CULTURAL COMPETENCE IN MENTAL HEALTH SERVICES: NEW DIRECTIONS

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ABSTRACT

This article describes existing problems with cultural competence definitions and examines new developments in cultural competence theory and practices that have the capacity to increase the mental health care system's proficiency in serving racial and ethnic minority clients.

CULTURAL COMPETENCE: THE FIRST 20 YEARS

Shifts in Canadian immigration policy have increased the number of newcomers arriving from non-Western nations and nations identified as part of the global south, greatly increasing the racial, ethnic and linguistic diversity of this nation. Accordingly, the health care system is working to respond to meet the needs of our diverse population. Moreover, there is recognition of a particular need to be equipped to address mental health concerns in newcomer populations. Immigrants and refugees are often coming from situations in which they have survived tremendous environmental stress, political persecution and other types of hardship, and the immigration process itself and stressors associated with settlement in a new environment can increase vulnerability to mental health problems (Perez Foster 2001).

The mental health care system has responded to these challenges by articulating the need for cultural competence at all levels of service delivery. The now classic definition of cultural competence identifies it as a set of integrated behaviours, attitudes and policies that enable a system, agency, and professionals to work effectively in cross-cultural situations (Cross, Bazron et al. 1989). This definition has been adopted by many North American health care systems and is evoked regularly in discussions surrounding the delivery of mental health care in multicultural environments. Yet, many have struggled with how to translate these guidelines into hands-on strategies that would alter mental health services to make them more effective for ethnic and racial minority populations. Many of the efforts to operationalize cultural competence have resulted in the development of programs to equip service providers with cultural knowledge about various groups, with the hope that increasing cultural literacy at the service frontline will improve the level of understanding that mental health professionals bring to their work with clients from different cultures (Husband 2000). This approach, however, has proven inadequate for several reasons.

First, the cultural content that has been used to educate service providers is often based on static representations of culture that either reinforce stereotypes or dominant group experiences, not taking into account within-group diversity or dynamic transformations in culture that accompany changes in environment (Williams 2006). Second, this version of cultural competence has not addressed the power dynamics that are associated with identification of cultural 'difference' and how these dynamics of racialization and marginalization are associated with oppressive experiences within and beyond the mental health care system (Williams 2002). Third, this discourse has done little to address the question of effectiveness in service delivery. Although there is some understanding that retaining racial and ethnic minority clients in services is a minimal indicator of culturally competent service delivery(Williams 2001), research is revealing that these clients do not consistently receive equal benefits from service as those individuals who are identified with the racial/ethnic majority (Bhui and Morgan 2007). This is especially troubling as effectiveness is becoming a major focus of mental health care service design, reinforced by the growing availability of evidence-based practices that we know are highly effective in alleviating mental distress and illness (Muñoz and Mendelson 2005). Unfortunately, efforts at increasing the cultural competence of the system seem to run parallel to efforts to increase the effectiveness of services in the system with little thought to how these agendas can be merged to increase equity in the mental health care system. Therefore, although the mental health care system has greatly increased its awareness of the need to evolve to meet the demands of

an increasingly diverse population, the efforts to date have done little to address Cross's (1989) assertion that cultural competence involves attention to both the cultural context of treatment and its effectiveness. The most common iteration of cultural competence falls short of equipping the system to adequately serve many member of our growing Canadian population.

NEW CONTRIBUTIONS TO THE CULTURAL COMPETENCE AGENDA

Twenty years after Cross defined cultural competence, new developments in theory, research and practice are converging to enrich the cultural competence agenda and address the concerns noted above. Notable new contributions in this area include evolving definitions of how culture should be understood as part of the practice context, indigenous additions to defining the scope of competence for practice with racial/ethnic minority populations, and research-based efforts to increase the accessibility of evidence-based practices by culturally adapting some of our most effective interventions.

DYNAMIC, MULTIDIMENSIONAL DEFINITIONS OF CULTURE

There needs to be attention to specific cultural practices that affect the experience of mental health problems, culture-bound syndromes that may appear in practice settings, and cultural dynamics that affect the helping relationship, as defined via cultural formulation (Lewis-Fernández and Díaz 2002). However, theoretical developments articulating how culture is experienced through intersectionality and in varying epistemological frames are broadening our understanding of what it means to engage with someone at a cultural level.

The intersectionality discourse is critical of the culture in cultural competence being identified primarily with racial and ethnic difference signaled by accent, physical appearance, etc. and urges practitioners to recognize culture more inclusively, in the attitudes, behaviours, characteristics and shared experiences of groups defined by other social markers like sexuality, age, class, religion, etc. (Kelly 2009). Layers of cultural experience intersect so that the lived experience of any one is affected by the simultaneous experience of the others. This understanding directs practitioners away from accepting essentialized, stereotyped definitions of cultural experience and toward raising questions about how gender, class, sexuality, religion and other social categorizations affect the way in which individuals access and adhere to cultural experience. This dynamic view of culture effects mental health practices by discouraging the delivery of services in 'one-size-fits-all' packages that cannot address the diversity of needs within a cultural group. This line of theorizing converges with epistemological contributions that can aid practitioners to recognize culture being lived and created in multiple forms. Although culture can be defined in a specific body of knowledge, it also manifests and changes based on consensus within and across groups, it is defined intersubjectively within specific interactions, it develops in response to dominance and oppression in different contexts, and it can be as unique as the individual we are trying to know (Williams 2006). All these ways of knowing culture are relevant to mental health care practice because of the importance of finding ways to gain knowledge of clients that will aid in understanding how illness and health is defined in the context of intrapersonal, interpersonal, intragroup, and intergroup environments. Both intersectionality theory and the epistemological lens on culture re-define cultural competence as multiple competencies that can support a range of responses to a range of cultural expressions and experiences. Although such contributions undoubtedly make cultural competence more complex, they also have the potential to make it more precise in its efforts to incorporate culture into practice.

THE EMERGENCE OF CULTURAL SAFETY

Another important development has been the iterations of standards for cross-cultural practices from indigenous populations, most completely articulated by Maori health practitioners in New Zealand who have developed standards for what they term 'cultural safety' (Kearns and Dyck 1996). Cultural safety acknowledges the importance of work already underway to recognize the points of disconnection between mainstream mental health care and health paradigms used by many racial and ethnic minority groups. It asserts, however, that these efforts must also recognize the power dynamics inherent in service delivery systems that are primarily organized and executed by racially, ethnically and political dominant groups who bring their higher social status into interactions with members of racial and ethnic minority groups. The consequences of this power and status manifest in the poor record that the mental health care system has had with such groups, as demonstrated in research documenting their mistreatment, misdiagnosis and poorer prognosis in Western mental health care systems (Williams 2002). The work of these Maori practitioners identifies negotiating this power dynamic as a skill that must be prioritized in training for service providers, as inattention to it easily leads to misuse of power, prejudice and discrimination that can alienate racial and ethnic minority clients from seeking services and/or completing treatment (Polaschek 1998). Cultural safety holds practitioners of all racial and ethnic backgrounds responsible for examining the power dynamics in practice

and recognizing their potential to contribute to systemic and interpersonal racism that can disengage and harm clients (Baker 2007).

CULTURAL ADAPTATION OF EVIDENCE-BASED PRACTICES

Finally, there is work underway to increase access to evidence-based practices by culturally adapting existing treatment models so they are more culturally appropriate. Cultural adaptation involves strategies like building on culture-specific models of health, integrating culturally-relevant rituals into treatment, using culturally syntonic examples for psychoeducation, and developing intervention strategies to address population-specific stressors in the current environment (Muñoz and Mendelson 2005). Evidence-based practices require cultural adaptation because they have usually been developed in mainstream settings and tested with clients who identify with the dominant culture. The assumptions, examples, goals and expectations for treatment embedded in these models do not necessarily translate effectively to racial and ethnic minority clients. Close examination of such work, for example, the prevention and treatment manuals developed for Latino populations at the San Francisco General Hospital (Muñoz and Mendelson 2005) suggests that effective cultural adaptation proficiency in making use of cultural knowledge as it is transformed in a specific environment, recognizing service practitioners as cultural bridges between immigrants and mainstream service institutions, and taking deliberate steps to modify practices so they are feasible, acceptable and culturally appropriate. Adaptations of our best practices is an important component of increasing cultural competence in the mental health care system, as it increases the likelihood that racial and ethnic minority clients will receive the same benefits from treatment as other clients.

These developments potentially form the foundation of the next generation of cultural competence. The standards set by the Cross definition continue to be relevant and useful, and theory and research are moving move us toward increasing our proficiency in attaining them.

CONCLUSIONS

Cultural competence has already been established as an ongoing process of identifying the cultural competencies necessary for practice in their environments and evaluating individual, service and system strengths and challenges in achieving those competencies (Williams 2005). These described new contributions give further shape to the definition of those competencies by suggesting that practitioners, in particular, need to understand the dynamic and multidimensional nature of culture, the impact of power dynamics in their practice, and the steps that must be taken to make evidence-based practices culturally appropriate and responsive. Service settings and systems can support practitioners in these efforts by prioritizing training for cultural competence and building relationships with newcomer and citizen communities that will support them in remaining responsive to mental health needs in racial and ethnic minority populations. Improving cultural competence at service and system levels is an ongoing process that will require regularly reevaluating the competence standards we have in place and the strategies we are using to achieve them. Diversity and equity have been named as priorities in health care planning at the provincial and federal levels, therefore a space has been created in which new contributions to cultural competence can be brought to attention. This should strengthen our resolve and our optimism about improving services available to immigrants and other racial and ethnic minority groups in the mental health care system.

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