

**EMBRACING CULTURAL COMPETENCE IN THE MENTAL HEALTH AND
ADDICTIONS SYSTEM**

DRAFT

ACKNOWLEDGEMENTS

This position paper evolved out of a need to address health disparities among various populations in Ontario. Various member agencies of the Ontario Federation of Community Mental Health and Addiction Programs noted that they were providing care increasingly to diverse populations. They relayed a sense of urgency to examine the need for cultural competency in the delivery of mental health and addictions care, within the overall mental health system, and its relation to the wide spread health disparities between various groups within the population. Their experience informed them of individuals who were unable to attain services due to multiple barriers such as language, sexual orientation, limited treatment options, and so forth. In addition, they observed that different organizations had different ideas of cultural competency, which led to differing applications in practice with varying focuses. And finally, while certain organizations claimed to have achieved a certain level of cultural competency, communities were telling them that in reality this was not the case.

Our appreciation goes out to those who stepped forward to voice the need for a more coherent and comprehensive treatment of cultural competence, and the need to further dialogue and collaborate around these efforts among member organizations. And while there are undoubtedly many more individuals and organizations who could have provided valuable input to the development of this paper, we would like to acknowledge the dedication and input of members who formed the Cultural Competency Steering Committee and the Position Paper Working. We would like to acknowledge the following people and their organizations:

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EXECUTIVE SUMMARY

The demographic background of Ontario has become vastly diverse. Service providers are finding it increasingly challenging to provide adequate mental health and addictions care to individuals from various populations. Thus, in Ontario, there has become renewed interest in the incorporation of cultural competence into the provision of care. Interest is further fuelled by the vast amounts of research evidence pointing to the differential and inadequate levels of services received by particular marginalized populations, which ultimately have serious negative consequences on their health outcomes.

Utilizing a cultural competence approach in the delivery of mental health and addictions services has shown numerous benefits and include improved access to services for underserved groups, improved quality, greater satisfaction of services received, and reduced health disparities. To move towards cultural competence, however, organizations and systems must address many barriers at the frontline, organization and governance, and system levels. Examples of barriers include lack of skills and knowledge by frontline workers, differing understandings of what cultural competence entails, varying levels of commitment to cultural competence as an essential component of service provision, perpetuation of stereotypes and biases of certain populations, and systemic allocation of resources that favour certain populations over others.

Key principles of cultural competence such as inclusiveness, holistic health, anti-oppression, valuing diversity, and so forth, are informative in the development of a conceptual framework on which to base programs and a service delivery model upon. Further, recommended steps for organizations to take are suggested for adaptation at the frontline, organization and governance, and system levels to move towards cultural competence. These steps may be adopted as is or adjusted to suit the context and culture of the individual organizations.

I. INTRODUCTION

The need for cultural competence in the mental health and/or addictions care of individuals with diverse backgrounds has evolved into a major issue in contemporary discourse. Service providers are recognizing that it is becoming increasingly difficult to ignore the challenges of providing adequate services to meet the diverse needs of their service users. There is increasing agreement that the challenges presented by Canada's diversity must clearly be addressed in the present as an acknowledgement that it is no longer acceptable to engage in practices or tolerate attitudes that limit the access of fellow Canadians to quality mental health and/or addictions system. Diversity in its broadest sense must be addressed as a prerequisite to creating a truly integrated health care system that embraces everyone. It must also be recognized as being fundamental to the improvement in quality of care and life for consumers and family members living with a mental illness and/or addiction.

It is the Ontario Federation of Community Mental Health and Addiction Programs' position that cultural competence and diversity must become core components at all levels of the mental health and addiction system including the delivery of direct mental health and addictions care, a part of the mission and vision of all mental health and addiction organizations, and a key policy and accountability requirement mandated by LHINs. This paper reflects the position of the Federation and we hope that organizations providing mental health and addictions care and the mental health and addictions system will expand on the ideas presented here and that productive dialogue will ensue.

In this paper, the relevance of culturally competent services in an increasingly diverse and multicultural Canada is explored. Key concepts and ideas in regards to cultural competence and diversity are examined which we hope will generate thought and discussion around issues of diversity and the underlying values and beliefs assigned to it. While the relevance of cultural competency can be seen in relation to many of the social determinants of health, the importance of cultural competence in determining accessibility to mental health and addiction services shall be the primary focus of this paper. Overall, the paper aims to challenge health service providers to reflect deeply on their existing practices at the frontline, organizational, and governance levels and to raise questions about aspects of the current health care system, which may act as or perpetuate barriers towards cultural competent care.

This paper begins by presenting background information on: (1) demographic changes in Canada and Ontario which heighten the need for cultural competent services; (2) disparities in health outcomes of marginalized populations; and (3) health as a fundamental human right. Next, the benefits of utilizing a cultural competence approach to the delivery of mental health and addictions care is presented followed by some of the barriers and issues presenting challenges towards cultural competence. The paper continues with a review of broad principles underlying issues of diversity and cultural competence and is followed by recommendations for implementation at the direct service, organization and governance, and system levels (starting on page 16). Suggestions for future follow up action round up the papers closing.

II. INTENDED USERS

A cultural competence approach can lead to enhanced care at all levels of the addictions and mental health care system from frontline workers to policy and decision makers. As such, this position paper can be informative for the following:

- a) Addictions and Mental Health Organizations;
- b) LHINS;
- c) Ministry of Health and Long Term Care; and,
- d) Other Systems and/or Funders (such as Ministry of Health Promotion, Ministry of Community and Social Services, United Way, Trillium Foundation, etc.)

While use of the position paper is encouraged by all of the above groups, as reflected in the introduction section, a primary purpose of the paper is to generate thought and discussion around the issue of cultural competence among member agencies of the Federation.

III. BACKGROUND AND CONTEXT

DEMOGRAPHIC CHANGES INDICATING INCREASING DIVERSITY

Within the last few decades, Canada has become increasingly diverse. According to Statistics Canada's *2006 Census of Population*, over six million Canadians today (19.8% of Canada's total population) are born outside of the country. Since the 2001 Census, there has been an 18.2% increase in Canada of individuals who speak none of Canada's official languages (Statistics Canada, 2007a). Among the Aboriginal population, the 2006 Census shows that those who self-identify themselves as Aboriginal has passed the one million mark with 60% identifying themselves as First Nations, 30% identifying themselves as Metis, and 4% as Inuit (Statistics Canada, 2006). Between 1996 and 2006, the Aboriginal population has increased 45%, a rate nearly six times faster than the non-Aboriginal population's growth rate of 8% (Statistics Canada, 2008).

In Ontario, the 2006 Census tracks a similar trend with a clear 28.3% of Ontario's total population identifying themselves as immigrants. Since the 2001 Census, there has been a 17.3% increase in Ontario of individuals who speak none of Canada's official languages (Statistics Canada, 2007b.) The province of Ontario has had the highest rate of immigration with 4.8% of all immigrants into Canada choosing Ontario as their choice of residence during the 2001 to 2006 time period (Statistics Canada, 2007b). Among the Aboriginal population, 242,495 lived in Ontario in 2006 (Statistics Canada, 2008).

The majority of projected growth in Canada is estimated to come from immigration with the vast majority of these new immigrants coming from non-European countries where most are non-white and speak neither English nor French (Statistics Canada, 1995). It is projected that by the year 2016, minoritized populations will account for one-fifth of the Canadian population (Statistics Canada, 1995). The majority of these minoritized populations are expected to choose Ontario as their primary choice of residency up until 2016 (56%), with most of the remainder in British Columbia (18%) and Quebec (14%) (Chard et al., 1999). Thus, Toronto, Vancouver and Montréal will likely become increasingly differentiated from other regions of Canada in terms of cultural diversity and the presence of minoritized populations (Chard et al., 1999).

Aside from increasing diversity along the lines of ethnicity or country of origin, there has also been an increasing number of Canadians who have self-identified as gay, lesbian or bisexual. Today, an estimated 346,000 Canadians identify themselves as such and together they represent 1.9% of Canadians aged 18 to 59 years of age (Tjepkema, 2008).

DISPARITIES IN MENTAL HEALTH AND ADDICTION OUTCOMES AMONG MARGINALIZED POPULATIONS

Canada's increasing diversity and the need for culturally competency in system is compounded by the disparities that exist among marginalized populations including immigrants, refugees, the low income, the homeless, those living with disabilities, the lesbian, gay, bisexual and transgender (LGBTIQ) communities, women, and so forth. Those who study the morbidity and mortality of a variety of diseases have long witnessed the association of disease prevalence and health outcomes with factors of social inequality (Farmer, 1999). Buchman (2007) confirms the fact that individuals of lower socioeconomic status (SES), marginalized or disadvantaged groups suffer disproportionately from addiction.

Marginalized populations are also exposed to discrimination. Exposure to discrimination has been found to be one of the more detrimental of social influences. Those who experience discrimination are noted to be at higher risk of having poor mental and physical health outcomes. A lot of evidence indicates a strong relationship between perceived discrimination and low self-esteem, low educational attainment, and poor physical and mental health outcomes among marginalized ethnic populations (Araujo et al., 2006). A study in the Netherlands found that people who perceived they were victims of discrimination were twice more likely to develop psychotic symptoms over three years than those who did not perceive being discriminated against; further, the more exposure to multiple forms of discrimination, the more likely the development of delusions (McKenzie, 2003).

Several groups who are highly marginalized in society are the LGBTIQ, the homeless, and those living with a mental health and/or addiction. Among the LGBTIQ groups, one study on gay and bisexual men – one of the groups to have been most impacted by HIV in the United States – indicated that ethnically minoritized men were most affected by the HIV epidemic. In the U.S., African Americans and Latinos were found to be eight and three times at risk of becoming diagnosed with AIDS than their white counterparts (Centers for Disease Control and Prevention, 1999). Diaz et al. (2001) also found in their study that many of their gay participants turned to substances – alcohol and drugs – as a coping tool against discrimination and stigma with some developing depression and having attempted suicide. For lesbians, studies have shown that presumptions that they are heterosexual, stereotyping and misconceptions about lesbians' health needs have created significant barriers to comprehensive quality health care (Dean et al, 2000). Thus, for the LGBTIQ groups, stigma, discrimination, prejudice and violence contribute to a hostile and stressful social environment that can cause mental health difficulties (Meyer, 2003). Among the homeless, the *2007 Street Health Report* (Khandor, 2007) indicated that homeless individuals have poorer health than the general population and they experience greater numbers of chronic and multiple health issues. In another study of homeless women without dependents living in shelters in Toronto, results revealed that those 18-44 years old were ten times more likely to die than women from the general population (Cheung et al., 1998). Not surprisingly, research shows a strong, positive link between housing stability and positive mental health (Canadian Mental Health Association, 2003). This reinforces the fact that Canada's universal health care may not be inclusive to everyone equally.

Thus, there is plenty of evidence that both systemic and frontline discriminatory practices play a pivotal role in the disparities in health outcomes of diverse and marginalized populations. The need for cultural competency in the provision of care for diverse and marginalized populations is therefore more urgent now than ever before.

DIFFERENTIAL QUALITY OF MENTAL HEALTH CARE AMONG IMMIGRANT POPULATIONS

In 1999, the U.S. Surgeon General reported that the public health burden of mental illness is not shared equally mainly as a result of disparities in access to services and variations in the quality of care (U.S. Department of Health and Human Services, 1999). Greiger (2001) also points out that in many countries, including Canada and the United States, ethnically minoritized populations and new immigrants experience a greater burden of morbidity and mortality due to systemic differences in the overall provision of health care. Evidence indicates that ethnically minoritized populations are less likely to receive advanced cancer treatment, renal transplantation or surgery for lung cancer compared with white patients matched for insurance status, income or education, severity of disease, comorbidity, age, hospital type and other possible confounding factors (Bach et al., 1999). Differences can also be found in basic elements of clinical care such as physical examinations, history taking, and laboratory testing across the entire spectrum of disease (Kahn et al., 1994; Avanian et al., 1999).

In Canada, while there is less research on overall health differentials among ethnic populations, there is still well-documented evidence indicating the inferior health status of Aboriginal groups (Young et al., 2000) and other immigrant populations (Wobeser et al., 2000). For Aboriginal groups, suicide rates, which provide a standardized measurement of population mental health, are 60% higher among residents of the North Region (Health Canada, 2002). For immigrant groups, while they have been shown to have equal or better health status than other Canadians upon arrival to Canada, this “healthy immigrant effect” seems to decline with increased residency so that immigrants’ health status become equal to or less than those of their Canadian counterparts (Vissandjee et al., 2004). In terms of mental health, Strachan et al. (1990) found that immigrants over 65 years of age have higher mortality rates from suicide than their Canadian-born counterparts. For women, first-generation immigrant women were found to have higher suicide mortality rates than their Canadian-born counterparts, with the highest for immigrant women from Asia (Strachan et al., 1990).

The Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988) determined that disparities in mental health services existed for racialized groups. Canadian researchers identified language to be the most pressing barrier to accessing appropriate mental health services. This finding is crucial as there is perhaps no other health area where effective intervention is as dependent on language and culture. Culture and language have been identified as definitive factors in the conceptualization of mental illness, its identification, accurate diagnosis, management and effective treatment by health care providers (Putsch, 1985; Marcos, 1979). Higher drop out rates from treatment regimens have also been attributed to services that are culturally or linguistically inappropriate (Flaskerud, 1986). These outcomes should be of concern because many immigrants and refugees face multiple stressors prior to and after migration to Canada and are, thus, known to generally be at high risk for developing mental health difficulties (Pumariega et al., 2005).

RIGHT TO HEALTH AND HEALTH CARE

The level of health disparities that exist in Canada and other parts of the world can be viewed as an infringement on basic human rights. The right to health and health care (which encompasses the right to mental health and addictions care) is highlighted as a fundamental human right of all individuals by international standards and covenants. In Canada, the *Canada Health Act* exists to ‘equalize’ the health status of all Canadians through the ‘equalization’ of access to health services. Internationally, the right to health is recognized by the *International Convention on the Elimination of All Forms of Racial Discrimination of 1965* in Article 5(e)(iv) (WHO, 2005). As well, the *Committee on Economic, Social and Cultural Rights* includes the right to a system of health protection which provides people with equality of opportunity to enjoy the highest attainable level of health (WHO, 2005). According to this Committee, entitlements include:

- Availability – adequate health care facilities and services must be available;
- Accessibility – health care and services must be made available to everyone without any discrimination (including physical accessibility, economic accessibility, and information accessibility); and,
- Acceptability – health care facilities and services must follow medical ethics and be culturally appropriate (all WHO, 2005).

Thus, systematic discriminatory practices leading to inequitable access to health resources can be viewed as violation of basic human rights as set out by international and local conventions. In fact, the World Health Organization (2005) note in their report, *WHO Resource Book on Mental Health, Human Rights, and Legislation*, that discriminatory practices in the provision of mental health services to minoritized populations can be played out in multiple ways including the following:

- Denial of access to community-based treatment facilities and deferred to treatment in inpatient facilities instead;
- Higher rates of involuntary admission;
- Interpreting social and cultural norms of behaviour as signs of mental disorders which may lead to involuntary admission;
- Involuntary treatment when in mental health facilities;
- Mental health facilities’ environment not taking into account the unique cultural and social needs of various groups; and,
- Higher rates of arresting certain populations for minor behavioural problems leading to higher rates of contact with the criminal justice system.

Working towards cultural competence in the provision of mental health and addictions care is one way for frontline workers, organizations and the mental health and addiction system to address some of the exclusionary practices and services, which systematically discriminate against various populations in our society. By doing so, the basic human rights of all individuals can be better accounted for.

WHAT ONTARIO HAS BEEN DOING TO ADDRESS DIVERSE POPULATION

This global diversity of inhabitants whose cultural, socio-economic, linguistic and political backgrounds are very different from each other creates a huge challenge in the provision of universal health care for the population. Danish et al. (2007) note that despite the reality of a diverse population, care for individuals living with mental health and/or addictions issues is usually practiced sporadically without systemic and institutional planning.

Such is the case in Ontario. While the Ontario Ministry of Health and Long-term Care's document, *Making it Happen*, makes references to diversity by recommending family initiatives "reflect community needs and diversity and address locally relevant ethnoracial issues" (Ministry of Health and Long-Term Care, 1999, p. 45), not much has been followed up with to address the increasingly diverse needs of Ontario's population around mental health and addictions services, until now.

In recent years, the Ministry of Health and Long-term Care has started a cross-Ministry research initiative to address health equity in a more integrated and coordinated fashion (Rachlis, 2007). More locally, some of the LHINs have also started organizing diversity committees or task forces to work on eliminating health disparities (Rachlis, 2007). Such initiatives are long overdue. It is the hope of the Federation that these efforts to address diverse needs of Ontario's population are ongoing and sustained as sporadic or non-existent attention to the diverse needs of the population can have real consequences on the health outcomes of individuals. Although there will no doubt be multiple challenges in overcoming barriers to address issues of diversity at all levels, including direct services, organizational practices, and systemic context, inaction can no longer be an option.

IV. VALUE OF PROVIDING CULTURALLY COMPETENT SERVICES

All individuals are influenced and shaped by the environment they grew up in. A person's environment can help form his or her worldview and behaviours. In turn, worldviews and habitual behaviours or customs can influence the way individuals conceptualize illness, view treatment options, access health services, and so forth. As such, incorporating cultural competence, which takes into account differences in individuals of diverse backgrounds, into the design and delivery of mental health and addiction services is warranted.

While Goode et al. (2006) note that the evidence base showcasing the benefits of utilizing cultural competence in the care of individuals is still in the early developmental stage, existing research indicates that there is indeed great value in utilizing a cultural competence approach in the provision of care. A systematic review and analysis of the literature on studies from 1980-2003 evaluating interventions to improve the cultural competence of health professionals concluded:

- There is excellent evidence that cultural competence training improves the knowledge of health professionals;
- There is good evidence that cultural competence training improves the attitudes and skills of health professionals; and,
- There is good evidence that cultural competence training positively affects patient satisfaction (all Beach et al., 2005).

Additional findings from research on the benefits of using a cultural competence approach are as follows:

- Cultural competent organizations foster many positive processes among clients and personnel, including: empowerment, decreased anxiety and fear of the health organization, greater access and representation of culturally diverse population members among clientele, increased client satisfaction, improved learning experiences for personnel, and improved respect among personnel (Anderson et al., 2003; Shaw-Taylor et al., 1998);
- Cultural competency is associated with improved quality of care and improved health outcomes for racialized and underserved populations (Anderson et al., 2003; Shaw-Taylor et al., 1998);
- Ethnic and linguistic matches between service providers and their clients are associated with a lower drop-out rate, more treatment sessions, and better clinical outcomes than when clients and providers are not from the same ethnic group or of the same linguistic background (Sue et al., 1991);
- A cultural competence approach improves understanding of the cultural aspects of treatment for immigrant populations, improves quality of care by decreasing misunderstandings and misdiagnosis (especially culture-specific diagnosis), and improves awareness of biases which may lead to a decrease in differential care, higher client satisfaction, and improved compliance (De Jong et al., 2005); however, some schools of thought qualify the idea of culture-specific diagnosis as relevant social determinants of health may not be accounted for;
- Cultural competence throughout all areas of health care is key to reducing disparities of access and enhancing quality of care (Betancourt et al., 2002);
- Culturally sensitive interventions such as cultural competence training and racial and ethnic concordance have shown improvements in subjective, self-assessed measures of provider knowledge and patient satisfaction (Fortier et al., 2003); and,
- Health promotion and education programs that used interpreters, community health workers, translated materials and other culturally sensitive approaches reported increased intake, program completion, and knowledge (Fortier et al., 2003).

While the evidence base for the effectiveness of a cultural competence approach requires further development, especially in relation to various marginalized groups, there is great promise in the flurry of recent and ongoing research activities which will undoubtedly shed light on ways systems, organizations and individuals can better prepare themselves to work with individuals and communities of diverse backgrounds. If all organizations can move toward cultural competence, individuals from diverse populations will not be limited in their choice of services and programs to ethno-specific organizations. The Ontario Federation of Community Mental Health and Addiction Programs encourages and is in full support of further research related to the above issues.

V. BARRIERS AND ISSUES POSING CHALLENGES FOR CULTURAL COMPETENCE

There are multiple barriers and issues posing various challenges for care providers, organizations and the mental health and addiction system to move towards cultural competence. A review of some of these barriers may shed light on areas that need to be addressed to promote change. As such, the following are highlights of some of the barriers and issues standing in the way of cultural competence:

VARIATIONS IN DEFINITIONS

One of the difficulties in identifying how to provide cultural competent care lies in the differences in the understanding of ‘cultural competence.’ Various definitions of the term ‘cultural competence’ and other similar terms including ‘cultural sensitivity,’ ‘culturally appropriate,’ ‘intercultural care,’ and so forth, are often used interchangeably adding to the confusion (Arthur et al., 2007). Further, Guarnaccia and Rodriguez (1996) note that there has been inadequate attention devoted to conceptualizing culture within the development of culturally competent mental health services, both in practice and literature. Arthur et al. (2007) agree that a definition of culture is an important first step in planning culturally competent mental health services. Without an examination of what ‘culture’ entails, it would be difficult to ascertain areas to address in the provision of culturally competent care. The definitions of both culture and cultural competence shall be addressed in following sections.

EARLY STAGE OF DEVELOPMENT

In recent years, there has been a resurgence of interest in cultural competence in the provision of services. However, the field as a whole is still in its early stage of development and as such, much more needs to be accomplished to move the field forward towards implementation. For instance, further work needs to pinpoint exactly which cultural aspects of interventions bring about improvements in care, apart from mechanisms of quality improvement or public health strategies inherent in interventions (Fisher et al., 2007). As well, there still needs to be further work to establish the impacts of cultural competence interventions on health disparities and health outcomes (Fisher et al., 2007). These efforts will help to establish cultural competence and diversity practices based on best practices.

LACK OF RESEARCH ON DIVERSE POPULATIONS

There remains a lack of representation of minoritized populations in health research (Shavers et al., 2005). This is pertinent as there have been proven differences in the way populations perceive illnesses, experience a disease, metabolize psychiatric drugs, comply with treatments or drugs, and so forth. Research priorities in non-mainstream cultures differ from priorities in mainstream cultures that may contribute to an under-representation of research questions relevant to minoritized groups (Shavers et al., 2005). Lack of attention to research questions concerning minoritized groups may stem from perceived bias in the peer review system towards grants addressing disparities, the availability of funding mechanisms, interest of journals and acceptance of relevant peer-reviewed publications, and the value and reward within academic institutions and other organizations for disparities research (Shavers et al., 2005). There may also be under-representation by minoritized groups because standard sampling methods may not have significant prevalence rates among small minoritized groups such as lesbian, gay, bisexual, transgendered, intersex and queer minoritized populations (LGBTIQ). Unfortunately, researchers are often slow to accept or unwilling to test alternative sampling methods which may hold promise (Magnani et al., 2005). To fully provide the best care to the diverse populations that exist, further research is required in all areas, including best practices for cultural competency in the provision of care.

LACK OF KNOWLEDGE, SKILLS, CONFIDENCE AND SO FORTH...

In a study of community nurses by Andrews and Boyle (1997), the nurses reported feeling that they lack the knowledge, skills and the confidence to care for patients from diverse backgrounds adequately. Further, Gonzales et al. (2000) reported that even nursing faculty members expressed feeling unprepared to teach the cultural context within the curriculum and that the cultural context within the curriculum is limited. In other studies, barriers towards cultural competence included lack of time to handle issues in cultural competent interactions effectively; a lack of resources such as interpreters; a lack of educational preparation; and lack of practical experiences with diverse clients (Kirkham, 1998; Boi, 2000). A study by Kulwicki et al. (2000) found persistent intolerance among some providers toward service users who do not speak English. Due to ethnocentrism and prejudice among service providers who react negatively to differences, interactions between the care provider and client are notably briefer, less participatory, and less therapeutic when clients are non-White (cited in Betancourt et al, 2002). These issues are not limited to nurses as similar concerns can be found among providers of mental health and addictions and thus require further discussion and action.

LACK OF AWARENESS OF BIASES AND SYSTEMIC BARRIERS

Becoming aware of one's own biases is another initial step required to move towards cultural competency. Unfortunately, despite the wealth of diverse needs that exist today, health care systems, organizations and service providers are still not paying much attention to existing biases and barriers in the whole health and social services sector. Understanding how one's own biases, assumptions and fears impact on the interactions with clients is important to the provision of quality care. In addition to personal biases, it is important for service providers to reflect on unseen or subtle biases that are systemic – built into organizational structures and processes. These may be more difficult to detect but are no less real and may be even greater in its impact on the well-being of individuals and communities. Systemic biases may ultimately lead to discriminatory practices and policies towards certain populations, whether intentional or not.

REINFORCEMENT OF BIASES, STEREOTYPES AND GENERALIZATIONS

Gregg and Saha (2006) acutely note that the current renewed interest in cultural competence is driven by a desire to eliminate racial and ethnic disparities in the quality of health care. Nonetheless, the traditional method of addressing cultural competence via cross-cultural education to alleviate barriers for immigrants, refugees and other marginalized groups is still the predominant mode being used today. In utilizing cross-cultural education, there are attempts to define cultural boundaries and norms which may unintentionally reinforce and or create racial, ethnic or other biases and stereotypes while doing little to clarify the actual complex socio-cultural-political contexts in which people live (Gregg et al., 2006). In other words, simplistic notions of culture and cultural differences need to be reexamined as they may actually perpetuate inequities among various populations. Further, such ethnocentric perspectives may filter and categorize information about any differences between populations in a way as to construct diverse individuals and communities as “the other” and thus reinforce existing power differentials (Haarmans, 2004).

Gregg and Saha (2006) also warn of oversimplification and generalizations of systems. In attempts to address racial and ethnic disparities through cross-cultural education or cultural competence training, it may be explicitly or implicitly suggested that cultural competence can address larger issues such as access for those living below the poverty line, racism, differential access and discrimination, and so forth (Gregg et al., 2006). A false message may be projected indicating that poverty and discrimination produce adverse health effects through their impact on cultural beliefs may trivialize the larger problems of social disadvantage and deprivation and the contributions of other social and structural forces in maintaining and promoting health disparities by race, ethnicities, and social class (Gregg et al., 2006). It is thus important to keep in mind that culture works dynamically in conjunction with economic, social, and other environmental factors to affect health behaviours and to decrease or increase health disparities.

LACK OF MEMBERSHIP BUY-IN

Within organizations, there may be obstacles in incorporating and sustaining cultural competence and diversity into the mission statement and within other aspects of the organization (Yearwood et al., 2006). For instance, members may not wish to accept and/or be willing to adopt cultural competence as a priority issue to be addressed (Yearwood et al., 2006). Hyde (2004) confirms lack of membership buy-in as a major barrier to cultural competence. More specifically, Hyde (2004) points to a hostile agency climate, lack of consensus around and lack of a clear articulation of the meaning of cultural competence, lack of consensus of the universal benefits of cultural competence, overemphasis in aiding white staff in gaining cultural competence skills, and lack of staff diversification as major internal barriers toward cultural competence (cited in Olavarria et al., 2002).

STRUCTURE AND DESIGN OF THE MENTAL HEALTH AND ADDICTIONS SYSTEM

Structural barriers to equitable access to quality of care include more than mere language barriers. The structure and design of the health care delivery systems themselves (such as the intake process, referral mechanisms, continuum of care, and allocation of resources) may stand as barriers to quality care for diverse populations (Betancourt et al., 2003). There is thus a need to carefully examine the potential barriers posed by the structure and design of health care delivery systems and to assess their various impacts on the health outcomes of different populations. For instance, certain populations within society are more susceptible to living in chronic poverty. Those who live in poverty have fewer options, less access to care, and experience poorer services and greater barriers to services than do those with more economic resources (Bent-Goodley, 2007). Poverty as a barrier itself must then be examined to assess and meet the complex needs of individuals living in poverty. One reason underlying access issues facing marginalized populations may be a lack of trust of service providers due to a history of discrimination, social exclusion and poverty. Thus, even though services may be made available to them, they may choose not to access them (Ontario Human Rights Commission, 2008).

Overall, it is clear that barriers to cultural competence exist at all levels: individual service providers lack the confidence, skills and knowledge to deliver appropriate services that incorporate cultural competence; members within organization have various degrees of understanding and commitment to cultural competence in the delivery of services and care and may sometimes even perpetuate stereotypes and biased views of various groups; and, the mental health and addiction system itself may be structured in a way that it provides differential care to different populations. Although the practice of cultural

competence is still in its early developmental stage, there must be efforts made to remove barriers to achieve equitable care for all.

VI. PRINCIPLES OF CULTURAL COMPETENCE

INCLUSIVENESS

This is in reference to organizational systems that incorporate decision-making that is inclusive of perspectives from diverse points of views, from within and beyond the organization, where appropriate (Hastings Institute, with reference to Byron Kunisawa and Websters New Collegiate, cited by the Ministry for Children and Families, Government of British Columbia, 2008). It includes getting to know the communities one works with, its people and its resources to identify strategies for service delivery and to establish partnership and collaboration (Ministry for Children and Families, Government of British Columbia, 2008).

REFLECTING DIVERSITY

This refers to the process of identifying or recognizing diversity of clients (culture, gender, sexual orientation, age, race, socio-economic situation, social location, etc.). This may include understanding the historical, social, political, geographical, and other environmental influences that may have shaped attitudes, values, beliefs and practices of individuals and communities we work with. Reflection is demonstrated through organizational statements and policies, practices, staff composition and climate (Ministry for Children and Families, Government of British Columbia, 2008). An example would be a mission statement that articulates principles and rationale for utilizing a cultural competence approach to care.

VALUING CULTURAL DIFFERENCES

This refers to the process that supports and incorporates culture into the delivery of service to clients who are diverse in race, ethnicity, language, beliefs, gender, sexual orientation, age, socioeconomic, immigration status, and so forth. It includes being knowledgeable about cultural differences and their impact on behaviours and attitudes and responding to them in a sensitive, understanding, respectful, and non-judgmental manner (Ministry for Children and Families, Government of British Columbia, 2008). This requires flexibility in adapting to changes in the cultural context and environment and reflexivity by dominant cultures. Members belonging to dominant cultures may not view themselves as having a specific culture due to an ethnocentric viewpoint and position of power that may have inadvertently been developed which may make them view culture as “others” (Haarman, 2004).

EQUITY & ACCESS

This describes approaches aimed at achieving equal access. The following present potential areas to address when looking at equity within organizations and the system:

Employment Equity

The primary focus of employment equity is the prevention, identification and removal of discriminatory barriers in an organization's recruitment, hiring, training, retention, career-pathing, promotion and income policies and practices (Ministry for Children and Families, Government of British Columbia, 2008).

Service Equity

This refers to the ability of an individual, organization or system to provide accessible and culturally and linguistically appropriate and relevant resources and services to groups that have been historically excluded from receiving equitable service. To do so, procedures to ensure elimination of barriers to service and consumer and community participation in the planning, delivery and evaluation of services and programs should be considered (Ministry for Children and Families, Government of British Columbia, 2008).

Funding Equity

This refers to a system of distribution within organizations and whole systems where funding is allocated equitably across various groups as required. An equitable distribution of funding would ensure that all populations within a society receive adequate attention and care to services and activities. This would diminish or cancel the effects of systemic biases that favour the accessibility to services and activities of dominant populations.

Socioeconomic Equity

This refers to the ability of social structures to provide a system where individuals have access to meaningful and sustainable socioeconomic opportunities to live independently. Without access to stable financial means, individuals and families living with mental illness and/or addiction may find it difficult to access resources and experience ongoing financial worries.

VII.CONCEPTUAL FRAMEWORK

DEFINITIONS OF CULTURE

As noted in the previous sections, Guarnaccia and Rodriguez (1996) note that there has been inadequate attention devoted to conceptualizing culture within the development of culturally competent mental health services, both in practice and literature. Arthur et al. (2007) agree that a definition of culture is an important first step in planning culturally competent mental health services. Without an examination of what 'culture' entails, it would be difficult to ascertain areas to address in the provision of culturally competent care.

Most of the definitions of culture that have emerged from literature stress the transmission of traditions, ways of living, coping behaviours, values, ideologies, worldviews, norms and beliefs from one generation to the next (Guarnaccia et al., 1996; Miranda et al., 2003; Thompson, 2005). Reinforcing this, Lopez et al. (1989) defined culture as the values, beliefs and practices often shared by groups identified by variables such as ethnicity, gender and sexual orientation. Later, Lopez et al. (2002) claimed that a “limitation of the values, beliefs, and practices definition of culture is that it depicts culture as static or fixed... Attempts to freeze culture into a set of generalized value orientations or behaviours will continually misrepresent what culture is. Culture is a dynamic and creative process, some aspects of which are shared by large groups or individuals resulting from particular life circumstances and histories” (p.63).

The idea of an evolving culture is echoed by others including Fuller (2002) who notes that with globalization, there is less likelihood for any particular group to remain completely isolated or for individuals within a group to share the same beliefs and attitudes. Fuller (2002) also notes that rather than being static, culture is constantly in flux and influenced by various social and environmental factors. Cultures may change depending on the political climate, restructuring of neighbourhoods, and patterns of migration (Fuller, 2002). Thus, Betancourt (2003) and Green et al. (2002) conclude that the importance of individual preferences and the individual socioeconomic factors must be taken into account when looking at what is involved in the concept of culture.

The connection between larger social factors impacting the behaviours and thoughts of individuals is reinforced by Zine’s (2005) definition of culture: “ever changing ideas, customs, art, produced by a particular society that influences people’s behaviour. Culture is something that is learned, not biological. Culture is understood to mean a broad set of ideas related to specific systems of meaning that are learned and shared by members of a group. Culture organizes people’s behaviour and thoughts in the context of their societies, history and environment and shapes their identities, attitudes, beliefs and practices.”

DEFINITIONS OF CULTURAL COMPETENCE

To date, there is no single definition of cultural competence that has been universally accepted. However, many of the definitions share common elements. Below are some of the more influential definitions that have helped to shape the field of cultural competence research and practice. Organizations may wish to adapt these definitions in whole or in part in accordance to their unique organizational culture. It is important to note, however, that definitions apply broadly to the service, organizational, and system (health care) levels. It is our position that all three levels must be addressed simultaneously since the exclusion of one may hinder the working towards cultural competence of the others.

Cross et al., 1989

The most commonly cited definition of cultural competence comes from Cross et al (1989) whose pivotal work and definition helped to establish a solid foundation for the field. According to Cross et al. (1989):

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

For Cross et al. (1989), the word culture implies the integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. The word competence implies having the capacity to function effectively.

National Center for Cultural Competence, 1998, modified from Cross et al.

Using Cross et al.'s 1989 definition of cultural competence, the National Center for Cultural Competence (1998) set parameters for organizations that wish to practice cultural competence. They state that cultural competence requires that organizations:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally;
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of communities they serve; and,
- Incorporate the above in all aspects of policy-making, administration, practice and service delivery, systematically involve consumers, families and communities.

Thus, cultural competence was noted to be a developmental process that evolves over an extended period. As well, cultural competence was viewed as a continuum where individuals and organizations are at various levels of awareness, knowledge and skills along the continuum.

Office of Minority Health, National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), 2001

The U.S. Department of Health and Human Services' Office of Minority Health, aimed to set national standards for culturally and linguistically appropriate services in health care, known as CLAS Standards, in 2001. According to this Office, cultural competence is defined as:

Having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviours and needs presented by consumers and their communities.

Substance Abuse and Mental Health Services Administration, Center for Mental Services, 2001

More specific to the mental health and addictions field, the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration defines cultural competence as:

Attaining the knowledge, skills, and attitudes to enable administrators and

practitioners within system of care to provide effective care for diverse populations, i.e., to work within the person's values and reality conditions. Recovery and rehabilitation are more likely to occur where managed care systems, services, and providers have and utilize knowledge and skills that are culturally competent and compatible with the backgrounds of consumers from the four underserved/underrepresented racialized groups, their families, and communities. Cultural competence acknowledges and incorporates variance in normative acceptable behaviors, beliefs and values in determining an individual's mental wellness/illness, and incorporating those variables into assessment and treatment.

Betancourt et al., 2002

A more recent definition of cultural competence in health care comes from Betancourt et al. (2002) who state that it involves “the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs.”

Jasmine Zine, 2005

A more broad definition of cultural competence incorporating elements of power dynamics between cultures comes from Zine (2005):

Cultural competence refers to the level of knowledge-based skills required to provide meaningful, supportive and respectful service delivery to clients from various marginalized groups in society (e.g. based on: gender, race, ethnicity, age, abilities, socio-economic status, language, religion, sexual orientation, immigrant status, religion, language ability, mental health status). This involves a recognition of and commitment to addressing the complex relations of power based on varying forms of social and racial location and privilege (including those structuring the relationship between service providers and clients from marginalized groups within organizational settings) and how this positioning provides or denies people material advantages in society. Within this framework, the notion of “culture” is defined broadly (as above) and is not seen as static or homogeneous, but recognized as being a complex, changing and diverse form of social organization and reference. Responding to and affirming cultural diversity as a valued component of human social and psychological organization is critical to service delivery in a plural society. Building an inclusive methodology for service delivery involves adopting the principles of anti-oppression and basing professional practice upon critical reflection, accountability, power-sharing, collaboration with marginalized groups, and valuing, legitimating and integrating the knowledge and experience of diverse cultural groups within the services and interventions provided. In a broader sense, cultural competence should act as a means to provide the critical knowledge and skills to transform institutional/ organizational systems and cultures based on principles of social justice and equity.

OTHER IMPORTANT CONCEPTS

In order to begin addressing cultural competence, we believe the following concepts are also foundational to the overall framework of cultural competence and must, therefore, be taken into account.

RECOVERY

Recovery has become an important theme on the mental health and addictions agenda. It is also an important concept when working towards cultural competency. While there is no set definition of recovery, there are certain commonalities found throughout. The concept of recovery is fundamental for both consumers and family members; it is a meaningful approach that facilitates improvement in the quality of life for consumers and family members. The following are some of the concepts thought to be critical to the concept of recovery among individuals living with a mental illness (the use of this concept in literature is usually in relation to mental illness versus addiction):

Identity

In light of lived experiences with a mental illness and stigma, individuals living with a mental illness need to reconstruct their perception of self and/or community as part of the recovery process (David et al., 2002). Psychologically, these individuals may have to learn to accept, understand and manage their illness while simultaneously integrating the illness into the concept of self and/or community (May, 2001b; Campbell, 2001). Whitehall (2003) adds that recovery would include the acquisition of a positive attitude and a reinvention of self and their role(s) in relation to community. In essence, recovery would facilitate individuals to reclaim a fulfilling, meaningful and satisfying life that may or may not include symptoms, and to learn to live alongside the psychosis (Roberts et al., 2004).

Inclusion

There is a lot of evidence to indicate that being included as a valuable and contributing member of society with an opportunity to work leads to greater outcomes for recovery, self-esteem, and quality of life (Hope, 2004; Marwaha et al., 2004; Fisher, 2005a). When individuals living with a mental illness are able to access services and activities in the mainstream society they are able to move away from being labeled (Samuel et al., 2005). Took (2002) adds that recovery from social expectations can be more of a challenge than recovery from the psychosis itself. Thus, part of the recovery process would include recovery from stigma, labeling, social exclusion, guilt and shame.

Hope

Hope is noted to be the central ingredient of the recovery process that should be at the heart of all discourse on recovery (Bracken et al., 2004). The ability to believe in one's own recovery is highlighted as being instrumental to the actual recovery (Ahern et al., 2001). Thus, hope is generally thought by many to be a precursor to a fulfilling life for those living with a mental health issue (Sayce, 2000; Wimberley et al., 2003; Kelly et al., 2005). Sometimes, however, clinical descriptions of mental illnesses include condemning language (Bracken et al., 2004). Caregivers should be on guard, therefore, as to the need for critical reflection on the use of negative language within the circle of care and its subsequent consequences.

SOCIAL DETERMINANTS OF HEALTH

Where health was once discussed merely in terms of the provision and funding of medical care, there is now growing understanding about the impact of the various elements of the social environment, called social determinants, on the health of populations. Although individual genetic susceptibilities to ill health are noted to be important, the common causes of the ill health of populations are environmental (WHO, 2003). Examples of such social determinants that can impact the health of individuals and populations include, but are not exclusive to:

- Social support
- Employment or job security
- Social inclusion
- Adequate working conditions
- Adequate transportation
- Access to services and activities
- Equitable policies
- Access to nutritious food or food security
- Safe neighbourhoods
- Access to education and early childhood care
- Exposure to discrimination, racism
- Gender identity and sexual orientation
- Religion/spirituality
- Language, culture
- Class or socioeconomic status
- Physical and mental ability
- Country or nation of origin
- Immigration/refugee status
- Etc. (all WHO, 2003; Communications and Community Relations, 2005)

Ideally, in a fair and equitable society, all individuals would enjoy equal access to basic social determinants and live free of harmful discriminatory and/or prejudicial practices. This is unfortunately not the case. As was evident in the introduction, there still exist numerous inequities, especially among marginalized populations. As such, working towards cultural competent care requires a commitment towards social justice and access for all.

ANTI-OPPRESSION

Building cultural competence into the health practices and care of individuals requires an understanding of the role power and privilege play out in group dynamics and in interactions with others. This is a critical step in determining how various segments of the mental health and addiction

system may be engaged in discriminatory and stereotyping practices that reinforce or even exacerbate discrimination and inequity. Although such dynamics may be unintentional, nonetheless, discriminatory and exclusionary practices marginalize specific populations increasing their vulnerability to poverty and ill health. Some examples of the impact that power and privilege play in group relationships and day-to-day interactions with consumers and/or family members include an inhibition to accessing necessary treatment and services, the ability to make formal complaints about the services received, reluctance to participate in group sessions, and so forth.

At the individual level, taking a major step towards cultural competence is only possible when one becomes cognizant of how oppression may occur on the basis of, but not limited to:

- Race, language, ethnicity, age, sex, ability, sexual or gender identity, sexual orientation, family status, income, immigrant or refugee status, place of birth, generational status, political affiliation, religious affiliation, etc.

At the organization and system levels, policies with a commitment to freedom from oppression in relation to the above are recommended. It is good to keep in mind, however, that policies remain mere policies until implemented or put into practice.

CHOICES, VALUES, CULTURAL BELIEFS AND PRACTICES

Cultural competency requires acknowledgement and understanding that each person and/or community holds values, cultural beliefs and practices that may be similar to or different from theirs. These underlying values, cultural beliefs and practices affect the types of treatment options an individual or community may seek or wish to receive. While a western medical model of treatment is most predominant in most areas of Ontario as it is considered a standard treatment path, the availability of non-medical services that are culturally specific should be considered and offered as a feasible treatment option for consumers and/or family members. It is important to keep in mind that many formal and informal practices, strategies, and knowledge outside a western perspective have been the main means of healing and building of healthy communities for many individuals and communities, despite experiences of trauma, marginalization, stigma, and so forth. In considering alternative and/or traditional practices of healing, an organization would be taking into account an individual's underlying values, cultural beliefs and practices and offering more acceptable treatment choices for a diverse population with diverse needs. Organizations would also be acknowledging that there is much learning and insight to be gained from the collective resilience, knowledge and practices of diverse communities.

In terms of mental health assessment and treatment, Dana (1993) therefore asserts that cultural sensitivity is a precursor to cultural competence: "To honor the world views of other cultures, practitioners should appreciate the influence of their own culture on their thinking and behavior" (Dana, 1993, p. 220). Dana (1993) asserts that this allows service providers to recognize culturally prescribed communication styles, etiquette, problem-solving approaches, and conceptions of health and illness that have developed from unique cultural histories.

VIII.RECOMMENDATIONS: BUILDING CULTURAL COMPETENCE INTO THE MENTAL HEALTH AND ADDICTION SYSTEM IN ONTARIO

The following are compilations of recommendations for service providers, organizations and the mental health and addictions care system. They are suggestions only and are offered as broad guidelines, which will hopefully serve as points for further discussion and dialogue. Appropriate solutions would depend on the specific circumstances of a health care organization, group of providers or system. This list is by no means exhaustive:

DIRECT SERVICE PROVISION LEVEL RECOMMENDATIONS

- Engage in critical self-reflection that involves identifying the assumptions governing one's own actions, locating and identifying the cultural and historical origins of the assumptions, questioning the meaning of the assumptions, and developing alternative ways of acting (Cranton, 1996) <http://www.inspireliving.com/business/reflection.htm> (Accessed November 20, 2008)
- Direct care and service delivery in a manner cognizant of cultural practices (Fisher et al., 2007)
- Have all publications and client information translated for the client groups served (Reynolds, 2004)
- Review all forms and procedures (such as intake, case management, complaint process, provision of resources, etc.) to see if they act to prohibit or exclude certain populations
- Use client navigators and lay educators to encourage regular screening and to dispel misconceptions about the illness (Fisher et al., 2007)
- Incorporate cultural specific messages to emphasize a positive self-image among clients undergoing treatment for substance abuse or prevention programs as this may boost the sense of self-efficacy (Fisher et al., 2007)
- Involve multidisciplinary interventions with a multidisciplinary team of providers; focusing only on education for physicians around disparities often emphasizes only cultural competence training which has been shown to make modest improvements in knowledge and attitudes (Beach et al., 2005)
- Continue to actively engage communities to develop solutions to the problem of health disparities such as removing language barriers because early community involvement ensures more than superficial support from the community (Fisher et al., 2007)
- Collaborate with consumers and/or family members at all levels of decision making around mental health and addictions care so the most appropriate and needed services can be designed and implemented

ORGANIZATION AND GOVERNANCE LEVEL RECOMMENDATIONS

- Acknowledge the need for organizational cultural competence and incorporate steps to move towards it into the organization's strategic plan, vision and mission statement (Reynolds, 2004)
- Engage in critical reflection that involves communities of practices coming together to reflect on their assumptions and current practices and to determine ways to embrace and apply multiple and/or alternative knowledge and practices (Cranton, 1996)

- Develop a policy that goes beyond prohibiting discrimination and encourages respect for differences (Reynolds, 2004)
- Develop a long-term management plan for health and health disparities which is contingent on a relationship that enables mutual exchange of information and development of treatment plans between the organization and their clients and/or the communities they serve (Fisher et al., 2007)
- Investigate and implement various cultural competency and/or diversity tools which can be adapted for use with various marginalized communities (Fisher et al., 2007)
- Develop a Diversity Task Force that could become a standing committee within the organization. The task force could make available ongoing education to all members around issues related to culture, inclusion and diversity (e.g., conferences, online continuing education, etc.). In addition, the task group could engage members in exercises to reflect on the “why’s” or benefits of learning how to work with diverse populations and initiate recruitment efforts with a goal of attracting and supporting culturally diverse students and people of various backgrounds to work throughout all levels of the organization. Timely and comprehensive feedback from members could be elicited by the group to challenge members in their thinking and assumptions about diversity issues (Yearwood et al., 2006)
- Support best practice of cultural competence and diversity throughout organization and among its membership (Yearwood et al., 2006)
- Incorporate into job descriptions and job performance measures skills sets related to cultural competency (Goode et al., 2000)
- Develop a conceptual framework of cultural competence (e.g., see Campinha-Bacote, 2002, who defined cultural competence as an ongoing process whereby health service providers continue to strive to develop competency to effectively work within the cultural context of the client) (Taylor, 2005)

SYSTEM LEVEL RECOMMENDATIONS

- Incorporate a commitment to issues of health disparities and appropriate care for diverse populations into the mission statement of the board by articulating the underlying principles, rationale and values for cultural competence in the delivery of services (Goode et al., 2000)
- Engage in critical reflection that involves ongoing critical examination of the existing systemic behaviours and thoughts sustaining current disparities and inequitable practices in the mental health and addictions system (Cranton, 1996); this may involve challenging the prevailing social, cultural, political or professional ways of acting (Brookfield, 2005)
- Establish leadership in the health care sector by officially committing to reduce health disparities within the health care system by developing/revising policies and procedures to better reflect this commitment (Goode et al., 2000)
- Make cultural competence and diversity a priority by ensuring that all member organizations incorporate ways they will work with diverse communities into their service delivery plans
- Develop benchmarks for organizations to hold them accountable to a commitment on improved services for the diverse populations they service
- Develop procedures for announcement of funding resources, request for proposals and contracting that use culturally appropriate practices and are inclusive to all potentially eligible organizations (Goode et al., 2000)

- Develop a framework for understanding the role of racism and discrimination in health and the health care system such as institutional racism, individually mediated racism and internalized racism (Jones, 2000)
- Strengthen linkages between the health care delivery system and populations it aims to serve and to have consumers and communities involved in the planning, implementation and evaluation of services and programs (Fisher et al., 2007)
- Support best practice of cultural competence and diversity throughout organization and among its membership (Yearwood et al., 2006)
- Allocate resources for cultural competence and diversity initiatives and professional development (Goode et al., 2000)
- Allocate resources to the creation of services or programs better suited to the diverse needs of the various populations (e.g., family support groups which the current individually focused treatment system does not allow much room for)
- Engage in cross-sectoral collaborations (e.g., Immigration and Health sectors) to best serve the needs of the various communities (Betancourt et al., 2003)
- Develop processes to systematically review and evaluate policies and procedures to assess relevance to the delivery of culturally appropriate services (Goode et al., 2000)

IX.MOVING FORWARD

It is clear that a lot more work needs to be done to improve services at the ground level and to remove barriers within health care organizations and systems. There is no doubt that moving towards cultural competence is an ongoing process. It is encouraging, however, that there is renewed interest in cultural competence by mental health and addiction organizations and the LHINs with the aim of reducing health disparities for marginalized populations. The Ontario Federation fully supports this direction by the sector and is committed to taking a leadership role in realizing steps towards cultural competence. Given the multiple detrimental effects on the health of diverse populations, neglecting or ignoring differences among service users is no longer a viable option.

As next steps, the Federation proposes the following:

- Collaborating with all stakeholders wishing to develop their cultural competency, assessing areas in need of support and working with them in the organizational change process;
- Applying for funding to collaboratively come up with recommendations for training around cultural competence and diversity and to implement training for all member organizations;
- Reviewing existing literature and resources to see what has been and is currently being done around cultural competence mental health and addictions care and developing a framework and check list of what cultural competence must incorporate with the aim of eventually hiring a consultant to develop a comprehensive cultural competency toolkit for use by all members; and,
- Encouraging organizations to participate in existing LHIN initiatives around cultural competence and diversity and/or aligning processes and supporting efforts for similar initiatives to be implemented across all LHINs OR encouraging organizations to initiate their own developments around cultural competence and diversity.

The Federation is committed to continue working towards and advocating for resources and improved care for all populations regardless of their race, ethnicity, sex, education, age, gender, and so forth. While next steps for both organizations and the health care system have been suggested, the Federation calls upon the sector for further collaborative dialogue about concrete action steps to move everyone forward toward improved access to mental health and addictions care and improved health outcomes for all.

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