. It is a cooperative, co-learning process that involves systems development and local community capacity-building.<sup>71</sup>

- Kohn et al. (2002) included culturally specific content in their **CBT** adaptation for **African American women** experiencing **depression**.<sup>64</sup> Adapted content focused on creating healthy relationships, discussing African American family issues, identifying faith-based coping strategies and the roles of spirituality, and combatting negative images and perceptions of Black women.
- In their work implementing **CBT** with **low-literacy, rural populations**, Kuhajda et al. (2011) worked to lower the associated reading level for the patient workbook.<sup>65</sup>

## Implementation Adaptation

Implementation adaptation typically includes modifying the role of the personnel delivering the intervention and/or modifying the format or channel of delivery (e.g., using a web-based delivery platform instead of in-person group sessions).<sup>68</sup> Less common methods of adapting EBP implementation include modifying procedures for training practitioners delivering the EBP and adjusting the evaluation methods.

Examples of implementation adaptation include:

- In their implementation of **MI** with **Latino adults** seeking to reduce their **alcohol consumption**, Lee et al. (2013) modified staff training to ensure MI therapists had the skills to elicit and then discuss stressful events that provoked thoughts about drinking.<sup>55</sup> Training enhanced therapists' abilities to facilitate discussions about experiences with being discriminated against, difficult relationships with close family members, or obstacles faced due to language barriers.
- While implementing **MI** as a treatment for **substance use disorders** for a **Southwest tribe**, Venner et al. (2016) recruited counselors who were fluent in their clients' language.<sup>56</sup>
- For their case study of **DBT**, Mercado and Hinojosa (2017) ensured that the practitioner assigned to work with a Latina woman to treat her **anxiety and depression** was culturally competent and understood the culturally influenced parts of the client's behaviors.<sup>60</sup>
- In their work implementing **CBT** with **low-literacy, rural populations for chronic pain**, Kuhajda et al. (2011) included pre-service trainings for therapists focused on improving cultural sensitivity, particularly in relation to income and minority populations.<sup>65</sup> During the intervention, therapists also adopted semi-flexible make-up sessions.
- In their implementation of **CBT** with **Afghan refugees** experiencing **PTSD**, Kananian et al. (2020) recruited Farsi-speaking therapists to deliver the program in the clients' native language.<sup>66</sup> The providers also decreased the treatment length, to minimize attendance issues or dropout caused by changes in the participants' life situations. Finally, providers held gender-homogenous therapy groups based on client preferences shared during preliminary focus groups.
- Bahu (2019) delivered their adapted **CBT** program on **trauma and well-being** for **Tamil refugees** and asylum seekers at a local Hindu temple and hired Tamil-speaking therapists to facilitate the program and create a supportive environment for the clients.<sup>67</sup> Therapists also offered tea and biscuits to clients after they shared wartime experiences in group sessions.

## Gaps in Research on Cultural Adaptations of EBPs

Research on cultural adaptations of EBPs using experimental methods, such as RCTs and QEDs, is lacking. This is due to reasons such as inherent bias among researchers that favors the majority white/male demographic, disinterest from communities who have been over-surveyed without any benefit to them, and fear or insecurity some vulnerable populations face (e.g., sexual and/or gender minorities and undocumented immigrants). The lack of experimental studies prevents researchers from establishing causal relationships between the implementation of cultural adaptations and mental health and substance use outcomes.

The adaptation process and associated outcomes have often not been well-documented in studies, leading to a shortage of evaluations of adapted EBPs.<sup>26</sup> Researchers should be encouraged to describe what they adapted, why they adapted it, how they adapted it, and the effectiveness of the adapted intervention with different populations.

Available studies do not address questions about the extent of adaptations needed to achieve cultural relevance and desired outcomes. One way to answer this question would be to implement an intervention that has been adapted in different ways (e.g., comparing adaptations that address contextual factors such as racism to adaptations that do not address such factors) to test their efficacy, feasibility, and cultural acceptability.<sup>72</sup>

Finally, researchers and funding sources should consider alternative ways to conduct research on the effectiveness of cultural adaptations such as **practice-based evidence studies** and **pragmatic clinical trials**. Practice-based evidence involves “the use of clinical expertise, the synthesis of evidence obtained from programs with similar (but not necessarily the same) aims and outcomes, and the gathering of evidence during practice.”<sup>73</sup> Pragmatic trials “inform a clinical or policy decision by providing evidence for adoption of the intervention into real-world clinical practice.”<sup>74</sup>

## Guidance for Adapting Evidence-Based Practices

This chapter provides best practices for adapting and then implementing the adapted [evidence-based practices](#) (EBPs). Specifically, individual sections summarize key considerations and strategies for organizations in carrying out each step of the adaptation process, as outlined in [Chapter 2](#):

1. Engage the community and define the issue
2. Assess organizational capacity and readiness
3. Review EBPs, choose one, and re-assess the organizational capacity
4. Select non-core components that can be modified and adapt the EBP
5. Train staff and test adapted materials
6. Implement the adapted EBP and evaluate implementation and outcomes
7. Assess and make further adaptations

The final section of this chapter includes a list of selected resources that provide further information on the adaptation process and best practices for working with under-resourced populations. Evaluation is the last step in the implementation process, as it is important to document what adaptations organizations made and why, as well as their effectiveness. [Chapter 5](#) discusses equitable evaluation.



## Step 1: Engage the community and define the issue

### Consideration:

With input from the community and its stakeholders, an organization should assess community needs. Based on the results of these assessments, organizations should define the problem in the population that they seek to address.<sup>75</sup>

**Stakeholders** are defined as “individuals, organizations, or communities that have a direct interest in the process and outcomes of a project, research, or policy endeavor.”<sup>76</sup>

Making decisions based on community input will ensure that the adapted EBP is appropriate for that population and will generate “buy-in” and trust from the community, which, in turn, facilitates a more successful implementation.<sup>77</sup>

### Strategies:

- **Identify all stakeholder groups** within the community, such as community members, clients, practitioners, and funders. Ensure that stakeholders have familiarity and experience with the community in question. Organizations should work with these stakeholders to systematically gather and analyze information about the community’s service needs and the issue at hand.<sup>78</sup>
- **Solicit direct input from community stakeholders** on the differences between the population of focus and the population for which the EBP was developed. Recognizing that under-resourced populations historically have not had significant input into the services they receive, organizations should gather information from community members regarding their past experiences with EBPs, their satisfaction with services, and their cultural beliefs. Organizations can gather this information through a [community-based participatory \(CBP\) approach](#). Practitioners can get training on, and then use, strategies like focus groups, one-on-one interviews, and phone or online surveys, to learn more about the needs and experiences of the community. Activities such as surveillance studies and needs assessments are useful in determining what problems community

members face, their perceived causes, and suggestions for helpful services.<sup>79</sup> If possible, organizations should compensate the community stakeholders for their time, experience, expertise, and contribution. In addition to monetary compensation, organizations should consider childcare arrangements, travel reimbursement, and provision of food during community engagement activities.

- **Identify funding to support community engagement activities.** Community engagement activities are resource- and time-intensive. Resources, such as the [Rural Community Toolbox](#), provide information on available grants and other tools to support these activities.

### An Example of the CBP Approach to Engage Stakeholders

Parra-Cardona et al. (2012) describe community engagement in the cultural adaptation of an established parenting intervention for low-income Latino/a immigrants.<sup>80</sup> The adaptation team held several meetings with leaders from local mental health agencies, community organizations, and churches to learn about their perspectives on parenting, thus ensuring all stakeholders were included. The team also conducted a study with Latino/a immigrant parents to learn in-depth about their aspirations and challenges as parents.

Based on the findings from this study, the team learned about:

- Adverse contexts and life circumstances of those Latino/a immigrant parents in their countries of origin.
- Parents’ own experiences of neglectful parenting as children.
- Parents’ experiences as immigrants in the United States, such as long working hours, language barriers, and racial/ethnic discrimination.
- Parents’ own child-rearing needs, such as their desire to instill cultural values in their children, while utilizing safe and non-punitive parenting practices.

The team then used this information to adapt the parenting curriculum, thereby increasing buy-in to the program from the immigrant parents.

## Step 2: Assess organizational capacity and readiness

### Consideration:

Early on, an organization needs to assess its own and the community's readiness for adapting and implementing an EBP. In response to the readiness assessment, an organization may need to undertake capacity-building efforts before adapting and implementing the adapted EBP.

### Strategies:

- **Assess community readiness**, which is the degree to which a community is willing and prepared to act on an issue. Organizations can use measures, such as the [Community Readiness Model](#), to evaluate its readiness.
- **Assess current resources and barriers** and the capacity to provide culturally competent services.<sup>77</sup>
  - Organizations can use tools, such as the [Evidence-Based Decision-Making Measure](#), for this purpose.
  - The [Cultural Competency Assessment Scale](#) provides actions that an organization can take to become more culturally competent.
  - The [National Standards for Culturally and Linguistically Appropriate Services \(CLAS\) in Health and Health Care](#) or the [Behavioral Health Implementation Guide for CLAS](#) can also guide organizations in adopting policies and practices that promote health equity and cultural competency.
- **Form steering committees or other teams** to inform development of the adapted EBP. Ideally, these teams should include practitioners, researchers, community advocates, parents, youth, and those who will benefit from the EBP.<sup>49, 80</sup>

### Consideration:

An organization needs to identify resources that are available to support adaptation, implementation, evaluation, and sustainability of the adapted EBP. This continuous process requires money and other resources, including those associated with staffing, conducting research, holding new training, developing materials, and conducting community outreach. Other resource considerations include the ability of community members to pay for the EBP services, as it will be a key determinant of whether the new population of focus can access services.

### Strategies:

- **Identify resources that could affect which and how services can be delivered** (e.g., staffing, physical space, and technology capabilities). This strategy will have implications for which EBPs organizations consider for adaptation.<sup>75</sup>
- **Identify and obtain additional funding** from government agencies, foundations, or other sources to improve the organization's ability to adapt the EBP and to implement services and/or the community's ability to access them. Organizations can use federal resources, such as the [Rural Health Information Hub](#) and [Department of Health and Human Services](#) or private organizations like the [Robert Wood Johnson, W. K. Kellogg, and Bill and Melinda Gates](#) foundations to identify additional funding. Organizations can also consider non-traditional sources of funding, such as insurance companies and nonprofit hospitals.





### Step 3: Review EBPs, choose one, and re-assess the organizational capacity

#### Consideration:

Based on the community input gathered in step 1, organizations should define the goal of the intervention (e.g., the desired behavior change). This strategy will be key as the organization and its adaptation team identify which (if any) existing EBPs are suitable and feasible given the organization's readiness and resources.

#### Strategies:

- **Assess how well the EBP might fit into the new cultural context or population of focus** by examining previous research and details about the EBP's components. Core elements of the EBP cannot be eliminated, so the team should verify that they are applicable to the new population.<sup>51</sup> Organizations should consider the various costs associated with EBPs, such as training and materials, while choosing the EBP to be adopted. Online resources document EBP details, including assessments of program effectiveness. These resources are provided at the end of this chapter under the [Identifying Evidence-Based Practices](#) heading.
- **Review studies demonstrating general program effectiveness or effectiveness for particular populations.** These studies can inform decisions on which EBPs to consider. In particular, the adaptation team may wish to focus on identifying key differences or similarities between the research contexts and their own organizational setting to determine whether the EBP is likely to be similarly effective in the new setting, and under what conditions.

- **Continue to engage community stakeholders.** Continued conversations with stakeholders will help ensure that adaptations are appropriate.

#### Consideration:

When adapting EBPs, organizations should give careful attention to the potential role of the EBP developer. Intervention developers typically have expertise on the core components of their EBP. For that reason, they can provide valuable input to the adaptation process, particularly when it comes to ensuring [fidelity](#) to key principles. However, some developers may have narrow definitions of what an EBP implementation should look like and may also require payment; these implications could restrict adaptation possibilities and the likelihood of achieving fit within the community.<sup>75</sup>

#### Strategy:

- **Collaborate and, when possible, establish working relationships with the EBP developers.** In addition, branded interventions may involve intellectual property issues that necessitate inclusion of the developer (or which impose other constraints on adaptation). Developers may also have a vested interest—financial or otherwise—in EBP delivery and evaluation. Adaptation teams should consider legal implications and conflicts of interest when selecting EBPs to adapt. Establishing clear guidelines upfront can mitigate the effect of such issues on the adaptation process.<sup>75</sup>

### A Note on Intersectionality

Organizations and practitioners may serve many different populations. Each service participant will have a unique background and set of identities. For example, they may belong to more than one historically disenfranchised group, such as those defined by sex, race, religion, gender identity, socioeconomic status, or sexual orientation, and may experience mutually reinforcing effects of disparity and/or systemic inequality.<sup>82</sup> Individuals with multiple, marginalized identities may face challenges that cause or exacerbate health issues and make seeking and receiving treatment more difficult.

Previous studies provide evidence that individuals experiencing discrimination are more likely to use alcohol and other substances as a coping strategy, and that those with multiple, marginalized identities are more likely to experience PTSD symptoms.<sup>83-86</sup> Alternately, individuals' perceived mental illness or substance use status increases the chances of having been discriminated against.<sup>87</sup> While adapted EBPs are likely to address treatment with a particular community in mind, organizations should take issues of individual identity into consideration throughout the engagement and treatment process.

## Step 4: Select non-core components to adapt and adapt the EBP

### Consideration:

Organizations should carefully consider which elements of the selected EBP are suitable for and/or require adaptation. Core elements should not be adapted, while other non-core components can be. Changes to the EBP should always be motivated by the goal of increasing effectiveness or feasibility when delivered to the community of interest. Finally, organizations should deliver and advertise services in the language, dialect, and method most appropriate for the community served.

### Strategies:

- **Consider the specific risk factors** for the community in relation to the outcomes of focus to help organizations identify where changes are needed.<sup>32</sup> For example, research has shown that individuals from ethnic minority backgrounds who experience structural racism are more likely to experience mental health

problems.<sup>88</sup> Consequently, organizations may need to adapt interventions conducted with such populations to address experiences of racism and discrimination explicitly and implicitly in relation to mental health.<sup>89</sup> Organizations should be cautious to avoid overemphasis on cultural issues and assumptions about cultural groups that are not grounded in treatment needs and response; adaptations based on such assumptions are unlikely to increase intervention effectiveness.<sup>32, 53</sup>

- **Modify the language in resources and materials.** These modifications could include translating materials into a community's preferred language or reducing the reading level of the language used to 5th grade or below.<sup>90</sup> The Flesch-Kincaid test in Microsoft Word is a free resource that assesses the reading level of a document. If program materials need to be translated, the best practice is to use an experienced translator from the community of focus, as well as to “back-translate” the

## An Example of Adapting Language and Other Components of an EBP

Kuhajda et al. (2011) describe adaptation of cognitive behavioral therapy for rural adults with low literacy.<sup>65</sup> As an initial step in the adaptation, the adaptation team worked to “translate” the existing manual for a lower-literacy population, following the [Plain Language Action and Information Network's](#) (PLAIN's) federal plain language guidelines. The team simplified manual language, metaphors, and layout to improve readability. Following the translation, the adaptation team conducted key informant interviews and focus groups with community members to refine the manual further.

Interviews and focus groups helped the adaptation team make other changes to the manual, including:

- Incorporating cognitive load theory guidelines—for example, completing homework examples during sessions before homework was assigned to clients, to familiarize them with the content and tasks. Likewise, the team used worksheets with completed example responses, to help patients generate their own responses.
- Using the “teach back” method when introducing new concepts—a strategy healthcare providers use to confirm whether a client understands what is explained to them. These methods were specifically incorporated into pre- and post-session understanding checks to see whether the content needed further review.
- Enlarging key illustrations from the manual and distributing them as poster-sized laminated figures to reinforce core concepts.
- Removing language and phrases from the initially translated manual that might have been considered condescending, due to oversimplification.
- Breaking the manual into session notebooks and providing those to clients sequentially, so as not to overwhelm them with the entire treatment manual.

This information also helped advise the organization's recruitment strategies. For example, one informant recommended emphasizing that the treatment was not a medication trial, given that the region's African American population may be distrustful of treatments involving medication for historical reasons.

materials into the original language to ensure that the content was translated clearly and accurately.<sup>91</sup> Translation of materials is also an opportunity to ensure that they are at the appropriate literacy level.<sup>78</sup> When it comes to oral translation, it may be tempting to solicit help from family members (e.g., bilingual children) to assist in communications between provider and service user, but it is an inappropriate practice. Instead, organizations should consider hiring bilingual staff and/or interpreters to assist in program delivery and provide sufficient training, so that they deliver translated content with fidelity.<sup>77, 92</sup>

### An Example of Pilot-Testing an Adapted EBP

Chu, Huynh, & Areán (2011) describe adaptation of problem-solving therapy (PST) for older Chinese adults.<sup>94</sup> After initial modifications to the PST manual and using the preferred language of the population, the adaptation team piloted the new intervention in a single case study. The provider delivered the entire 12-week intervention to a single patient, who was assessed with the Patient Health Questionnaire-9 (PHQ-9) before and after treatment. Following the intervention, both the practitioner and the patient were interviewed to gather opinions on the feasibility and acceptability of the treatment, including whether any further changes were needed.

This pilot test provided feedback that helped the adaptation team refine the manual. For example, the team incorporated feedback that older Chinese clients may have difficulty brainstorming solutions to their particular problems on their own, and consequently added therapist-assisted questions and prompts. The pilot test results also suggested that practitioners provide a binder of visual aids and materials for clients to create more of a feeling of legitimacy (in comparison to separate worksheets and handouts) and improve engagement with at-home assignments. Post-pilot interviews also confirmed that the materials and content were acceptable and comprehensible to the patient.

## Step 5: Train staff and test adapted materials

**Consideration:** Once an organization adapts an EBP, it will need to ensure that staff are trained to deliver the adapted content and/or adhere to the adapted methods of delivery with fidelity.

### Strategies:

- **Provide formal training or certification** from the developer. Organizations should inquire about these trainings and offer them to practitioners, along with any additional trainings specific to the adaptation.
- **Consider the characteristics** of an organization's practitioners and determine whether it may be preferable or necessary to hire additional staff whose backgrounds align more closely with the community being served. Research indicates that service users often prefer to work with a provider from the same cultural background.<sup>93</sup> When possible, aligning the provider's and the service user's culture can help reduce language barriers or miscommunication of content or sentiments and can improve retention in treatment and achievement of desired outcomes.<sup>95</sup>

## Step 6: Implement the adapted EBP and evaluate implementation and outcomes and Step 7: Assess and make further adaptations

### Consideration:

Organizations should pilot the adapted program before initial delivery to assess whether they have addressed issues adequately and whether the adapted intervention is acceptable to the community and feasible to deliver.<sup>79</sup> The community members receiving the EBP services should be heavily involved in these assessments, and organizations should make any necessary modifications for improving quality based on the results. Organizations should seek Institutional Review Board (IRB) approval whenever deemed necessary. Finally, organizations should ensure a community's access to the implemented EBP. Additional considerations and strategies on evaluation are described in [Chapter 5](#).

An IRB is an appropriately constituted group that has been formally designated to review and monitor biomedical research involving human subjects. In accordance with FDA regulations, an [IRB](#) has the authority to approve, require modifications in (to secure approval), or disapprove research. This review serves an important role in the protection of the rights and welfare of human research subjects.

The purpose of IRB review is to assure, both in advance and by periodic review, that appropriate steps are taken to protect the rights and welfare of humans participating as subjects in the research. To accomplish this purpose, IRBs use a group process to review research protocols and related materials (e.g., informed consent documents and investigator brochures) to ensure protection of the rights and welfare of human subjects of research.

### Strategies:

- **Use measures from the original EBP to assess fidelity**—the extent to which the adapted intervention reflects the core components and is delivered with careful attention to the original intended process. The scale of this assessment can be based on the resources available within the organization.
- **Eliminate barriers to care**, either as part of the adapted EBP or as a preliminary step before implementation to increase service receipt and improve outcomes. For example, organizations should locate services in appropriate community spaces or along public transportation routes and offer services at convenient hours, when possible.<sup>77,95</sup> Additionally, organizations should consider offering incentives to the under-resourced populations they serve. These incentives may pose financial challenges for organizations but will increase the likelihood of equitable access.
- **Gather information on the implementation** from providers, [peer recovery coaches](#) and specialists, and families and extended families, using the [wraparound method](#).
- **Avoid additional or spontaneous changes to the intervention** (e.g., in response to unforeseen user circumstances) during full-scale implementation as they may impact core components and are not carefully planned.<sup>96-97</sup> Any changes, if needed, should be made only after repeating all steps in the process of adaptation.



# Resources

Online, free resources are available to help practitioners and administrators adapt EBPs and implement the adapted versions.

## Resources on Adapting Interventions

- The Research Foundation for Mental Health’s [Toolkit for Modifying Evidence-Based Practice to Increase Cultural Competence](#) provides mental health services organizations with a structured method and considerations for adapting interventions and meeting the needs of their clients.
- The National Research Center on Hispanic Children & Families’ [Developing Culturally Responsive Approaches to Serving Diverse Populations: A Resource Guide for Community-Based Organizations](#) aims to help organizations recognize and meet the cultural and linguistic needs of diverse populations.
- The Prevention Technology Transfer Center Network’s [Quick Guide For Adapting Evidence-Based Interventions \(EBIs\)](#) gives practitioners an overview of the process of adapting evidence-based interventions.
- The University of Texas at Austin Child & Family Research Institutes’ [Developing Strategies for Child Maltreatment Prevention: A Guide for Adapting Evidence-Based Programs](#) provides practitioners with tools to make decisions on whether they need to make adaptations to an intervention and how to make them.
- The TA Network’s (National Technical Assistance Network for Children’s Behavioral Health’s) [Cultural Adaptation Planning Tool](#) can be used to assess the cultural fit of a program, in partnership with the communities being served, prior to selecting the program and also during the cultural adaptation process.

## Resources on Identifying Evidence-Based Practices

- SAMHSA’s [Evidence-Based Practices Resource Center](#) provides clinicians, communities, and policy makers with information on implementation of various EBPs.

- The [California Evidence-Based Clearinghouse for Child Welfare](#) is a registry tool that can help organizations identify, select, and implement interventions for children and families affected by the child welfare system.
- The Title IV-E [Prevention Services Clearinghouse](#) reviews and rates programs and services aimed at providing support to families and preventing foster care placement. The Clearinghouse provides information about interventions and their evidence base.
- [Blueprints for Healthy Youth Development](#) is a registry of scientifically rigorous and accessible prevention and intervention programs aimed at addressing youth health and behavior issues, such as preventing antisocial behavior and reducing obesity rates.
- The [Home Visiting Evidence of Effectiveness](#) website presents evidence for early childhood home visiting models that assist families with pregnant women and children.
- The [Social Programs That Work](#) website identifies programs through a systematic review process, to create a registry of proven EBPs in a variety of policy areas.
- The [What Works Clearinghouse](#) reviews studies of education interventions, including those for student behavior and development.

## Resources on Treating Particular Populations

- SAMHSA’s Treatment Improvement Protocols on:
  - [Substance Use Treatment for Persons With Co-Occurring Disorders](#) helps practitioners understand the impact of substance use treatment on persons with co-occurring mental health and substance use disorders.
  - [Substance Abuse Treatment: Addressing the Specific Needs of Women](#) helps practitioners understand the specific needs of women when addressing substance use disorders.
  - [Behavioral Health Services for People Who Are Homeless](#) helps practitioners understand how to provide health services for people living with housing instability.

- [Addressing the Specific Behavioral Health Needs of Men](#) helps practitioners understand how to address the specific behavioral health needs of men.
- [Trauma-Informed Care in Behavioral Health Services](#) helps practitioners understand the impacts of trauma and develop models of trauma-informed care to support recovery.
- [Improving Cultural Competence](#) helps practitioners understand the role of culture in service delivery and discusses racial, ethnic, and cultural considerations.
- SAMHSA’s [Psychosocial Interventions for Older Adults With Serious Mental Illness](#) explains approaches to providing care to older adults with substance use or mental health considerations.
- The Council of National Psychological Associations for the Advancement of Ethnic Minority Interests published a brochure on [Psychological Treatment of Ethnic Minority Populations](#) containing guidance for practitioners working with minority patients.
- Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling’s (ALGBTIC’s) [Competencies for Counseling LGBTQIQA](#) and [Competencies for Counseling Transgender Clients](#) present steps that practitioners can take to improve their counseling approach and produce a safe, supportive, and caring environment for sexual and gender minority individuals.
- SAMHSA’s [A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals](#) informs administrators and clinicians about appropriate diagnosis and treatment approaches that will help ensure the development or enhancement of effective LGBT-relevant programs.
- Multi-Racial/Ethnic Counseling Concerns’ [Competencies for Counseling the Multiracial Population](#) contains a list of competencies developed to help practitioners utilize sound professional counseling practices to address the needs of diverse populations.
- Uniformed Services University’s [Military Culture Course Modules](#) contains a list of competencies for healthcare professionals.

## Additional Tools

- Human Services Research Institute’s [Toolkit on Translating and Adapting Instruments](#) equips evaluators with a list of descriptions of methodologies and instruments for use in assessing specific topics.
- The World Bank’s [A Guide to Assessing Needs: Essential Tools for Collecting Information, Making Decisions, and Achieving Development Results](#) is designed to aid practitioners in learning practical strategies, tools, and guides that address the assessment needs of communities.
- The Community Tool Box’s [Assessing Community Needs and Resources](#) provides instructions for administering assessments of community needs and resources.
- The Multi-Lingual Orientation Service Association for Immigrant Communities’ [The Partnership Toolkit](#) includes tools to help organizations build and sustain partnerships with communities and meet the challenges, and achieve the benefits associated with partnering.

## Examples of Cultural Adaptations of Evidence-Based Practices

This chapter highlights three examples of organizations developing and implementing adapted [evidence-based practices](#) (EBPs) for under-resourced populations in their communities. The three examples differ from one another in terms of the context, EBP, and adaptations to the EBP.

- The first example, **Youth AFFIRM**, describes the adaptation and implementation of cognitive behavioral therapy (CBT) for Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ+) young people. The creators found a shortage of evidence-based treatment interventions created for and tested among LGBTQ+ young people with mental health conditions and identified components of standard CBT that could be adapted to resonate more deeply with individuals they hoped to serve.
- The second example describes how the **Choctaw Nation Department of Behavioral Health** has adapted motivational interviewing (MI) as a culturally resonant and effective form of treatment for members of the Choctaw Nation. Providers integrated [behavioral health](#) into primary care; incorporated cultural values like collectivism, stickball, and storytelling into MI; and trained non-Native therapists to understand the history and culture of the Choctaw Nation.
- The third example does not focus on a specific EBP; it describes the **Ma’at Program**, which is a holistic, therapeutic approach to delivering behavioral health services to Black individuals



and families in San Francisco. Designed to uplift the Black/African American community’s mental health and wellness, the Ma’at program uses an Afri-centric approach for the delivery of all behavioral health services.

[Chapter 2](#) describes a process of cultural adaptation, which is not always linear. Programs typically begin with community engagement, and the sequence of next steps is often driven by information gathered previously. The process is also iterative. Cultural adaptations occur in many ways, as is evident from the examples presented in this chapter. Sometimes adaptations are made to a specific practice through modification of a program’s content or implementation (as discussed in [Chapter 2](#)). In other situations, cultural adaptations may begin holistically and become part of the organizational culture; all programs and practices delivered by the organization then reflect this cultural approach.

Despite differences in cultural adaptations and the populations for which they are intended, the three programs presented in this chapter have several common features.

1. The goal for each adaptation is to enable the program to better meet the needs of specific populations and communities the program serves.
2. Each example demonstrates how programs put into practice steps of the adaptation process and implement both types of adaptations (content and implementation), as described in [Chapter 2](#).

3. Each program begins the adaptation process with community engagement and continues to value community engagement at every step in the process. Each program's goal is to engage all stakeholders in a meaningful and authentic way.
4. Each program uses client and stakeholder feedback to assess program fit and make continual modifications.
5. For each program, building trust was an important initial step in the process. While this is critical for most behavioral health services, it is particularly relevant when working with under-resourced populations. Building trust takes time and is an essential element for successful outcomes.
6. Engagement from community members and other stakeholders with lived experience helped strengthen the effectiveness of each program and its chance for success.





## Youth AFFIRM

Shelley Craig and Ashley Austin designed, implemented, and evaluated an adapted version of CBT. The adapted program, called AFFIRM, reflects the needs and lived experiences of LGBTQ+ populations. Various settings and communities across the United States have implemented the program since it was first developed in 2012.

### Program

AFFIRM is an eight-module, manualized, group CBT curriculum adapted specifically for LGBTQ+ youth and young adults. Schools, child welfare and health centers, behavioral health clinics, and community organizations are implementing the curriculum, both in person and online.

### Challenge (steps 1, 2, and 3 in adaptation process)

While leading standard therapy groups for youth, the creators of the AFFIRM program recognized that standard CBT does not focus on LGBTQ+ young people's unique needs and contexts, which can include discrimination, rejection, bullying, and [minority stress](#).<sup>98</sup> For example, it is difficult for a young person who self-identifies as LGBTQ+ to challenge the automatic thought, "I am worthless," when the society, community, media, and family may be saying that LGBTQ+ individuals are less worthy than their straight and/or cisgender counterparts. Additionally, studies typically do not track depression or anxiety outcomes for LGBTQ+ youth in standard CBT programs.

Other therapeutic adaptations to CBT have been relevant for specific identities within the LGBTQ+ community (e.g., gay men), but AFFIRM creators wanted a program that would be effective for all individuals in the LGBTQ+ community. Adapting CBT to focus on the common underlying stressors for LGBTQ+ individuals and build social support was a primary objective.

Having identified these challenges, AFFIRM practitioners embarked on an "adapt and evaluate" process.<sup>99</sup> They conducted an extensive community needs assessment and enhanced the standard CBT tenets with additional context, strategies, examples, and modules that speak to the LGBTQ+ experience.<sup>100</sup>

### Solution (steps 4 and 5 in adaptation process)

**Developers embedded a trauma-informed, affirmative practice, and minority stress framework** throughout all aspects of the intervention—manual content, therapist training, and implementation. The program uses a CBT approach to explore the impact of structural oppression and discrimination.

**Developers adapted the CBT components to reflect the unique and varied elements of the LGBTQ+ experience.** Certain CBT tenets are less relevant to the LGBTQ+ population than to other populations. For example, applying the concept of "universalizing," which is the idea that "everyone goes through this," to LGBTQ+ specific stressors such as parental rejection, is counterproductive. Using the concept with this population undermines and invalidates the unique experiences of minority stress faced by LGBTQ+ people. Hence, during AFFIRM therapy sessions, therapists help their clients explore automatic thoughts and their triggers through a lens of oppression, stigma, and minority stress.

**Developers added modules focused on hope and social supports.** A module on *hope for the future* was added to specifically address hopelessness and suicidality, two common presentations in LGBTQ+ youth. The hope module involves goal-setting for the future and creating a [Hope Box](#), which is an evidence-based tool where clients put tangible items that represent hope for the future (e.g., notes from family, comfort objects, pictures that bring up positive memories) into a container. A module identifying social supports is already part of CBT, and AFFIRM developers adapted this module to include a discussion on building *affirming* social support networks and how to assess and modify social supports that invalidate LGBTQ+ experiences, identities, and communities.

**Developers piloted the adapted components.**<sup>101</sup> Before the adapted curriculum was rolled out, developers conducted a feasibility study, resulting in minor modifications to the session pace, processing of key activities, facilitator coaching processes, relevant content examples, and workbook visuals. During the pilot, many participating LGBTQ+ youth stated that it was their first time participating in a program that was designed specifically for them. The experience was validating while increasing trust and buy-in from youth.

## Youth AFFIRM

**Developers gathered regular feedback from youth, the community, and AFFIRM facilitators.** Program developers seek continual feedback from community and youth advisory boards (including AFFIRM graduates), as well as from facilitators in community organizations. The developer uses this feedback to inform updates that they regularly make to the participant workbook, facilitator manual, and the training. Updates include implementation processes of telehealth groups<sup>102</sup> and the inclusion of relevant identity and regional examples.

**There are costs associated with AFFIRM implementation.** To facilitate AFFIRM, providers participate in an AFFIRM training, whose cost includes training and the facilitator manual. Providers are encouraged to integrate AFFIRM into their existing services to avoid extra costs for clients. Payment options vary considerably. In many instances, AFFIRM is free for clients (e.g., implemented in schools, provided through grant-funded programs) and in other instances, health insurance may cover the cost.

### Outcomes and Other Benefits (steps 6 and 7 in adaptation process)

Longitudinal research on AFFIRM, including randomized controlled trials with LGBTQ+ youth ages 14 to 24, have demonstrated the following mental health outcomes in both in-person and telehealth groups<sup>101-105</sup>:

- Reduced depression symptoms, as measured by the [Beck Depression Inventory](#) (BDI-II)
- Increased coping skills, as measured by the [Brief Coping Orientation to Problems Experienced Inventory](#) (COPE)
- Improved stress appraisal, as measured by the [Stress Appraisal Measure-Adolescents](#) (SAMA)
- Increased hope, as measured by a modified [Adult Hope Scale](#) (AHS)

### Lessons Learned

- Organizations should be ready and have the capacity to implement the adapted curriculum, demonstrated through commitment from leadership and staff to serve the unique needs of LGBTQ+ young people.
- Organizations should seek ongoing input from the community and youth served to ensure effective and relevant facilitation and implementation.
- Staff delivering AFFIRM should be willing to engage in training and continued coaching. Staff need to complete the evidence-based AFFIRM training to facilitate the AFFIRM intervention.
- Organizations should avoid assuming that because a facilitator has lived experience in the LGBTQ+ community, it alone qualifies them to deliver the curriculum; competence in CBT as well as LGBTQ+ affirmative practice skills are imperative.

### Related Resources

- [Affirmative Research Collaborative](#)
- [AFFIRM at the Center of Excellence on LGBTQ+ Behavioral Health Equity](#)
- [AFFIRM Infographic](#)

## The Choctaw Nation Department of Behavioral Health (Oklahoma)

The Choctaw Nation Department of Behavioral Health provides integrated health services for adults, adolescents, and children. Therapists implement Native American MI, which is an adaptation of evidence-based MI tailored to the American Indian population.

### Program

The Choctaw Nation Department of Behavioral Health serves the Choctaw Nation, a vast, rural territory covering approximately 11,000 square miles in southeastern Oklahoma. Services include outpatient and inpatient counseling, integrated behavioral health within primary care, residential treatment with a particular focus on opioid use disorder, and a residential therapeutic school for children. The department serves other tribes as well, but its primary population is the 85,000 Oklahoma members of the Choctaw Nation.

### Challenge (step 1 in adaptation process)

The Choctaw Nation has cultural touchpoints that are relevant to how members approach and engage with behavioral health services, specifically MI. Members tend to focus on the collective well-being of the tribe and are usually highly motivated to maintain culture and engage in cultural activities. These values are not incorporated in the standard MI practice. Additionally, members of the Choctaw Nation are often reluctant to access behavioral health services.

### Solution (steps 4 and 5 of adaptation process)

The department integrated behavioral health into primary care, mainly to serve those in the [precontemplation stage](#). The first step in adapting MI for the Choctaw Nation was to integrate behavioral health services into primary care settings by offering brief relationship building, care, and referrals to outpatient services. Since many tribal members were in the precontemplation stage, this integration increased member engagement and buy-in.

**Services incorporate Choctaw values.** MI helps individuals clarify their values, motivations, and reasons for changing identified unhelpful behaviors. To adapt MI for members of the Choctaw Nation, practitioners incorporated the Choctaw's focus on identity, collectivism, cultural understanding of time, and traditions like storytelling and stickball.

- **Identity:** Choctaw identity is central to the delivery of Native American MI. Practitioners understand that there can be healing in finding and relating to the Choctaw identity, particularly because many individuals in the Choctaw Nation have been prevented from expressing cultural identity. When conducting Native American MI with Choctaw individuals, practitioners explore how the Choctaw identity has shaped the person and what factors motivate the individual to remain connected to the Choctaw identity, which is central to understanding an individual's motivations and values.
- **Collectivism:** Choctaw Nation places strong emphasis on collectivism versus individualism. Unlike in standard MI, the family often participates in therapy with the identified client and, frequently, the individual's reason for living and/or motivation for change involves the well-being of the family.
- **Storytelling:** Practitioners use storytelling to both elicit values and motivation from the client and allow the client to identify values. For example, one clinician at the Chi Hullo Li Women's Residential Treatment Center tells the story of a time when she was instructing the group in basket weaving. A large wasp flew down to the center water bucket, and the atmosphere of the group went from calmness and relaxation to one of fear and anxiety. In this teachable moment, the group discussed their relationship to nature, their responses to stimuli and fear, how to quiet anxiety with breathing, and the respect and value their Choctaw ancestors held for all living beings.

## The Choctaw Nation Department of Behavioral Health (Oklahoma)

- **Stickball:** Stickball is a full-contact tribal sport played by many southeastern tribes. Providers within the Choctaw Nation use stickball to help teach emotional regulation and identify values and motivations. In playing the sport, it is easy to act impulsively and react to stimuli in the heat of the moment. Practitioners use stickball to practice reactions, identify where in the body individuals are experiencing emotions, and choose how to respond, based on values and desired outcomes. They can also link the activity with storytelling to discuss triggers (i.e., how an individual reacts in a game may be connected to how they react outside of a game). Stickball can provide a safe place for clients to test different responses and then process those outcomes.
- **Time:** Practitioners understand that time is culturally relevant to clients in the Choctaw community, which could translate into variable therapy durations.

**Building trust is essential.** Practitioners understand that it may take longer to build rapport and develop a therapeutic relationship, given the mistrust sometimes held against therapists, particularly those who are non-Native.

**Training non-Native staff in the Choctaw culture is important.** Many therapists in the Choctaw Nation Department of Behavioral Health are Choctaw themselves, which can increase the therapeutic alliance because of lived experience and shared community. For therapists who are non-Native, the department provides cultural training to learn the history of the Choctaw tribe and understand the community's cultural components. The program teaches non-Native therapists about the treaty at [Dancing Rabbit Creek](#) and the forced removal of the Choctaw people from their land, as well as Choctaw traditions and cultural values.

**Cost associated with services are covered.** Practitioners participate in specific trainings and obtain certifications in MI, both of which are paid for by the Choctaw Nation. There is no cost to Choctaw Nation members to receive MI services.

### Outcomes and Other Benefits (steps 6 and 7 of adaptation process)

Qualitative and anecdotal data indicate that the number of behavioral health services offered to tribal members has increased, which has reduced the number of individuals with untreated severe mental illnesses.

Clients' self-referrals, referrals of their families, and community buy-in to behavioral health services have increased. Clients have shared that they are benefiting from involvement in cultural and traditional activities like social dancing, stickball, and basketry as part of participating in behavioral health services.

### Lessons Learned

- It is important to be patient and start small. MI is one component of therapy offered by the Choctaw Nation. Adapting MI to be culturally relevant (one that is respectful of Choctaw values, motivations, and traditions) can produce benefits for therapy in general, leading to better clinical outcomes for clients.
- It is essential to pay attention to the people. While activities and traditions like [Choctaw social dancing](#) and stickball are crucial to Choctaw culture, practitioners should keep in mind that Choctaw culture is more than just activities. It is a way of thinking, teaching, and living and carries specific cultural values and motivations for being.

### Related Resources

- [Choctaw Nation Cultural Center](#)
- [Choctaw Nation Language Department](#)
- [Native American Motivational Interviewing](#)

## Homeless Children's Network's Ma'at Program

The Ma'at Program, a supportive, holistic, therapeutic community program of the [San Francisco Homeless Children's Network](#), provides culturally responsive behavioral health care to Black/African American families and individuals. Ma'at refers to the ancient Egyptian concepts of truth, balance, order, harmony, and justice. This model affirms and uplifts the Black/African American community's mental health and wellness through collaboratively focused, Afri-centric, heartfelt behavioral health services. Ma'at services include individual and family therapy, mobile community outreach, group support, case management, youth leadership and development, culturally based referrals, violence prevention and intervention, and community organizing and advocacy.

### Program

The Ma'at Program aims to improve behavioral health outcomes for Black/African American children, youth, families, adults, and seniors in San Francisco and address the historical legacy of intergenerational racism, inequity, and trauma. Ma'at is a unique Afri-centric initiative that addresses barriers to care for Black people, including stigma associated with mental illness, distrust of the healthcare system, absence of culturally competent providers from diverse backgrounds, and lack of insurance or underinsurance. It employs an Afri-centric approach to behavioral health services by radically and unapologetically affirming Blackness. The community is as much the focal point of these efforts as the direct work with children, families, and adults.

An average of 123 children and youth per month participate in Ma'at Program services. For every young person therapists have a relationship with, they interact with an average of nine other community members who support that young person.

### Challenge (step 1 in adaptation process)

While five percent of San Francisco's population is Black/African American, almost half of homeless adults with children are Black, and Black communities continue to be disproportionately affected by poverty and trauma. Experiences of poverty and racism during early years increases risks of mental health problems throughout the lifespan.

Black San Franciscans are in urgent need of mental health support, yet many Black families are reluctant to engage with medicalized, conventional models of mental health service provision. Limited mental health models are centered in Black/African American principles and worldviews, and few community resources for families exist within this community.

### Solution (steps 4 and 5 in adaptation process)

Ma'at employs a community mental health model, in which neighborhoods, histories, and families are key factors in service design and delivery. Community partners, peers, experts, and elders provide oversight to ensure implementation of principles that uphold Black/African American community members.

Ma'at's "Hub and Spoke" model empowers collaborations for reciprocal learning. The Homeless Children's Network is the hub for all activities, with community partners, such as schools, churches, shelters, family resource centers, substance use treatment programs, and housing sites serving as spokes and referring clients to the hub activities.

**Ma'at program's trauma-informed services and trainings are implemented using a lens of Afri-centric qualities, such as:**

-  **Understanding Trauma and Stress**  
– Lens: Ancient Wisdom Intelligence
-  **Compassion & Dependability**  
– Lens: Intuition-inspired Intelligence
-  **Safety & Stability**  
– Lens: Insight-inspired Intelligence
-  **Collaboration & Empowerment**  
– Lens: Spirituality-inspired Intelligence
-  **Cultural Humility & Responsiveness**  
– Lens: Cultural Creativity-inspired Intelligence
-  **Resilience & Recovery**  
– Lens: Emotional Intelligence

## Homeless Children’s Network’s Ma’at Program

Acting as a trustworthy partner for families and individuals with a historical and reasonable distrust of conventional mental health treatment, Ma’at centers on healing and wholeness. Ma’at therapy is “love-informed”, and hesitation to engage in therapy is viewed as informative rather than a barrier. Therapy is based on the seven cardinal values of *balance, order, righteousness, harmony, justice, truth, and reciprocity*.

Black therapists deliver the Ma’at Program, and Black administrators, supervisors, and directors support them. Therapists and clientele share lived experience and community while also recognizing the range of culture, language, religious, and spiritual practices within Black communities.

Whole person, trauma-informed care focuses on self-acceptance and resilience, while identifying areas of client strength and normalizing client experience. Ma’at offers space to process collective grief and fear without judgment as well as to celebrate joy and healing, often integrating a client’s family and community members in services.

The program regularly conducts culturally relevant activities, such as [drumming circles](#), meditation and prayer revivals, healing circles, quiet corners, and focus and listening groups.

The Ma’at Program thrives on partnerships, offering mental health, outreach, and cultural services to Black/African American LGBTQ+ communities and others. Ma’at services are available free of cost to the community.

### Outcomes and Other Benefits (steps 6 and 7 in adaptation process)

Qualitative and survey data collected from children, youth, and their parents/guardians who received services through the Ma’at Program have demonstrated the following outcomes:

- Increased understanding and acceptance of their own Blackness
- Improved communication within the family
- Increased access to a caring, nonjudgmental, culturally affirming therapist with shared lived experience
- Decreased stigma associated with receiving mental health services

### Lessons Learned

- An Afri-centric model for behavioral health services starts from within the Black community.
- Programs should gather community feedback and buy-in, in part by approaching individuals in the neighborhood and community and inviting them to engage in services. The programs should embrace community engagement as organic and expansive. Community engagement strategies, as well as intervention modalities, must be Afri-centric in vision, delivery, and implementation.
- Programs need to extend established relationships with providers in the community.
- It is essential to acknowledge vicarious and secondary trauma experienced by Black therapists, supervisors, and directors.
- Therapy should balance the needs of the family with an Afri-centric, culturally responsive approach while incorporating ongoing feedback loops and self-assessment.
- Programs should advocate for less restricted funding, which allows flexibility to leverage multiple approaches and multiple streams to meet the needs of the community.

### Related Resources

- [Ma’at Program Evaluation Report](#)



## Resources for Evaluation

This chapter focuses on the last two of the seven steps of the adaptation process described in [Chapter 2](#):

- Implement the adapted [evidence-based practice](#) (EBP) and evaluate implementation and outcomes (step 6)
- Assess and make further adaptations (step 7)

Evaluating an adapted EBP can:

- Document the adaptation process
- Answer critical questions about how well teams implemented the adaptations
- Determine whether the adaptations improve the cultural relevance of an EBP
- Assess the extent to which the adapted EBP produces desired outcomes for specific populations

This information can be helpful in making further adaptations, if necessary, and demonstrating the value of the adapted EBP to justify its continuation. In addition, [stakeholders](#) can use information gathered through evaluation to encourage implementation of the adapted EBP in other settings or communities or with other populations. As mentioned in Chapter 2, the adaptation effort should include evaluation costs.

This chapter first highlights equitable evaluation, which organizations can use to guide their evaluation activities. The chapter then provides an overview of the types of evaluations that organizations can conduct to document and

assess the adaptation process, as well as the implementation of and outcomes from the adapted EBPs. Additionally, the chapter describes different data sources an organization could use and highlights the importance of community participation in the evaluation process. The chapter concludes with a list of resources specifically focused on evaluating EBP implementations and outcomes.

## Culturally Responsive and Equitable Evaluation (CREE)

Equitable evaluation is a type of culturally responsive evaluation. It does not consider culture as a subjective factor that needs to be controlled; instead, it explicitly acknowledges [culture](#) and context when assessing program effectiveness.<sup>106</sup> Equitable evaluation relies heavily on engaging the very participants with whom the EBP is implemented and from whom evaluation data are collected.

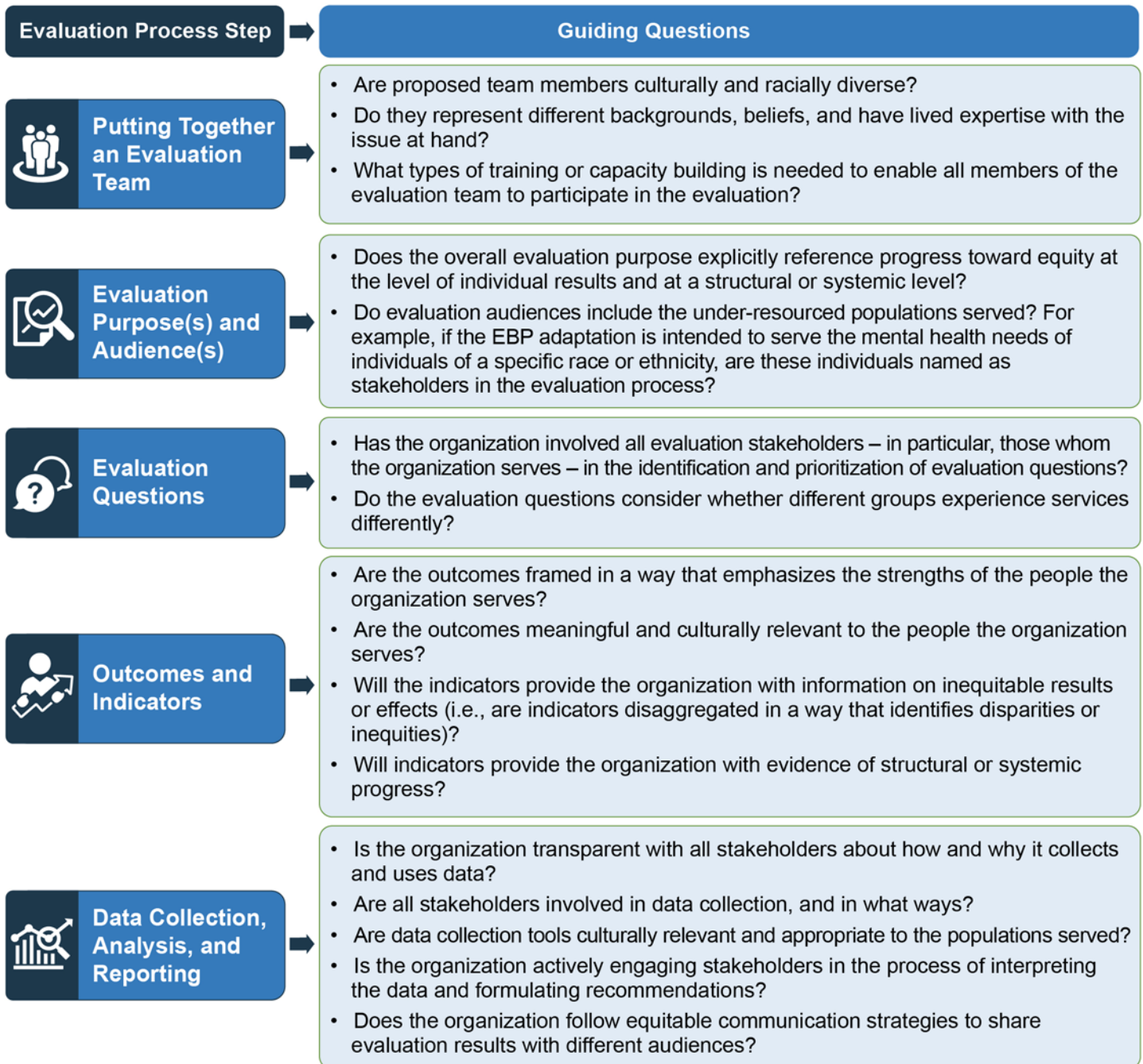
[Expanding the Bench Initiative](#) defines Culturally Responsive and Equitable Evaluation (CREE) as “evaluation that incorporates cultural, structural, and contextual factors (e.g., historical, social, economic, racial, ethnic, gender) using a participatory process that shifts power to individuals most impacted. CREE is not just one method of evaluation; it is an approach that should be infused into all evaluation methodologies.”

According to the [Equitable Evaluation Initiative](#) (EEI), evaluation efforts should be in service of equity, and evaluators should consider the following aspects while developing their evaluation approach:

- Diversity of their evaluation teams, including cultural backgrounds, disciplines, beliefs, and lived experiences of team members
- Cultural appropriateness and validity of evaluation methods
- Ability of the evaluation design to reveal structural and systems-level drivers of inequity (present-day and historical)
- Degree to which communities have the power to shape and own how evaluation happens

### Strategies to Put Equitable Evaluation into Practice

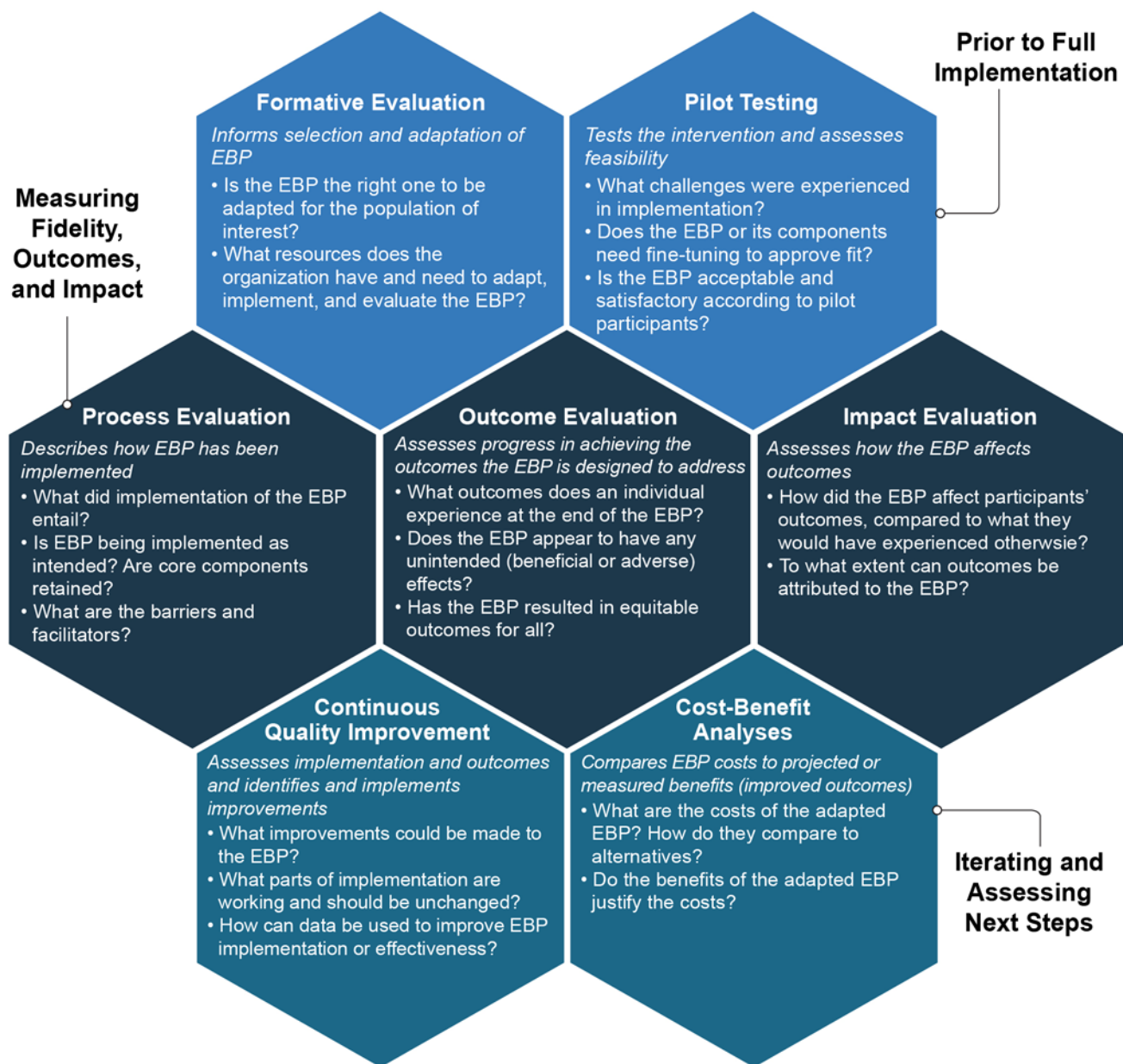
Organizations can use the following questions to apply CREE practices at each stage of the evaluation process.<sup>107</sup>



Adapted from: Youth Development Executives of King County. (n.d.) *Equitable evaluation guiding questions*. <https://ydekc.org/wp-content/uploads/2021/05/Equitable-Evaluation-Guiding-Questions.pdf>



## Engagement and Partnership with the Community Throughout all Phases of Evaluation Planning, Data Collection, Analysis, and Dissemination



Adapted from: National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. (n.d.) *Types of Evaluation*. Centers for Disease Control and Prevention. <http://www.cdc.gov/std/program/pupestld/types%20of%20evaluation.pdf>.

Movsisyan, A., Arnold, L., Evans, R., Hallingberg, B., Moore, G., O’Cathain, A., Pfadenhauer, L. M., Segrott, J., & Rehfuess, E. (2019). Adapting evidence-informed complex population health interventions for new contexts: a systematic review of guidance. *Implementation Science*, 14, 105. <http://doi.org/10.1186/s13012-019-0956-5>.

# Types of Evaluations

Different types of evaluation activities can be conducted throughout the adaptation and implementation processes (see graphic for descriptions of each evaluation type).

Before an adapted intervention is implemented, *formative evaluations* and *pilot testing* can help determine intervention feasibility and acceptability.

When implementation begins in full, *implementation* and *process evaluations* can record how the intervention is being delivered and assess whether fidelity is being maintained. Programs can assess [fidelity](#) using checklists provided by EBP developers. When data are collected from participants, *outcome* and *impact evaluations* can measure the extent to which intended outcomes were achieved, to what degree they are attributable to the adapted intervention, and whether positive outcomes are experienced equitably across populations within the community.

*Continuous quality improvement* activities can be conducted throughout and following implementation to refine intervention components. *Cost-benefit and cost-effectiveness analyses* can help organizations assess how the intervention's benefits compare to its costs and the extent to which the intervention is sustainable.

## Evaluation Data

Evaluation data provide information on what did and did not work. Data collected as a part of any type of evaluation are either quantitative or qualitative, which are mutually complementary, with each providing critical insight into whether and how the intervention is operating and achieving the intended objectives.

- **Qualitative data** include any text-based information, such as verbal, visual, or written data. Qualitative data collection methods include interviews, focus groups, clinical observations, gathering data from documents and images, and open-ended survey questions and polling responses.
- **Quantitative data** are any data that can be processed by mathematical or statistical analysis. Quantitative data collection includes close-ended survey questions and polling responses, service and utilization data, and claims and encounter data. Quantitative data may also be collected during interviews and focus groups.

Community-based participatory methods should be used for collecting and analyzing data and disseminating findings throughout the evaluation process.

The community-based participatory (CBP) approach is based on the following foundational principles<sup>108</sup>:

- Promote collaborative and equitable partnerships and involve an empowering and power-sharing process.
- Recognize community as a unit of identity.
- Emphasize building upon the local knowledge of the community, relying on and strengthening community resources, and improving community health.
- Facilitate co-learning and capacity building among all partners.
- Focus on problems of relevance to the local community using an ecological approach that attends to multiple determinants of health and disease.
- Disseminate findings and knowledge gained to the broader community and involve all partners in the dissemination process.
- Promote a long-term process and commitment to sustainability.

The types of evaluations discussed in this chapter are valuable for documenting why and how an EBP was adapted and the extent to which outcomes were achieved and possibly improved because of an organization's adaptations. Evaluations can also provide important lessons for adaptation of other EBPs and help justify costs associated with the adaptation process. However, the resources needed to conduct an evaluation may be limited, and organizations need to consider what is feasible with the available resources. In the three case examples provided in [Chapter 4](#), the types of data collection and evaluations conducted are described in the section "Outcomes and Other Benefits."

# Evaluation Resources

## Resources on Evaluation

- The Centers for Disease Control and Prevention’s (CDC’s) [Framework for Program Evaluation](#) summarizes essential elements of program evaluation in public health.
- Rural Health Information Hub’s (RHInhub’s) module on [Evaluating Rural Programs](#) offers information on designing and implementing an evaluation of health programs in rural settings.
- University of California, San Francisco’s [Family Health Outcomes Project](#) includes resources for program evaluation and performance monitoring.
- The Center for Community Health and Development at the University of Kansas’s [Community Tool Box](#) includes a [step-by-step guide](#) to develop an evaluation of a community program or initiative and offers specific tools and examples.

## Resources on Culturally Responsive and Equitable Evaluation

- The Equitable Evaluation Initiative’s [Equitable Evaluation Framework](#)<sup>TM</sup> seeks to provide foundations, and nonprofit organizations with an understanding of equity and how to use an equity lens while performing evaluations.
- Mathematica Policy Research’s [Using a Culturally Responsive and Equitable Evaluation Approach to Guide Research and Evaluation](#) introduces the CREE approach and tools to maximize its utilization.
- Child Trend’s [How To Embed a Racial and Ethnic Equity Perspective in Research](#) provides researchers with guiding principles in accomplishing research and evaluation in an equitable manner.

- WestEd Justice & Prevention Research Center’s [Reflections on Applying Principles of Equitable Evaluation](#) offers practical solutions stemming from equitable evaluation processes.
- The Handbook of Practical Program Evaluation, Fourth Edition, chapter 12, [Culturally Responsive Evaluation: Theory, Practice, and Future Implications](#) provides a foundation for culturally responsive evaluation—from preparation for evaluation to disseminating and utilizing results.

## Resources on Cultural Competence

- The American Evaluation Association’s (AEA’s) [Public Statement on Cultural Competence in Evaluation](#) stresses the importance of cultural competence in evaluation and provides a guide for using cultural competence while performing evaluation.
- The Foundation Review’s [Raising the Bar – Integrating Cultural Competence and Equity: Equitable Evaluation](#) presents a framework for building equitable evaluation capacity.
- The paper [A Language Justice Framework for Culturally Responsive and Equitable Evaluation](#) proposes an evaluation framework grounded in language justice, which is defined as the right to communicate in the language one feels most comfortable with.
- The HHS Office of Minority Health’s [Evaluation of the National CLAS Standards Tips and Resources](#) describes a toolkit developed to guide efforts to evaluate the National CLAS Standards across four settings: ambulatory care, behavioral health, hospitals, and public health.

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# Glossary

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**Association:** Evidence demonstrating a *statistical relationship* between an intervention and outcomes measured in the study's sample population. Association is *not* causation.

**Behavioral health:** The promotion of mental health, resilience, and wellbeing; the treatment of mental health and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.

**Causal impact:** Evidence demonstrating that an intervention *causes* or is *responsible for* the outcomes measured in the study's sample population.

**Cissexism:** The belief or assumption that [cis](#) people's gender [identities](#), [expressions](#), and embodiments are more natural and legitimate than those of [trans](#) people.

**Community-based participatory approach:** An approach that involves the engagement and the equal participation of individuals who are affected by the issue or problem at hand and recognizes and appreciates the unique strengths and resources each person contributes. It is a cooperative, co-learning process that involves systems development and local community capacity-building.

**Culture:** A broad, multi-dimensional construct that refers to integrated patterns of human behavior including language, spirituality, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

**Cultural adaptation:** The systematic modification of an evidence-based practice's protocols and/or content to incorporate language, culture, and context that is compatible with a client's cultural patterns, meanings, and values.

**Cultural competence:** A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable them to work effectively in cross-cultural situations.

**Cultural integrity:** The practice of respecting and honoring the ownership of materials, traditions, and knowledge that originate from a particular culture or community.

**Culturally relevant system of care:** A healthcare system that considers and respects individuals' cultural orientations by understanding and honoring attitudes, values, and behaviors unique to each person.

**Culturally Responsive and Equitable Evaluation (CREE):** An evaluation that incorporates cultural, structural, and contextual factors (e.g., historical, social, economic, racial, ethnic, gender) using a participatory process that shifts power to individuals most impacted.

**Ecological validity:** The generalizability of study findings or therapy situations to the participant's real-life settings.

**Evidence-based practices:** Interventions for which there is consistent scientific evidence showing that they improve individual-level or population-level outcomes.

**Fidelity:** The extent to which an intervention was delivered as conceived and planned.

**Health inequities:** Differences in health status or the distribution of healthcare and other resources between population groups arising from the social conditions in which people are born, grow, live, work, and age.

**Heterosexism or homophobia:** The marginalization and/or oppression of people who are lesbian, gay, bisexual, queer, and/or asexual based on the belief that heterosexuality is the norm.

**Implementation science:** The scientific study of methods to promote the systematic uptake of clinical research findings and other evidence-based practices into routine practice to improve the quality and effectiveness of health care.

**Stakeholders:** Individuals, organizations, or communities that have a direct interest in the process and outcomes of a project, research study, or policy initiative.

**Structural racism:** A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing, ways to perpetuate racial group inequity.

# Appendix 1: Acknowledgments

The guide is based on the thoughtful input of SAMHSA staff and the Technical Expert Panel (TEP) on Adapting Evidence-Based Practices for Under-Resourced Populations from October 2021 through June 2022. A series of guide development meetings and two TEP convenings were conducted during this time.

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# APPENDIX 2: Background Information on the Evidence-Based Practices Discussed in Chapter 2

## Motivational Interviewing

### Goal

Motivational interviewing (MI) is a treatment approach that helps individuals overcome ambivalent feelings and insecurities. In the process, individuals become motivated to change their undesired behavior. MI developers define it as “a directive, client-centered counseling style for eliciting behavior change by helping clients explore and resolve ambivalence.”

### Core Principles

Five underlying principles guide how practitioners should interact with clients while using this practice. Practitioners should:<sup>6</sup>

- Express empathy through reflective listening.
- Identify discrepancies between a client’s goals, values, or hopes and their current behavior.
- Roll With Resistance through avoiding arguments and direct confrontations with a client and adjust to a client’s resistance rather than opposing it directly.
- Support self-efficacy and optimism.

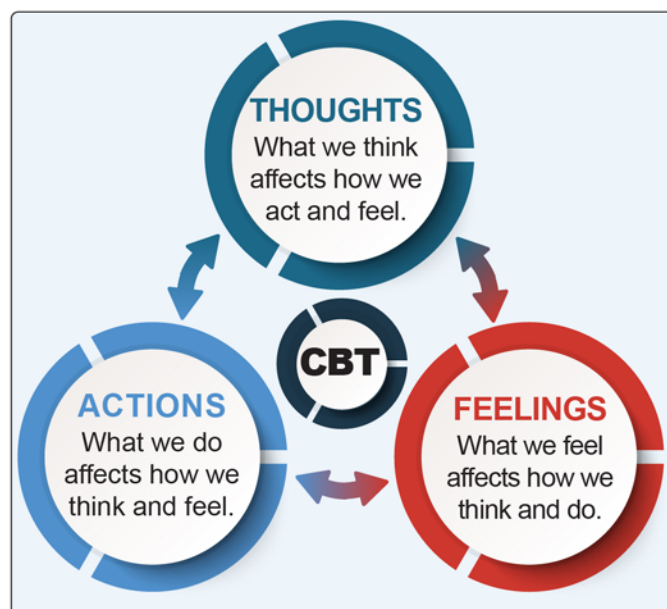
### Typical Implementation and Delivery

MI is intended for use by a wide variety of practitioners, including primary care providers, behavioral health professionals, and peer providers. [Training on MI](#) is available for clinicians, non-clinicians, peers, and those with minimal or no training in counseling or therapy. Treatment with MI for substance use and mental health outcomes does not have a prescribed time period; it can range from a single session of 15 minutes to multiple, hour-long sessions.

## Cognitive Behavioral Therapy

### Goal

Cognitive behavioral therapy (CBT) is a short-term, goal-oriented psychotherapy treatment that enables individuals to understand their current problems, challenges, and experiences, in order to change their behaviors and patterns of thinking. CBT helps clients develop accurate assessments of circumstances and their feelings, so that they can develop realistic strategies. CBT also is used to address depressive cognitions and other cognitive distortions associated with depression, generalized anxiety disorders, and substance use disorders.



### Core Principles

Through CBT, clients are trained to evaluate faulty patterns of thinking, actions, and negative feelings associated with the desired mental health or substance use outcome. CBT is tailored to the needs of the individual, with the goals of each therapy session uniquely based on the client’s experiences and personal circumstances.

<sup>6</sup> Rollnick, S. & Miller, W. R. (1995). What is motivational interviewing? *Behavioral and Cognitive Psychotherapy*, 23, 325-334.

CBT is founded on the following principles<sup>7</sup>:

- Psychological problems are, in part, due to faulty or unhelpful ways of thinking.
- Psychological problems are based, in part, on learned patterns of unhelpful behavior.
- People with psychological problems can learn better ways of coping with them, thereby relieving their symptoms and becoming more effective in their lives.

### Typical Implementation and Delivery

Practitioners can use CBT effectively in a wide range of healthcare settings, from inpatient psychiatric rehabilitation to community outpatient programs. A variety of professionals trained in CBT principles can implement the program, including behavioral health professionals, primary care staff, and criminal justice personnel. The [National Association of Cognitive-Behavioral Therapists](#) offers CBT training for mental health professionals, as well as non-professionals with a four-year college degree.

CBT is typically customized to the needs of each individual. Most people who seek CBT receive counseling for a period ranging from 5 to 10 months. A standard therapeutic session is approximately 50 minutes long.

A newer approach to CBT uses a [digital format](#) for delivery to clients. This format draws on the [National Institute on Drug Abuse's CBT manual](#) and offers CBT sessions either online or through an app.

## Dialectical Behavior Therapy

### Goal

[Dialectical behavior therapy \(DBT\)](#) is a psychotherapy treatment originally developed by Dr. Marsha Linehan to treat individuals at-risk for suicide and/or those with borderline personality disorder (BPD). DBT is commonly used to address depressive symptoms, substance use disorders, posttraumatic stress disorders, and a wide range of other disorders. It focuses on dialectical or opposing strategies of acceptance and change.

### Core Principles

DBT is founded on the following principles<sup>8</sup>:

- **Mindfulness:** Accepting and tolerating negative emotions that often arise when clients are confronted with their challenging habits or beliefs or uncomfortable situations.
- **Interpersonal effectiveness:** Addressing the clients' interactions with the people around them and focusing on their interpersonal relationships.
- **Distress tolerance:** Helping clients tolerate, accept, and find meaning in the distress that occurs in their lives.
- **Emotion regulation:** Teaching people in recovery how to identify, regulate, and feel emotion often associated with impulsive behaviors.



<sup>7</sup> American Psychological Association. (2017). *What is Cognitive Behavioral Therapy?* <https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral#>

<sup>8</sup> Behavioral Tech. (n.d.). *What is Dialectical Behavior Therapy (DBT)?* <https://behavioraltech.org/resources/faqs/dialectical-behavior-therapy-dbt/>

## Components of Dialectical Behavior Therapy (DBT)



### DBT Skills Training

which teaches clients skills in mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation.



### Individual Psychotherapy

designed to enhance client motivation and apply skills to manage their lives and confront specific challenges.



### In-the-Moment Phone Coaching

in which therapists provide coaching to clients on how to apply the skills learned and cope with everyday challenges.



### DBT Consultation Teams for Therapists

through which therapists are supported and treatment fidelity is monitored.

## Typical Implementation and Delivery

While DBT was originally designed for use with populations with [BPD](#), it has since been used with a wide variety of populations, to treat an array of mental health concerns.

DBT practitioners typically undergo intensive training to obtain certification. Certification is offered through the [DBT-Linehan Board of Certification](#) (DBT-LBC) to licensed mental health professionals. It requires practitioners to complete 40 hours of didactic training and pass a test.

DBT typically has a duration of about 24 weeks, consisting of weekly skills training groups, in addition to hour-long, weekly individual therapy sessions. DBT's phone coaching component permits clients to call their therapist between sessions, to receive real-time coaching and care.

**Source:** Behavioral Tech (n.d.) *What is Dialectical Behavior Therapy (DBT)?*. <https://behavioraltech.org/resources/faqs/dialectical-behavior-therapy-dbt/>



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