Review

Child and Adolescent Mental Health

Child and Adolescent Mental Health Volume **, No. *, 2022, pp. **–** doi:10.1111/camh.12547

Review: Cultural adaptations to psychosocial interventions for families with refugee/asylum-seeker status in the United Kingdom – a systematic review

Alice Taylor[1,2], Gillian Radford[1] & Clara Calia[2]

[1]*NHS Lothian, Edinburgh, UK*
[2]*School of Health and Social Sciences, University of Edinburgh, Edinburgh, UK*

Background: Young people with refugee or asylum-seeker status (R/AS) often present with complex mental health needs, in the context of traumatic life experiences. Generic mental health services in the United Kingdom (UK) may be ill-equipped to manage the unique experiences of these young people. Culturally adapted interventions (CAI) could provide a culturally sensitive approach to mental health support for refugee children experiencing difficult symptoms. A systematic review was conducted to determine the different types of cultural adaptation in the included studies, and to determine the efficacy of CAIs in comparison to generic treatment. **Methods:** Systematic searches of eleven databases were completed in December 2020. Any psychosocial interventions conducted in the United Kingdom aimed at providing mental health support for refugee young people and families were included. This was to ensure the potential inclusion of all studies regardless of their adherence to the traditional framework of assessment and intervention in high-income countries, for example randomised control trials. **Results:** Eleven studies of varying methodology, participant group, intervention type and outcome measures were included in this review. Studies used a variety of cultural adaptations including surface-level and deep-level adaptations. Studies showed some support for the use of CAIs with young people with R/AS, with varying degrees of symptom reduction. It was not possible to compare the effectiveness of CAIs against 'treatment-as-usual', nor to determine the effectiveness of different CAI components. **Conclusions:** Whilst there is evidence for the use of CAIs with R/AS young people, the heterogeneity between studies limits the generalisability of these results. The available research is not sufficient to provide conclusive evidence of the use of CAIs over 'treatment-as-usual'. Research and clinical implications are highlighted. Future research could examine the most effective components of CAIs and aim to increase the evidence base of interventions for young people and families with R/AS.

Key Practitioner Message

- Mental health interventions for young people with R/AS are not widely researched. There have been inconsistent approaches to supporting young people with R/AS across the United Kingdom.
- To the researchers' knowledge, this is the first systematic review exploring culturally adapted mental health interventions in the United Kingdom.
- All studies showed improved outcomes for participants across a range of quantitative and qualitative measures. It was not possible to determine specific elements of the adapted interventions were most effective.
- This review gives recommendations to provide high-quality care to young people with R/AS. It is hoped that continuing to increase the evidence base for alternative and existing interventions may encourage researching and using more creative ways of working with young people with R/AS.

Keywords: cross-cultural; adolescence; refugees; mental health; intervention

Introduction

Refugees and asylum-seekers are recognised as individuals and their dependents who seek asylum within a country not of their nationality, due to a fear of persecution in their own country (UN General Assembly, 1951). Approximately half of all refugees and asylum-seekers are children and adolescents under the age of 18 (UNHCR, 2004). When refugees first settle in a country, physiological and safety needs such as housing, employment and transition to a new culture often take priority over mental health (Murray, Davidson, & Schweitzer, 2010). However, young people with R/AS have often experienced multiple traumas, missed a significant amount of education and are at risk of developing significant mental health difficulties (Fazel & Stein, 2002; Murray et al., 2010). Assimilation to a new country and

Note: For the purposes of this article, the use of 'refugee' throughout the text represents the refugee and asylum-seeker population.

culture, whilst dealing with the traumatic events that required initial displacement may further contribute to significant distress (Derluyn & Broekaert, 2007).

The context in which mental health is viewed influences policies and government strategies, therefore dictating how care is delivered to at-risk individuals (Singer, Bulled, Ostrach, & Mendenhall, 2017). Traditional Western frameworks sometimes view individuals and their direct environment as the main cause of mental health difficulties, possibly overlooking social, ecological and political contexts (Singer et al., 2017). By tackling issues early, services may be able to prevent long-term mental health difficulties, leading to more positive outcomes for the young person and less reliance upon services in the future (Beauchaine, 2017).

Unfortunately, there are concerns about the accessibility (and quality) of child and adolescent mental health services for refugees, across the United Kingdom (CAMHS; Mind, 2009). Many refugee families can be reluctant to avail themselves of mental health services, for various reasons including stigma (Ali, McLachlan, Kanwar, & Randhawa, 2017), distrust of authorities (Hek, 2005) and practical barriers such as transport or language (Brown, Rice, Rickwood, & Parker, 2016). Research suggests that although 58% of unaccompanied minors experience psychological distress, only 13% access mental health services (Bean, Derluyn, Eurelings-Bontekoe, Broekaert, & Spinhoven, 2007).

Young refugees within public mental health services may experience teams with limited knowledge of specific unmet needs and cultural sensitivity, leading to feelings of inadequacy from staff and poorer outcomes for the child (Mind, 2009). The majority of mental health research has been conducted in Western countries on native populations, often with strict criteria excluding non-English speakers, neurodiverse individuals and ethnic minorities (Cardemil, 2010). Additionally, certain communities, such as those where refugees may originate, consider family involvement and collectivism extremely important, for example Africa, South America or Middle East (Alden et al., 2018; Krys et al., 2021). Conversely, Western communities tend to promote independence, and therefore generally offer individual support for mental health difficulties (Dimitrieva, Chen, Greenberger, & Gil-Rivas, 2004). It is therefore unsurprising that many of the empirically supported interventions may not be generalizable to those who do not fit into the Western constructs of mental health expression and pathways for services (Shiraev & Levy, 2016). Similarly, psychometric measures used to assess mental health and treatment outcomes, may not be cross-culturally valid (Kaiser et al., 2019; Rüdell, Bhui, & Priebe, 2009). One approach to addressing these limitations is the use of culturally adapted interventions.

Culturally Adapted Interventions (CAI)

Cultural adaptation is defined as the methodological modification of an intervention to consider unique aspects of a client's needs, including language, culture and values (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999). This is in contrast to 'treatment-as usual' which refers to nonculturally adapted interventions. Researchers have described two categories of cultural adaptation to interventions; surface structure and deep structure components (Cardemil, 2010). Surface structure adaptations represent small or superficial modifications to the content and delivery of an intervention, for example language or relatable images (Castro, Barrera, & Martinez, 2004; Thompson, Johnson-Jennings, Baumann, & Proctor, 2015). On the other hand, deep structure adaptations describe more careful considerations to an intervention, designed to address 'core cultural values' related to psychological, environmental and social norms within the community, for example collectivism (Barrera, Castro, Strycker, & Toobert, 2013; Mier, Ory, & Medina, 2010). Further categorisation of cultural adaptations includes peripheral, evidential, linguistic, socio-cultural and constituent-involving categories, see Table 1 (Barrera et al., 2013; Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003).

Despite growing calls to develop psychological interventions inclusive of ethnic minorities and young people with R/AS, research has been slow to accrue and existing studies have struggled with difficulties of sample size and categorisation of cultural adaptations. Griner and Smith (2006) conducted a comprehensive meta-analysis of 76 studies, and found a medium effect size (d = 0.45) for CAIs with an increased effect when the intervention was available in the client's preferred language. Griner and Smith (2006) argued the necessity of including studies even with heterogeneous comparison treatment types and poor-quality studies, despite limitations, as they can provide useful information for engaging young people in CAIs. Many interventions such as culturally adapted groups, evidence-based interventions and specialist novel services for young people with R/AS have supported the use of adapted treatment components (Colucci, Valibhoy, Szwarc, Kaplan, & Minas, 2017; Jackson-Blott, O'Ceallaigh, Wiltshire, & Hunt, 2015; Rosselló, Bernal, & Rivera-Medina, 2008).

Table 1. Categories of cultural adaptation (recreated from Barrera et al., 2013)

Strategies	Description
Surface	
Linguistic	Ensure that intervention materials are available in a young person's preferred language and at the literacy level of clients
Evidential	Use narratives and statistics relevant to the target group and raise awareness of difficulty within specific culture, e.g., peer role models
Peripheral	Use of activities, photographs and titles to relate to the client's own ethnicity, cultural norms and environment, e.g., music, dancing, photos of females wearing headscarves etc.
Deep	
Socio-cultural	Using a community's culture to explain difficulties within a context which is familiar and understood e.g., using food, stories, religion, collectivism etc.
Constituent-Involving	Training and using members of the target population to increase engagement from community, by increasing approachability and knowledge of community health beliefs

Others (Huey & Polo, 2008) have found limited support for cultural adaptations; results showed no significant outcome differences between several CAI and standard treatment for minority young people. Clinicians must consider the potential consequences of untested cultural adaptations if they may compromise components of effective interventions (Lau, 2006). However, these conclusions must be taken with caution as several of the reviewed studies lacked sufficient power and assessment was not conducted on the content or quality of the cultural adaptation. Additionally, it may be that clinicians are already adjusting their treatment to the cultural needs of their young people, without documenting it in the research literature (Harper & Iwamasa, 2000; Huey & Polo, 2008), therefore confounding the comparisons between CAIs and standard treatment. However few interventions have deliberately included sufficient participants from multiple cultures within their evaluation of efficacy (Cardemil, 2010).

Rationale

The need for effective psychological interventions for young people with R/AS is highlighted by their elevated risk for developing mental health difficulties. The multiple barriers they face in accessing mental health services and the limited research base, regarding their unique needs, explains their experience of mental health services. There is some evidence to support cultural adaptations to mental health interventions in host countries for young people with R/AS, however this is sparse.

This systematic review aims to collate information from various studies conducted in the United Kingdom. The extension of inclusion criteria to family studies ensures the inclusion of interventions which considered the importance of collectivism from the outset (Alden et al., 2018). This will explore the effectiveness of cultural adaptations to psychological interventions for young people and families with R/AS. The combining of study results can provide more power than a single study (Sterne, Egger, & Smith, 2001), and to the researchers' knowledge, this will be the first review of such studies.

Aims

This study aims to initially determine the different types of cultural adaptations applied to mental health interventions for young people with R/AS. Secondly, it aims to explore the effectiveness of culturally adapted mental health interventions for young people and families with R/AS, in the United Kingdom, and evaluate their experiences of participating in such interventions.

Methods

This review is in adherence with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher, Liberati, Tetzlaff, & Altman, 2009). This protocol has been registered through PROSPERO (ID: CRD42020138553).

Eligibility criteria

To ensure that all study and intervention types were included within this review, broad eligibility criteria were applied;

- Location: Interventions conducted within United Kingdom (within public or private services)
- Participants: Young people (below 18 years old) or families with R/AS
- Intervention: Any culturally adapted psychosocial intervention intended to improve mental health or emotional wellbeing. The inclusion of traditional evidence-based and/or alternative interventions allows the evaluation of treatments which may not strictly adhere to a Western construct of therapy
- Outcomes: This systematic review examined quantitative data such as comparisons of pre- and postintervention questionnaire scores and qualitative information such as interview data.
- English Language

The combination of study designs in systematic reviews are increasingly required to provide sufficient evidence for clinical, organisational and policy decisions (Lizarondo et al., 2017), therefore there were no limitations on study design. This was considered especially important given the already limited research base on mental health in young people with R/AS.

Search strategy

Searches of eleven online scientific databases were conducted (PsycINFO, MEDLINE, ASSIA, PubMed, SCOPUS, Web of Science, CABI (Global Health), IBSS, the Knowledge Network, OpenGrey and Google Scholar) (15 pages). The search aimed to identify both published and unpublished studies conducted between 1950 and 31st December 2020, (see Table 2 for key terms). Snowballing techniques included reference list searches and contacting various authors for any relevant or unpublished data.

Following PRISMA guidelines, studies were screened by two reviewers independently (PRISMA, 2020). Study abstracts were used in the first instance to determine whether study content was relevant to the systematic review, for example participant type, targeting mental health or emotional well-being, etc. Full-text analysis of the studies was then conducted by the same reviewers and eligibility criteria were used to determine inclusion or omission, see Figure 1.

Quality assessment

The included studies were quality assessed using guidelines by Kmet, Cook, and Lee (2004) who designed criteria for assessing both quantitative and qualitative studies. This allowed for parallel evaluation of the various methodologies and has been used effectively in similar reviews (Barnett et al., 2019; Reardon et al., 2017). Items on both checklists use scales for determining

Table 2. Search terms

"refuge*" OR "immigra*" OR "migra*" OR "asylum*" OR "illegal*" OR "unaccompanied minor*" OR "displac*" OR
AND
"mental*" OR "mental health" OR "psycholo*" OR "psychiatr*" OR "emotion*" OR "wellbeing*" OR "distress*" OR "stress*" OR "mood*" OR "trauma*"
AND
"intervene*" OR "treat*" OR "therap*" OR "program*" OR "group*" OR "support*"
AND
"CAMHS" OR "child*" OR "adolescen*" OR "young pe*" OR "young*" OR "famil*" OR "parent*" OR "carer*" OR "caregiver*" OR "teenage*" OR "infant*" OR "Mum*" OR "Dad*" OR "mother*" OR "father*" OR "minor*"
AND
"culturally sensitive*" OR "culturally enhance*" OR "culturally appropr*" OR "*culturally inform**" *OR "culturally ground**" OR "culture specific**" OR "culturally focus**" OR "cultur**"
OR "adapt*" OR "ethnic*"

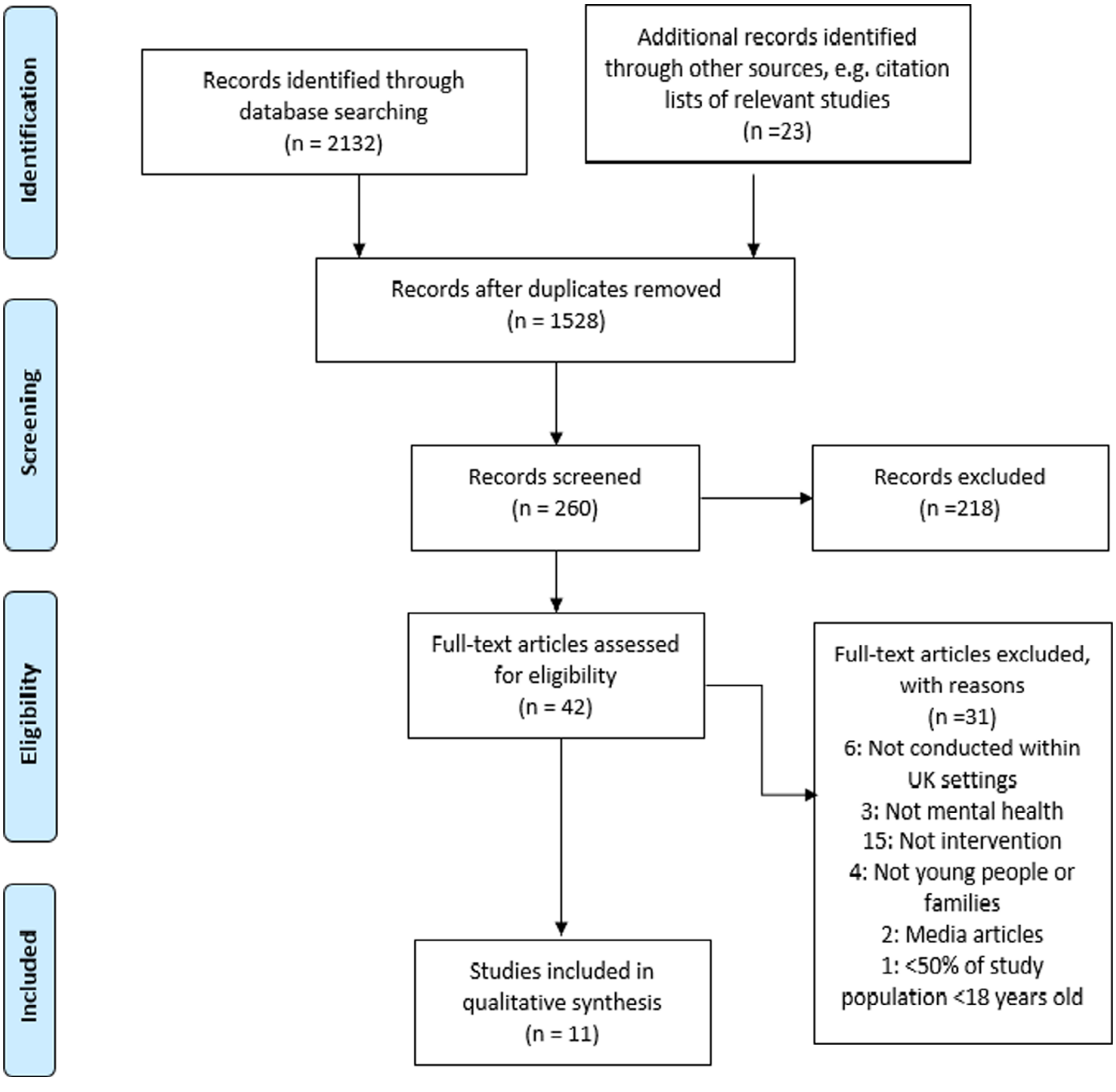

Figure 1. PRISMA flow diagram of search

adherence to item criteria (0 –no, 1- partial, 2- yes). A Cohen's Kappa test is often used to assess the rates of agreement between reviewers assessing independently of each other. The results of the test (0.81) suggested good inter-rater reliability (Viera & Garrett, 2005). Scores have then been represented as a percentage for easier comparison over both study types. Studies were found a score of ≥54% on all studies indicating varied adherence to recommended guidelines (See Table 3).

Data extraction

Details of eligible studies were extracted, including author(s), study design, intervention type, outcome measures, results and any other points of interest (see Table 5). Outcomes included various questionnaires, including the Strength and Difficulties Questionnaire (SDQ; Goodman, 1997), and statistical test results comparing pre- and postintervention data.

Qualitative information was identified as feedback comments made by any participant group within the included studies. These comments were collated and compared, searching for common content, phrases or words. Similar themes were grouped by participant type, for example young people, mothers or teacher.

Results

Study selection

Figure 1 outlines the procedure for the identification and screening of studies conducted between 30th September 2019 and 31st December 2020. The literature search yielded a total of 1528 studies, which reduced after Abstract screening and a further 31 papers were omitted after full-text review. Eleven studies met final eligibility criteria and were quality assessed.

Participant characteristics

The sample size per study ranged from 2 to 141 with a combined participant number of approximately 420, (103 female, 215 male and 102 unknown). There were

Table 3. Quality assessment of included studies

	King and Said (2019)	Durà-Vilà et al. (2013)	Said and King (2019)	Ehntholt et al. (2005)	Fazel et al. (2009)	O'Shea et al. (2000)	O'Shaughnessy et al. (2012)	Fazel et al. (2016)	Vickers (2005)	Hughes (2014)	Chiumento et al. (2011)
All Studies											
Objective Described	1	2	2	1	2	1	2	2	2	1	1
Design appropriate to objective	0	2	2	2	2	1	2	2	1	2	2
Results support conclusions	2	2	2	2	2	2	2	2	2	2	2
Quantitative Assessment											
Method of subject selection appropriate	1	2	1	1	2	1					
Subject characteristics and variables described	2	2	2	1	1	2					
Random allocation to treatment/ control group	N/A	N/A	N/A	0	N/A	0					
Blinding of investigators to intervention type	N/A	N/A	N/A	N/A	N/A	0					
Blinding of participants to intervention type	N/A	N/A	N/A	N/A	N/A	N/A					
Outcome and exposure measures defined	1	2	2	2	1	1					
Suitable sample size	1	2	0	1	2	1					
Analysis appropriate	2	2	1	2	2	2					
Estimate of variance reported	2	1	0	2	2	1					
Controlled for confounding	N/A	N/A	0	0	2	0					
Results reported	1	2	1	2	1	2					
Qualitative Assessment											
Context of study is clear							2	2	2	2	2
Connection to theoretical framework							2	2	2	2	0
Sampling strategy relevant							1	2	1	0	1
Data collection methods systemic							1	2	0	0	2
Data analysis described, complete and systemic							2	1	0	0	1
Use of verification procedures							0	2	0	0	0
Reflexivity of account							1	0	1	2	2
Total Score (Percentage)	14 (70%)	21 (95%)	13 (59%)	16 (67%)	19 (86%)	14 (54%)	15 (75%)	17 (85%)	11 (55%)	11 (55%)	13 (65%)

0 –no compliance to criteria, 1- partial compliance, 2- full compliance.

both child (estimated 398) and parent participants (22), although this number does not encompass parents included as indirect members of their child's therapy. One study (Hughes, 2014) did not report the number of young people participants and the researcher was unable to confirm through author correspondence. Participants reported a number of origin countries including Afghanistan, Albania, Congo, Ethiopia, Gambia, Horn of Africa, Iran, Iraq, Ivory Coast, Kosovo, Nigeria, Sierra Leone, Somalia, Sudan and Turkey.

Specific mental health difficulties were identified in less than half of the included studies. Case studies described young people presenting as sad, withdrawn, unsettled friendships, nightmares and flashbacks, (Durà-Vilà, Klasen, Makatini, Rahimi, & Hodes, 2013). Two studies (Said & King, 2019; Vickers, 2005) focussed their interventions on clinically diagnosed Post Traumatic Stress Disorder (PTSD). Teachers reported seeing symptoms of PTSD, aggressive behaviour, adjustment disorder and ADHD-type symptoms. Other studies targeted the general mental health needs of the refugee population through specialist refugee services or to evaluate the feasibility of easy-access locations, for example schools (Ehntholt, Smith, & Yule, 2005; Fazel, Doll, & Stein, 2009; Fazel, Garcia, & Stein, 2016; O'Shea, Hodes, Down, & Bramley, 2000). The mental health of mothers was the focus of two studies (Hughes, 2014; O'Shaughnessy, Nelki, Chiumento, Hassan, & Rahman, 2012), with the premise that this influenced their child's attachment relationships, emotional well-being and behaviour.

In addition to evaluating mental health difficulties pre- and postintervention, several studies collected demographical information about traumatic experiences and exposure to conflict. Common participant experiences in all studies included separation from parents, loss of loved ones, witnessed and/or experienced violence and difficulties with the asylum process (Ehntholt et al., 2005; O'Shea et al., 2000; Said & King, 2019).

Study methodologies

Studies used a variety of study designs including qualitative (3/11), case control (2/11) and mixed methods (5/11) and 1 case study. Both case controls used matched control groups; Fazel et al. (2009) matched on age and gender whilst Ehntholt et al. (2005) matched groups on gender, country of origin and legal status. There were no randomisation or blinding methods used in either study. O'Shea et al. (2000) and Durà-Vilà et al. (2013) used the same clinical vignettes (some details changed) to illustrate the type of symptoms and interventions used within their studies.

The majority of studies explored the effectiveness of specific interventions, including cultural adaptations to cognitive behavioural therapy (CBT), 'Tree of Life' narratives and narrative therapy (Ehntholt et al., 2005; Vickers, 2005), whilst others described evaluations of specialist refugee services such as the Haven Project (Chiumento, Nelki, Dutton, & Hughes, 2011; Durà-Vilà et al., 2013; O'Shea et al., 2000). Chiumento et al., (2011) described a range of group interventions available to young people with R/AS within their specialist service; art therapy, psychodrama and horticulture. The results of only two intervention groups were reported in their paper and attempted author correspondence did not provide additional information.

Some studies provided multiple format options for intervention including structured or unstructured group sessions, individual sessions and systemic work with families or schools. Many studies reported family involvement, however others evaluated direct support provided to mothers. Of those who specified, treatment ranged from 6 weeks to 37 weeks, however others did not provide this information.

Researchers typically provided descriptions of the adaptations to the interventions in their studies, however there were no efforts taken to measure the extent and quality of such adaptations. There were commonalities between the studies as to the cultural adaptations made to evidence-based interventions, see Table 4.

Main findings

Studies evaluated the interventions using a variety of methods including routine outcome measures, for example Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997), focus groups or individual interviews and case studies.

Quantitative studies used routine outcome measures to complete an evaluation of young people's mental health difficulties pre- and postintervention, see Table 5. Most commonly used were the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) and the Child Revised Impacts of Events Scale (CRIES-8; Perrin, Meiser-Stedman, & Smith, 2005).

Statistical tests were conducted by Ehntholt et al. (2005), Durà-Vilà et al. (2013) and Fazel et al. (2009). Ehntholt et al. (2005) found statistically significant reductions in PTSD symptoms for the experimental group. Improvements in anxiety symptoms were not significant and there were no changes in depression symptoms for both groups. Participants in Fazel et al. (2009) reported significantly reduced symptoms of peer relationship and hyperactivity difficulties, however these improvements were modest. Durà-Vilà et al. (2013) found a significant difference in types of difficulties between recently resettled young people and those who had been living in the United Kingdom for more than two years. There were also significant differences in the types of interventions used by young people; those settled more recently (<2years) were more likely to have indirect systemic work compared to longer-term young people who received significantly more direct individual sessions. Durà-Vilà et al. (2013) reported significant overall improvements in approximately three quarters of participants, with symptom reduction in peer relations and hyperactivity.

Other studies were not able to conduct statistical analysis due to the small sample size and lack of power but presented some measures of improvement (King & Said, 2019; O'Shea et al., 2000; O'Shaughnessy et al., 2012; Said & King, 2019). Case studies outlined by Vickers (2005) showed improvement for both young people, one case anecdotally and one case using scores on the Post Traumatic Diagnosis Scale (Foa, Cashman, Jaycox, & Perry, 1997).

Table 6 displays the qualitative information collected from seven reviewed studies, through interviews, focus groups, and open-ended written questions. Duplicate analysis by an independent researcher was reported in Fazel et al. (2016) and Said and King (2019). No studies commented upon completion of data saturation for

Table 4. Cultural considerations and adaptations, as categorised by Kreuter et al. (2003); Barrera et al. (2013)

Strategies	Examples	Studies (*N*)
Linguistic	• Bilingual and bicultural materials • Use of interpreters • Consideration of developmental & literacy level	King & Said, 2019; O'Shaughnessy et al., 2012; Durà-Vilà et al., 2013; O'Shea et al., 2000; Fazel et al., 2016; Vickers, 2005; Said & King, 2019; Hughes, 2014 (8 studies)
Constituent-Involving	• Bilingual and bicultural staff • Specialist training for native community health workers • Workers employed from native community	O'Shaughnessy et al., 2012; Hughes, 2014 (2 studies)
Peripheral	• Inclusion of culturally familiar activities, e.g., music, games or food • Role models from native ethnic background	O'Shaughnessy et al., 2012; Chiumento et al., 2011; Hughes, 2014 (3 studies)
Socio-cultural	• Inclusion of cultural values in intervention design or implementation, e.g., religion (fasting during Ramadan, evolution discussions) or familism • Intervention content targeted to specific cultural difficulties, e.g., asylum legal process, education on host country social norms etc. • Use of culturally specific symbols	King & Said, 2019; O'Shaughnessy et al., 2012; O'Shea et al., 2000; Fazel et al., 2016; Vickers, 2005; Said & King, 2019; Chiumento et al., 2011; Hughes, 2014 (8 studies)
Evidential	• Acknowledgement of loss, family difficulties and vulnerable narratives • Use of trauma or war specific questionnaires • Focus on unaccompanied minor health, prevalence of traumatic experiences	King & Said, 2019; O'Shea et al., 2000; Durà-Vilà et al., 2013; Ehntholt et al., 2005; Said & King, 2019; Chiumento et al., 2011; Hughes, 2014 (7 studies)
Other	• Delivery of intervention in group setting • Delivery of intervention in safe location, familiar to participant, e.g., school or mosque • Provision of hands-on activities • Involvement of family in intervention • Use of social support and networks • Sensitivity to staff lack of knowledge regarding conflict experiences • Sensitivity to mental health stigma • Culturally specific outcome measures	King & Said, 2019; O'Shaughnessy et al., 2012; Durà-Vilà et al., 2013; Ehntholt et al., 2005; O'Shea et al., 2000; Fazel et al., 2016; Fazel et al., 2009; Chiumento et al., 2011; Vickers, 2005; Said & King, 2019; Hughes, 2014 (11 studies)

themes or any processes of member checking to reduce bias. There appeared to be no effect of data collection type (interview, focus group, written) or publication year on emerging themes.

Consensus occurred regarding the emerging themes of peer support, alternative approaches to mental health difficulties and intervention setting. One quote extracted from Said and King (2019), is representative of the perceived improvement in mental health, '*It is extremely helpful. It benefits you on so many levels. It stores the problems you have through your life, so it does not come to you unexpectedly any moment, you do not suffer from them as before'*.

Qualitative information was gathered from families in two studies (Hughes, 2014; O'Shaughnessy et al., 2012). Mothers in both studies described themes of improved mother-child relationships and enjoyed psychoeducation including infant development and communication, '*it makes so much difference. It makes me to know my daughter much better, what she wants, what she doesn't want'*. No information was collected from fathers, siblings or other family members in any of the included studies.

For those school-based studies, teachers discussed themes such as the helpfulness of location, the feelings of containment and relief, '*it takes the weight and responsibility of counselling off staff*' (Chiumento et al., 2011) and improvements to increase accessibility.

Discussion

This review aimed to determine types of CAI evaluated within the United Kingdom, and explore the efficacy of such interventions for young people with R/AS. Some adaptations were similar across many studies such as translated resources or inclusion of cultural values, whilst others were rarer; use of staff from native community (Hughes, 2014; O'Shaughnessy et al., 2012). This review provides support for the use of CAIs when working with young people with R/AS in the United Kingdom. Across the eleven different studies, each found clinical improvement for participants using a variety of methods. Several reviewed studies have shown support for cultural adaptations to evidence-based interventions such as narrative therapy (Said & King, 2019) or CBT (Ehntholt et al., 2005), whilst others indicate the merit of specialist refugee services (Chiumento et al., 2011). Alternative treatments and supportive activities such as art, horticulture, culturally familiar food and activities also provided opportunities for young people and their families with R/AS to feel heard and supported (Chiumento et al., 2011; King & Said, 2019). Some qualitative data supported the involvement of families, schools and other support systems, by both validating and containing family and teachers but also improving outcomes for young people who may need more systemic support (Fazel et al., 2009; Hughes, 2014; Vickers, 2005).

Table 5. Reviewed study characteristics

Study ID Quality Assessment	Design	Sample & Study Location	Country of Origin & Status	Targeted Domain	Study Summary
King and Said (2019) 70%	Mixed Methods Evaluation of intervention	14 participants Mean Age: 16 1 female & 13 male United Kingdom	5 Afghanistan, 3 Ethiopia, 5 Sudan, 1 Somalia (all unaccompanied asylum-seeker)	No symptoms specified: General R/AS well-being	• Effectiveness of a CBT group for unaccompanied minors with R/AS (adaptations include use of interpreters within group setting, sensitivity of language stigma, focus on transitions & resettlement, racism, developmental needs, religious sensitivity, focus on physical health). • Outcome Measures: Strengths & Difficulties Questionnaire (Goodman et al, 1994), Reliable Change Index, (Jacobson & Truax, 1991), Child Revised Impact Events Scale (Perrin et al., 2005), focus group, • Half of participants showed reliable improvement on SDQ whilst a third of participants showed improvement on CRIES. • Identified themes included helpfulness of group, feeling welcome & safe, peer support, increased well-being strategies.
O'Shaughnessy et al. (2012) 75%	Qualitative Evaluation of service	13 dyads (mother & infant) Mother Age Range: 17-32 Liverpool, United Kingdom	Gambia, Sierra Leone, Ivory Coast & Nigeria (all asylum-seeker)	No symptoms specified: General R/AS mother and infant well-being	• Mental health group intervention for mothers and babies <1 year old, with aim of increasing secure attachment opportunities (adaptations include cross-culturally trained facilitators, outreach services, visual aids, culturally appropriate food, sensitivity to parenting beliefs and increased social support). • Outcome Measures: Infant CARE- Index (Crittenden, 2007), session by session Likert scale and reflective focus groups • Mothers reported improvements in mood, understanding of their child's needs using session by session questionnaires. Results for Infant CARE Index showed improvement for 2 mothers, good enough for 1 mother and borderline for 2 mothers, regarding relationship quality. • Identified themes included increased social support, feeling less alone, feeling safe, improved parenting knowledge, mother & baby relationships and untold narratives.

(continued)

Table 5. (continued)

Study ID Quality Assessment	Design	Sample & Study Location	Country of Origin & Status	Targeted Domain	Study Summary
Vickers (2005) 55%	Case Study Evaluation of intervention	2 participants 6 & 14 years old 1 female & 1 male London, United Kingdom	1 Africa, 1 Balkans (2 refugee)	PTSD	• Case studies illustrating use of Ehlers & Clark (2000) model of Post-Traumatic Stress Disorder (adaptations included sensitivity to confidentiality, focus on trauma, resettlement and legal process, family work). • Outcome Measures: Post Traumatic Diagnosis Scale (Foa, in Wilson & King, 1997) • Both case studies showed descriptive support for the adapted use of Ehlers & Clark (2000).
Ehntholt et al. (2005) 67%	Case Control Evaluation of intervention	26 participants (15 CBT group & 11 control group) Mean Age: 13 9 female & 17 male London, United Kingdom	11 Kosovo, 10 Sierra Leone, 3 Turkey, 1 Afghanistan, 1 Somalia (15 asylum-seeker, 2 refugee, 6 unaccompanied minor)	Teacher identified emotional & behavioural difficulties: PTSD, depression, anxiety	• School-based 6-week manualised CBT group compared to control group (adaptations include focus on trauma and war experiences, school-setting, adapted outcome measure). • Outcome Measures: 13-item Revised Impact of Events (R-IES, Smith et al, 2003), DSRS (Birleson, 1981), Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1978), adapted WTQ (Macksound, 1992), teacher SDQ (Goodman, 1994). • Statistically significant differences on R-IES *total score* & *intrusion* subscale and SDQ *total score* & *emotional difficulties* subscale in the CBT group. There were no significant differences for control group outcome measures. • Follow-up of 8 participants showed no statistically significant improvements
Durà-Vilà et al. (2013) 95%	Mixed Methods Evaluation of service	102 participants Mean Age: 10 26 female & 76 male London, United Kingdom	45 Middle East, 27 Africa, 23 Europe, 7 others	No symptoms specified: General R/AS well-being	• Exploration of 3 year community-based mental health intervention for young people with R/AS (individual therapy, problem-solving, multidisciplinary working, family therapy) • Adaptations include interpreters, school/ charity based, focus on loss, • Outcome Measures: Strength & Difficulties Questionnaire for teachers and therapists (Goodman, 1994) • Statistically improvement was seen in postintervention scores in 75% of participants. Participants who had been living in the United Kingdom longer were most likely to have significantly improved

(continued)

Table 5. (continued)

Study ID Quality Assessment	Design	Sample & Study Location	Country of Origin & Status	Targeted Domain	Study Summary
Fazel et al. (2009) 86%	Case control Evaluation of service	141 participants (47 young people with R/AS, 47 ethnic minority controls, 47 indigenous controls) 30 female & 64 male, 47 unknown Oxford, United Kingdom	R/AS group: 24 Balkans, 20 from Asia & India, 3 Africa	Teacher identified emotional & behavioural difficulties: anxiety, preoccupation, aggression	• Evaluation of school-based intervention for young people with R/AS and two control groups (weekly teacher consultations, individual, family, group & indirect work, in-home & crisis intervention). Adaptations include school-based, multidisciplinary liaison and staff support • Outcome Measure: Teacher rated Strength & Difficulties Questionnaire (Goodman, 1994), custom closed and open-ended questions. • SDQ scores across all groups reduced significantly postintervention, with improvement in the *hyperactivity* and *peer difficulties* subscales for R/AS young people • Themes from teachers and young people explored helpfulness of service, limited resources for service provision and negatives of the service.
O'Shea et al. (2000) 54%	Mixed Methods Evaluation of service	14 participants Mean Age: 9.6 2 female & 12 male London, United Kingdom	9 Middle East, 3 Sub-Saharan Africa & 2 Europe (8 refugee & 4 asylum-seeker, 2 unknown)	Teacher identified emotional & behavioural difficulties: severe psychological difficulties, Stage 2 special education needs	• Exploring a school-based mental health intervention (adaptations include location, tailored questionnaire, interpreters, systemic support, focus on loss, and support with legal processes). • Outcome Measures: teacher rated Strength & Difficulties Questionnaire (Goodman 1994), Exposure to War & Violence Questionnaire (Espino, 1991). • Case studies illustrated some descriptive improvement, but no statistical comparisons reported.

(continued)

Table 5. (continued)

Study ID Quality Assessment	Design	Sample & Study Location	Country of Origin & Status	Targeted Domain	Study Summary
Hughes (2014) 55%	Qualitative Evaluation of service	9 mothers, unspecified number of children London, United Kingdom	Mothers: Afghanistan Children: Congo, Horn of Africa, Afghanistan	No symptoms specified: General R/AS well-being	• Strength-based, narrative 'Tree of Life' approach to support mothers to understand their history, mental well-being and managing children's' 'difficult' behaviour. For young people to recognise mental health difficulties and develop strategies to manage adjustment to life in the United Kingdom • Adaptations included practitioners from R/AS community, accessible and nonstigmatising location, focus on heritage, empowerment to write own narrative and visual supports • Standard Western questionnaires were not used, verbal and written feedback encouraged instead. Mothers themes included sense of belonging, community, pride in culture and religion, peer support for parenting children. Child themes included pride in heritage, increased self-confidence, shared problem-solving and peer support
Fazel et al. (2016) 85%	Qualitative Evaluation of service	40 participants Mean Age: 17 11 female & 29 male Glasgow, Cardiff & Oxford, United Kingdom	9 Europe, 13 Africa, 9 Iran/ Iraq/ Afghanistan, 7 Asia, 2 South America (29 asylum-seeker, 11 refugee, 13 unaccompanied minor)	No symptoms specified: General R/AS well-being	• Evaluation of school-based mental health interventions for young people with R/AS (individual, family and group therapy). • Adaptations included school-based, increased involvement of school & family, education on social norms, focus on asylum process. interpreters • Semi-structured interviews explored using framework analysis. • Themes identified included location of service, role of teachers, type of therapeutic intervention/ adaptations, asylum process and pre- & postdisplacement stressors.

(continued)

Table 5. (continued)

Study ID Quality Assessment	Design	Sample & Study Location	Country of Origin & Status	Targeted Domain	Study Summary
Said and King (2019) 59%	Mixed Method Evaluation of intervention	4 participants Mean Age: 16.5 1 female & 3 male United Kingdom	2 Sudan, 1 Vietnam, 1 Albania (4 asylum-seeker)	PTSD	• Evaluation of Narrative Exposure Therapy for young people with R/AS (adaptations include use of interpreters, focus on trauma). • Outcome Measures: Child Revised Impact of Events Scale-8 item (Perrin, Meiser-Stedman & Stein, 2005), Child PTSD Symptom Scale for DSM-5 (Foa et al, 2018) and semi-structured interviews. • Reported reliable improvement for 3 participants (scores below clinical cut-off at postintervention) • Themes identified included perceived benefits of engagement and challenging aspects of therapy
Chiumento et al. (2011) 65%	Mixed Method Evaluation of service	42 participants (split across several groups) Liverpool, United Kingdom	-	No symptoms specified: General R/AS well-being	• Exploring the effectiveness of the Haven Project, a specialist refugee mental health service (adaptations included school-based, alternative therapies such as art therapy & horticulture, focus on loss and resettlement, groups). • Outcome Measures: Strength & Difficulties Questionnaire (Goodman 1994), interviews with participants. • Scores from questionnaires showed improvement in emotional well-being for many participants. • Themes included helpfulness of service, alternative therapies, confidence and peer support.

Where information is not given, it has not been possible to collect this information from the publication or with author correspondence

Table 6. Summary of qualitative themes

Themes	Said and King (2019)	Fazel et al. (2016)	Chiumento et al. (2011)	Fazel et al. (2009)	King and Said (2019)	O'Shaughnessy et al. (2012)	Hughes (2014)
Young People							
Benefits of alternative therapies such as art, music (I couldn't have just talked about it, helps to make things)			X				X
Benefits of Group Work (peer support, share strategies)			X		X		X
Perceived Benefits of Intervention (effectiveness, self-confidence)	X	X	X	X	X		X
Challenging Aspects of Intervention (including hard to talk about experiences, increased symptoms, can be stressful)	X	X		X			
Benefits of community-based location (ease, non-threatening, hospitals are scary)		X	X	X			X
Disadvantages of community-based location (issues of privacy, peers mocking them, missed lessons)		X		X			
Positive relationship with clinician (trusted, caring)		X	X	X	X		X
Difficult and traumatic experiences	X	X	X	X	X		X
Difficulties in adjusting to Life in UK		X	X	X	X		X
Uncertainty about the future		X			X		X
Impact of asylum process		X					
Feeling safe		X		X	X	X	X
Mothers							
Benefits of Interventions for mothers (I know I'm not alone, pride in my culture, parenting strategies)					X	X	X
Teachers							
Benefits of Intervention for Teachers (Containment, improved outcomes for young people)			X	X			X
Disadvantages of Intervention for Teachers (So few children are seen)			X	X			
Role of Teachers (Understanding and helped me)		X	X	X			X

Research on attachment relationships emphasises the importance of a secure relationship for a young person's future progress and mental health (Heard, 2018).

These conclusions are in line with similar systematic reviews using international data (Hinton, Rivera, Hofmann, Barlow, & Otto, 2012; Metzner, Reher, Kindler, & Pawils, 2016) suggesting that CAIs may be effective within community settings. To the researchers' knowledge, this is the first study to systematically examine CAIs for young people with R/AS, within the United Kingdom. This review was able to add to the evidence base for CAIs however it is important to acknowledge the limited statistical analysis of findings, due to issues with sample size and study heterogeneity. Furthermore, these conclusions must be taken with caution, as some studies may not achieve the rigorous standards set by scientific journals published in high-income countries, for evidence-based practice, for example the use of randomised control trials (RCT).

Included study limitations

As with much of the research surrounding young people with R/AS, there are several limitations to be considered. A smaller sample size and the heterogeneity of the refugee population could have consequences for the generalisability of findings. The nature of working with young people with R/AS is a smaller pool of participants from which to recruit from and higher attrition rates due to unfamiliarity with social norms, stigma, relocation or asylum legal applications, (Ali et al., 2017; Durà-Vilà et al., 2013). Of particular note, Ehntholt et al. (2005) added strict requirements of conversational English from young people with R/AS, further reducing their sample size. This may also limit the generalisability of their results as young people would have to learn English before arriving in the United Kingdom, or have settled long enough in the United Kingdom to learn English. There is evidence that migrants may go through a 'cultural transition' regarding their beliefs about illness and intervention, as they continue to integrate into their host societies (Pumariega, Rogers, & Rothe, 2005). It is important for services to consider while providing support.

Within the studies themselves, many used outcome measures available only in English and validated only within a Western population during peacetime (CRIES-8 & CPSS-5; Ehntholt et al., 2005; Said & King, 2019). As suggested by other researchers, unvalidated questionnaires may not capture the gravity of mental health difficulties if they only measure the Western symptoms (Gadeberg & Norredam, 2016; Stolk, Kaplan, & Szwarc, 2017).

Many of the reviewed studies also argue that a generalised universal, top-down approach may not be the most effective way of supporting young people from different ethnic backgrounds. Despite this, even these

studies could fall into the trap of over-generalising young people, for example similar geographical locations areas, even if these may be vastly different culturally, (Fazel et al., 2016). On the other hand, for practical reasons (resources and training), it may be necessary to have generalised transferable skills with a more person-centred approach at an individual level rather than too culturally specific to one ethnicity.

Finally, some of the cultural adaptations were poorly specified, and therefore, it is difficult to draw information about which components of CAI may be most helpful or unhelpful. None of the included studies managed to compare the effectiveness of CAIs to a nonadapted mental health intervention where no culture adaptations were introduced. This sorely limits the ability of this review to determine whether cultural adaptations are of significant benefit to young people and families with R/AS, compared to 'treatment-as-usual'. Due to the resources needed to reach matched control samples, it may be possible to evaluate interventions based on engagement rates and qualitative feedback as a starting point (Weersing & Weisz, 2002).

Systematic review limitations

Despite the precautions taken to search grey literature, this review may be subject to publication bias. Enticott, Buck, and Shawyer (2018) suggested governmental departments may be an additional source of literature, which is not often published on academic forums. Additionally, studies varied significantly in methodology, model of therapeutic intervention and population. This is understandable, given the necessary creativity needed to engage the refugee population, however the heterogeneity of studies limits the strength of findings. Quality assessment and missing information highlighted weaknesses in addressing potential biases and limited the amount of information regarding implementation of interventions, respectively.

There were particular issues with construct validity regarding the targeted area of mental health, and heterogeneity of interventions. It was difficult to determine the target difficulties for the majority of included studies, as they did not focus on presenting symptoms, instead appearing to be preventative interventions for everyday resettlement stressors. Western frameworks around treatment may not fit with the presenting symptoms or with the specific strengths and coping strategies that are unique to young people with R/AS (Byrow, Pajak, Specker, & Nickerson, 2020). It may be argued that these studies were focussing on the first stage of trauma intervention; safety and stabilisation (Laban, Hurulean, & Attia, 2009; Robertson, Blumberg, Gratton, Walsh, & Kayal, 2013). Other studies focussed on particular presentations of PTSD, anxiety, depression and poor educational attainment, and the effectiveness of evidence-based interventions, making it difficult to compare the two types of intervention.

Research and clinical implications

Within research, the use of labels can narrow the focus of studies to Western approaches and limit the extent to which researchers can learn from participants and therefore develop effective treatments (Beneduce, 2019). Clinically, professionals are then forced to choose between (1) acknowledging the broader contexts of refugee mental health, possibly reducing the chances of accessing financial, health and legal resources or (2) labelling a refugee child with an ill-fitting Western diagnosis, enabling access to increased, but potentially ineffective support (Beneduce, 2019). Rather than forcing limiting and dismissive categories on individuals who have experiences out with the Western constructs of trauma, mental health and resilience, it may be most helpful to allow participants to first identify their own aetiology of difficulties (Hughes, 2014; O'Shaughnessy et al., 2012). Development of this approach as a research paradigm may help to better inform policymakers and clinicians on how they can work collaboratively with a young person or family to identify true needs and an effective care-plan moving forward (Watters, 2001).

It can, however, be difficult to step away from the traditional methods of mental health categorisation and study design. This review keenly highlights the importance of considering all study types (not only traditional RCT's) when evaluating culturally adapted interventions, as relevant information may otherwise be dismissed. Based on the findings of this review, the following recommendations may be helpful when conducting research within populations with R/AS, from a methodological perspective.

- An emphasis on qualitative research to define difficulties within a refugee context before attempting to quantify experiences across entire populations, for example with questionnaires or symptom checklists
- Inclusion of more young people with R/AS in clinical trials, for example RCTs
- Increase sample size of CAI studies
- Evaluate the efficacy of different components of CAIs

Despite the recognised limitations, it appears that the included studies were able to address the stigma and barriers for refugee populations and therefore may provide insight into how mental health services could improve, for example use of cultural brokers, practical supports etc.

One key element of seven of the included studies was the implementation of treatment within a school location. Schools may provide an ideal setting to access young people, as they are often of key importance for integration and opportunities for the future (Tay & Silove, 2017). As suggested in Ehntholt et al. (2005) meaningful interventions for young people and their families could be completed by many professional disciplines including teachers, mental health nurses or art therapist, if training is provided (Fazel et al., 2009). This could preserve CAMHS and other specialist services for young people who are experiencing the most severe mental health difficulties.

Within the reviewed studies, there has been a highlighted difference with regards to evaluations of novel services compared with adaptations to pre-existing evidence-based interventions. Although both have suggested their efficacy within the United Kingdom, it must be noted that all interventions, excepting one study (Vickers, 2005) were completed within specialist services for young people with R/AS. Although it is promising to see specific provisions set up for this population, it is

particularly important to highlight in the context of increasingly limited resources and understaffed public services.

Medical models of mental health are not merely scientific labels, but also a means for financial support, resource allocation and treatment availability. Although the traditional model of diagnosis-led treatment has some benefit, it may not adequately acknowledge many of the socio-economic factors which contribute to both the development and presentation of mental health difficulties of refugees, for example legal status uncertainty, loss, acculturation and discrimination, (Kirmayer et al., 2011). Additionally, whilst considered a symptom of 'repressed' emotion in Western cultures, many cultures recognise an explicit relationship between emotional difficulties and physiological symptoms (Scheper-Hughes, 1992; Watters, 2001). The Western categorisations of mental health can also fail to account for the unique strengths and resilience needed to manage difficulties generally not experienced by peace-time populations, including torture, military conflict, severe poverty, and extreme and continuous danger (El-Khodary & Samara, 2020; Fino, Mema, & Russo, 2020). Finally, there are dangers to 'lumping' all R/AS experiences together, without regard for country of origin or ethnicity. Even with a formulation-led approach, it can be difficult to encompass the various cultural norms and thinking styles from different countries and ethnic origins (Tay & Silove, 2017).

Conclusion

Although empirically supported treatments for young people with R/AS are not well established, there is a growing evidence base to support the use of cultural adaptations to mental health interventions, with the aim to meet unique needs. This systematic review provides information for clinicians, services and policymakers about the efficacy of CAI within a UK public health settings. Most would agree that differences in ethnicity, religion, gender or nationality should not be barriers to high-quality professional care. Services must adapt to the increasingly multicultural population that require support within the population, without assuming homogeneity of all ethnic minorities. Although not yet defined, there is promise for developing psychological frameworks and political policies on how UK services can best support families with R/AS.

Acknowledgements

This study received no funding of any kind. A.T. confirms that she had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. G.R. and C.C. were involved in reviewing accuracy and write-up of the research article. The authors have declared that they have no competing or potential conflicts of interest.

Ethical information

No ethical approval was required for this article.

Correspondence

Alice Taylor, NHS Lothian, Edinburgh EH1 3EG, UK; Email: alice_taylor_16@yahoo.co.uk

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Accepted for publication: 21 January 2022